

**THE DELIVERY OF COMPREHENSIVE HEALTHCARE SERVICE BY PRIVATE
HEALTH SECTOR IN AMHARA REGION, ETHIOPIA**

by

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DECLARATION

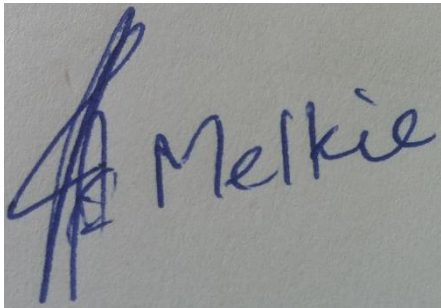
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I declare that the above thesis is my own work and all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the thesis to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

A photograph of a handwritten signature in blue ink on a light-colored surface. The signature is stylized and appears to read 'Melkie'.

30 November 2019

SIGNATURE

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THE DELIVERY OF COMPREHENSIVE HEALTHCARE SERVICE BY PRIVATE HEALTH SECTOR IN AMHARA REGION, ETHIOPIA

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ABSTRACT

The purpose of this study was to investigate the health service delivery by private health sector and develop guidelines to enhance provision of health service so as to increase their contribution in the country's health system. Interviews with 1112 participants were conducted in phase I. Descriptive statistics, chi square tests and logistic regression analysis were used for analysis.

Private health facilities (30.5%) were providing healthcare services in their own buildings that were constructed for that purpose while others work in a rented houses built for residence or others. Some facilities (11.7%) received loan services from financial institutions in the region. A significant association was found between obtaining loan and owning building for healthcare services delivery ($\chi^2=13.99$, $p<0.001$).

Private health facilities were mainly engaged in profit driven and curative services while their participation in the promotive and preventive services like FP, ANC HIV test, TB and malaria prevention and control was not minimal. Majority, 247 (96.5%) provide services for extended hours out of normal working time such as evening, weekends and holidays. Physicians, more than other professionals were found practicing part time work (dual practice).

Service consumers of the private health sector were urban dwellers 417 (71.6%) and 165 (28.4%) rural residents. Nearly three-fourth (73.0%) of study participants had a history of multiple visits to both public and private health facilities for current medical condition. Median payment of patients in a single visit including diagnosis and medicine was 860 birr (\$30.85) (IQR = 993 (\$35.62)). Only 2.1% have paid through insurance services while others through out of pocket payments. Price of services delivered in private health facilities were set mainly by owners' will (91.4%) while others with established team. Satisfaction on the fairness of prices to services obtained from each facility were reported by 63.1% service consumers. Those patients without any companion (AOR=1.83, 95% CI=1.16-2.91) and no history of visit to other facilities (AOR=1.97, 95% CI=1.24-3.12) were more likely to be satisfied than those coming with companions and those with history of visit. In addition, as age of consumers increase, satisfaction to services prices tend to decline (AOR=0.97, 95% CI=0.96-0.99).

Uncomplimentary regulatory system to private health facilities, lack of training and continuing education for health professionals, unavailability of enough health workforce in the market and shortage of supplies to private facilities were among main gaps disclosed. Based on findings, five guidelines were developed to enhance health services delivery in the private health sector, namely, increase facilitation for financial access to actors in the sector, increase facilitation to access regular updating trainings and continuing education for healthcare workers, enhance and scale up the capability of existing association in the private health sector, strengthen and support working for extended hours to promote user friendly services and accessibility of healthcare services for the poor through community based health insurance and exemption. Therefore, these recommendations to help enhance the private health sector for better performance and contribution.

Key words: private health facilities, health services, Amhara, Ethiopia, private health sector, health service delivery

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DEDICATION

This study is dedicated for all private healthcare providers working to serve their people with their utmost commitment to professional ethics.

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ABBREVIATIONS AND ACRONYMS

ANC	Ante Natal Care
AOR	Adjusted Odds Ratio
APHFPA	Amhara Private Health Facilities and Professionals Association
APHI	Amhara Public Health Institute
ART	Antiretroviral therapy
CBE	Commercial Bank of Ethiopia
CEO	Chief Executive Officer
COR	Crude Odds Ratio
DOTS	Directly Observed Therapy Short Course
EDHS	Ethiopian Demographic and Health Survey
EPHI	Ethiopian Public Health Institute
EQA	External Quality Assurance
ESA	Ethiopian Standards Agency
ESPA	Ethiopian Service Provision Assessment
ETB	Ethiopian Birr
FMHACA	Food, Medicine and Health Administration and Control Authority
FMoH	Federal Ministry of Health, Ethiopia
GP	General Practitioners
HIV	Human Immuno-deficiency Virus
HSTP	Health Sector Transformation Plan
IDBC	Intervention Development Behaviour Change
IFC	International Finance corporation
IRB	Institutional Research Board
NGO	Non-Governmental Organisations

NHA	National Health Account
OBS & Gyn	Obstetrician and Gynecologist
OECD	Organisation for Economic Co-operation and Development
OPD	Outpatient Department
OR	Odds Ratio
PFSA	Pharmaceutical Fund Supply Agency
PPPH	Public Private Partnership for Health
SOP	Standard Operations Procedure
STI	Sexually Transmitted Infections
TB	Tuberculosis
UHC	Universal Health Coverage
UNISA	University of South Africa
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1. INTRODUCTION

There is a change in the disease landscape towards an increase in the prevalence of non-communicable diseases primarily in urban settings in Ethiopia where majority of the private health facilities resides. The government of Ethiopia together with the private health sector intends to improve delivery of comprehensive and higher quality healthcare services to address the above mentioned reality. This approach will enhance performance in health service coverage, by expanding access and improving the quality of healthcare services.

Basu, Andrews, Kishore, Panjabir and Struckler (2012:1) in their systematic review do not support the claim that private sector is usually more efficient, accountable or medically effective than the public sector. However, the public sector appears frequently to lack timeliness and hospitality towards patients. It is common sense that governments have a responsibility to ensure the equitable provision of healthcare. Yet in most countries in sub-Saharan Africa, those on higher incomes are more likely to have access to private sector health services than the poorest people and only 25% of the region population has access to any kind of quality healthcare (Guy, Kwasi, Kelechi, Allan & Jeffrey 2014:5). Government and non-governmental organizations (NGOs) such as mission/faith-based non-profit facilities are most likely to offer the basic services.

There is considerable variation in service provision among private for profit and other government facilities. For example, although nine of every ten private for profit facilities offer child curative care and sexually transmitted infection (STI) services (Ethiopian Public Health Institute 2014:15), only 2% offer child vaccination services (Ministry of Health 2016, Ethiopian public Health Institute 2016 & WHO 2016:54). The types of products and services provided, the target population for them, and their service quality is strongly

affected by the health providers' motivation for profit making or perceives health as to the public good. A cultural shift is required on the 'acceptable' role of the private sector in health markets beyond trade or donations (Guy et al 2014:3). Quality is something that all healthcare providers favour, but it is not, as many would like to believe, something that happens without planning and meticulous effort. The outside world is demanding that healthcare organisations provide care of the highest quality at a reasonable price (Susan & Harnais 2011:178).

Health provider, service purchaser and health regulator are the three pillars on which the health sector is organized to ensure check and balance. Currently, the government of Ethiopia has dual roles as health provider and regulator (Ministry of Health, Ethiopia 2015:71); and an impact imposed on creating competitiveness in provision of services as well as maintaining quality in the private and public health services. However, the public private partnership for health document of the country anticipates that the public sector will shift its role towards policy making and regulations; and the role of the private health sector service delivery and healthcare financing will grow.

The International Finance Corporation (IFC) and World Bank Group (2008:n.d.) state that lack of regulatory and accreditation frameworks combined with a largely uninformed patient population can sometimes allow on unscrupulous minority to prevail over responsible providers to the detriment of the reputation of all. Private sector is very competitive, so success in meeting users' perceived needs and retaining clientele is vital to economic survival of providers. At times, especially in most of the low-income countries in Sub-Saharan Africa, the private sector operates in an environment of poor government effectiveness and low regulatory quality (Viroj, Supon, Walaiporn, Chitpranee, Phusit & Suladda 2008:36). Private providers may use treatments they know to be ineffective because of actual or perceived users demand. They may engage in what they know to be unethical practices in order to maximize income. Many private providers in the region may lack access to essential diagnostic and treatment facilities.

1.2. BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

In Ethiopia, national documents promote the participation of private health sector. However, the type of services provided at the ground level, magnitude and level of support needed and actually provided is not properly documented and in order to show their contribution, they less likely report to the government system than public facilities (Ministry of Health 2016, Ethiopian public Health Institute 2016 & WHO 2016:66). In other words, the role and contribution of private health sector in the country, as well in the region is not clearly demonstrated. Private health providers are always blamed for not following the recently recommended guidelines of the country and had poorer outcomes (UNDP 2015:10; Basu et al 2012:14) seemingly because they are not regularly updated.

Private health facilities were not allowed to provide some selected services like vaccination due to various reasons like lack of standard necessary equipment for cold chain, lack of human resources and not clearly understand the capacity potential in the sector. Only 2% of private health facilities in Ethiopia offered child immunisation services compared to 94% of the public health facilities (Ministry of Health 2016, Ethiopian public Health Institute 2016 & WHO 2016). The private health facilities in Amhara region are not involved in the provision of immunisation programs and insurance services. In addition to that there is an exempted services to the public like free delivery service at the public health facilities (USAID Health systems 2020 2012:9) and as it clearly creates non-competitive environment, it will endanger their profit making and create fear for sustainability and continuous development. There is no compensation mechanism for private health institutions as they are licensed working to make profit.

Private sector can play greater part of meeting the need for more and higher quality healthcare in Sub Saharan Africa. They have meaningful and growing role in closing Africa's healthcare gap and account for as much as 50% of healthcare provision (IFC, World Bank Group (2008:n.d.): VII). The way for the development of private sector in Ethiopia was paved by the public health sector by sensitizing the population to the need for sophisticated care and created more demand for healthcare (Vilasini, Sudhakar, Challi

& Kora 2010:64). Even though public healthcare facilities expanding and health service utilization increased, the growing demand of healthcare will not be fulfilled by public sector alone (Vilasini et al 2010:61). In Ethiopia, Kenya, Nigeria and Uganda, more than 40% of people in the lowest economic quintile receive healthcare from private, for-profit providers (IFC, World Bank Group (2008:n.d.): 8). Surprisingly, in many Sub-Saharan African countries such as Mauritania, Ghana and Tanzania, it is the wealthy, not the poor who disproportionately benefit from public health spending (IFC, World Bank Group (2008:n.d.): 8). Moreover, the distribution of the health workforce is skewed towards public sector employment and this is largely a result of a strong government public sector emphasis in Ethiopia (Feyisa, Herbst, Lemma, & Soucat 2012:19).

Building on the lessons learned in implementing the earlier plans of the country and to be highly responsive to the current socioeconomic scenery, the government of Ethiopia has developed Health Sector Transformation Plan (HSTP). HSTP is the first phase of the 20-year health sector strategy (Ministry of Health, Ethiopia 2015:12-13) a sector-wide approach with national health targets and vast resource requirements. It is on implementation by the public sector together with development partners, the private sector, non-governmental organizations and the community at large. The roles and responsibilities of all actors are indicated giving due emphasis for the involvement of all relevant stakeholders, including the private sector having a shared vision (Ministry of Health, 2015:146).

Ethiopia follows the three tier health service delivery system as primary, secondary and tertiary levels with defined catchment populations. The rural part of the country is being served by the primary health center with five satellite healthcare posts in order to provide services to a population of 25,000 (Ministry of Health, Ethiopia:2015:142). A health center is staffed with an average of 20 workers while only two health extension workers assigned for the health post. In urban settings health centers are expected to serve 40,000 people. A primary hospital is organized to serve a population of 60,000 to 100,000. The next level is a general hospital and expected to provide services to 1-1.5 million beneficiaries. At

the apex of the structure is a specialized hospital which serves 3.5 to 5 million people. (Ministry of Health 2014:4)

Private health facilities (private hospitals, centers and clinics) were not indicated in the three tier health system as they do not have defined catchment population. Additionally, they were not displayed in the illustration to indicate formal flow of information and pharmaceuticals in the standard operating procedure (SOP) integrated pharmaceutical logistic system (IPLS) (Pharmaceuticals Fund and Supply Agency (PFSA) 2015: IV). As a result, it is difficult to make smooth participation and deliver their contribution to health service coverage in the region and country as a whole.

Majority of health facilities (85%) are health posts (69%) and health centers (16%) owned by the government whereas the rest are private clinics and hospitals account 14% and 1% respectively (Ethiopian Public Health Institute 2014:3). The private health sector in Ethiopia can be divided up mainly into private for profit and private for not profit. The private for profit can further be subdivided into formal and informal health services and products provider. Ministry of health listed private for profit health service provider facilities in Amhara region as 10 hospitals, 188 medium, 746 primary and 48 specialty clinics in 2014 (Ministry of Health Ethiopia 2017:49).

Even though the private health sector has an advantage of passing immediate decision on its resources, lack of health resources is one of the key challenges in Ethiopia that hampers healthcare access and quality. Consolidating effective partnership with different stakeholders will also help to mobilize adequate health resources for the sector. Different activities were carried out in 2014/15, including developing and implementing public-private partnership for health (PPPH) along with others like donor funding (Federal Ministry of Health 2015:74). Since the primary goal of donor funding in health is to ensure health services for the poor and most donors felt that money should only be given to the public sector as commonly perceived the gov't served the poor who were unable to pay for services while, private sector to provide services mostly for the wealthy in any country. However, it does not accurately represent reality, and that the private sector often is the

primary source of treatment for the poor while the government system often provides far more services to the rich than the poor (Mitchell [S.a]:4) Similarly, 44% of the lowest quintile and 48% of the highest quintile population in Ethiopia received care from for-profit providers of modern medicine (IFC. World Bank Group 2008:9).

Before the release of public private partnership in health strategic framework for Ethiopia in 2013, the private health sector and government were not clear on how to establish, implement, mainstream, coordinate, monitor and evaluate partnership (Ministry of Health, Ethiopia 2013:2). Even though implementation of public private partnership for health the country and partners' involvement in carrying out public health programs in the private health sector is being undertaken, there are still lot of issues of the private health sector remained unaddressed. Their contribution and involvement in the national health planning and public health matters is not clearly validated.

1.3. RESEARCH PROBLEM

Statement of the problem is a clear statement of the specific problem to be investigated. In this study, the statement of the research problem indicates why the particular problem is of importance. It outlines the basic rationale on which the study derives and is specific and backed by evidence. The statement of the problem is the focal point of this research.

The HSTP aims to obtain high level of success by enhancing partnership between the public and private as one of the main strategy (Ministry of Health, Ethiopia 2015:81). As stated earlier, the private health sector is perceived serving the wealthy and the urban but many poor people from the rural area using private sector health services. The researcher has also observed that there is a persistent problem in management of supplies for the public health programs run by the private health facilities. Distribution of supplies were not as per request, at the right time and poor reporting and feedback mechanism. Private facilities (75%) are relatively less likely to report to the government reporting system than facilities managed by government authorities (99%) (Ministry of Health, Ethiopian public Health Institute and WHO: 2016). Private health service provision in the health system of

the country is growing fast (researcher's observation) and it is vital to conduct research to understand and provide valuable recommendations for further improvement.

The national documents promote the participation of private health sector but the type of services provided at the ground level, magnitude and level of support needed and actually provided is not properly documented. In other words, the role and contribution of private health sector in the country, as well in the region is not clearly identified. Private health providers are out of line in case of updating them with recent guidelines in the country. As the subject is very dynamic and becoming highly dependent on ever changing technology, they need to participate in trainings provided by the government and other partners. In many cases, training institutions are owned only by the government and private providers denied access.

In recent years, in parallel to the economic growth and increased population, the public sector unable to fulfill the health needs of people, and the private health sector becomes flourishing and growing in number mainly in urban settings. The economic growth has improved the life expectancy of people and expected more ageing population which is highly consumers of healthcare. There is also high flow of people from rural areas to the towns. Many of the private health facilities especially those with better equipped and run by reputable specialists are located in cities and towns. These facilities are more demanded by the people with chronic health problems and then frequent visits to the well-known health worker probably working in private will be bigger. Due to high demand of healthcare services from both the public and private, they always overloaded with patients. In the meantime the private sector wants to work with minimum possible number of staffs so as to maximize profit.

The World health Organization (2016:38) by the World health statistics document indicate that in some low and middle income countries, where patients have to pay for medicines in the public sector, the prices of some generic medicines in the public sector are on average 2.9 times higher than international reference prices, and 4.6 times in private facilities). There is huge difference in setting prices for services fees among private health

facilities in the country. Widespread rumours in the community says private health facilities imposed exaggerated price for their services. On the contrary, some says it is the wealthy primarily receives services as the poor may not afford. Those who can't able to pay for the service even at the time of emergency or critically ill will not be accepted or helped. In addition, there are lots of myths and misunderstandings related to cost of services, ethics of providers and service quality in the private health sector and it is high time to analyse related drawbacks and produce valuable recommendations to make the sector conducive for all beneficiaries. Shah & Mohanty (2010:79) has described quality of medical care in private sector seems to be poor and at times compromised or unlikely the leading cause of preference.

1.4. AIM OF THE STUDY

The aim of this study was to investigate the health service delivery by private health sector in order to develop guidelines that will be used to enhance health service delivery and to further increase their contribution in the country's health system.

1.4.1. Research objectives

Research objectives refer to what it is that the researcher wishes to attain during the research. Attaining objectives is a fundamental sub-process inherent in the research process (UNISA 2017:66). The objectives of this study were to:

- analyse and describe the profile of consumers and health providers of private healthcare (socio-economic status) in Amara region,
- describe the factors that influence the nature of private healthcare services,
- identify and describe challenges of the healthcare delivery by private healthcare system, and
- develop the guidelines to enhance health service delivery.

1.4.2. Research Hypotheses

A hypothesis is the expression of a tentative solution to a research question, phrased in the form of a conceptual relationship between variables (Bowling 2014:161). Du Plooy-Cilliers, Davis and Bezuidenhout (2014:68) define a hypothesis as a tentative statement about a relationship between variables, or a statement that the researcher aims to accept or reject at the end of the research.

For this study the hypothesis was that, “there is an association between patients’ choice to use private health facilities and the socio demographic variables of patients”. The researcher had an assumption that more wealthy people use health services delivered by the private health facilities, more urban people use health services delivered by the private health sector and patients with chronic health problems are more likely to use private health services delivered by the private health facilities in the region. In addition to all these, self-reported factors associated with service delivery in private health facilities and patients’ choice of was observed.

1.5. SIGNIFICANCE OF THE STUDY

The significance of this study lied in searching enough knowledge about the profiles of consumers and healthcare providers and challenges faced in the service delivery by private health sector to commend guidelines for better service delivery. The private health sector in Ethiopia is growing fast from time to time. Now, the country has started implementing public private partnership for health especially in some selected public health programs like tuberculosis, HIV, family planning and sexually transmitted infections. Private health facilities have been involved in the implementation of these public health programs in collaboration with the government and other partners. Thus, it is high time for the government as well as researchers and other decision makers to make available enough evidence and recommendations especially in health service delivery of the private health sector and their customers.

1.6. DEFINITIONS OF CONCEPTS

A concept is an abstract idea representing the fundamental characteristics of what it represents (<https://en.wikiquote.org/wiki/Concept>). Concepts are mental representations that can be expressed by a single word or a set of ideas described by a few words (Esther [S.a]:1). The focus in this study was on how services are delivered and who were the consumers and challenges encountered in the process in private healthcare provider facilities. Valuable inputs were acquired to develop guidelines, which will be used for further improvement of service delivery in the private settings.

- **Comprehensive Health Services:** Health services that are managed so as to ensure that people receive a continuum of health promotion, disease prevention, diagnosis, treatment and management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course (WHO 2011: 4).
- **Healthcare delivery:** The provision of care, services and supplies related to the health of an individual. Healthcare includes preventive, diagnostic, therapeutic, rehabilitative, maintenance, counseling and palliative care.
- **Private health sector:** Those organizations and individuals working in health outside the direct control of state and government, and not benefiting from direct allocations of government's budget (Ministry of Health 2013:11).

1.7. OPERATIONAL DEFINITIONS

An operational definition is nominal rather than real, but it achieves maximum clarity about what a concept means in the context of a given study (Babbie 2008:140). It is a working definition for the purposes of an inquiry (Babbie 2008:140). In this study the following concepts are operationalised to enable a phenomenon observed and measured.

- **Patients:** Those persons came to the healthcare facility seeking care and treatment for their current illness and who are greater than 18 years old.

- Healthcare providers: professional health workers who provide healthcare in the healthcare institutions.
- Private health facilities: those health facilities outside the direct control of regional state, and not benefiting from direct allocations of government's budget. It includes only for-profit and not-for-profit clinics, specialty centers and hospitals.
- For-profit private health facilities: Those private hospitals, centers and clinics continued on profit making from the services provided for their clients.
- Not-for-profit private health facilities: These hospitals, centers and clinics are not intended for making profit from the service.
- Service consumers: Those people who came to the private health facilities to get healthcare services and pay some amount of money or things.

1.8. THEORETICAL FOUNDATIONS OF THE STUDY

Polit and Beck (2008:13) states that a paradigm is a worldview, a general perspective on the complexities of the real world. A quantitative approach was followed. The quantitative research methodology drew on objectivity, measurability and predictability of health service delivery by private health sector with emphasis on drawing appropriate inferences from the results. The study followed a positivist approach. Positivist approach is a systematic and scientific approach that is rooted in the physical sciences; where a methodology of physical science can be applied to social phenomena. Positivism predominates in science and assumes that science quantitatively measures independent facts about a single apprehensible reality. The researcher adopted this approach as the data required statistical models of analysis.

1.8.1. Conceptual framework

A conceptual framework is an alternative way of depicting a set of related variables and outcomes in the study in an elaborative schematic diagram. It shows the key factors, presumed relationships and possible outcomes of the research problem. The conceptual framework helps to outline the research questions and core variables included in the data

collection instrument. As the study progresses, concepts and their relationships become clearer through interaction with the participants. The researcher used the Intervention Development Behaviour Change (IDBC) model to influence the logic of the study as patient behaviours are central to the success of any treatment programme and consequently to health outcomes. The proposed guidelines were described and presented using Donabedian's quality care standards. This framework includes structure, process and outcome standards, which related to the service delivery of private healthcare. The conceptual framework is discussed in detail in chapter 2 with literature review.

1.9. INTRODUCTION TO RESEARCH DESIGN AND METHODS

A research design is an overall plan for addressing the question and for providing answers to the research questions (Polit & Beck 2012:58). A quantitative approach was followed; which is a formal, objective, systematic study process to describe and test relationships and to examine cause and effect interactions among variables (LoBiondo-Wood & Haber 2010:584; Grove, Burns & Gray 2013:706). This approach helped to generate an account of the reality in private health service delivery. The study was conducted in two phases in which Phase I entailed data collection and analysis as preparation for evidence to develop the guidelines to enhance health service delivery. Phase II entailed the proposed development of guidelines and is the outcome of the research. A detailed description of the phases is discussed in Chapters 3, 4 and 5.

Cross sectional descriptive survey was implemented to examine the profile of patients, health workers and nature of health services in the private health facilities in the Amhara region. The region is one of the nine regions of Federal Democratic Republic of Ethiopia and formally called as Amhara National Regional State. The region contains only ten privately owned hospitals (eight private for-profit and two for-not-profit hospitals) (Ministry of Health Ethiopia 2017:49).

In order to make samples more representative for the region, six administrative zones and three bigger zone status towns were selected. A summary of the research methods is presented in Table 1.1. Detailed sampling techniques, sample size calculation and sampling procedures are discussed in chapter 3. Additionally, data collection and analysis, data quality and ethical considerations are discussed in detailed in chapter 3.

Table 1.1: Summary of study objectives, methods and data analysis

Phase of the study	Objectives	Approach	Sample	Sampling method	Data collection	Data analysis
Phase I	To analyse and describe the profile of consumers and health providers of private healthcare in Amara region	Quantitative	Private health facilities	Purposive	Questionnaire (structured interviews conducted face to face with individual participant)	Descriptive analysis- SPSS version 20 <ul style="list-style-type: none"> • Chi-square tests • Logistic regression • P-value • Independent variables • Odds ratio
	To describe the factors that influence the nature of private healthcare services To identify and describe challenges of the healthcare delivery by private healthcare system	Quantitative	Patients, health providers and owners or managers in private health facilities in the region	Systematic sampling		
Phase II	To develop the guidelines to enhance health service delivery	Quantitative	Experts	Purpose	Evidence from phase I, Literature review	Deductive and inductive reasoning

1.10. STRUCTURE OF THE DISSERTATION

- Chapter 1 - Orientation to the study
- Chapter 2 - Literature Review
- Chapter 3 - Research design and methods
- Chapter 4 - Analysis, Presentation and description of the research findings
- Chapter 5 - Guidelines to enhance health service delivery
- Chapter 6 - Conclusions, recommendations and limitations of the study

1.11. SUMMARY

This chapter presented an orientation to the study, which includes background, research design and methods of the study. The purpose of the study, the research questions and the objectives for the study were also explained. Relevant concepts were defined and the structure of the dissertation was outlined. The next chapter (Chapter 2) will present the literature review relating to the services delivered by private health sector and related to challenges and opportunities in different situations and population.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

Thompson Rivers University writing center define literature review as an objective, critical summary of published research literature relevant to a topic under consideration for research (Thompson Rivers University [S.a] [1]). Similarly, Polit and Beck (2010:558) define literature review as critical summary of research on a topic, often prepared to put a research problem in context or to summarize existing evidence. The literature review delivers readers with a background for understanding current knowledge on a topic and illuminates the significance of the new study. Literature review is often intertwined with the argument for the study that is part of the statement of the problem (Polit & Beck 2010:170).

A literature review is a crucial early task for most researchers in the quantitative method as it can help to shape research questions, contribute about the arguments for the need of the new study, suggest appropriate methods, and to point the conceptual framework. A literature review can also help the researchers to interpret their findings (Polit & Beck 2010:170). Consequently, the review of literatures for this study has identified the current available knowledge and gaps, the extent to which health services in the private health sector is practiced, consumers' service preference in different settings in the context of public and private health sector and different models of public private partnership in health. Ethiopia is among the African countries such as Ghana and Uganda that have public-private partnership policy specific to healthcare delivery among the priority areas of partnership (the king & Jeffers 2013:23).

This literature review helped the researcher to understand about the conceptual framework, using both the Intervention Development Behaviour Change (IDBC) model and Donabedian's model of quality healthcare. The researcher examined literature, which

relate to the practices as well as challenges in the healthcare delivery by the private health sector. Different levels of private health sector engagement and public-private partnership was also noted with their achievements and drawbacks in different settings. The reviews were done from different sources including PUBMED database, UNISA repository, World Health Organization, World bank and other webpages and journals from MEDLINE and Google scholar.

2.1.1. The Intervention Development Behaviour Change (IDBC) Model

The Intervention Development Behaviour Change (IDBC) model was used as the conceptual framework for this study as highlighted in chapter 1. A conceptual framework is an alternative way of depicting a set of related variables and outcomes in the study in an elaborative schematic diagram. It shows the key factors, presumed relationships and possible outcomes of the research problem (Polit et al 2010:74). In addition, Bowling (2014:291) indicated that all research needs to be explicitly set in an appropriate conceptual framework. It helps to outline the research questions and core variables included in the data collection instrument. When quantitative research is performed within the context of a conceptual framework, the findings may have broader significance and utility (Polit et al 2010:74).

Patient behaviours are central to the success of any treatment programme, and consequently to health outcomes, then the researcher used the Intervention Development Behaviour Change (IDBC) model to influence the logic of the study.

2.1.2. Donabedian's quality care model

The proposed guidelines will also be described and presented using Donabedian's quality care dimensions. Quality is complex and multidimensional, and no single basket of indicators is likely to capture all perspectives or cover all dimensions of quality in general practice (The king's fund 2011:42). Donabedian model is based on three related dimensions; structure, process and outcome of healthcare which are connected by

unidirectional arrows in an order. Donabedian points out the need of detailed information about the causal linkages among the structural attributes of the settings in which care occurs, the processes of care, and the outcomes of care (Donabedian 1988:1743). Although literature on the application of Donabedian's framework focus on the provision of quality of care delivery, in this study it was applied on the valuation of comprehensive care delivery system in the private sector.

Structure denotes the attributes of the settings in which care occurs. This includes the elements of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure (such as medical staff organization, methods of peer review, and methods of reimbursement) (Donabedian 1988:1745). The structure of private healthcare facilities and their levels, equipment and supplies to provide care, training status of staffs and skill mix up were measured. In addition, ways of practice by providers and attitudes towards working in the private and their clients, supervision type and its frequency and comforts of facilities were addressed.

The second concept is processes of patient care that denotes what is actually done in giving and receiving care. It includes the patient's activities in seeking care and carrying it out as well as the practitioner's activities in making a diagnosis and recommending or implementing treatment (Donabedian 1988:1745). Process refers to intermediate products of care, such as patterns of diagnostic evaluation, access to care, rate of utilization, and choice of therapies. There is an assumption that better healthcare produces better health outcomes and measurement of process is actually a surrogate to measurement of the real goals of healthcare: improved health status, function and comfort (Berwick & Knapp 1987:49). It relies on the structures to provide resources and mechanisms for participants to carry out patient care activities. In addition, processes are performed in order to improve patient health in terms of promoting recovery, functional restoration, survival and even patient satisfaction. As Donabedian states process measures in general are more timely, sensitive and specific however, outcome measures by their nature are delayed, less sensitive, and less specific (Donabedian 1987:77).

In the process section of this study, services offered by the private health sector, patient access (both physical and financial) to healthcare services were measured. In addition, payments to healthcare services and other related variables to patients of the private health sector were measured.

The third one is outcome of patient care, which is the impact of healthcare on the health status. Outcome indicates the combined effects of structure and process. Donabedian argued that the most important consequences and markers of high-quality care were care outcomes (The king's fund 2011:28). Good quality means providing patients with appropriate services in a technically competent manner, with good communication, shared decision making, and cultural sensitivity. In practical terms, poor quality can mean too much care (e.g., providing unnecessary tests, medications, and procedures, with associated risks and side effects); and too little care (e.g., not providing an indicated diagnostic test or a lifesaving surgical procedure), or the wrong care (e.g., prescribing medicines that should not be given together, using poor surgical technique) (Schuster, McGlynn & Brook 2005:844). Private health providers usually provide too much attention to their consumers.

Outcomes such as completion of treatment and health status, by their nature, are delayed, and if they occur after care is completed, where information about them is not easy to obtain (Donabedian 1988:1746). As a result of this, patient satisfaction to service delivery at the exit was taken to measure outcome. Patients' satisfaction especially to services delivered was collected. Patients were also requested to judge services provided to the cost they incurred.

Outcome of patient care is the end result from the medical care delivered to the patient and patient's underlining characteristics. Donabedian model has been criticised for failing to incorporate antecedent characteristics (e.g. patient characteristics, environmental factors) which are important precursors to evaluating quality of care. In focusing on the linkage between what is under the control of the medical profession and effects patient outcomes, Donabedian's framework purposely does not account for patient, economic or

social factors outside of the care delivery system (McDonald, Sundaram, Bravata, Lewis, Lin, Kraft, McKinnon, Paguntalan & Owens 2007:114). However, characteristics of patients and healthcare workers including the private health facilities' practice of working together were assessed.

2.2. HEALTHCARE SERVICES DELIVERY IN ETHIOPIA

Healthcare service delivery is the primary interface between the health system and population (Marjolaine & Maxwell 2017:5). Service delivery covers both the way in which services are provided and the mix of inputs and processes required to produce outputs and outcomes. Moreover, differences in organization, management and financing of delivering services can lead to large variation in their quality, cost and effectiveness (Marjolaine & Maxwell 2017:5). Provision of healthcare services by the private for profit sector that adhere to the government standards is one of the core ingredients of effective health service delivery system (Buxbaum 2010:1037).

Health systems should ultimately seek to serve people and society. Each health system function contributes to the service provision (World Health Organization 2014:3). Health service delivery as the core function of health systems, concerns the selection of which service to provide, how to organize provision, how to assure the continuous improvement of care process and the managerial oversight throughout. Ensuring the selection of comprehensive range of interventions, delivered in coordination across providers, with continuous monitoring of quality patient care and its equitable, efficient/effective delivery are the purposes of optimizing service delivery functions. Ministry of Health of Ethiopia in its health promotion and communication strategic document stated that despite achievements in the health system, low utilization of health services is observed due to barriers such as cultural and traditional factors compounded with unfriendly atmosphere and poor communication between providers and clients which has negatively affected the adoption of health seeking behaviors and health service uptake (Ministry of Health 2016:1). Delivery of health services should be centered around people and involve putting people first in terms of how services are designed and delivered, and not merely orienting

services on the basis of diseases, or for the convenience of clinicians (Sheikh, Ranson & Gilson 2014:ii3).

Promotion of private health sector and NGO participation are among the essential components of the health policy of Ethiopia (Government of Ethiopia 1993:12). It is estimated that more than 7,000 private health facilities function currently across the nation (Ministry of Health, Ethiopia 2015/16:56). Despite impressive changes in access to health services and improvements in health outcomes, the health sector in Ethiopia still suffers from the existence of inequality, poor quality of health service and a high burden of communicable and non-communicable diseases. Poor governance is one of the underlying causes as expressed by theft of medicines, diversion of patients to private facilities, health workforce absenteeism, corruption, weak regulation and inadequate accountability (Ministry of Health, Ethiopia 2016:2). The skills required to deliver health services efficiently exist in most countries, but often are concentrated in the private health sector and underutilized by governments due to lack of experience and technical knowledge to successfully influence the private providers (The Global Health Group 2009:4). Consequently, successful pro-poor for-profit business models in healthcare are not yet well developed.

There is an increasing trend of community dissatisfaction with the health system (Ministry of Health 2016:2). Complaints by the public have been increasing in type and magnitude and the major reasons are unavailability of service, unaffordable cost, unethical health professionals, frequent service disruption and poor service quality (Tesfaye, Abate, Seid, Lemma, Kemal, Akilie & Tamiru 2016:14). In a study conducted in Addis Ababa, dimensions of quality of care and the cost of services were identified as influencing decisions about whether to seek care in the public or private sector (Shiferaw, Berhane, Gulema, Kendall & Austin 2016:307). In another study conducted in Jordan, there is a significant statistical difference of the impact of health service quality on patient's satisfaction between hospitals of public and private sector. The impact of health service quality on patient's satisfaction in private hospitals is better than that in public hospitals (Zamil, Areiqat & Tailakh 2012:123).

Nearly half of health facilities in Ethiopia are owned and operated by the private for profit health sector (Department for International Development (DFID) 2014:14). Distribution of health facilities and other infrastructures is higher in most populous and urban areas. According to the Ethiopian service provision assessments (Ethiopian Public Health Institute 2014:18) about 88-100% hospitals (both public and private), 84% private higher clinics, and 61% private lower clinics have regular power sources. About three quarter of facilities, (both public and private) have an improved water sources in their facility.

The private sector provides more than 50% of all healthcare in Sub-Saharan Africa (Marek, O'Farrell, Yamamoto & Zable 2005:1; IFC [S.a]:1). Lars Thunell, executive vice president and CEO of IFC mentioned that the private health sector provides half of all health services in the sub-Saharan Africa to the rich and the poor alike (The World Bank & IFC 2011: ix),. In India, 80 % of the first-contact healthcare and nearly 50% of TB care occurs in the private sector (Satyanarayana, Nair, Chadha, Shivashankar, Sharma, Yadav, Mohanty, Kamineni, Wilson, Harries & Dewan 2011:6-7). Due to all these reasons, more effective engagement between the public and private healthcare sectors in terms of better policies, regulations, information sharing and financing mechanisms, including for the poor, would be required to improve the performance of healthcare system (The world Bank & International Finance Corporation 2011:ix). Sub Saharan Africa accounts for 13.6% of the world's population yet bears half the world's people in extreme poverty and 24% of global disease burden but only 3% of health workers commanding less than 1% of world health expenditure (World Health Organization 2006:XIX) with poor health outcomes (International Bank for Reconstruction and Development 2017:2).

The private health sector in low and middle-income countries is highly influenced by, and influences, the public sector (Mackintosh, Channon, Karan, Selvaraj, Zhao & Cavagnero 2016:596). A reasonably competent and highly accessible public sector can generate a complementary, reasonable quality private health sector. It also can reduce both the exclusion and reliance by the poor on low quality private providers and medicine sellers (Mackintosh et al 2016:596).

The private/public health sector behavior is influenced by the structure of healthcare system including availability of public/private healthcare providers, referral system, financing mechanisms for the demand and supply side, the supply and location of health workforce as well as their decision on care provision, health information available to the public and government policies (Pomeroy, Koblinsky & Alva 2014:i40). Patients' choice to use services from private or public healthcare providers are determined by a number of factors such as socio-demographic characteristics, economic, social and physical access based on factors such as household wealth, familial and community mores, and proximity to facilities, and actual/perceived need for healthcare based on risks associated with childbirth, previous experiences on healthcare services (Pomeroy et al 2014:i40). It is usually assumed that the rich use private sector more than the poor (Smith, Brugha & Zwi 2001:10). However, the difference is not great. In a study conducted in nine poorest countries, an average of 47% healthcare visits by the poorest 20% of people and 59% of such visits by the richest 20% were to the private health providers rather than to the public sector providers (Smith et al 2001:10).

2.3. UNIVERSAL HEALTH COVERAGE (UHC)

Universal health coverage is ensuring all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. It aims to reorient health system resources and utilization towards high quality and comprehensive primary healthcare (Thomas, Makinen, Blanchet & Krusell, eds. 2016: v). For a service to be comprehensive, the totality of a patient's health problems must be recognized in order for appropriate actions to be taken (Starfield 2011:17). To achieve and sustain universal health coverage and ensure access to quality primary healthcare services for all consumers, the health systems of most countries need to engage both public and private health sector providers (Thomas et al 2016:vii). Government-run health systems across developing countries are often in disrepair, with poor quality services provided in run-down facilities (The Global Health Group. 2009:4).

Universal health coverage is a critical component of sustainable development and poverty reduction, a key element of any effort to reduce social and gender inequalities, and a hallmark of governments' commitment to improve the wellbeing of all its citizens and promote health security (Marjolaine et al 2017:1).

Despite the remarkable progress in expanding access to healthcare in Ethiopia, substantial inequalities still exist in health outcomes based on differences in economic status, education, place of residence and sex (Ministry of Health 2016/17:16). There are greater variations among regions in different health programs like Amhara region where this study conducted was among the low performer regions in TB case detection, ANC coverage, ITN distribution and neonatal mortality whereas highest performer in contraceptive acceptance rate. There is also high dispersion among districts with in the region. Identifying and understanding inequalities helps to pinpoint key drivers and inform the target solutions to improve the disadvantaged groups (Ministry of Health 2016/17:6).

Although the private health sector is an important healthcare provider in many low and middle-income countries, its role in progress towards universal health coverage varies. The type of health services delivered and outcomes influenced by characteristics of patients, structure of both public and private health sector and the regulation of the sector (Morgan, Ensar & Waters 2016:610). Similarly Stallworthy, Boahene, Ohiri, Pamba & Knezovich (2014:3) state that the role of private health sector remains subject to much debate especially with the context of achieving universal health coverage. The private health sector will play an important role in the future healthcare system. However, it needs to identify the gaps and issues that might be more effectively filled by the private health sector.

In most developing countries, when people first seek diagnosis and treatment for an illness they visit private healthcare providers and these are often significant part of the health system (Smith et al 2001:1). Smith et al (2001:9) indicates that ease of geographic access, short waiting time, longer or flexible working hours, greater availability of staffs and drugs, confidentiality, perceptions of more responsive, perceptions of greater

technical quality and continuity of care are the most reasons for seeking care first from private healthcare providers.

The private health sector is an avoidable force in modern, globalized healthcare delivery as a significant proportion of global healthcare is delivered by private providers (Wadge, Roy, Sripathy, Prime, Carter, Fontana, Marti, & Chalkidou 2017:7). Government and investors need to be capable of engaging with private health providers particularly with in holding them accountable to high standards of behaviour and care (Wadge et al 2017:7). Ensuring a net positive impact while minimizing risk is a clear challenge facing the private healthcare providers (Wadge et al 2017:7). In an underdeveloped public health sector, the government should invest first in primary care while private health providers can fill the gap in secondary and tertiary care in low and middle-income countries to attain universal health coverage (Wadge et al 2017:6).

2.4. THE ROLE OF PRIVATE HEALTH SECTOR

The private health sector is very heterogeneous. There is a growing appreciation and recognition of the role of private health sector in the development of the health systems and the improvement of healthcare worldwide. The private health sector plays a vital role in health systems development, management and effectiveness and it is an area which remains to be very much underexplored and uniformed (Bishai & Sachathep 2015:i1). At the country level, feasible strategies depend on the potential of different components of the private health sector and the capacity of governments and their partners for collaboration (Waters, Hatt and Peters 2003:127). Private providers are sometimes the only source of healthcare for the poor. They are often closer than government facilities and may be less expensive once lost working time, travel, and unofficial user fees are taken into account. However, the quality of care is inconsistent, and poor clients may get inadequate services for their money (Buxbaum 2010:10:34).

Even though the size, contribution and makeup of the private sector vary from country to country, in some parts of East and West Africa, they are major source of healthcare for

people across all socioeconomic strata. Public health programs are usually designed by the public sector with little consideration of private providers. In addition there is no guideline for the private health sector or may not have system for sharing. In a study conducted by Global Health group, the primary challenges presented by private providers are a) private providers are often excluded from the design, planning and implementation of public health programs b) the goals of the national programs and that of the private health sector may differ c) many private providers do not recognize the value and importance of counting and reporting all cases d) a large proportion of private providers have only limited trainings in accurate diagnosis and reporting e) new regulations and protocols may not be communicated to all private providers and providers may choose not to follow current regulations and protocols (Global Health Group 2014:8-9).

The role of private health sector in low and middle-income countries is most important especially in child healthcare. Private health sector and non-governmental providers are the most commonly consulted source of care for child illnesses in many countries offering significant opportunities to expand the reach of essential child health services and products (Waters et al 2003:127). The importance of private health sector is also increasingly critical to many of the major issues prioritized by the nation government initiatives. For instance, as the global trend towards facility deliveries accelerates, public facilities in many countries have failed to keep pace with the increased demand (Forsberg & Montagu 2014:i2).

As the private health sector grows rapidly, their contribution to the national health system mainly in provision of health services have become increasing from time to time. In 2015, the private sector healthcare providers (WHO, Global Tuberculosis Report 2016:59) notified 11% of TB cases in Ethiopia. Whereas the regional health bureau report shows the contribution of private health sector in the notification of TB cases in EFY 2008 (2015/2016) raise to 30% (5,393/17,709). The Ethiopian Demographic and Health Survey (EDHS) 2011 also stated 13% of modern contraceptive users reported that they have obtained their contraceptive from the private facilities (Central Statistics Agency & ICF international 2012:99).

The private health sector can be engaged for reaching public sector goals (Forsberg et al 2014:i2). A study conducted in Ethiopia and Pakistan among private family planning providers indicated that quality improvements in the private sector can be delivered to the poor in some settings (Shah, Wang and Bishai 2011:i70). Another study conducted in Ethiopia, Amhara region showed that there is lesser health system delay in private health institutions than public health centers and health posts in the diagnosis of tuberculosis (Gebreegziabher, Bjune & Yimer 2016:5).

In order for health programs to sustain in low income countries, private sector investment in health is crucial factor (Forsberg, Montagu & Sundewall 2011:i2). Even though the investment in HIV/AIDS sector in some countries like Kenya, Rwanda, Tanzania, Malawi and Zambia, increased the out of pocket expenditure decreased (Sulzbach, De & Wang 2011:i81). However, the private for profit sector has been crowded out by the not profit sector and it poses a question of dependency and sustainability over time (Forsberg et al 2011:i2).

Wadge et al (2017:18) stated that the role of the private health sector must be complementary, integrated with the local health system, and it must be prepared to work on areas of common concern such as medical education or communicable disease strategies. Service integration is defined along a continuum, ranging from the narrowest sense the combination of two formerly separate services into a single, coordinated service to a full package of preventive and curative health services available at a multipurpose service delivery point under one manager (Buxbaum 2010:10:20). Integrated health services delivery translates the interdependencies of health services delivery processes and the underpinning health system conditions set by other system functions that need to be accounted for in order to promote aligned actions that tackle the root-causes of shortfalls (Tello & Barbazza 2015:46).

In some low and middle income countries such as Nigeria and Ethiopia the private sector is still denied recognition by the policy makers and funding for research especially on the

role of private sector in health systems is scarce (Forsberg et al 2011:i2). The private health sector providers are usually nearer, open for longer time, and are seen as more considerate and sometimes less expensive than the public sector (Smith et al 2001:1). Consequently, in order to improve the performance of the health system, governments' focus on private health sector becomes highly important (Smith et al 2001:1).

2.5. HEALTHCARE FINANCING

At the meeting of African health and finance ministers held in Addis Ababa in 2013, Dr. Kesetebirhan Admasu, the previous minister of Health, Ethiopia, said that financial resources are a crucial input for provision of adequate and quality health services. However, the ever-increasing cost of healthcare and multiple competing priorities in resource poor countries makes financial resources insufficient to make substantial improvements in access and quality of healthcare (African Union, Media release 2013:1). Out of pocket payments have increased in all of African countries and as a result 11 million African falling in to poverty every year (World Bank & WHO 2016:4). The government expenditure on health in Ethiopia as percent of the total government expenditure was 11% in 2012 (WHO 2014:20) which is below the Abuja target (15%) (African Summit 2001:6) whereas the total expenditure on health to GDP was only 4% in 2015 (World Health Statistics 2018:62). Later on, the government of Ethiopia including other three countries Malawi, Swaziland and Gambia met the Abuja target in 2014 (World Bank & WHO 2016:16).

Private health providers (both for profit and for non-profit) received 16% of national health expenditure (NHE) in 2010/11 (Ministry of Health 2014: xiv). Despite increasing of NHE from time to time, it is still inadequate to buy better health for all Ethiopians. The Ethiopian government share of health spending has increased to 49%, while 34% of health spending managed by households (all out-of-pocket) and only less than 1% managed by insurance (Ministry of Health 2014:20). Eleven percent of reproductive health resources, 14% of child health resources, 15% of tuberculosis resources and 6.7% of malaria resources went to private health providers (Ministry of Health 2014: xvi-xvii).

In poor countries, private health providers especially those at the primary care level usually require direct payments at the point of service to underwrite the full costs. This is the least equitable approach to financing (Chapman 2014:131). It prevents millions from accessing services and results in financial hardships, even impoverishment, for many millions more (Chapman 2014:131). Another study showed that there is demonstrated willingness to pay for the private health services even cheaper public health service alternatives available (Waters et al 2003:127). Globally, in low-income countries 41% of all health financing comes from private, out of pocket household payments, compared with 33% in middle-income countries and 22% in high-income countries (Waters et al 2003:127). Out of pocket spending on health remains very high in many countries and pushes 100 million people in to poverty every year (Marjolaine & Maxwell I 2017:1).

2.6. HEALTH WORK FORCE

Health workers are the most critical input in the delivery of health services. The shortage of skilled health workers has been the consistent bottleneck to achieve UHC particularly severe in Sub-Saharan Africa (World Bank 2016:19), which is only three percent of global health workforce (WHO 2006: xvii). There is a worldwide shortage of healthcare workers and the situation is worsening (Darzi & Evans 2016:2576). There can be no effective healthcare system that provides high quality care without an adequate supply of trained healthcare workers to deliver it (Darzi et al 2016:2577).

Ethiopia has one of the lowest work force density (Ethiopian Public Health Association 2016:31). The total work force per 1000 population is 1.3 where for Africa is 2.2. It is explained by wider regional disparity, highest in Addis Ababa and Harar and lowest in Afar and Amhara (Ethiopian Public Health Association 2016:28). The country is included in the list of 53 critical shortage of health services providers and is also among the countries highly losing its health work force to Europe and America due to low pay, high cost of living and little chance to further education in the country (Ethiopian Public Health Association 2016:31). In 2011/12, health workers density in the country was one medical doctors for 28,847 people, one health officer for 17128 and a nurse for 2299 people

(Alebachew & Waddington 2015:6). A large proportion of Ethiopian medical doctors, about 15% of general practitioners and close to 40% of specialists work full time in the private sector but less than 5% of nurses do (Feyisa et al 2012:xiii).

2.7. REGULATION

The World health summit in Berlin in 2013 raised health as human right rather than a marketable good and debated, leading to discussion on the potential of regulation in preventing a profit driven market distorting the ability of all citizens especially the poor to afford and access quality health services (World Health Summit 2013:2). The panelist suggest that healthcare services require an equally diverse group of actors (public and private) to deliver and there is a need to invest in creating a more informed and educated patient population able to identify, select and evaluate healthcare services appropriate to them (World Health Summit 2013:3). Private provision of health services does not change the role of the state as the ultimate guarantor of the realization of health rights obligations, but it makes implementing its responsibilities more difficult. Moreover, fragmentation of the health system complicates oversight and the promotion of a right based approach to health (Chapman 2014:123).

Regulation is a powerful policy tool for improving the private sector's contribution to national health goals (The World Bank Group. 2013:19). A study conducted in the East and Southern Africa by Doherty states that the type and quality of services provided by private health providers and professionals is not well regulated and monitored (Doherty 2015:i93). However, the price of services was minimally regulated and the researcher highlighted the power of private sector's effort against efforts for increased regulation should not be undermined (Doherty 2015:i93). On the contrary, a study conducted in Ethiopia, India and Nigeria indicated that private health providers and NGOs in Ethiopia are tightly regulated and are required to submit monthly reports including service delivery information to the district health office (Avan, Berhanu, Umar, Wickremasinghe & Schellenberg 2016:ii8). However, there is lack of standardized, participatory decision

making among stakeholders and their role to specific health services like MNCH is limited (Avan et al 2016:ii11).

Private facilities are less likely than public facilities to report to the government reporting system (75%) and to have documented external supervisions (56%) (Ministry of Health, Ethiopian Public Health Institute & WHO 2016:20). Policy makers in the East and Southern Africa countries need to embark on a programme of action to strengthen regulatory frameworks and instruments in relation to private healthcare provision and insurance (Doherty 2015:i94). Medical boards and associations of strong internal leadership and external accountability are very effective in regulating their members besides the government (The World bank group 2013:20).

A study done by Forsberg et al (2011:i2), presents that private health providers need to make a profit an issue of debate in many countries. The principal-agent problem in healthcare asserts that providers, being imperfect agents of patients, will act to maximize their profit at the expense of patients' interests. Forsberg et al 2011:i2 also states that private providers in Vietnam prescribe more drugs to induce demands and suggests that regulation and check can provide another guard against provider-induced demand in the healthcare market. The healthcare market does not function well, unlike markets for other private goods and services, which function perfectly due to interaction with moral hazard problems of market and information asymmetry. There are several limitations in the health market that lead to market failure (Viroj et al 2008:4). As a market driven sector, the private health sector is positioned better to manage its resources and operations flexibly lending itself to better efficiency (Ministry of Health 2013:9). Existing country experiences in outsourcing catering, security, and sanitary services in public facilities indicate the attainment of the desired efficiency gains (Ministry of Health 2013:10).

The government of Ethiopia through Food, Medicine and Health Administration and control Authority (FMHACA) regulates both public and private health facilities towards ensuring quality service and high professional standards. New sets of standards decreed by FMHACA and application to regulate health facilities in the country both for the new

and old facilities has been started (Ejigu & Tadeg 2014: v). A standard is a document established by consensus and approved by recognized body that provides, for common and repeated use, rules, guidelines or characteristics for activities or their results, aimed at the achievement of the optimum degree of order in a given context (International organization for Standardization (ISO) online [S.a.]. Licensing is generally by the Ministry of Health and based on fulfilment of minimum requirements for the levels of appropriate inputs such as professionals, practice, premises and products.

2.8. SUMMARY

The literature review provided a summary of the existing evidence related the research topic, discussed current available knowledge, gaps and practices in the private health sector's service delivery. The conceptual framework was discussed in detail. The roles of private health sector in the healthcare system especially in the way towards universal health coverage were presented. Current and available concepts and practices related to healthcare financing, regulation and the health workforce in the private health sector were explored from different sources. The next chapter will be research design and methods.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. INTRODUCTION

This chapter presents a complete plan for data collection for this study. Data management and analysis, ethical considerations and instrument design and administration are explained as well.

3.2. RESEARCH DESIGN AND METHODS

Research design is a plan or blueprint for answering the research questions and fulfilling the objectives of the study while research methodology focuses on the research process and the kind of tools and procedures to be used (Ambe 2016:2). Likewise, Saunders, Lewis and Thornhill (2009:136) have defined research design as “the general plan in answering the research questions”. While, research methods refers to techniques and procedures used to obtain and analyse data.

Health services research is concerned with the relationship between the provision, effectiveness and efficient use of health services and the health needs of the population (Bowling 2014:6). The process refers to how the service is organised, delivered and used. It includes accessibility (e.g. proximity to public transport, waiting time), the way in which personnel and activities work together, and interaction between health personnel and patients (Bowling 2014:11).

3.3. PHASE I

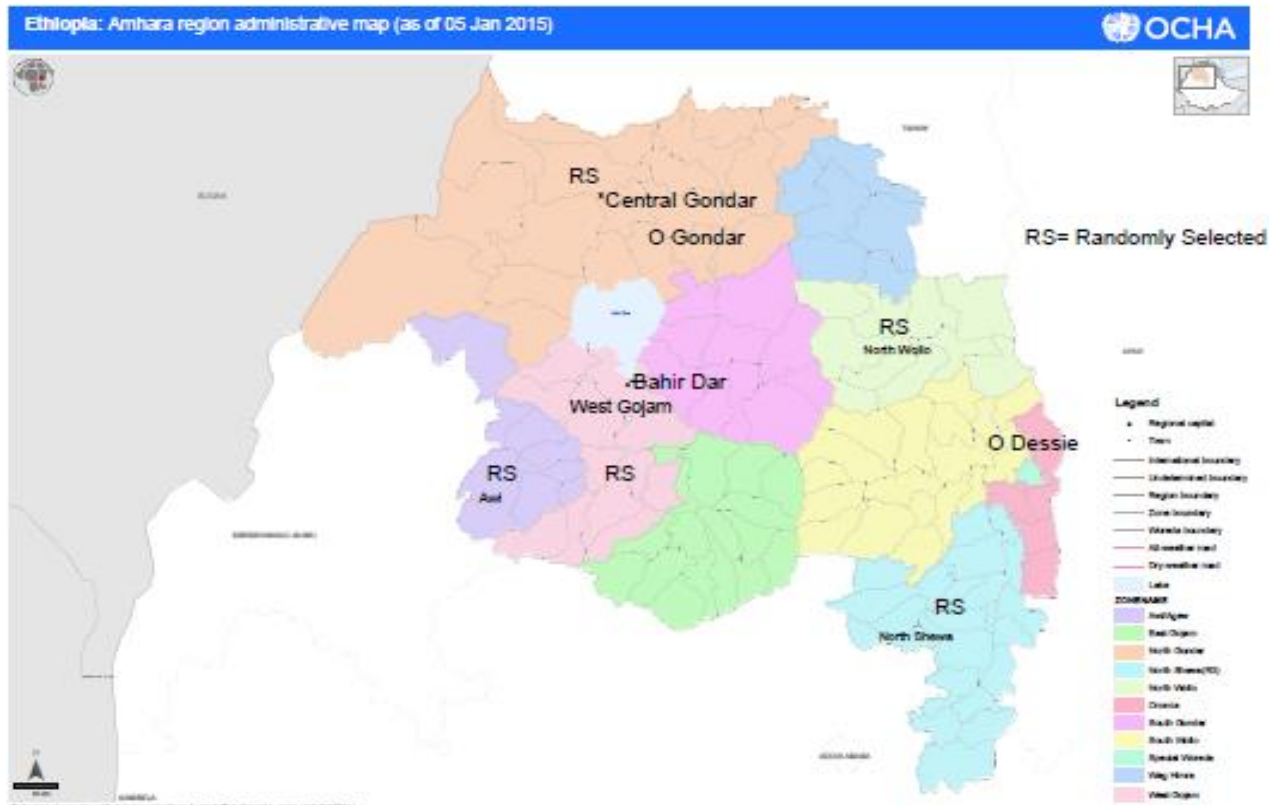
A quantitative approach was followed for this study. Quantitative research describes research that produces countable or numerical results (Garcia, Jha, Verma & Talwar [S.a]). It deals with quantities and relationships between attributes; it involves the

collection and analysis of highly structured data in the positivist tradition (Bowling 2014:214). Quantitative studies usually involve concepts that are fairly well developed, about which there is an existing body of literature, and for which reliable methods of measurement have been (or can be) developed (Polit & Beck 2010:146). The design issue in quantitative studies is whether the research design provides the most accurate, unbiased, interpretable, and replicable evidence possible (Polit & Beck 2010:249). In this study, this approach was expected to generate an account of the reality during provision of health service delivery by private health facilities.

A cross sectional health facility based survey was implemented to examine profiles of patients, health workers and nature of health services being practiced by the private health facilities in the region. Survey research deals with present events and is quantitative in nature. It may further be sub-divided into; discretionary, correlational and exploratory type of research (Pandey & Pandey 2015:12). However, exploratory type of research was not applied in this study.

3.3.1. Setting and population of the study

Settings in research are the specific places where information is gathered and a site is the overall location for the research; it could be an entire community or an institution within a community (Polit & Beck 2010:62). The setting to this study was private health facilities at multiple sites of Amhara region, which is one of the nine regions of Federal Democratic Republic of Ethiopia. The region has an estimated population of 21,134,988 (Amhara National Regional State Health Bureau 2016/17:1).



*Recently North Gondar Zone is divided into three as North, Central and West Gondar zones.

Figure 1. Administrative map of Amhara region (2015) (http://www.amharabofed.gov.et/population_report.html)

The area of Amhara region is estimated 155,127 square kilometers and further divided into 12 zones and three zone status towns including Bahir Dar, the region’s capital, Gondar and Dessie towns (Amhara region Bureau of Finance and Economic Development 2013:1). Some selected zones was part of this study to represent the region considering homogeneity of private health facilities distribution. All zone status towns in the region were represented as private health facilities predominantly operated in bigger towns.

The Amhara private health facilities’ and professionals association’s special bulletin in 2016/2017 states that there were 2,169 private health institutions licensed to provide healthcare services in different level and category. It includes all privately owned and run

hospitals, different level clinics, standalone diagnostic laboratories, pharmacies and drug outlets in the region. Private healthcare facilities in total covers provision of 35% of health services coverage in the region (Amhara Private Health Facilities' and Professionals Association (APHFPA) 2016/17:6).

The list of facilities in the regional health bureau indicates that most of private health facilities especially higher levels are residing in bigger metropolitan towns like Bahir Dar, Gondar and Dessie (Amhara Regional Health Bureau Health Facility List 2017). Primary clinics are mainly situated in smaller towns, mainly in the rural part of the region. The same list shows that the region contains only seven private for-profit hospitals; one in Gondar, two in Bahir Dar, one in Debre Birhan and three in Dessie towns. Yifat primary hospital in Shewarobit town is established by a philanthropist considering highly minimal profit and in addition to these, one for-not-profit primary hospital in Kobo town run by the Catholic Church. There were also 61 specialty centres and clinics together, 166 medium clinics, 15 non-profit clinics and 719 primary clinics owned privately (Amhara Health Bureau Health Facility List 2017).

3.3.1.1. Study population

A population of a study is all individuals in whom a researcher is interested and to whom he or she would like to generalize the study results (Polit & Beck 2010:569). The population in this study were patients who were seeking and using healthcare service in the private health sector, health providers working in the private health sector and owners or managers representing respective private health facilities in the region.

3.3.2. Sample and sampling methods

A sample is a representative part of a population or as subset of the population (Bowling 2014: 454). Bowling (2014: 454) defines sampling as the process involving selection of a finite number of elements from a given population of interest, for purposes of inquiry. In addition, Kumar (2015:177) explains sampling as the process of selecting a few (a

sample) from a bigger group (the sampling population) to become the basis for estimating or predicting the prevalence of an unknown piece of information, situation or outcome regarding the bigger group. The ideal sampling strategy is one in which the elements truly represent the population being studied while controlling for any source of bias (LoBiondo-Wood & Haber 2014:73). Customers of private health facilities, healthcare providers in private healthcare settings and managers or owners were represented by fair sample for the study.

3.3.2.1. Selection of study settings

In this study, to get the most potential sites and obtain representative samples for the region, some administrative zones (50%) was selected randomly considering their homogeneity in the distribution of health facilities and administration type in order to make rational representation of the regional picture. As most of the hospitals and specialty clinics reside in the three bigger zone status metropolitan towns (Bahir Dar, Dessie and Gondar towns) (Amhara Health Bureau Health Facility List, 2017), all these towns were included into sites where sampling was conducted.

In order to select some zones from the rest, number of private health facilities and their type in each zone counted as per the list from the health regulatory department of the regional health bureau. Selection was made based on their number and consideration of the facilities' distribution and homogeneity with the nearby zones. Consequently, six zones namely West Gojjam, North Wollo, Central Gondar, North Shewa, Oromia and Awi zones were selected randomly from the aggregate together with all the three zone status towns, Bahir Dar, Gondar and Dessie. Their geographic distribution in the region were very good for representation and totally selected zones constitute 59% (555/941) of private health facilities. Waghemira zone was not entered in the poll as it has very minimal number of private health facilities as compared to others due to their small geographic area and population.

Sampling frame of private health facilities in each zone and town was prepared considering their level provided during licensing. Sample facilities were selected by systematic random sampling method from the sampling frame containing list of all private health facilities in the region. To make the sample proportionally representative, the list was prepared considering their specialty type and level licensed by the regulatory body as well as distribution in the region. Those facilities who started providing services recently, less than 6 months, were not included in the poll as their experience to the health system is low.

Ethiopian health tier system shows that hospitals are the referral centers for health posts, health centers and other lower level healthcare facilities (Ministry of Health 2015:142). Hospital clients are referred from other primary and medium private clinics as well as lower level public health facilities of various levels and from far distant area of the region or neighbouring regions. Due to this reason it was found worthwhile to take all nine hospitals from all selected areas. There were 47 specialty clinic/centres and non-profit facilities, 101 medium and 406 primary clinics in the selected zones. In order to make the sample more representative, 50% of the facilities were included from each category. Consequently, from 47 specialty clinic/centres and non-profit facilities in the selected zones, 50% (24) were selected and distributed proportionally to all selected zones and towns. Similarly, from 118 medium clinics in the selected zones, 50% (59) medium clinics and from 357 primary clinics in the selected zones, 50% (179) primary clinics were taken randomly from the selected towns and zones. Therefore, total sample of health facilities calculated was 269. However, 256 (95.17%) healthcare facilities were contacted and interviewed (Table 1). Information in some facilities 13 (4.83%) were not accessible during data collection after repeated visits due to different reasons not related to the study like too busy in providing care for critical cases and some others not functioning at the time of visit.

Each private health facility owner working within the facility or hired manager for monitoring, internal and external communication purposes was interviewed. Some private health facilities established by multiple owners and the assigned head of that facility was

communicated and interviewed. Accordingly, the number of health facility managers or owners remains the same, 256 as the number of selected private health facilities.

The health standards regulatory department of regional health bureau in 2017 has licensed 992 private health facilities (Ministry of Health, Ethiopia 2017) providing different health services at different level, however only list of 941 facilities were found (Amhara Health Bureau Health Facility List). This contains nine all level hospitals (six general and three primary hospitals), 61 specialty centres and clinics, 166 medium clinics and 719 primary clinics. Selection of health facilities was done by considering their number and distribution in the region.

Selected facilities were distributed proportionally to each facility level as per their expected patient flow and health workers in the facility. As primary clinics are doing what is ordered by higher level facilities, or in other words they are not licensed to provide diagnostic services and not primarily prescribers (Ministry of Health, Ethiopia 2011:24-25), their patients are either referred from other higher level private facilities or public health facilities. In addition to this, as the number of patient flow to these facilities was minimal, no patient interviews was conducted in primary clinics. Clinic owner and available health worker other than owner of the facility were interviewed with appropriate instrument. Because of this, sample of customers of private health facilities were proportionally distributed across hospital, specialty and medium clinics based on the ratio calculated from prior information obtained from contacted private facility owners.

After selection of facilities, the owner or manager assigned was interviewed to acquire pertinent information about the facility and related variables. In order to attain number of healthcare workers and patients for interview, total number of health workers in the selected facility and estimated daily patient load information from each facility were collected and used.

After receiving list of health workers, samples were distributed proportionally and selection done by systematic random sampling and then interviewed. Likewise, patient

samples were selected from daily register by systematic random sampling after calculating sampling fraction. Sampling fraction or sampling interval is the standard distance between selected cases. It can be calculated by dividing the total eligible population to the sample size. The first respondent, the k^{th} case will be selected by simple random sampling from the first band in the list and adding sampling fraction will result the next respondent and so forth (Polit & Beck 2010:315). The first band was determined by dividing the expected number of patients per day in the facility to number of patients to be interviewed per day. In order to assign number of sample patients proportionally to each selected facility, patient load information was collected prior to the data collection days by telephone and in person contacts. Patients who were critically ill or who were either in mental or physical disorder at the exit were interviewed in assistance of accompanying family members. The source of patients were selected hospitals, specialty clinics/centers and medium clinics owned privately.

3.3.2.2. *Sample size calculation and sampling procedure*

Sample size was calculated using single population proportion formula at 95% confidence interval and margin of error (d) = 5%. For the purpose of this study, researcher decided to take a result from International Finance Corporation (IFC) (2008:9) that states 48% of the highest and 44% of the lowest income quantile of people in Ethiopia have received healthcare from private for profit health facilities. Taking this proportion for the calculation of sample size would be reasonable as this study aimed to analyse and describe profiles of customers of the private healthcare sector related to their income level. In addition, taking the already available data related to study variables would help the researcher to better estimate the sample size. Bigger proportion (48%) will make the sample size bigger that will help to determine better sample size. Determining the size of the sample population is one of the most difficult decisions to make survey and a larger sample can yield more accurate results but more expensive (Garcia, Jha, Verma & Talwar [S.a]).

The total expected number of healthcare service customers from the private health sector in the region during the study time of three months was one million. This data was

obtained by asking some private health facility owners from each category about the average number of visiting customers in a day and multiplied by the number of working days in the study time and total number of facilities. Using the statcalc of EPI Info 2000 7.1.3.0, population survey or descriptive and entering information like population size greater than 999,999 and expected frequency 48%, confidence limit 5%, 95% confidence interval and design effect of 1.5, the final sample size calculated was 582 (for patients). An addition of 10% non-response rate $582 \times 10\% = 58$, the total sample size calculated for patients was 640. However, actual data were collected from 582 (91%) patients and clients.

The expected number of health workers in the selected facilities according to the facility standards in Ethiopia are two nurses for primary clinics (Ministry of Health, Ethiopia 2011:27), 1 HO/BSc nurse, 2 Diploma nurse, 1 midwife (optional), 2 lab, 1 radiology professional for medium clinics (Ministry of Health, Ethiopia 2011:28). Specialty clinics are for internal medicine and surgery and 6 health professionals needed including internist/ surgeon, general practitioner (GP), nurses, lab and radiographers (Ministry of Health, Ethiopia 2011:89-97)). Primary and general hospitals are expected to be staffed by 53 and 234 professionals respectively (Ministry of Health 2015:142). However, as per the information obtained through telephone contact with hospitals' sources, number of health professionals varies. Accordingly, there were relatively higher number of staffs and professional mix in hospitals and on average 30 health professional in each primary hospital and 62 for general hospital expected and the total health workers in all selected hospitals (both primary and general) was 370.

Having the above information, the total number of health workers employed in the private health facilities selected for this study was estimated 1,500. By taking information, the total number of sample health workers participated in the study was calculated considering the following assumptions: Margin of error (d) = 5%, 95% confidence interval. Having all these information, the number of health workers calculated was 285 (Saunders et al 2009:219). This number was proportionally distributed to selected health facilities as

per their employed health providers in the facility and considering professional mix of the sample.

Information obtained from selected private health facilities, daily patient load varies greatly among different level health facilities and departments. For the purpose of selecting and distributing sample patients, the daily patient register/OPD abstract register of the facility was referred at the time of data collection. Health workers list in the facility was obtained from the human resource unit or as usually found from matron. The patient load per day determined the total number of patients interviewed.

3.3.2.3. Eligibility criteria

The eligibility criteria designate the specific attributes of the target population, by which people are selected for inclusion in a study (Polit & Beck 2010:553). Inclusion and exclusion criteria used as guides for the researcher to decide who can and cannot participate in the study and to make the population more homogenous. Facilities were checked for their license update for the fiscal year and their agreement to participate in the study. Health workers were also checked for their duration of experience in the private health facility. Age of customers was checked for decision of inclusion or exclusion in the study.

3.3.2.3.1. Inclusion criteria

These were characteristics that each prospective subject should have in order to be participant of the study. All customers above 18 years old who came for healthcare service at the private health facilities were included after asked their voluntariness. Part-time staffs and facility managers who work in day time and more than two consecutive month experience of working in current private healthcare setting were included. All licensed healthcare providers and managers working in the private healthcare settings were eligible to take part of the study except those with experience less than two months. Owners of the private health facilities were given priority of selection for participation when

the facility have both health professional owner and manager. Both were included when non-health professional owner as both may have faced different challenges and preferred solutions.

3.3.2.3.2. Exclusion criteria

This is the criteria specifying characteristics that a study population does not have (Polit & Beck 2010:554). These characteristics disqualified prospective subjects from participation. Private health facilities that did not have updated license for the current physical year were not included in the list. Health workers and facility managers who were hired recently, less than two months or in their probation period were not interviewed, as they are relatively inexperienced about the private healthcare sector. Those practicing healthcare providers working as an intern were not part of the study.

3.3.3. Data collection methods

A pretested structured self-designed instrument was used as an instrument for data collection by the principal investigator. A questionnaire is a document used to gather self-report data of questions (Polit & Beck 2012:740). As the study geography is very wide, two well-trained professionals by the researcher solely for collecting quantitative data under the direct daily follow up and supervision of principal investigator were hired. A one-day training provided by the investigator for these assistants in order to make them understood objectives, contents and methods used. Brief discussions on data management, communication and ethical issues conducted. Data collected by these assistants were checked every day for any error and corrective actions or decisions taken soon by the researcher. Some attitudinal questions were included in the instrument and used as per the Likert scales (Brown [S.a]: 1-4).

Both the data collection instrument and consent form were prepared first in English (Annexure D & F) and translated to Amharic language (Annexure E & G) by the local language translator who knows clearly the social and cultural values of the community.

Selection of appropriate equivalent words was done for mainly sensitive words and replaced them with others less sensitive and not offending.

3.3.3.1. Data collection for Phase I

Data collection was started soon after obtaining approval from the health research and Technology transfer directorate of Amhara Public Health Institute (APHI) (Annexure C) and it took three months. The support letter from the UNISA office, Ethiopia (Annexure B), supported this. In addition to this, APHI was asked for support letter in written and obtained on time. As it is a cross sectional study, all data was collected once.

A total of 1,112 interviews with different participants (582 with patients, 274 with healthcare providers and 256 with health facility managers or owners) was conducted. Information was obtained before data collection for the purpose of planning from four matrons of health facilities (GAMBY general hospital, Selam general hospital, Gizewa and Adam Medium clinic) through telephone contact and an experiencing person (President of private health facilities and professionals association for the region and the country) showed that average number of patients per day for a hospital, specialty center and clinic, medium and primary clinic was 250, 150, 20 and 5 respectively. In the same way, the minimum number of healthcare providers in a hospital, specialty clinic, medium and primary clinic was 30 (except GAMBY General Hospital - 62), 5, 3 and 1 respectively.

With the above information, 582 patients were selected proportionally to all selected healthcare facilities based on the total number of patients seen in a day. Averagely, 40, 30, 15 and 5 patients were interviewed from each general hospital, primary hospital, specialty centers and clinics. Likewise, the 274 healthcare providers were from selected hospitals, specialty clinics and medium clinics tried to keep its distribution proportionally. Approximately, one healthcare providers from each medium clinic, two from each specialty clinic, three from each specialty center, four from each primary hospital and 10 from each general hospital were interviewed.

Data was collected from patients at their exit who used services of the private health facilities. In addition, data was collected from health workers in the private health facility as well as facility managers or owners. Participants' responses to each question raised by the researcher were recorded on the structured instrument prepared for the face-to-face interview. The principal investigator along with two assistants collected data using structured and pretested data collection instrument. Unclear data during interview was verified from any available and reliable source like from medical records. Permission was obtained both from the patient and health facility.

Data collection was conducted during official working hours (morning 8:30 am – 12:30 pm and afternoon 1:30 pm – 5:30 pm) including Saturdays. Private health facilities usually operates on the entire days in a week except Sundays.

3.3.3.2. *Data collection Instrument*

Data collection instrument was prepared and organized in three sections: the first section for patients of private health sector, the second for healthcare providers in the private health sector and the third for health facility managers or owners. Each section of the instrument was designed to include pertinent questions related to socioeconomic status of patients, inputs used by the private health sector itself and its patients, processes and outputs gained from being served in the private health sector. Challenges faced and the probable solutions were included in its appropriate section, at the end. Its preparation was in accordance of measuring variables correctly to answer objectives of the study. The instrument contains a number of questions designed to enable the researcher to address objectives and maximum effort was done to make them easier for recording as well as analysis.

Closed ended questions with fixed alternatives as well as open ended which allowed participants to respond with their own words were in the instrument. Inclusion of open ended questions helped to capture potentially useful responses that were not addressed by the researcher or difficult to present closed ended way. All responses from participants

were circled or written on a printed copy and ready for data entry and analysis. Participants of this study were able to list some other than listed on the instrument and it helped the researcher to identify more valuable options overlooked.

The data collection instrument was first prepared by English and then translated into Amharic language (Annexure G) which is the official language of the region as well as the country as a whole. Consequently, media of communication with patients, healthcare workers and managers was Amharic. Those patients who could not listen and speak the language were approached through family members who accompanied the patient.

3.3.3.3. *Data collection instrument administration*

Data collection instrument was used for interview by the interviewer in person, not administered for the interviewee to be filled and collect it back or was not done through telephone or electronic methods. All questions were made clear for the interviewee and only to be used for the intended purpose. Regarding the content of the instrument, all responses of the interviewee were recorded on a paper content wise. There was no any order set to collect data from each setting like doing first hospital and then clinics or first healthcare providers and then patients. The data collection instrument was printed ready ahead of data collection and availability of enough copy ensured as per the intended sample size including for training.

Pretesting of the instrument was done at one of the private health facilities in Bahir dar town. A sample of patients, health workers and manager/owner were interviewed with the prepared instrument. During interview, there were valuable inputs gained from the interviewee and it was used to further develop instrument. This process gave the researcher to see missed variable or rearrange it in the best ways for analysis and even administration of question. The convenient time for study participants and some other issues sought during pretesting. Feedbacks were collected from participants of pretest interviews. All valuable comments collected were included and an updated and revised

instrument produced at the end, which enabled the researcher to measure each variable in better way possible. Piloted facilities were excluded from the final list of facilities.

3.4. VALIDITY AND RELIABILITY

Polit and Beck (2010:571) define validity as a quality criterion referring to the degree to which inferences made in a study are accurate in measurement, the degree to which an instrument measures what is intended to measure. Validity is concerned with whether the findings are really about what they appear to be about (Saunders et al 2009:157). Face validity refers to whether the instrument looks as though it is measuring the relevant construct whilst content validity is concerned with the degree to which the an instrument contains appropriate items being measured.

In this study, the researcher used literatures related to the problem statement, purpose and the objectives of the study to enhance content validity of the instrument. In addition, the instrument was assessed by the supervisor for relevancy of questions before it was administered. In addition, a statistician was consulted at the time of formulation of the questions in order to ensure data analysis is congruent.

Pretesting of the instrument was done to ensure that questions are relevant for the study. The instrument was pretested in one of the private health facility in Bahir Dar town not included in this study in order to test if it measures the study variables efficiently. Pretest assisted the researcher in refining the tool, identifying confounding variables that need to be controlled and familiarizing with the technique for interview schedule.

Reliability is defined by Polit and Beck (2010:566) as the degree of consistency or dependability with which an instrument measures an attribute. The extent to which data collection technique or techniques will yield consistent findings, similar observations would be made or conclusions reached by other researchers or there is transparency in how sense was made from the raw data (Saunders et al 2009:600). To ensure reliability,

the researcher along with two well informed and trained professionals instituted the instrument to the participants. Questions were the same to all participants even when pretesting the data collection tool. Furthermore, reliability was ensured through using existing literature sources, theories and models; and finally all the questions in the instrument were the same, and the data collection process was the same for all participants.

Consideration of both validity and reliability influences confidence in the results of the study (LoBiondo-Wood & Haber 2014:97). Access, safety, timeliness, and patient-centeredness problems in clinical settings are ideal candidates for quality improvement solutions (LoBiondo-Wood & Haber 2014:137).

3.5. ETHICAL CONSIDERATIONS

Polit & Beck (2010:121) has stated that there are three primary ethical principles on which standards of ethical conduct in research are based as articulated by Belmont report and these are beneficence, respect for human dignity and justice. The ethical principle governing research is that participants should not be harmed as a result of their involvement, and they should give their signed, informed consent to participate after reading information about the study aims, confidentiality and anonymity, and what it involves (Bowling 2014:183).

Ethical approval was obtained from Research Ethics Committee of the Department of Health Studies, UNISA (Annexure A). The health research and technology transfer directorate of APHI was also asked to provide approval to conduct this study in the region. After obtaining this letter of approval (Annexure C) from the institution, it was presented to each recruited facility's owner or manager in charge and their permission required to proceed to interviews. All participants of the study were informed about the purpose of this study and potential benefit for the whole private health sector and its patients and consequently to the region in general. At the same time they were informed as they have the right to refuse from the study for any reason they have during interview.

3.5.1. Beneficence

One of the most fundamental ethical principles in research, which imposes a duty on researchers to minimize harm and increase benefits. Participants will not be subjected to unnecessary risks of harm or discomfort, and their participation in research will be essential to achieving scientifically and societally important aims (Polit & Beck 2010:121). Participants of this study; namely, facility owners or managers, health providers and patients were assured that no harm imposed up on them in relation to this study. They were also informed that the outcome of this study will have direct impact to the improvement of the health service delivery by the private health sector and as a result, the community at large in the region will be benefited. Informed consent in Amharic (Annexure D) was taken from participants for their time for interview and told that no harm will come due to their views towards any of the questions. Questions were prepared considering the cultural and social values of the community in order to avoid any incidental stress and discomfort from improper use of words, emotions and language itself.

3.5.2. Respect to human dignity

Respect to human dignity includes the right for self-determination and the right to full disclosure (Polit & Beck 2010:121). The principle of self-determination means that prospective participants have the right to decide voluntarily whether to participate in a study, without risking penalty or prejudicial treatment and they have the right to ask questions, to refuse to give information, and to withdraw from the study (Polit & Beck 2010:121). The researcher described the nature of the study, the person's right to refuse participation, and likely risks and benefits.

Participants of this study; private health facility managers or owners, healthcare providers and patients were communicated clearly their rights to participate voluntarily, ask any questions in between and refuse to provide their view in respect to any question. They were informed about their right withdraw from the study due to any prior reason they have.

Participants were fully informed the objectives and benefits of the study ahead of their participation.

3.5.3. Justice

This principle includes participants' right for fair treatment and the right to privacy. Fair treatment means that the researcher will treat people who decline to participate in a study or who withdraw from it in a non-prejudicial manner; will honour all agreements made with participants, demonstrate sensitivity to (and respect for) the beliefs, habits, and lifestyles of people from different backgrounds or cultures; and afford participants courteous and tactful treatment at all times (Polit & Beck 2010:124). Participants have the right to expect that any data they provide will be kept in strictest confidence. Vulnerable populations will be protected and no exclusion of selective groups for reasons unrelated to the research will be applied (WHO 2014:29).

Consequently, the selection of participants in this study was done solely based on the requirement of the study not based on their social, economic or any other requirements, mainly on probability sampling. Any information was kept confidential for this research and only for the fulfilment of objectives mentioned above.

3.6. DATA MANAGEMENT AND ANALYSIS

Each data collection instrument at the time of data collection and data entry was checked for content, completeness, consistency and accuracy by the investigator. Data was kept secured and prevented from and damage at all stages of data collection. In order to identify and correct data entry errors, it was double entered. The data was verified and ensured consistency with the data on the instrument and prepared for statistical analysis. In order to answer the research questions, collected data were analysed in an orderly and coherent fashion. All data for this study was entered and analysed using IBM SPSS version 20. Descriptive analysis was executed for selected variables. Additionally chi-square tests were computed for addressing the study objectives. Units of analysis were

patients of private health workers, healthcare providers and managers or owners representing their respective facilities. There were some variables analysed using the private health facilities themselves such as time of establishment, operation time, building ownership, number of health workers working and the like.

Independent variables like age of consumers, sex, residence, income, duration of illness, professional mix of healthcare providers, ownership of facilities and access to loan were tested whether they have association or not with dependent variables like satisfaction to service delivery and prices of services at exit and nature (provision of diagnosis and referral, treating of referred patients, both diagnosis and treatment services, provision of some selected prevention services and the like) of private healthcare service using statistical tests like logistic regression. P-value less than 0.05 was taken as the level of significance.

The association between the explanatory and dependent variables was computed by calculating the odds ratio (OR) and 95% confidence interval.

3.7. PHASE II

This phase relates to development of guidelines to enhance health service delivery in the private health sector in Amhara region. The steps to develop guidelines include compilation of evidences from the findings of phase I. The findings of phase I are presented in chapter 4 and used as input in the phase II. Formulation of guidelines was done by the researcher based on the findings from phase I and with support of literature. The proposed guidelines were given to selected experts in the field for validation. Senior experts with sufficient experiences in the sector, all greater than 10 years, were purposively selected and were provided the proposed guidelines through email and on hand for their comments and scoring.

Data from experts were analysed using inductive and deductive reasoning as well as synthesising information. Detailed information on the methods and development of guidelines are discussed in chapter 5.

3.8. SUMMARY

This chapter presented the research design and methods used in this study. It also includes purpose and objectives of the study, setting in which the study was conducted, detailed data collection method and phases, instrument design and administration, ethical consideration and validity and reliability issues. The next chapter will present analyses of the data that is descriptions, interpretations and presentation about the healthcare delivery in the private health sector in Amhara region.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1. INTRODUCTION

This chapter presents the results of the study. The results were summarized using descriptive words and tables. Discussions were also included in order to explain similarities or contrasting findings with other researches and expectations.

The objectives of the study were to:

- analyse and describe the profile of consumers and health providers of private healthcare (socio-economic status) in Amara region,
- describe the factors that influence the nature of private healthcare services,
- identify and describe challenges of the healthcare delivery by private healthcare system, and
- develop the guidelines to enhance health service delivery.

At the end of budget year 2016/2017, a license to provide healthcare services granted to 992 private health facilities (hospitals, specialty centers, specialty clinics, medium and primary clinics) in Amhara region (Ministry of Health, Ethiopia 2017). As presented in chapter 3, a total of 1194 interviews from three sources of data (health facility owners/managers (269), healthcare workers (285) and services customers (640)) were expected. However, primary data were gathered from 1112 participants namely, 256 health facility owners or managers, 274 healthcare workers and 582 service consumers through interviews using pre-tested instrument designed separately for each group.

The overall non-response rate were 6.8%. The non-response rate in health facility owners/managers, healthcare workers and service customers were 4.8%, 3.9% and 9.1% respectively. Efforts to reduce the non-response rate were done by repeated visits of facilities and agreed appointments. Data from service consumers were collected at their

exit after receiving services however, they were in hurry at the exit and some lost before interview and increased the non-response rate to 9%. All the response to each questions were tried recorded and rechecked before departure and stored in a protected. Data were entered in to prepared format in SPSS and checked row by row by the researcher. Some variables like monthly income of service customers were challenged to measure at spot especially for informal workers and their personal best estimate were taken. Data were kept secured with paasword and back ups and prevented from any damage. Descriptive statistics, chi square tests and logistic regression were conducted for data analysis in phase I.

4.2. PROFILES OF INCLUDED HEALTH FACILITIES

A total of 256 private health facilities were enrolled for the study. Owners or managers of healthcare facilities were interviewed on availability of inputs in the facility, services provided and different related matters pertinent to the objectives of the study. Structural inputs, services delivery processes and gaps in the sector were assessed. Among the included private health facilities, nine (3.5%) were hospitals (3 primary and 6 general hospitals), 39 (15.2%) were specialized centers and clinics. Majority, 116 (45.3%) and 92 (35.9%) were medium and primary clinics, respectively (Table 1). Median service years of the facilities was 6.1 years (Inter quartile range (IQR) = 6.23). Majority, 210 (82.0%) of the facilities were led by owners and the remaining 46 (18.0%) were led by appointed managers. Fifteen healthcare facilities (5.9%) were established by shareholders. A total of 55 private health facilities have reported providing radiography services.

Table 4.1: Level and number of included private health facilities, Amhara Regional State, 2019

Level of facilities	Number of facilities (N=256)	Percent (%)
Primary clinics	92	35.9%
Medium clinics	116	45.3%
Specialty clinics	15	5.9%
Specialty centers	4	1.6%
Primary Hospitals	3	1.2%
General Hospitals	6	2.3%
Other clinics	20	7.8%

The data showed that, 247 (96.5%) private health facilities provide services out of normal working time such as evening, weekends and holidays. Only few, 9 (3.5%) were closed only on Sundays and annual holydays. As reported by owners and managers, average number of patients per day in a general hospital, a primary hospital, a specialty center, a specialty clinic, a medium and a primary clinic were found 130, 60, 61, 29, 15 and 8, respectively. Median number of health workers in a facility was three (IQR = 3).

4.3. PROFILES OF HEALTHCARE WORKERS

The sample included 274 healthcare workers. Among these, 147 (53.6%) were males and 127 (46.4%) were females. Only 9 healthcare workers have refused to respond for the interview. The mean and median age of healthcare workers interviewed were 30.45 and 28 respectively. Regarding professional profile, 11 (4.0%) were specialists, 11 (4.0%) were general practitioners, 74 (27.0%) were health officers and BSc nurses, 72 (26.3%) were diploma nurses, 64 (23.4 %) were laboratory and the rest 42 (15.2%) were from other health professionals (Table 2).

Table 4.2: Characteristics of included healthcare workers in private healthcare facilities in Amhara region, 2019

Item	Count (n=274)	Percent (%)
Sex		
Male	147	53.6
Female	127	46.4
Age (year)		
20-29	168	61.3
30-39	78	28.5
40-49	17	6.2
50-59	6	2.2
60-69	5	1.8
Total service years (year)		
0.5 (6 month)-5	147	53.6
5.1-10	88	32.1
Above 10	39	14.3
Service years at this facility (year) (n=273)		
0.5 (6month)-1	94	34.4
1.1-5	139	50.9
5.1-10	35	12.8
10.1-15	5	1.8
Participant's profession		
Specialist*	11	4
General practitioner	11	4
Health officer	19	6.9
BSc Nurse	55	20.1
Diploma Nurse	72	26.3
Pharmacy	13	4.7
Laboratory	64	23.4
Midwifery	16	5.8
Others	13	4.7

*Internists, surgeons, Obstetrician & Gynecologists and pediatricians together

Regarding to the path to attain their current educational level, 197 (71.9%) were generic whereas 77 (28.1%) were upgraded from lower level. Nearly half, 135 (49.8%) were private college graduates and 126 (45.9%) were public university or college graduates while others 13 (4.7%) were from in both public and private. Most 198 (72.3%) healthcare workers were born in towns while others 76 (27.7%) were in rural areas. Half, 137 (50%) of participants were married, 131 (47.8 %) were not and others 6 (2.2%) were divorced. Among healthcare workers graduated from private health institutions (49.8%), females were larger in number while males were greater in public health institution.

Healthcare workers were asked their plan to continue working in the private health sector or leave for another opportunity. As such, 135/268 (50.4%) healthcare workers have planned to leave as soon as possible. Moreover, 77 (58.8%) were seeking employment at the public healthcare facilities. Those healthcare workers graduated from private tends to seek employment at private healthcare facilities while those graduated from public health universities/colleges were hired first at public healthcare facilities. Of healthcare workers employed in private facilities 61/271 (22.5%) felt unsecured of their job.

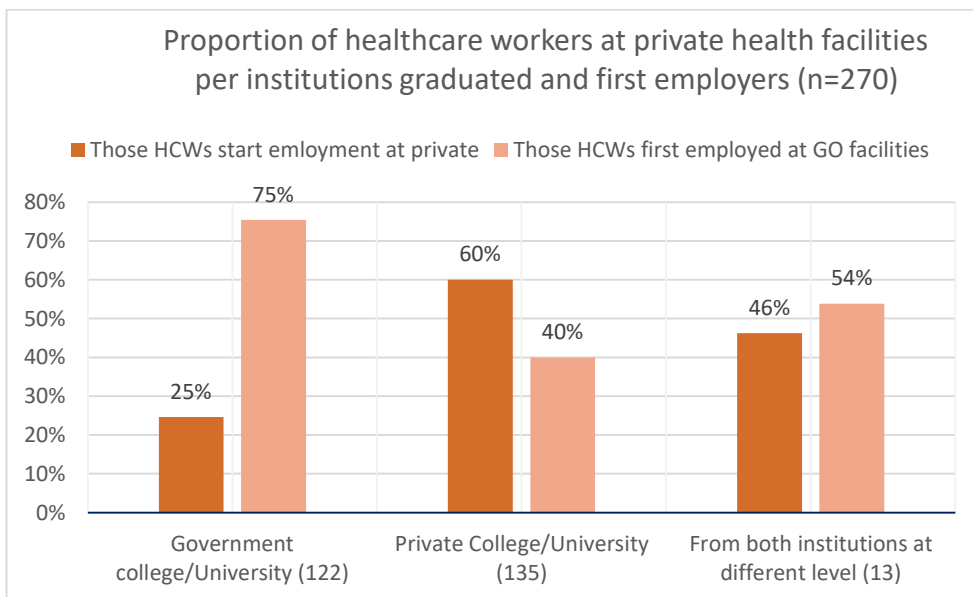


Figure 4.1: Proportion of healthcare workers at private health facilities per institutions graduated and first employer

Table 4.3: Sociodemographic characteristics of patients of private health facilities participated in the survey, Amhara regional state, 2019

Characteristics	Count (<i>n</i>=582)	Percent (%)
Sex		
Male	306	52.6
Female	276	47.4
Age		
15-24	86	14.8
25-34	202	34.7
35-44	158	27.1
45-54	86	14.8
55-64	19	3.3
≥65	31	5.3
Residence		
Urban	417	71.6
Rural	165	28.4
Current work as		
Farmers	132	22.7
Merchants	127	21.8
Government workers	160	27.5
Self employed	75	12.9
House wife	38	6.5
Educational status		
Not educated	169	29.0
Primary school (1-8)	124	21.3
Secondary school (9-12)	102	17.5
Diploma holders	96	16.5
Degree and above	90	15.5
Income quantiles (<i>n</i>=390)		
Q1-Poorest (Lower quantile)	78	20.0
Q2-Poor	79	20.3
Q3-Medium	89	22.8
Q4-Rich	82	21.0
Q5-Richest (Higher quantile)	62	15.9

4.4. PROFILES OF SERVICE CONSUMERS (PATIENTS/CLIENTS)

Three hundred six (52.6%) males and 276 (47.4 %) females) patients were participated in the study. The mean and median age of patients were 36.3 (SD = \pm 12.6) and 35 (IQR=15) years respectively. Majority, 417 (71.6%) were urban dwellers and the rest, 165 (28.4%) were from rural areas. Table 3 below summarizes the sociodemographic features of included patients.

More than half of patients (296/581) travel over 20km to reach their preferred private healthcare facility. Some patients reported a history of 400km travel history for accessing PHS. Nearly, three-fourth of participants 425 (73.0%) had a history of multiple visits to both public and private health facilities, holy water and traditional healers for their current medical condition (Table 4). Even though patients still complained the same illness, 298 (70.1%) reported satisfaction from their previous visit while only 92 (21.6%) did report dissatisfaction.

4.5. NATURE OF HEALTHCARE SERVICES AT PRIVATE FACILITIES

Private health facilities are working in different levels and capacities as per the national standard of the country. The survey indicated that, private health facilities are providing range of medical services that supposed to do. Except 8 medium clinics (4.9%), all other eligible facilities 156 (95.1%) have laboratory professionals at the time of visit and support their diagnosis with laboratory tests. In addition to this, some private health facilities 68 (26.6%) were organized by imaging services like x-ray, ultrasound, and endoscopy and perform accordingly. The referral linkage to either public or private and to higher or lower health facilities is open. Unfortunately, the included private health facilities did not have regular health education program except case specific counseling tailored to each particular diagnosis for a patient and may be companions.

Table 4.4: Variable related to patients' healthcare service consumption at private healthcare facilities in Amhara region, 2019

Item	Count (N=582)	Percent (%)
Time to seek healthcare service (n=555)		
Within two weeks	378	68.1
Above two weeks	177	31.9
Patients with companions (supporters)		
Yes	440	75.6
No	142	24.4
Expenses for services (n=569)		
Very low expense	114	20.0
Low expense	115	20.2
Medium expense	116	20.4
High expense	111	19.5
Very high expense	113	19.9
Sources of payment for healthcare services		
Self-deposit	338	58.1
Sell resources or others help (family&...)	244	41.9
Previous visit health facilities		
No	157	27.0
Yes (n=425)	425	73.0
Public health facilities	297	69.9
Other private health facilities	153	36.0
Same facility	92	21.6
Diagnosis supported by imaging		
No	234	40.5
Yes	344	59.5
Satisfaction at exit to service delivery (n=581)		
Satisfied	564	97.1
Not satisfied	17	2.9
Satisfaction at exit to cost of services (n=580)		
Satisfied	366	63.1
Not satisfied	214	36.9

4.5.1. Healthcare services provided

While adult OPD is the preferred and most common service at private health facilities, family planning 229 (89.5%) and ANC 161 (63%) were available with different modalities. In addition, HIV testing 104 (40.6%) and radiography 55 (21.4%) services were also exercised by private health facilities. Moreover, there are services rarely practiced by the private health facilities like vaccination (1.6%), ART (7.4%) and inpatient (9.5%) services. Selected private health facilities in the region have been allowed to run specific health programs that were primarily practiced only public healthcare facilities including provision of preventive health services. Provision of HIV testing and care, tuberculosis, malaria and family planning were among these healthcare services. Thus, 95 (37.1%) private health facilities reported providing HIV counseling and testing service, 65 (25.4%) providing TB DOTS services and 19 (7.4%) providing HIV care and treatment services.

Even though it is resource intensive, private hospitals strived to make state of the art medical services by hiring specialist physician and installing advanced diagnostic technology such as x-ray, ultra sound and automated laboratory machines, computerized tomography and MRI. It enables them even to serve patients referred from the public health facilities and attracting clients from remote areas. Moreover, as part of quality service, 83 (50.6%) laboratories from these private health facilities had regular external quality assessment (EQA) programme and demonstrated good performance. No private facility laboratory has obtained supervisory role for EQA as all were selected from the public sector.

Multiple laboratory order is reported among the included private health facilities. For instance, 377 (71.5%) patients requested multiple laboratory tests. Commonly requested sample for diagnosis was blood 497 (94.3%) followed by stool 371 (70.4%) and urine 320 (60.7%). In addition to this, 344 (59.1%) patients were also sent for other diagnostic techniques and imaging. Accordingly, 212/344 (61.6%) were sent for x-ray, 225/344 (65.4%) were sent for ultra sound and 24/344 (7.0%) for ECG/Echo. Facilities serving for longer years (>10 years) and provision of imaging services have shown significant

association ($\chi^2=17.55$, $p<0.001$). CT scan, endoscopic and pathological tests were not requested commonly.

4.5.2. Emergency care, inpatient and referral services

Management of emergency cases was practiced in all (256) sampled private health facilities at different level, at least providing first aid services and referred critical cases to other health facilities for better assistance. In order to get these services, patients or their companions need to pay immediately. A system of provision of free services for emergency cases was not established and practiced at private healthcare settings. All private health facilities except GAMBY General Hospital in Bahir Dar town, have no experience of providing any service for free for an emergency case and reimburse expenses back from any agent in the region. GAMBY General Hospital in Bahir Dar town has reported providing emergency services for free and reimburse their expenses from the regional health bureau. Even though private health facilities receive emergency cases for providing first aid services, all including hospitals do not fully engaged in provision of intensive care.

Patients of private health facilities were often referred to higher-level public and private health facilities for further investigation and management when failed to progress or get worsened. On the other hand, referrals were made to lower-level facilities when there is a need for follow up and continuation of care as per established standard. A total of 146 (57.0%) private health facilities have experienced patient referrals to other private health facilities in both directions beside referrals to public facilities too while the rest abstain to do that. Additionally, they were also making recommendations informally by providing oral advice to where or whom to visit for.

In-patient services were only allowed for higher-level facilities like specialty centers and hospitals unless for only resuscitation purpose for 24 hours. A total of 489 beds were found available in 23 private healthcare hospitals and centers for this study. The average

number of beds found for general hospital, primary hospital and specialty center were 37.5, 39 and 23 respectively.

4.5.3. Healthcare services for the poor

The public health sector have devised mechanisms to ease access for the poor or to increase health seeking behaviour to some selected health services especially high public importance. This has been done through fee waiver system, availing exempted services and community health insurance scheme. However, none of these were working in the private health facilities even if some reported providing free healthcare services to selected clients.

Facility managers and owners were asked to report the effect of health insurance and exempted services provided by the public health sector on the health market. Most, 193 (75.4%) private health facility owners/managers have reported that the difference did not affect their market. Many of the private health sector service users were coming after visiting public health facilities where minimal expenses required but with bad complaints on services. On the same way, 160 (62.5%) reported that community health insurance which is being practiced only in the public health sector will not affect our market due to the same reason mentioned above. In addition to this, a significant association was observed between the no effect attitude towards exempted services and insurance services practiced at the public sector ($\chi^2= 62.58, p<0.001$).

As mentioned above, systems were established to address poor population groups to access healthcare services in the public health facilities. However, the private is doing it differently and for different purpose. As self-reported by their managers and owners, 179 (69.9%) of private health facilities provided health services free of charge to some selected patients they think and confirmed poor by their own way. A total of 1,053 patients were supported free of charge at any level by the private health sector in one month time prior to data collection only by 179 facilities visited. Majority of these healthcare facilities 171/179 (95.5%) reported that free services were just to make social contribution.

4.5.4. Price setting for health services in private health facilities

Owners in 234 (91.4%) private health facilities performed setting price for each healthcare activity. Others 9 (3.5%), especially with higher number of healthcare workers and better organized facilities, have established a team to study prices of health services in the nearby similar facilities' and assess the market price of majority of inputs to set their own for each activity. Some other facilities owned as share company, 13 (5%) have formal established team to set price for all services and medicines they are prepared to deliver. They are also responsible to modify prices as per the current market around. Setting prices were by considering inputs executed to avail services, taxes and perceived profits.

The town or district revenue office often persuade facilities to post their price list at visible area in the facility to be seen by their clients mostly at the patient waiting area. However, no one from either government regulatory bodies, community members or clients' representatives if any, has influenced price settings for any service in any facility in order to meet agreed objectives. Similarly, no facility reported any consultation meeting with the population expected to be served in any matter at the beginning, in between or any time they make changes.

The median payment performed for single visit including diagnosis and medicines was birr 860 (\$30.85) (Exchange rate US\$1=27.8813 (National Bank of Ethiopia)) (IQR = 993 (\$35.62)). The maximum payment found in this study for one occurrence of treatment was birr 60,000 (\$2,151.98) and it was from in-patient. Whereas the 25th, 50th and 75th percentiles were birr 492.5 (\$17.66), 860 (\$30.85) and 1,485 (\$53.26) respectively. Similarly the 25th, 50th, and 75th percentiles of patients' monthly income were ETB 2,000 (\$71.73), 3,137 (\$112.51) and 5,097 (\$182.81) respectively. Only 12 (2.1%) of patients payed through private insurances while others payed out of pocket for their healthcare. About 42% of patients have used up sources other than deposited for generating payment for their health service. This has significant association with urban-rural residence as living in rural exposed more for use up of other sources than self-deposited for payment

($\chi^2=108.3$, $p<0.001$) and being a farmer, self-employed and house wives use up other sources than merchants and government employees ($\chi^2=220.24$, $p<0.001$).

All median expenses in all patient categories were more than a quarter of respective median incomes. More variation of median income observed in sex of patients (3,909 in males and 3,000 in females) while median expense varied minimally (865 in males and 860 in females). Even though too difficult to estimate incomes per month from informal sector like farmers and merchants, patients from urban areas had greater median income than rural areas (3,510 ETB urban/2000 ETB rural) while median expense of those from rural areas were much higher than those from urban areas (765 ETB urban/1,037 ETB rural). The total average paid amount is 39.9% of the total average monthly income reported by patients and even higher in some segment of the population groups like widows 150% and not educated 60.9%.

4.5.5. Data recording and reporting

A total of 229 (89.5%) private health facilities reported that they have prepared and submitted monthly report to the nearest government structure for compilation and analysis. For the purpose of reference, 210 (82%) facilities retained copy of reports. Only 67 (26.2%) facilities used standard printed copy of nationally recommended OPD abstract registers while others 181 (70.7%) used plain (handmade) register for recording of few variables. Printed out patient charts for each patient were used in 104 (40.6%) private health facilities while others prepared either plain charts made from cut rough papers or some other plain register from the market. Similarly, 197 (77%) healthcare facilities have used printed prescription papers while others have used plain paper with signature and facility's stamp. There is significant association between supervision visits and submission of regular monthly reports ($\chi^2=7.46$, $p=0.008$). Facilities serving for longer years (>10 years) and submission of regular monthly report show significant association ($\chi^2=5.12$, $p=0.021$).

Participants (n=130; 50.8%) from private health facilities reported that supportive supervision conducted in the last one year before data collection visit for this study. The average frequency of supportive supervision reported among these facilities was 2 per year. Supervisions were conducted by health managers including professionals from partner organisations with sometimes cover the fund. Facilities supervised more frequently were those supported by some partner NGOs working for only selected healthcare programs. For example, those facilities providing family planning services, HIV testing and care and tuberculosis diagnosis and treatment have been supervised more than others. Of the 130 supervised private health facilities, 118 (90.8%) reported that they feel benefited from supervisions and improved services.

Among 226 private health facilities, 186 (82.3%) were noted inspection visits at least once in the previous 6 months before data collection visit. The main feedback elements provided to these private health facilities during inspection were incompatible premises for healthcare delivery, few and below the standard sanitation materials and shortage of some professionals. Feedbacks were mainly extracted from the currently used healthcare standard corresponding to their level. From 250 private health facilities' managers/owners, 96 (38.4%) were not satisfied with the leadership of the healthcare managers at the government health structure of any level. Whereas others 154 (61.6%) were reported satisfied by the same level healthcare managers.

A total of 204 (81.3%) private health facilities stand against the working standard. However, the health managers responsible to evaluate facilities in their own area have categorized 172 (82.7%) private facilities as green (best prepared as per the standard) and 36 (17.3%) as yellow based on the previous completed year assessment result while the rest have not been assessed at the time of visit. No facility classified as red at the time of visit. Owners or managers of 70 (27.3%) health facilities were participated at least once either in the national or regional meetings in one year time before data collection. Most of them 49/70 (70%) were participated in the meetings that was organized by their association, Amhara region private health facilities and professionals association (APHFPA).

4.5.6. Choice of private healthcare services

Different patient reasons were stated to choose healthcare services provided in private health facilities. Among these, 295 (50.9%) of patients were due to their desire to save time and receive prompt help, 260 (44.8%) were due to expectation of better diagnostic products and experienced HCWs, 235 (40.5%) were for better responsiveness, 189 (32.7%) were as they know an experienced healthcare worker working in the facility and need his expertise and 120 (20.7%) don't know but expect experienced professionals in the health facility. A total of 265 (45.9%) patients were self-referrals, while some 216 (37.4%) were referred by their relatives or friends and others 62 (10.7%) were referred by other patients who visited the facility previously.

However, patients were also observed gaps that need to be addressed or organized better in health facilities they visited. Among these gaps identified by patients from private health facilities, 74/314 (23.6%) were reported high price services like for laboratory, drugs and other services provided, 43/314 (13.7%) were reported poor time management and 40 (12.7%) reported poorly staffed. Moreover, patients also mentioned 'unnecessary' requests for laboratory tests and procedures, poor diagnostics and staff turnover.

4.5.7. Delay in seeking care

Of 555 patients responded to question of how long you stayed ill at home before seeking healthcare, 68% were within two weeks of onset of illness. However, some have reported delayed up to a year or more. Regarding reasons, 208 (36.5%) patients were delayed to seek healthcare services due to different reasons such as lack of money, expectation of improvement by itself, busy time on other own businesses and transport problem. In addition, patients had visited other health facilities both public and private but returned back with same complain or no improvement. On the other hand patients reported that delay at the health facility was on average 2.86 hours.

It is a tradition that patients are accompanied by their family members as assistance if anything happened. About three fourth of patients, 440 (75.6%) were at the healthcare facility attended by their families, close friends or relatives. The number of companions varies from 1 to 10. However, in this study no association was found between the number of companions at health facilities and distance of their home from the healthcare facility or time taken to reach health facility.

4.5.8. Satisfaction at exit to service delivery and its price

Patients were asked their satisfaction level at exit and 563 (97.1%) of patients were reported satisfied to services they have received from each respective facility. However, patient’s satisfaction towards price of services were found different and only 366 (63.1%) of patients have reported satisfaction on the fairness of prices to services obtained from each facility. Others 168 (28.9%) of patients were dissatisfied to the prices of services provided. Surprisingly, from the satisfied group to the prices of services in the private health facilities, proportions of patients in the poorest and richest quartile were almost equal and lower while the middle group were relatively higher. Regarding to the not satisfied, proportions decreases from the poorest towards richest quartiles (figure 2).

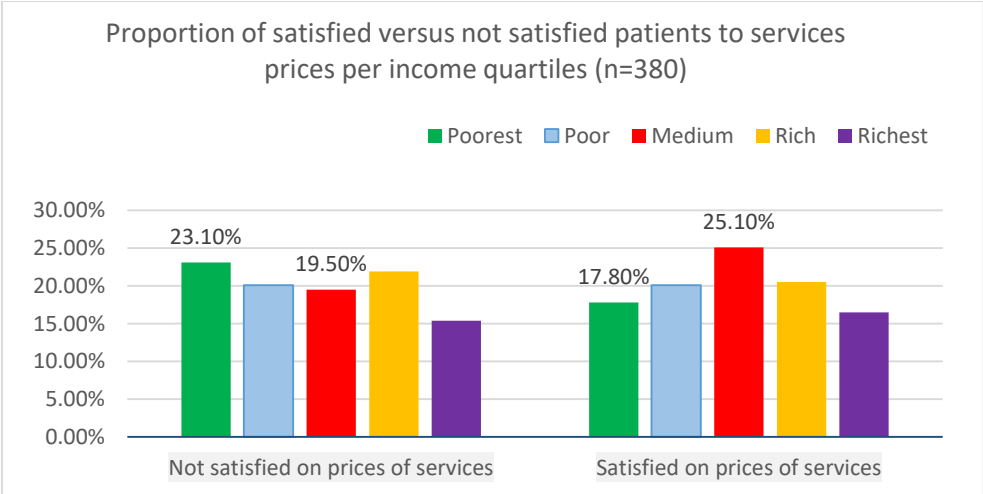


Figure 4.2: Proportions of satisfied versus not satisfied patients to price of health services per income quartiles

Satisfaction to prices of services were analyzed through logistic regression and showed significant association with some variables of this study. Significant association is found between satisfaction with prices to services and patients accompanied by companions and visit another health facility for this illness. Those patients coming to private health facilities without any companion were more likely to be satisfied (AOR=1.83, 95% CI=1.16-2.91, $p<0.01$) than those coming with companions. In the same way, those patients who had no history of visit to other facilities were more likely to be satisfied (AOR=1.97, 95% CI=1.24-3.12, $p<0.01$) than those who had history of visit. In addition, analysis showed as patients age increase, satisfaction to prices of services tend to decline (AOR=0.979, 95% CI=0.964-0.994, $p<0.01$).

Table 4.5: Factors significantly associated to satisfaction of patients to cost of services and related supplies at exit

Selected factors		Satisfaction to cost of services			COR (95% CI)	AOR (95% CI)
		Total	Yes	No		
Visit other health facility	No	156	121	35	2.53 (1.66-3.85)	1.97 (1.24-3.12)
	Yes	424	245	179	1	1
Age	(mean=36.3, SD=12.63)	580	214	366	0.97 (0.96-0.98)	0.98 (0.97-0.99)
Have companions	No	142	109	33	2.33 (1.51-3.59)	1.83 (1.16-2.91)
	Yes	438	257	181	1	1
Seeking health	Within two weeks	378	253	125	1.85 (1.28-2.66)	1.36 (0.91-2.02)*
	More than 2 weeks	176	92	84	1	1

*no significant association

4.6. MIX OF HEATH WORKFORCE IN FACILITIES

The total health workforce, with different professional and skill mix working in all selected private health facilities during the survey were 1,655 (1,350 fulltime and 305 par timers).

Number of health workers working in facilities also varies as per their clients and patients load to be served and level of the facility (Table 6).

Table 4.6: Average number of patients per day and healthcare workers by level of private health facility in Amhara region, 2019

Level of facility	Average number of patients/clients per day	Average number of health workers
Primary clinic	8	2 (1.6)
Medium clinic	15	5 (4.5)
Specialty clinic	29	8 (7.6)
Specialty center	61	23 (23.3)
Primary hospital	60	31 (30.7)
General hospital	130	52 (52.2)
Other clinic	7	3 (3.3)

The average number of full time workers were higher in general hospitals 52.2, followed by primary hospitals 30.7 and medical and surgical specialty centers 23.3. Even though low number of total par timers compared to total fulltime workers, number of doctors working for par time were a little higher than those hired fulltime. The total number of full time doctors were 140 (87 with specialization and 53 GPs) and those who practiced part-time were 149 (81 with specialization and 68 GPs) in private health facilities sampled for this study.

Some 72 (28.2%) private health facilities have par time workers of different experience and professional mix at weekends and nighttime. From the 305 par timer healthcare professionals reported, 81 (26.6%) were specialist doctors, 68 (22%) were GPs, 58 (19%) were nurses, 31 (10.2%) were health officers, 19 (6.2%) were laboratory professionals, and 44 (13.8%) were other professionals like pharmacy, radiographers and midwifery nurses.

Table 4.7: Number of fulltime and par time healthcare workers by professional type in the included private health facility in Amhara region, 2019

Healthcare workers in the included private health facilities	Fulltime workers	Par time workers	Sum (fulltime & par time)	% Par Time workers
Specialty doctors	87	81	168	48.21
General Practitioners	53	68	121	56.20
Health officers	137	31	168	18.45
Nurses	654	58	712	8.15
Laboratory prof.	247	19	266	7.14
Midwives	62	4	66	6.06
Others	110	44	154	28.57
Total	1350	305	1655	18.43

Physicians, both general practitioners and specialists account nearly half (48.5%) of par time workers. Average number of part time healthcare workers were observed high in general hospitals 15.2, followed by internal medicine and surgical centers, 12.8. Those facilities with higher part timer workers have served greater average number of patients per day.

A total of 110 healthcare workers (HCWs) left from 57 private health facilities in the last 6 months prior to data collection visit. Among the HCWs left private facilities, 63 (57.3%) nurses from 47 facilities and 21 (19.1%) laboratory professionals from 19 facilities were major constituents. On the other hand, 141 HCWs were hired in the same period in 69 private health facilities. Similarly, 78 (55.3%) nurses in 53 facilities and 24 (17.0%) laboratory professionals in 21 facilities were among those employed in the same period either for replacement or for the first time hire. A total of 177 facilities reported that they were in lack of at least one health professional that they have a capacity to hire. Among

these more than three fourth of facilities, 138/177 (78.0%) were suffered from unavailability of laboratory professionals in the market.

Healthcare workers have worked in a number of health facilities, both private and public, ranges from 1 to 11 until the time of visit. Private health facilities were the first gate of employment for 75 (28.4%) of healthcare workers. Other healthcare workers at the private health facilities were either resigned form public healthcare facility 96 (36.4%) or from another private health facility 93 (35.2%). Of the 274 study participants, 171 (62.4%) were still working to the first private health facility while others have changed up to six private health facilities. On average, the time period to get first hired for HCWs graduated from private health institutions was 4.34 months, while those graduated from public was nearly one month.

Plan to be closer to their families and live in towns in which a number of opportunities available like chances to continue education were among the reasons mostly cited for their leave from public healthcare facilities. While others that leave from the private health facilities were sought for better salary. There were also healthcare workers pushed out from their previous institution by disputes with their private healthcare managers or owners mainly due to high burden of work to unparalleled to payment.

A total of 260 (94.9%) healthcare workers have disclosed their monthly earnings and it widely varies among owned professions, number of service years and living with family. Consequently an average monthly salary was ETB 5,897.41 (\$211.52) and median ETB 4,000 (\$143.47). At the time of this study, the minimum monthly salary was ETB 1,000 (\$35.87) for a nurse and the maximum monthly salary was 50,000 (\$1,793.32) for an internist. Specialist doctors (internists, surgeons, obstetricians and gynecologists and pediatricians) averagely paid ETB 34,185.71 (\$1,226.12), general practitioners paid ETB 12,988.18 (\$465.84), health officers paid ETB 7,447.06 (\$267.10) and diploma nurses paid ETB 3,411.79 (\$122.37). Wide variations was also seen in the same professional category in different facilities and even within. Low income makes them to search for better payment and leave frequently from facilities and most of them inclined to go to

public health sector as the public is considered providing not lesser salary with additional benefits like chance for trainings, continuing education and lesser work burden.

4.6.1. Continuing education and training participation

A total of 68/241 HCWs (28.2%) reported as they lose chances of continuing education while working in the private health sector. At the time of this study, the criteria for continuing education especially some departments in the government universities preferred by healthcare workers in the private denied those healthcare workers from the private health sector.

However, some healthcare workers in some selected private health facilities supported by partners and projects for some selected health programs like HIV, TB, malaria and family planning were provided chances for some selected disease specific short-term trainings. A total of 118 (43.1%) healthcare workers reported that they have participated in at least one short term professional training of any type while working in current private health facilities. All trainings were provided by NGOs in collaboration with the regional bureaus mainly related to some specified health programs aimed to support.

Of 274 healthcare workers who participated in this study, only 29 (10.7%) reported assigned to work out of their profession like injection of drugs by laboratory professionals, reception and other admin activities at the time working in the private health sector. Even though not well specified, some 116 (42.3%) of healthcare workers reported that they have obtained some additional benefits other than salary mainly for overtime work in the facility. Only 6 (2.2%) reported absent from work while 25 (9.2%) reported late from work in the last one week of data collection visit.

4.7. WORKING PREMISES

Seventy eight (30.5%) private health facilities were providing services using their own buildings designed for such services while others 178 (69.5%) were working in rented

buildings which were built for residence or other business purposes. However, among facilities operated in their own buildings, 59/69 (85.5%) were categorized green while 113/139 (81.3%) facilities working in rented buildings obtained the same but no significant association were granted ($\chi^2=0.572$, $p=0.56$). private health facilities working with rented buildings have paid averagely ETB 7,460.7 (US\$ 267.59) per month and the range varies from ETB 380 (US\$ 13.63) to 68,750 (US\$ 2,465.81).

Private health facilities are working in very different capacities and settings even among same level facilities. However, only 30 (11.7%) of private facilities reported that they took loan from financial institutions like banks and credit associations in the region. Relatively higher number of owners who received loan services 18 (60%) from any lender have built their own buildings and providing services within while others 12 (40%) were on the process of building or bought medical equipment for service initiation and maintenance. A significant association is found between obtaining loan from any financier and owning building for provision of healthcare services ($\chi^2=13.99$, $p<0.001$). Additionally, obtaining loan services and paying better rent price (above its median ETB 4000) were significantly associated ($\chi^2=4.96$, $p=0.034$). However, the association of obtaining loan and staff retention was not found significant ($\chi^2=4.07$, $p=0.06$). As may be expected, this study found a significant association between increasing service years of facilities and ownership of facility buildings ($\chi^2=15.60$, $p<0.001$).

Table 4.8: Additional service elements found in private healthcare facilities in Amhara region

Item	Count (n)	Percent (%)
Working building		
Own building	78	30.5
Rented building	178	69.5
Facilities provide free care for anyone		
Provide free care	178	69.5
Not provide free care	78	30.5
Facilities refer to other private health facilities		
Yes	146	57.0
No	110	43.0
Member of Amhara private health facilities and professionals association		
Yes	162	63.3
No	94	36.7
Facilities label by regulatory body (<i>n=208</i>)		
Green	172	82.7
Yellow	36	17.3
Facilities visited for supportive supervision in last one year		
Yes	130	50.8
No	126	49.2
Provide regular monthly report		
Yes	229	89.5
No	27	10.5
Obtain loan from any financing institution		
Yes	30	11.7
No	226	88.3
Who set service price for the facility		
Owner of the facility	234	91.4
Shareholders of the facility	13	5.1
Team established for this purpose	9	3.5

4.8. WORKING TOGETHER

A total of 250 (97.7%) private health facilities have purchased their equipment or other necessary drugs and medical tools from private distributors. Private health facilities in the region have no any union or association that aims continuous availability of drugs and commodities common to all in order to be benefited from bulk purchasing.

Private facilities and some professionals who have work relations within the private health sector have established an association in the region in April 2013 called Amhara Private Health Facilities and Professionals Association (APHFPA 2017). Of the 256 facilities visited, 162 (63.3%) have been registered as members. Main anticipated purposes for prospected or registered members of this association were to fight for their rights 74/195 (37.9%), to construct bridge between private healthcare sector and government bodies mainly to deal on the standard 58/195 (29.7%) and seek benefits of standing in unity for better system. Membership to association and increased services years of facilities have significant association ($\chi^2 = 15.34$, $p < 0.001$). Two third of facility managers/owners 192 (75%) believed that the association can bring improvement to the private healthcare sector in the region and beyond.

The association sets different goals that will help the private health sector to better and faster flourish in the region and the country. Of the 189 owners/managers responded to question of what the association to focus on, 130 (68.8 %) prioritized to fully represent the private health sector and participate during policy decisions. A total of 104 (55.0%) private health facilities wanted their association to be delegated member of the inspection team organized by the regulatory body in the district or other government health structure and 104 (55.0%) to conduct promotion of the private healthcare sector. Provision of legal advice for its members when the need arises was raised by 101 (53.8%) facilities and nearly half, 94 (49.7%) needed provision of trainings tailored to their interests and gaps in the sector that may or may not related to specific health profession.

4.9. CHALLENGES IDENTIFIED

Private health facility owners and managers in the region have identified gaps and challenges. The main gaps disclosed were uncomplimentary regulatory system to private health facilities, lack of trainings and continuing education for health professionals, unavailability of enough health work force in the market and shortage of supplies to private facilities (Table 9). The regulatory system to the private health sector was mainly considered as fault finding and didn't recognize the existing economic, political and social situations, rather depended only on the provided tool extracted from the standard. Healthcare professional hired in the private health facilities were also identified most gaps mentioned above like lack of training and continuing education for staffs working in the private, unhealthy regulation system, high cost of services for clients and supply shortage.

Table 4.9: Identified gaps experienced during health service delivery in private healthcare facilities in Amhara region

Identified gaps related to	Number of health facilities reported the gap (n=212)	%
Regulatory system of private facilities	114	53.8
Training of health professionals	111	52.4
Continuing education HCWs	111	52.4
Health work force availability	107	50.5
Supplies to the private facilities	103	48.6
Land for establishing facilities	84	39.9
Loan for establishing facilities	73	34.4
High cost of services in private	35	16.5
Ethics during service delivery	20	9.4
PPPH	9	4.2

A total of 205 (75.6%) HCWs reported that they have seen training gaps for health workers in the private health facilities and 203 (73.9%) report no chance for further education except for some HCWs allowed time arrangement to continue their education at weekends and night time by their own cost. Nearly ten percent, 26 (9.6%) reported that services accumulated by healthcare workers working in private health facilities were not counted or dropped during competitions to join back government facilities. Healthcare workers 111 (41%) reported gaps related to regulation system as more pressure laid on private than public sector. Moreover, 109 (40.2%) believed the presence of gaps related to price setting to services in the private healthcare sector.

Table 4.10: Service areas where gaps reported by healthcare workers in private health facilities in Amhara region

Service areas where gaps are reported by HCWs	Number of healthcare workers	Percent (%)
Training for staffs at private	205	75.6
Education facilitation for staffs	203	74.9
Regulation system	111	41.0
Cost of services	109	40.2
Supply shortage	93	34.3
Ethics practiced by privates	75	36.1
Loan facilitation for private	41	15.1
Service years at private dropped when back to public	26	9.6
Gaps in working with public (PPPH)	25	9.2

4.10 DISCUSSION OF THE RESULTS

4.10.1 Distribution and contribution of private healthcare facilities

At the end of budget year 2016/2017, a total of 992 private health facilities (hospitals, specialty centers, specialty clinics, medium and primary clinics) were granted a license to provide healthcare services in Amhara region (Ministry of Health, Ethiopia 2017). The licensing and relicensing of these healthcare facilities is conducted as per the predefined set of standards prepared by Food, Medicine and HealthCare Administration and Control Authority (FMHACA). FMHACA formed by proclamation No. 661/2009, to avert health problems due to substandard health institutions, incompetent and unethical health professionals, poor environmental health and communicable disease (Federal Democratic Republic of Ethiopia 2010). Therefore, FMHACA in 2011 released 39 different standards for healthcare settings which are mandatory and currently implemented by the public and private facilities nationally and later endorsed by Ethiopian Standards Agency (ESA) in 2012, (Ejigu & Tadeg 2014:18).

Private health facilities are found densely in towns where there is better infrastructure and easier access to medical supplies available. The Ethiopian Ministry of health also acknowledges the growing role of private health facilities especially in urban areas (Ministry of health, Ethiopia 2019). This might be the reason and manifested as urban dwellers sought outpatient health services in private hospitals more than seven times than rural individuals (Ministry of Health, Ethiopia (NHA V) 2014:42). Service delivery by the private health sector is becoming important for the achievement of health system goals. The government recognizes that it cannot alone meet the existing infrastructure, capacity and delivery shortages in the current healthcare system.

Patient of private health facilities in the region were mainly attracted by positive perception about diagnostic equipment and treatment, expectations of better skilled professionals, low waiting time and better supportive customer strategies. A study conducted in Ghana stated perceived health system responsiveness was better in private than in public

(Awoke, Negin, Moller, Farell, Yawson, Biritwum & Kowal 2017:6). Another study conducted in Ethiopia on mothers' utilization of skilled birth services in public facilities indicated that perception of availability of adequate equipment was among significant predictors (Girmatsion, Yemane, Alemayehu, Wondwossen 2017:749). Additionally, the fifth household health services utilization and expenditure survey of Ethiopia stated that there was higher rate of dissatisfaction with waiting time and availability of pharmaceuticals (Ministry of Health, Ethiopia 2014:49). The 2017 Ethiopian health accounts, household services utilization and expenditure survey indicated availability of medicines, good counseling by staff, low waiting time and qualification of staff were among reasons of people choosing outpatient healthcare providers (Ministry of Health, Ethiopia 2017:1). To add more, a study conducted in India showed that private providers are more likely to offer a diagnosis (Das, Holla, Mohpal & Muralidharan 2016:3783) and this might be the first thing a patient wants to know.

As showed in the result section, there is remarkably few private health facilities accessed loan services from any financier and thus only few have built their own buildings and equipped better with medical tools. Private health facilities are working in very different capacities and settings even among same level facilities. Variations were in regarding to their premises, professional mix and experiences and available products for running services. Access to finance and availability of land are among major constraints to private sector development in Ethiopia (TAK-Innovate Research and Development Institution PLC 2016:20-21). In addition, the same document indicates the value of collateral needed for a loan (as compared to percent of loan amount) in Ethiopia is much higher (296.2%) and greater than the sub-Saharan average (214.2%) (TAK-Innovate Research and Development Institution PLC 2016:19).

However, older facilities have possessed their own working building and access to loan was significantly associated with working in own buildings, rented premises above median rental prices and better staff retention. Access to loan from any financial institution is a challenge especially for those facilities established recently with no assets for collaterals. Amy and Priya (2018:24) highlight this as commercial banks in Tanzania are unwilling to

lend to health facilities due to lack of adequate collateral and a high-perceived risk of lending to health facilities or providers. On the other hand, business owners are much recommended to invest more in private institutions such as hospitals and clinics as they are essential for favorable health outcomes (Bein, Unlucan, Olowu & Kalifa 2017:253).

4.10.2 Healthcare workers in private health facilities

The average number of full-time healthcare workers in each private health facilities were found much lower than expected by the standards. As stated in the standard, general hospitals shall have on average 234 professionals and primary hospitals shall have 53 professionals (Ministry of Health, Ethiopia 2015:142). A study conducted in public primary hospitals in four regions including Amhara were found that the average number of clinical staffs was 71 (Berman, Alebachew, Mann, Agarwal, Abdella 2016:13) which was higher stated in the standard. However, the result of this study reveals average number of staffs in general and primary hospitals were 52 and 31 respectively which is lower than both expected by the standard and results of the study in public facilities. Lower work force might limit healthcare services delivery and consequently, comprehensiveness as well as quality of care.

On the other hand, this study found higher average number of par time workers in general private hospitals followed by internal medicine and surgical specialty centers. Additionally, part-time workers mainly from public facilities might continuously adjust shortage of health workers in the privat health facilities as per variability of number of patients in a day. Number of doctors working for par time were found comparably equal to those doctors hired fulltime in private health facilities, even though the total number of par timers were few when compared to fulltime workers.

The presence of dual practice (working for public and private) in the region mainly by doctors seems high. In a study conducted in Ethiopia, more than 90% of physicians in the public have exercised dual practice in order to supplement income and associated with circular diversion pattern of patients (Abera, Alemayehu & Herrin 2017:1). Highly qualified

specialists can be directly accessed by patients' preference. In addition to this, specialists count part time working as a source of additional income. The same doctor in both public and private practice has a spent more time with cases and more likely to offer correct treatment in the private relative to the public practice (Das et al 2016:3767). The same document also indicated that dual practitioners provide less effort in their public practices relative to those without a private practice (Das et al 2016:3794).

Private health facilities were affected by high attrition and shortage of healthcare providers. Similarly, in a study conducted in Ethiopia, higher attrition rate of doctors (43.3%) were recorded in the public sector of Amhara region (Tsion, Damen, Wubegzier, Miliard, Wendimagegn 2016:285). On the other hand, there were evidences of shortage of healthcare workers especially middle and higher-level professionals in the region as well as in the country (Feyisa et al 2012:24). The health and health related indicators released by the ministry of health, Ethiopia in 2017 showed that number of all nurses, doctors (GP + specialists), health officers and laboratory professional in the region's public health facilities were 5401, 614, 1776 and 649 respectively (Ministry of health, Ethiopia 2017). It indicates that the healthcare workers to population ratio is below both national and international standards, which is more, sever in some professional categories like doctors. For example in 2009, the number of doctors and (nurses and midwives) for 1000 population in Ethiopia were 0.03 and 0.25 respectively (Ministry of health, Ethiopia 2019).

Private health facilities hired HCWs by searching from the market. This study also showed that those healthcare workers first employed at private facilities were graduated from private health institutions while those workers employed first at public facilities were graduated from public institutions. Low competition capacity of private facilities in providing benefits to their staffs, even though private health facilities have opportunities of short decision-making process, may have effect on recruitment. The imbalance between the demand of private health facilities and shortage of healthcare workers in the market may create higher work overload on existing staff and consequently will affect service quality. However, as most patients have history of previous visit to other health

facilities that will enable acquiring enough pre-information about services in private facilities, better quality might be their expectation. A single professional resigning from private health facilities, that used to execute work with less number of staff, potentially disturb the service quality.

Private health facilities used to work for extra time out of normal working hours at the evening, weekends and holidays. The finding of opening for extended hours per day is supported by Smith et al (2001:1) stated as private facilities are opened for longer time. This helps to catch clients, which will not have access to public health facilities as only emergency cases served out of normal working hours. In addition to this, weekends are very suitable for some patients (cold cases) outside the town as they or their companions will not be occupied by other businesses. Weekends might be appropriate for most people to receive health advices or make health visit for their non-emergent illnesses. On the other hand, private health facilities to work more time in order to satisfy clients as well as increase incomes.

4.10.3 Healthcare service delivery

The fifth household health service utilization and expenditure survey of Ethiopia indicated 19.8% of outpatient healthcare services were delivered by private health facilities (Ministry of Health, Ethiopia 2014: x). However, another community based cross sectional study in Dessie town, Amhara region, showed a higher proportion (38.4%) of the population obtained modern medical services from private health facilities (Bazie & Adimassie 2017:7). Additional document showed private health sector were providing better healthcare services to 35% of the population in the region (APHFPA 2017).

Excellence in health service delivery is one of the health sector strategic pillar of the HSTP. Good health service delivery is vital element of any healthcare system and attributes includes comprehensiveness, accessibility, coverage, continuity, responsiveness and coordination (Ministry of Health, Ethiopia 2015:75). Selected private health facilities with better staffed and laboratory set up have been allowed to provide

services such as TB DOTS, HIV care and treatment and malaria treatment, which were primarily practiced in public health facilities. Thus, additional supportive supervisions, trainings and follow up visits made by better skilled professionals mainly from NGO funded projects besides routine activities done by experts from government structure. The health services delivery function is the processes of selecting services, designing care, organizing providers, managing services, and improving performances. It does not act alone, influenced by other health system functions of governing, financing and resourcing (Eric & Juan 2016:46).

The availability of services were not found the same across private facilities themselves. Private health facilities need to increase satisfaction of their clients by providing better quality healthcare services tailored to clients' interests. In addition to that, private health facilities appreciate the importance of availing diagnostics and medicines mainly not easily accessible from public health facilities. However, provision of HIV testing services, participation in TB DOTS, malaria treatment programs and vaccination were among services installed at only few private health facilities. Drugs and other supplies for these programs were run merely by public facilities. Promising partnership were established with private health facilities in working to elevate healthcare access. This witnesses that private health facilities can provide public health services if provided inputs and available requirements. Consequently, this might have impact on clients' satisfaction and building capacity for further competition, profitability and sustainability. More satisfaction were observed in patients from the private hospitals than patients from public hospitals in Addis Ababa, Ethiopia (Tateke, Woldie & Ololo 2012:1).

Private health facilities have mainly engaged in providing outpatient services for all adult and pediatric patients. Family planning and antenatal care (ANC) services were also delivered by more private health facilities while antiretroviral therapy (ART) and immunization services were seen rarely practiced. Similarly, service availability and readiness assessment in 2016 in Ethiopia revealed that only 2% of non-government facilities have provided child immunization services in the country (Ethiopian Public Health Institute 2017:34). A systematic review on the role of private health sector in

providing quality health services showed that private health sector contribute much in creating access to health service delivery like family planning and control of communicable diseases (Weldemariam, Bayray 2015:12). Lower immunization and ART services may be due to requirement of high technical competencies and the need of consistent supply chain management in addition to the presence of profit oriented management and services in the private health sector.

Moreover, only less than one in five private health facilities provided delivery service. The Ethiopian services provision assessment plus survey (ESPA+) has also reported that normal delivery service were provided 27% of private for profit facilities (Ethiopian Public Health Institute 2014:172-173) which is higher than the result in this study. It might be due to the patients increasing use of community health insurance in recent years that only favours the public health facilities.

Private health facilities were not found using their full capacity to run some healthcare services. Since many of maternal and child care services (ANC, delivery, postnatal care (PNC) and immunization) are exempted in public health facilities (Ministry of Health, Ethiopia 2017:117), services consumers of private health services may waver to choose these services in private settings. Exempted services are offered free to everyone regardless of income level (Ministry of Health, Ethiopia 2017:117). HIV counseling and testing services including care and treatment were also among exempted services. However, four in ten private health facilities were found providing HIV testing services while findings stated in Ethiopian service provision assessment plus described as 45% and 72% among medium clinics and higher clinics respectively (Ethiopian Public Health Institute & Ministry of Health, Ethiopia 2014:195). HIV and other diagnostic test are not allowed in private primary clinics, as they have no laboratory setup (FMHACA 2011).

Even though private health facilities are mainly targeted on diagnosis and curative services, their engagement to the preventive activities were not found minor. For example, participation in the provision of family planning and ANC were found greater. However, the 2016 HSTP I annual report indicated that contributions of private healthcare

sector were only 10.5% in contraceptive acceptance rate, 4.3% in ANC 4+ and 3% delivery but relatively higher cesarean section, 19.9% (Ministry of Health, Ethiopia 2016:18). Unfortunately, there was no formal health education session provided in the private healthcare settings. However, it is common to provide tailored health education messages specific to disease diagnosed for patients and companions by healthcare workers at the spot. Thus, the provider may easily catch patients' attention to deliver basic information on how to prevent the disease diagnosed or reduce the disease's further detriment, ways of transmission and possibility of cure by their physician.

Only half of private health facilities were supervised in a year time and majority acknowledge benefits even though inadequate. Yet, regular supportive supervision is an important tool to improve service delivery in different aspects including maintaining better quality and to align with current recommendations and directions. It also encourages team building for problem solving and decision making towards goals of the healthcare facility. Similarly, external reviewers for quality assurance assessed only half of laboratories' of private health facilities. It was mainly in line to the presence of some health programs like TB and HIV diagnostic services in the facility. Assessment mainly checks professionals' technical capacity assigned to perform laboratory tests, availability of required reagents and accessories, functionality of the laboratory equipment, and provision of feedbacks and follow up by trained and experienced professionals from higher and networked institutions.

Managing of emergency cases, at least providing first aid and referral services were provided in all (256) private health facilities included in this study. However, patients in private health facilities were requested to pay immediately for services. Moreover, at the time of emergency, it is very difficult to pay for services that may even require admission to intensive care or get someone nearby for support. Similarly, another study in Ethiopia found emergency care in private hospitals is often not even initiated without a down payment. In addition, the same study elaborates investigative and therapeutic procedures are often withheld until payment is received and those patients who lack sufficient funds are directed to seek care at government hospitals (Fikre, Tesfaye, Tsegazeab, James,

Kidist 2012:5). On the other hand, an editorial in the WHO bulletin indicates the need of strategies aims to ensure emergency care for all people regardless of sociocultural factors and the ability to pay before receiving services (Hagos, Frew, Gebreyesus, Sambo & Reynolds 2019:582). Another WHO document urges member states to create policies for sustainable funding, effective governance and universal access to emergency care for all, without regard to sociocultural factors and requirement for payment prior to care (WHO 2019:3).

In some cases, private health providers referred their patients due to the patients' inability to pay for services in private as the public health facilities provide care in lowest payment or for free through fee waiver and exemption system. Patients from rural areas were subjected to more expenses than those from urban areas. Patients from urban areas can seek healthcare services early and before complicated. Those patients living in rural areas and farmers, self-employed and housewives were exposed to use up resources other than deposited. In the same way, Ministry of health of Ethiopia in 2018 has reported unexpected illness requires patients to use up their life savings, sell assets, or borrow and it will destroy their plan and often those of their children. Expenses were not only to medications and to treatments; it includes other incidental costs for food, housing and transport during their stay. Majority, 98% of patients payed out of pocket which is the least fair way to pay for health (The Save the Children Fund. 2019) and cause of household financial pressure for patients (WHO 2010:2).

Private health facilities were not fully involved in provision of intensive care for seriously ill patients due to different reasons. Some critically ill patients required higher-level experienced and skilled professionals often in teams and too costly services. Therefore, seriously ill patients commonly referred to public healthcare facilities. Tynkkynen & Vrangbaek (2018:1) in their review showed that public facilities tend to treat patients who have riskier lifestyles and higher levels of co-morbidity and complications than patients treated in private hospitals. Similarly, a study to analyse mortality outcomes in hospitals of different ownership in Chile revealed that severely ill patients could be directed to public hospitals when they come from lower socioeconomic settings and their health status on

admission to hospital were mentioned as reasons to a lower proportion of death in private facilities (Pedraza, Herrera, Toledo & Oyarzún 2015:i81).

On the other hand, referrals to among private facilities were practiced less commonly. Some patients may understand referrals as indication of all round better quality services and performances. However, referrals usually done not only for critical cases but also to search for services, diagnostic equipment and closeness to patients' residence for follow up and continuation of services. Referral is a two way process and ensures that a continuum of care is maintained to patients or clients and can be among public, private, community based and other traditional and alternative medicine practitioners (Ministry of Health, Ethiopia 2010:2). In general, patient referral to either side, public or private, up level or down is very important and should exhaust all the benefit of patients. Patients perceptions about the healthcare providers, perceptions about healthcare equipment, advice from relatives and friends and access to healthcare facilities were identified to have resulted in the bypass of the primary healthcare facilities in favour of the secondary level of care (Koce, Randhawa & Ochieng 2019:1).

Highly experienced physicians in private health facilities have spent more time on cases less complicated or can be dealt with other less experienced healthcare providers. This was mainly done due to better respecting of patient preference. It is highly beneficial practice for clients to access senior physicians directly in their first contact. However, it looks a wastage of few and essential healthcare providers mainly to provide better support for patients in critical condition. The referral system needs to devise the way in which these resources in private health sector can be used more easily and efficiently.

The average number of hospital beds found in this study met the standard or exceeds except less in general hospitals. This shows that the private health sector contribution to in-patient healthcare services is high as there is a general shortage of hospital beds in the region. In-patient service is only allowed and functional in specialty centers and hospitals. The minimum number of beds required for the general and primary hospitals and specialty centers as per their specialty were 50, 35 and 10 respectively (Ministry of

Health, Ethiopia 2011). The hospital inpatient bed availability in Ethiopia stagnated at around 2.1 per 10,000 due to population growth (Alebachew, Laurel, Matt, Sharon 2014) whereas WHO and The World Bank in 2017 estimated 3.1 per 10,000 in 2015 (WHO and The World Bank 2017). There were 5,117 in-patient beds in Amhara region (Ministry of Health, Ethiopia, 2017).

4.10.4 Healthcare financing

The median expense of patients per single visit of private health facilities in this study was 860 ETB, nearly a two fold increase to a result (310 ETB) of a study among Ethiopian public primary hospitals even though, greater variability among regions like 510 ETB in Amhara (Berman et al 2016:8). This mainly support complains of high service price in private facilities and raise the issue of fairness. A study conducted to assess impact of user charges on health outcomes in low and middle-income countries suggested that reducing user charges is likely to have beneficial effects on health outcomes and reduce health inequalities (Qin, Hone, Millett, Moreno-Sera, McPake, Atun & Lee 2019:10). Owners or a team established including shareholders have responsibility of setting price for services in their facilities. Private health facilities are licensed to serve people with best attainable healthcare services and expected to avail it with an affordable price.

The average expenses of patients of the private health families varies as per residence while their income varies per their residence and sex. Those living in rural areas and females are with the lower incomes. Almost all service customers (98%) and healthcare services in the private health sector were obtained through out of pocket payments. This might have favored customers with better income. The Ethiopian household health services utilization and expenditure survey in 2017 indicate that individuals living in the richest households were about four times more likely to use private hospitals and about five times less likely to use government health centers or NGO hospitals compared with the poorest households (Ministry of Health, Ethiopia 2017:2). The same document showed that individuals from the rural area are predominantly using public health services.

In this study, patient satisfaction to prices of services delivered was significantly associated with availability of companions, age of patients and history of visit to other health facilities. Patients who visited private facilities with companions during their stay have lower satisfaction to prices for services delivered. This is probably due to additional incidentals for companions may require additional expenses and pressures to patients. In the Ethiopian demographic and health survey of 2016, 42% of women mentioned a reason of not wanting to go alone to healthcare facilities as barrier to access (Central Statistics Agency & ICF international 2016:141). The number of companions found in this study varies from 1 to 10.

Visiting other healthcare facility before this visit for the same illness was also found associated with lower satisfaction to price of services. This may be due to patients' exposure to more financing system at different facilities that will enable to acquire knowledge for comparison one from other and had longer time to understand related issues. On the contrary, Trivedi & Jagani (2018:21) have stated that there were no significant difference of patient satisfaction among patients who visited doctor earlier and those visiting first time. Similarly, another study also demonstrated no difference between first and repeat patients to their satisfaction to service quality (Mthethwa & Chabikuli 2016:458).

Patient satisfaction decreased as patients get older and this is against a study to measure women satisfaction to delivery services in public health facilities in Ethiopia (Tefaye, Worku, Godana & Lindtjorn 2016:5). Likewise, another study in china showed older people were more likely to express satisfaction towards hospital inpatient care (Shan, Li, Ding, Wu, Liu, Jiao et al. 2016:7). This might be due to differences in service delivery settings, public or private. However, a study in Ghana indicated that older age group is associated to use private health facilities than public (Awoke et al 2017:4). Occurrences of repeated and chronic illnesses at older ages may expose to increased payments and will lead them to dissatisfaction.

Private health facilities were not included in the provision of healthcare services free of charge, which is allowed and practiced in public healthcare facilities. Free service provision is through fee waiver and exemption. Amhara region was the best performing region in terms of waivers covered about 7% of the regional population in 2014 (Alebachew, Yusuf, Mann, Berman, 2015:45). Yet, covering 7% percent of the regional population is very low compared to the estimated number of households living below poverty line i.e. 23.4% (National Planning Commission & The United Nations in Ethiopia 2015:20). This action mainly is in order to facilitate access to healthcare services for the poor and boost the healthcare seeking behavior of the people. However, a mother prefer to deliver in the private health facility has to pay for services and medicines she might have to take free of charge in the public health facilities. Exclusion of private health facilities from such service provisions will have effect on the accessibility of services and increase burden on the public health facilities. Eleven percent of patients admitted to inpatients services were due to availability of exempted services (Ministry of Health, Ethiopia, 2017:2).

Even though, the government of Ethiopia highly promotes and implements community based health insurance (CBHI) scheme, private health facilities were not included and only public health facilities are the service providers for members. CBHI is believed to create and trigger the health seeking behavior of the community and may increase burden on the public health facilities. It consequently create outflow of patients from public to private. Private health facilities that have gone through accreditation and agreed to provide services at established tariff were planned to be considered (Dibaba, Hadis, Ababor & Assefa 2014:14). Unless a particular drug or service is unavailable in the public facility, enrolled households may not seek care in private facilities (Yilma, Mebratie, Sparrow, Dekker, Alemu & Bedi 2015:3). However, majority of private healthcare managers reported that exclusions from either insurance system or exemptions may not have impact on the existing market. On the contrary, there were private health facilities considered it as unfair and the system from the beginning should have to plan for the private too. Otherwise, insurance system and other way of free healthcare delivery mainly

practiced in public health facilities may create market imbalances in the health sector unless equally available across sectors.

Many health programs especially maternal and child healthcare in the health system are run with support from donations through different projects and partners. The share of health spending by external sources was almost 50% in 2010/11 in the country while out of pocket (OOP) and government spending to health in the same years was 34% and 16% respectively (Alebachew et al 2015:57). The private health sector's involvement to access these supports for full-scale service availability was minimal. The private health sector is working legally and serves large segment of population but both the private health actors and clients were left without benefits from these supports. The allocated budget for health by the regional government (Amhara) from the total woreda government budget 2013/14 was 10% (Alebachew et al 2015:39). Both the government and other spending from external sources were rarely reached to the private health sector. This will certainly affect the healthcare delivery practice in the private health facilities and its clients.

There is no established system of serving patients who cannot afford service cost in private health settings. The fee waiver system to address the poor access healthcare services is only provided in the public health facilities. Those witnessed poor by the local administrative council will get healthcare services in the public health facilities freely (Ministry of Health, Ethiopia 2016:117).

The absence of mechanisms persuaded private health facilities to provide free services like first aids and anti-pains or more for those patients they think poor at the time of service delivery. Within one month time before data collection visit, included private health facilities have reported waive or decrease payment for 1,053 patients unable to pay by providing charity care. In order to achieve UHC, private healthcare providers are an essential component of free or low cost healthcare delivery (Roland, Bhattacharya-Craven, Hardesty, Fitzgerald, Varma, Aufegger, Orlović & Nicholson 2018:04). This

suggests clear potentials private health facilities supporting the poor and indicate windows of opportunities to provide available services run through donations.

Either private health facilities did not report any consultation meetings with the population they are expected to serve in any matter at the beginning, in between or any time they make changes. However, involving people and communities during the design of health services by health facilities is becoming recognized as a key determinant of better outcomes (WHO, OECD, and The World Bank 2018). The health sector transformation plan stated that the legal framework for the health service delivery administration, governance and management encourages health facilities to administered by a joint governing board established with representation from the community, health institutions' staff, and other government offices (Ministry of Health, Ethiopia (HSTP) 2015:43-44).

4.10.5 Standards and regulatory practice

The private health sector is mainly targeted to curative healthcare services. In Ethiopia, private primary hospitals, medium and primary clinics are considered as part of primary level of care, the first tier of health services delivery (Ejigu & Tadeg 2014:8). Provision of promotive, preventive and essential healthcare services are mainly practiced by facilities in this level of care as per the standard. The health facility standards currently at work were officially launched in 2013 (Ejigu & Tadeg 2014:15). Yet, different complains are still unsettled about the standards such as it is above facilities' level of work situations. This was basically raised by private health facilities and asked long grace period (Ejigu & Tadeg 2014:20). However, adapting minimum required standards to all private facilities promises to have a large positive impact on service quality (Cross, Sayedi, Irani, Archer, Sears & Sharma 2017:339).

Standards for each level, especially for higher-level facilities require professional and financial capacity beyond common expectations. Private facility owners repeatedly complained that materials rarely needed or used in the facility were also required by the standard while their price affects the facility's economic capacity and sustainability.

Moreover, the standard also requires professionals and materials that are not easily available in the market. A study conducted in Ethiopia revealed that human resources were consumed more than half of public primary hospitals' expenditure (Berman et al 2016:8). This indicate the burden created in healthcare facilities increased when staff number increased.

The regulatory body used professionals in the government structure for health in each respective district to conduct regular inspections for monitoring to all healthcare service provider facilities. Even though there were infrequent visits reported from private health facilities, about a third of facility owners or managers expressed dissatisfaction with comments or directions provided during inspection visits. It highlights the need of consistent regulatory practices such as inspection and accreditation. A document prepared by WHO and The World Bank stated that suboptimal clinical practice is common in both private and public primary healthcare facilities in several low and middle-income countries (WHO, OECD, and The World Bank 2018). However, implementation of regulatory system encourages double standard, which criticized to impose more negative influence on private health facilities. In the same way, the Ethiopian national healthcare quality strategy indicated weakness of the health system in the national level as public and private sector are not always held to the same criteria or standards (Ministry of Health, Ethiopia 2015:64).

Only few private health facilities have standardized data recording tools like OPD abstract logbook while majority of facilities have regularly submitted monthly reports to their respective district health offices. This probably affects data quality reported for national and regional for further analysis and decision-making. Private health facilities need to report what they have done as per the national schedule through the government structure. The distribution of private sector data is similar to that of public sector and 74% of private sector data captured are related to service delivery (Bhattacharyya, Berhanu, Tadesse, Srivastava, Wickremasinghe, Schellenberg & Avan 2016:i28). Reports usually prepared in a weekly, monthly and quarterly basis and submitted to the district health offices or zonal health departments for further analysis and decision-making.

4.10.6 Working together

In order to act and contribute better to the national health performance, private health facilities should have to enhance their effort to work together on common matters. As a result, private facilities and some professionals in the region have established an association in April 2013 called Amhara private health facilities and professionals association (APHFPA) (APHFPA 2017). The association has working to maximize members and identified common priority goals especially to improve level of the working field in relation to current health facility standards. This association has also country level structure to better coordinate and enable making an impact on the healthcare system policy and others nationally. It aims to improve members' presence to speak loud on common interests and act together on various issues in the sector.

It is only a quarter of private health facility owners or delegates have participated in at least one regional or national meeting in a year. Even though national or regional meetings were few and organized occasionally, participation of the private healthcare sector ensures provision of inputs in identification of national health priorities and better contribution to health policies and strategies. Availability of such discussions will help the private sector to better organize and exercise their rights as well as carry responsibilities. Responsible bodies while developing strategies to improve health sector quality and outcomes will further discuss ideas produced in such meetings. The private sector provided an immense opportunity for complimenting the public and growth by mobilization of skilled work force, establishing strong network of supplies and introduction of new services and products to ease healthcare delivery towards achieving UHC.

Private health facilities in the region did not establish any union or association tying available and fragmented capacity together especially in medicines and other supplies distribution common to all. This will lead them to lose benefits of purchasing in bulk and affect availability of supplies negatively. Canadian pharmacist association (2005:1) showed that some Canadian hospitals and individual pharmacists pooled together to use

bulk purchasing of drugs to save money. Consequently, such problems might have bigger influence in setting of health services prices in private facilities and contributed for higher price health services and medicines in private facilities. A review on policy options for pharmaceutical pricing and purchasing stated that medicine pricing is interdependent on the medicine purchasing system and patients are price acceptors (Nguyen, Knight, Roughead, Brooks & Mant 2015:275).

Pharmaceutical Fund and Supply Agency (PFSA) was established for coordinating sector wide effort aimed at significantly improving sustainable availability of quality assured pharmaceuticals at an affordable price to the public (PFSA 2015). However, private health facilities reported that they rarely accessed it. This might be due to priority given for the public health facilities or private health facilities discouraged by long procedures. Therefore, private health facilities are obliged to purchase their medical supplies from private importers and distributors.

4.10.7 Challenges in the private health sector to deliver services

The private health facilities have identified lots of gaps and challenges in the region such as uncomplimentary regulatory system to private health facilities, lack of trainings and continuing education for health professionals, unavailability of enough health work force in the market and shortage of supplies to private facilities. Vilasini et al (2010:64) have mentioned availability of work force, cost and availability of drugs, availability, cost and maintenance of equipment, cost of capital and financing mechanisms as critical factors affecting private providers. In addition, Ministry of Health of Ethiopia in its press release in 2018 has stated major challenges to UHC in the country as highly dependent on external sources, high socioeconomic, urban-rural and regional inequalities in health service coverage. The cumulative effect of a number of sociodemographic, economic and environmental changes as well as rising care expectations have placed new demands on health services to deliver care that is proactive, comprehensive and continuous that is built on sustainable patient-provider relationships (World Health Organization 2018:1).

Private health facilities often complain their contribution in the healthcare provision not well acknowledged and regulators habitually saw private sector as working only to maximize and sustain profits. Private health facilities are serving the public by respecting the rules and regulations of the country even though significant number of private health institutions practicing illegally (Ministry of Health, Ethiopia 2015:53). Moreover, Morgan et al. (2016:606) stated that the performance of the private sector seems to be linked to the structure and performance of the public sector, which suggests that a regulatory response focused on the health-care sector as whole rather than individual providers alone in order to obtain population benefit from the private health-care sector. Another study conducted in Nigeria, detailed that technical quality in private for profit will be inferior to that of public when the public is weak and will be superior when the public provides reasonable health services (Hirose, Yisa, Aminu, Afolabi, Olasunmbo, Oluka, Muhammad & Hussein 2018). Similarly, WHO stated that when the regulatory capacity is not strong and the development of private sector regulation is limited, mixed health systems often do not voluntarily operate in consistent way with the country's health goals (World Health organization 2018:2).

Both short and long-term trainings along their professional line or other essential areas of continuous development were not easily accessible for the private health sector. Healthcare workers who specializes or sub-specializes left public health facilities to work in private after completion of contract. Healthcare providers need to be updated regularly or given chances for further education by the support of the government or the private sector itself. Otherwise, result will be low adherence to latest guidelines and compromised quality of services, which will lead for mistreatment. Since medical regulatory activities are both financially and human resource intensive, it can be challenging to ensure that guidelines are followed especially in poorer countries (WHO, OECD, and The World Bank 2018).

Access to loans demanded by private health facilities to buy basic and contemporary medical equipment, employ competent professionals with prominent reputation and build or renovate premises that fits the needs of their clients and regulatory bodies. Due to

limited financial and technical assistance, some private facilities may fail to implement quality improvements and open to warnings and exposures (Ministry of Health, Ethiopia 2015:60). On top of that, access to land free or in lower price may assist the sector to better available service. Vilasini et al (2010:61) have described the active role of government is a facilitator for the growth of private facilities in the country. Otherwise, the sector will not escape out of running businesses in poor settings, which will finally influence quality of services provided and poor users' outcomes. A statistically significant association of obtaining loan and owning health facility buildings evidences this. Many private healthcare facility owners and managers start their business with difficulty mainly to make fit as per requirements from health facility standard, which require large initial investment.

The private health facilities raises weak partnership of working with the public health sector in the region in order to influence to use maximum potentials of the private sector. Similarly, Weldemariam & Bayray (2015:12) have stated partnership between public and private in developing countries remained weak mainly due to poor governance, in appropriate design, poor regulation and lack of standardization and financial limitations. Facilitating exchange of skills and expertise between the public and private sectors helps to learn each other and augment the health system for better performance. The same population is being served by both sectors but have different ownership, management and resources. Public and private partnership to enhance utilization of all available health resources timely and efficiently. For example, outsourcing of non-clinical services to the private sector is increasing especially from hospitals were mentioned in the Health Sector Transformation Plan (Ministry of Health, Ethiopia 2015:50). In Amhara region, only 4 public hospitals have opened private wing and 21 public hospitals have outsourcing non clinical services such as security, food for patients and maintenance to private organisations (Ministry of Health, Ethiopia 2017:118).

The interaction will facilitate more the culture on how to hold services consumers and experienced healthcare workers in better way of payment parallel for better performance, reputations and market. Partnerships emerge not only due to financial gains and benefits

between parties but can also be attributed to certain non-financial factors like transfer and exchange of knowledge and technical know-how, management abilities and reduction of risks involved (Thadani 2014:309). Promoting and implementing the public private partnership for health in the region can certainly reduce the burden of public health facilities. Minister of Health of Ethiopia has given attention to work collaboratively with private sector by engaging them in the provision of secondary and tertiary care health services, manufacturing indigenous health products, alleviating human resource constraints and nurturing the existing PPP in the health system (Ministry of Health, Ethiopia 2016:119).

Price of services in the private sector is considered high by their patients as it is mostly compared to prices mainly in public. The complaint might be related to low financial capacity of patients seeking care in the sector. Total expenses were also made higher in some private health facilities by ordering unnecessary requests and procedures just to earn money. Similarly, Basu et al 2012:5 has mentioned unnecessary antibiotics and procedures including cesarean section prescribed by private facilities and physician-induced demands when prescribers are also drug store owners. This conflict of interest highly affects ethical values at the time of provision of medical services. Payments to healthcare services needs to be reasonable, reward providers equivalent to their performances and respect health policy objectives.

4.11 SUMMARY

This chapter explained findings of the study in detail that was sample description including inferential analysis of some variables in line to objectives of the study. Discussion of results in relation to expectations, comparisons to other study findings and literatures was also included. The next chapter will deal on the guideline to recommend health services delivery in the private health sector to better enhance health system of the region as well as the country.

CHAPTER 5

GUIDELINES TO ENHANCE HEALTH SERVICE DELIVERY

5.1. INTRODUCTION

This chapter presents guidelines to enhance health service delivery in the private health sector. The chapter builds up from the evidence collected for delivery of comprehensive service as indicated in the findings for phase 1 (chapter 4). The findings from phase 1 were presented in line with the theoretical model used for this study. It is envisaged that the guidelines will have great support in the improvement of health services delivery by the private health sector in the Amhara region. The development of the guidelines required the involvement of multiple stakeholders such as policy makers, partners, health program managers, healthcare providers and patients/clients.

5.2. PURPOSE OF GUIDELINES

The purpose of the guidelines was to support the improvement of utilisation of healthcare services in the private health sector in the region for this study. It is envisaged that the guidelines would increase the contribution of private health sector in the enhancement of healthcare system to better fit the local and regional healthcare demands.

5.3. SUMMARY OF DONABEDIAN'S QUALITY CARE MODEL AND THE FINDINGS OF PHASE 1

The proposed guidelines are described and presented using Donabedian's quality care dimensions. Donabedian points out the need of detailed information about the causal linkages among the structural attributes of the settings in which care occurs, the processes of care, and the outcomes of care (Donabedian 1988:1743).

Although, the application of Donabedian's framework focus on the provision of quality of care delivery, in this study it was applied on the assessment of comprehensive care delivery system in the private health sector. The structure of private healthcare facilities and their levels, equipment and supplies to provide care, training status of staff and skill mix up were measured. In addition, ways of practice by providers and attitudes towards working in the private and their clients, supervision type and its frequency and comforts of facilities were addressed.

The second concept is processes of patient care that denotes what is actually done when giving and receiving care (Donabedian 1988:1745). In the process section of this study, services offered by the private health sector, patient access (both physical and financial) to healthcare services were measured. In addition, payments to healthcare services and other related variables to patients of the private health sector were measured.

The third one is outcome of patient care, which is the impact of healthcare on the health status. Patient satisfaction to service delivery at the exit was assessed to measure outcome. Patients were requested to judge services and related supplies provided to the cost they incurred.

5.4. METHODOLOGY FOR THE GUIDELINES

The guidelines were formulated in relation to evidence from phase I (chapter 4). The results of the quantitative study in phase I revealed that private health sector experienced the following challenges and opportunities:

Challenges

- The poorest service consumers could not access community based health insurance, exempted health services and fee waiver system from private health facilities.
- Access to financial institutions such as for loans were low in private health facilities.
- Low availability of health work force in the private market.

Opportunities

- Private health facilities were open for extended time out of normal working hours; such as in the evenings, on weekends and holidays
- Private health facilities have started affiliations with organized labour associations.

For each challenge and/or opportunity in the private health sector in the region, support guidelines and rationale were stated. Some guidelines proposed were already implemented, however, are further proposed to enhance them or have them scaled up.

5.5. STAKEHOLDERS BENEFIT FROM GUIDELINES

These guidelines might be beneficial for any actors in the private healthcare sector in the region of Amhara and beyond. They may ultimately benefit health service consumers by improving access or quality of healthcare in the private sector. Private healthcare facility owners and health care workers in the private sector may also benefit much if the proposed guidelines are implemented. Policy makers and decision-makers would obtain valuable areas for discussion and work on the challenges, opportunities and suggested guidelines in the private health sector.

5.6. OUTLINE THE GUIDELINES

In this section, a summary of challenges and opportunities of the private health sector in the Amhara region are indicated in Table 5.1 with suggested guidelines and their rationale.

Table 5.1 Suggested guidelines

Challenge or opportunity	Background	Guideline	Rationale
<p>The poorest service consumers could not access community based health insurance, exempted health services and fee waiver system from private health facilities.</p>	<p>There is no systematically established way of serving patients who cannot afford service cost in private health settings. The fee waiver system to address the poor access healthcare services is provided in the public health facilities only. Even though quite a lot of private health facilities have provided free healthcare services intermittently for the probably poor, their contribution in this regard is minimal. Many service consumers complain on the high price of healthcare services in the private health sector and on the other hand high burden in the public health facilities where there is such facilitation.</p>	<p>Guideline 1. Increase accessibility of healthcare services for the poor through community based health insurance, fee waiver and exemption in the private health sector.</p>	<p>Private health facilities have the potential of reaching lots of beneficiaries if promoted and well facilitated to provide such services as to what is being exercised in the public health facilities. The poorest will either have to access the required health service free by fee waiver or exempted service. Others may have access-desired services through community based health insurances system. This will help services to be available and increase accessibility for larger portion of population. It will further have impact on reducing the burden of public health facilities and quality improvement too.</p>
<p>Low access to updates and continuing</p>	<p>Availability of health work force in the market is low especially in some selected healthcare professionals like specialists, laboratory</p>	<p>Guideline 2. Increase facilitation to</p>	<p>Healthcare providers need to be updated regularly or given chances for further education by the support of the government</p>

<p>education for healthcare workers in the private health sector</p>	<p>professionals and radiographers. Healthcare workers in the private health sector remained distant to opportunities for continuing education and difficult to be updated on recent guidelines. Lower training and continuing education opportunities in the private health sector has contributed to the low availability of competent health work force in the private health sector. Lack of continuous updating trainings and professional development were among challenges by healthcare providers working in the private sector.</p>	<p>access regular updating trainings and continuing education for healthcare workers in the private health sector</p>	<p>or the private sector itself. Otherwise, low adherence to latest guidelines and compromised quality of services will be the result, which will also lead for mistreatment.</p>
<p>Low accessibility to financial institutions in private health facilities</p>	<p>Increasing access to financial privileges would help the private health sector alleviate several problems that can hinder the health services availability and quality. Shortage of supplies and medical equipment in the private health sector especially in the start appears as bottleneck. It further affected the capacity of the private sector in the use of its full potentials.</p>	<p>Guideline 3. Increase facilitation for financial access to actors in the private health sector in the region</p>	<p>Access to finance is a key for alleviation of many problems in the health sector especially for the beginners. Health sector investments at the beginning demands a lot of finance for premises, availability of reputable healthcare workers, state of the art products and equipment in the sector. The private health sector is complimenting</p>

			the public health sector and close gaps in the healthcare system.
Private health facilities were open for extended time out of normal working hours at evenings, weekends and holidays	The private health sector in the region comprised of a number of health facilities with different scope of work and professionals with various type and level of expertise. Even if concentrated in towns, the roles of private healthcare facilities were found great in increasing access to healthcare services in the region. In addition to their presence in large number, they were open out of normal working hours such as in the evenings, on weekends and holidays. Moreover, the number of health providers practicing in private set ups especially physicians were not few. The private health sector contribution to the national health system was found to be huge. However, better attention should have to be given to increase their participation in the general health system.	Guideline 4. Strengthen and support working for extended hours to promote user friendly services	Private healthcare facilities open for extended working hours like weekends, holidays and evenings to provide user-friendly services. They have served a number of healthcare services to significant number of service consumers.

<p>Private health facilities have started affiliations with organized labour associations</p>	<p>In order to make contributions from the private health sector more beneficial and influencing, the need of working together is much significant either to deal with challenges specific to the sector or to maximize impact to the region as well as the country. Even if the private health facilities and professionals in the private health sector in the region have established an association recently, it still needs close support from stakeholders and members to strengthen to its full capacity to perform intended objectives well. However, there is no any union or association in the region intends to support the availability of medical supplies and equipment for the private health sector. Fragmentation of financing within the health sector or across sectors is a constraint to the efficient delivery of health goods for populations (Sparkes, Kutzin & Earle 2019:13). Pooled funding, may be together with the existing structure like Ethiopian</p>	<p>Guideline 5. Strengthen, enhance and scale up the capability of the existing association in the private health sector</p>	<p>Private health facilities have actually shown greater interest to be members of association established in the region to fight for their rights and make their voices heard at large during planning and prioritizing health programs. This will increase involvement and participation in the national and local health related problems and solutions timely. It consequently promotes their contribution to health outcomes in the region. It will also increase the habit of efficiency and effectiveness on use of space, human resource and finance. Enhancement of the association will enable members to attain better achievements and maintain sustainability in the sector.</p>
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	<p>Pharmaceutical supply Agency (EPSA) or in different local pools for single health program or selected common health goods might have bigger influence on the financial capacity of health facilities and consequently on the general affordability of services in the sector.</p> <p>Participation in the regulation system will benefit more for the sector as it increases trust and commitment to recommendation. It will also reduce fraudulence and other negative pressures during regulation and monitoring system.</p>		
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5.7. VALIDATION OF THE GUIDELINES

The proposed guidelines were listed and sent to a nominal group of experts in the private health sector through email and on hand. The targeted experts were those who have served for longer than 10 years in the private health sector management, owners of private health facilities in the region, regional health bureau and public facilities, academic institutions and stakeholders working in the private health sector in the region. Experience in the sector, current occupation and profession were used for selection of the experts for inclusion in the validation of the guidelines. The purpose of the validation was to ensure that the guidelines were feasible, practical and acceptable.

Five experts who met the criteria mentioned above were selected for validation. The researcher ensured that all experts were well aware of and understand the purpose of the study, the validation process and the proposed guidelines. This was achieved through addressing the request for validation in a letter, which was accompanied by the summary of the results with list of guidelines (Annexure H). A review form was included for scoring, comments and space for their occupation, year of experience and profession to be returned by email or collected by hand from experts.

5.7.1. List of Guidelines

The list consisted of five recommended guidelines:

Guideline 1: Increase accessibility of healthcare services for the poor through community based health insurance, fee waiver and exemption in the private health sector

Guideline 2: Increase facilitation to access regular updating trainings and continuing education for healthcare workers in the private health sector

Guideline 3: Increase facilitation for financial access to actors in the private health sector in the region

Guideline 4: Strengthen and support working for extended hours to promote user friendly services

Guideline 5: Strengthen, enhance and scale up the capability of the existing association in the private health sector

5.7.2. Instructions for validation of the guidelines

Each guideline was validated by the selected experts through the identified criteria as indicated in Table 5.2. Instructions of how to validate and purpose of validation were prepared and sent along with proposed guidelines for each expert.

Instruction: Acceptability, applicability, feasibility, effectiveness, relevance and sustainability were used criteria for this validation purpose to each proposed guideline. Each proposed guideline should be validated in relation to the adjacent criteria. The validation has only two options, namely, agree (value 1) and disagree (value 0). Experts were requested to put “x” on appropriate column. If an expert respond disagree, comments were put on the space adjacent to it. The proposed guideline may not be new but to give high attention and provide proper emphasis for the responsible bodies.

The developed guidelines and criteria for validation were as follows:

Guideline 1: Increase accessibility of healthcare services for the poor through community based health insurance, fee waiver and exemption in the private health sector

Table 5.2 Criteria for validation of increase accessibility of healthcare services for the poor through community based health insurance, fee waiver and exemption in the private health sector

Criteria	Agree (Value 1)	Disagree (Value 0)	Comments
Acceptability: the guideline is acceptable in terms of the physical, psychological and emotional support needs of the private health sector			
Applicability: The usefulness of the guideline as part of a support system for the private health sector			
Effectiveness: The guideline is able to achieve its objective as support means for the private health sector within the context of the study.			
Feasibility: The implementation of the guideline is possible in terms of resources in the private health sector.			
Relevance: The guideline is ideal for application in relation to the private health sector			
Sustainability: The ability of the guideline to address the present and future emotional needs of the private health sector			

Profession _____ Occupation _____ Work experience _____

5.7.3. Results of validation of the guidelines

Five experts were recruited for validation of guidelines. All experts returned feedback (by email or hand) within 10 days. Experts who responded had spent most of their working experience in the private health sector in different positions and responsibilities including with frequent interaction with the public health sector too. The biographic information of experts who responded is indicated in table 5.3

Table 5.3 Biographic information of experts

Ser. No.	Profession	Occupation	Work Experience (Years)
1	Public Health Specialist	APHFPA President, Head of private Hospital	39
2	Public Health Expert	Programs Director	17
3	Public Health Expert	Senior Programs Officer	12
4	Physician	Physician and owner of private health facility, APHFPA board member	13
5	Consultant in internal medicine	Deputy chief of party – private health sector project, Ethiopia	29

5.7.4. Calculation of validation scores

Each expert calculated a validation score in respect to each guideline. The sample validation score from an individual expert (3) for each guideline was presented in table 5.4.

Table 5.4. Sample calculation of validation score from an individual expert (3)

Criteria	Guideline 1	Guideline 2	Guideline 3	Guideline 4	Guideline 5
Acceptability	1	1	1	1	1
Applicability	1	1	1	1	1
Effectiveness	0	1	1	1	1
Feasibility	0	1	1	1	1
Relevance	1	1	1	1	1
Sustainability	0	1	1	1	1
Total	3	6	6	6	6

Consequently, condensed validation score of experts were calculated for each guideline and presented in table 5.5. The total at the bottom indicates that the total count of 'agrees' by all experts for each guideline. The numbers may not explain one guideline is more important than others or do not necessarily show priority order but its value as per the preset criteria.

Table 5.5. Condensed validation score for guidelines

Criteria	Guideline 1	Guideline 2	Guideline 3	Guideline 4	Guideline 5
Acceptability	11111	11111	11111	11111	11111
Applicability	11110	11111	11111	11111	11111
Effectiveness	11011	11111	11111	11111	11111
Feasibility	11010	10111	11111	10111	11111
Relevance	11111	11111	11111	11111	11111
Sustainability	11001	11111	11111	10110	10111
Total	24	29	30	27	29

5.7.5. Evaluators' comments on low rated guidelines

Guideline 1: increase accessibility of healthcare services for the poor through community based health insurance, fee waiver and exemption in the private health sector

This guideline is the one with more disagree counts (6) than others by evaluators in the field. As private health facilities are delivering fragmented services, it would be difficult to apply the guideline especially in terms of the current health policy and legal environment. Two other experts have questioning its feasibility and sustainability due to its requirement of big budget.

Guideline 2: Increase facilitation to access regular updating trainings and continuing education for healthcare workers in the private health sector

One evaluator has reservation on the feasibility of this guideline, as it requires external support to increase facilitation of trainings and education for staffs working in the private health sector. As the private health sector is not well organized and capacitated, it may not have the capacity to train and educate its staffs by themselves.

Guideline 3: Increase facilitation for financial access to actors of the private health sector in the region

No comment on this guideline.

Guideline 4: Strengthen and support working for extended hours to promote user-friendly services

One evaluator has a comment on the feasibility and sustainability of this guideline, as it will incur cost on the facility and users and requires capacity-building follow up. Another one disagrees with sustainability as the market in the private health sector is immature, it may be difficult to predict the emotional needs of healthcare workers in the future.

Guideline 5: Strengthen, enhance and scale up the capability of the existing association in the private health sector.

One evaluator has commented on the sustainability of this guideline, as it requires high level of members' mobilization and not an easy work.

5.8. SUMMARY

This chapter presented the proposed guidelines to enhance health services delivery in the private health sector from findings of chapter 4 and validated with experts in the private health sector for long time in the region as well as in the country. Challenges and opportunities were selected for the purpose of seeking solutions and ease of facilitation in the sector from the respective responsible bodies in the region. The proposed guidelines emanated from these challenges and opportunities in the sector.

These guidelines include to increase accessibility of healthcare services for the poor through community based health insurance, fee waiver and exemption in the private

health sector, increase facilitation to access regular updating trainings and continuing education for healthcare workers in the private health sector, increase facilitation for financial access to actors in the private health sector in the region, strengthen and support working for extended hours to promote user friendly services and strengthen, enhance and scale up the capability of the existing association in the private health sector. The conclusions and recommendations will be discussed in detailed in Chapter 6.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1. INTRODUCTION

This chapter presents conclusions drawn from results and discussions of the study and additional evaluations experienced experts in the private health sector. The study assessed and analysed data from the private healthcare sector in Amhara region to document profiles, nature of services provided and challenges of the sector. The aim of the study was to investigate the health service delivery by private health sector and develop guidelines to enhance health service delivery in the private health sector and to increase their contribution in the country's health system. Findings of this study including discussions in relation to expectations and other available literatures were presented in detail in chapter four.

Consequently, results from the phase I study enables the researcher to propose guidelines that were intended to help improving the health system performance by enhancing health services delivery in the private health sector in the region. These guidelines were validated by senior experts in the private health sector in the region and beyond. All these helped the investigator to produce valuable conclusions and convey recommendations for different responsible bodies mandated to influence better improvements accordingly.

6.2. RESEARCH DESIGN AND METHODS

This study has passed two phases. In phase I, a quantitative and descriptive research design were applied. A cross-sectional health facility based survey was implemented in private health facilities at different level, healthcare workers working in the private health facilities and their clients or patients. All included facilities were recruited from Amhara

region, which is one of the nine regions of Federal Democratic Republic of Ethiopia. Interviews were conducted with 582 service consumers and 274 healthcare providers working in 256 private health facilities along with owners or managers in the region. Private hospitals, specialty centers, specialty clinics, medium and primary clinics were among the selected private health facilities in which owners, healthcare workers and consumers selected from. A pre-tested data collection instrument was designed for each group in order to gather primary data from each participant. Facilities were checked for their license update for the fiscal year and their agreement to participate in the study.

Ethical Clearance Certificate was obtained from the Research Ethics Committee: Department of Health Studies of University of South Africa (Annexure A). In addition to a support letter to conduct the study was obtained from Amhara Public Health Institute (APHI) (Annexure C). The data collected were analysed with SPSS version 20 and finally summarised using tables and graphic presentations. This was followed by phase II of the study, formulation of guidelines from the findings in phase I and validated by senior experts in the subject.

6.3. CONCLUSIONS

The Ethiopian Ministry of Health encouraged to work with private health sector and planned to increase their contribution by investors, joint venture and through PPPH with the government especially in provision of specialized health service delivery and pharmaceutical supply. The health sector transformation plan for Ethiopia prepared in 2015 has clearly indicated the necessity of private health sector participation in the health sector reform effort in order to meet the national health priorities. The role of the private health sector increasingly growing through time, which is needed by the public sector towards public health goals.

Conclusions of this study are presented in line to the aims of the study. The specific objectives of the study were to analyse and describe the profile of consumers and health

providers of private healthcare, describe the factors that influence the nature of private healthcare services and identify and describe challenges of the healthcare delivery by private healthcare system in Amara region.

6.3.1. Profile of consumers and health providers of private healthcare

In order to get the perceived high quality health services within short waiting time from the reputable provider, patients preferred private health facilities knowing that higher service charges required. Due to high interest of service customers to know the diagnosis they are being treated for, professionals in the private health facilities commonly tell the diagnosis and treatments prescribed with tailored counseling. Even though majority (71.6 %) of patients were urban dwellers, and 50.9% of them were travelled more than 20km in order to seek services from private health facilities.

Service prices in the private health sector seems high and may be beyond the capacity to pay for service consumers and especially the poor. This raises the issue of equity of access of offered health services by the private sector as the poor may face difficulty of accessing services. Only 2.1% of patients payed through private insurances while others payed out of pocket for their healthcare. Fourty two percent of patients have used up sources other than deposited for generating payment for their health service and it would have lead them to poverty. It consequently affect efforts to achieve universal health coverage without any financial hardship.

Significant number of health workers were practicing healthcare provision in the private health facilities in a fulltime or part time work. Higher proportion of physicians (both specialist and GP) as compared to proportions in other health professionals like health officers, nurses and laboratory professionals in the private sector were working part time. Senior physicians in the private sector are available for every patient/client who can pay for services. However, the time of these senior physicians that could be invested on seriously ill cases may be occupied in cases that can be relatively served by other junior

practitioners. Therefore, those patients who critically need skilled professionals will access skilled and experienced physicians.

Higher number of healthcare worker graduated from public universities and colleges were first hired in the public health facilities while those graduated from private healthcare universities and colleges were hired in private health facilities.

Realistic and practical regulatory system that considers the local situation and developed with full participation of those providing services including private health sector needs to be strengthened further in order to function well through the whole system. The focus on corrective and supportive actions rather than picking up negative findings and punishment would encourage and help more. Negative findings might cause fear and repeated blaming regulatory body that will consequently disrupt the system not to function towards its goals. The regulatory needs to work in order to ensure provision of services are as per the current standards and guidelines that guaranties the fulfilment of essential dimension of quality such as safety, effectiveness, integration, continuity and people centeredness. It has to be strong that can have influence the health care delivery system function as per required standards and prevent double standards.

Owners or managers of private health facilities need more modification of the current health facility standard in the region to make more suitable and fit for the sector and greater participation of the private sector in the process. It requires professionals; materials and equipment not easily found in the market and have low importance in the provision of service delivery. Private health facilities have worked in their own buildings while others worked in rented premises. Owning buildings have significant association with obtaining loan services from any financiers and serving for longer years. Owners in majority of private health facilities were led their facilities and median years of services was 6.1 years. Private healthcare facilities have served a number of healthcare services to significant number of service consumers. They are opened for extended working hours like weekends, holidays and night time providing user friendly services.

6.3.2. Nature of private healthcare services

A number of medical services in agreement to their level were provided by private health facilities. The referral network is open and functional to either public or private and from lower or higher facility. Formal health education service was not provided in the private health facilities except providing one to one counseling to each patient/client focusing on issues connected to the current diagnosis, treatment and others issues. Multiple laboratory tests were found requested for majority of patients that would actually increase the precision of diagnosis and treatments prescribed. However, it will increase service customers' expenses and decrease satisfaction to prices of services. In addition, the necessity of some tests were seen unconvinced. Provision of imaging services in the private healthcare facilities were significantly associated with staying for long years of service delivery (>10 years) as it might suggest development of better capacity through time.

Private health facilities have mainly providing curative services to their patients with different age and socio economic status. They have also providing preventive as well as promotive services in relation to some selected health programs. Effective healthcare service delivery is a result of well-organized and well-functioning health system that clearly understands the health priorities of the prospective community. Private healthcare facilities and providers could create and avail services tailored to the local health needs of the community by proper scanning and focusing on health problems that have highest concern. Comprehensive and integrated health services need to be designed to maximize benefits to the intended population.

Private healthcare facilities tend to provide services that are more profit driven and ensure sustainability of their service. However, they are involved in preventive and other promotive services that have no direct profit making purposes like provision of tuberculosis, malaria and HIV prevention and control activities that are partly provided free. In addition majority of facilities were providing family planning and ante natal care

services. Private health facilities have demonstrated the participation in external quality assessment plans in some specific health programs like TB, HIV and support in maintaining quality services. Private health facilities are used to provide some basic emergency services and then refer or oral indication of patients to other suggested healthcare facilities to be better assisted mainly based on patients' informed consent.

The system of providing free healthcare services for the poor in the region such as fee waiver and exempted services is working only in the public health sector. Moreover, the government of Ethiopia highly promotes and implements community based health insurance (CBHI) scheme, which in the private health facilities were not included, and not participating. It excludes the participation of private health sector. However, in order to keep the healthcare market balanced and make opportunities equal, facilitation of engagement of private health sector in the provision of free healthcare services for the poor with clearly set guidelines would help improvement of access in the region as well as the country. Even though majority of private health facilities used to report to the next health office, data recording tools to document complete information of reportable indicators were not captured the required data well especially in lower private health facilities.

Private health facilities have established association in the region as well as in the country with other similar entities in other regions to create an opportunity to come together to discuss and work on issues common to all. However, there was no any functional association or union for private health facilities in the region to make available common supplies. The sector as well as the community would have benefited from joining capacities together than staying fragmented by helping to lower the health services prices. On the other hand, healthcare workers in private health facilities were not organized and exercised associations and unions that will stand with their rights and responsibilities. For example, even though there is high shortage of healthcare professionals in some professional streams, others few were found relatively in excess especially in bigger towns where education and other opportunities available. In this case

some professionals may be subjected to be paid less and a need to fight to set for at least minimum wage, over time and other benefits of professionals in the private health sector. Private health facility owners or managers used to set prices for services they are going to deliver and no one supervises or oversees whether it fits the cost it incurred and considers the capacity of the community or not. Unaffordable services can be considered as inaccessible. Patients from rural areas were paying more expenses than those from urban areas contrary to estimated income. This might be explained by patients from urban areas may have better health seeking awareness and search for healthcare services early, before their illness going complicated and required higher payment. Those patients who had no history of visit to other health facility for the same illness and those who have no companions were more likely to be satisfied with price of services.

The true cost of healthcare services may not be clearly known by the community as many of healthcare services delivered by public health facilities are supported by donations and subsidized. Service consumers used to compare prices of the private health facilities to that of public health facilities and even among private healthcare facilities of different level and professional mix and diagnostic equipment. It consequently magnifies the price of services in the private health sector or creates confusion of prices of healthcare services. Private healthcare facilities have experienced HCWs attrition but replaced as soon as possible. Private health facilities can make short decision-making procedures. However, availability of HCWs in the market was not uniform as more shortages complained in some professional categories like laboratory and radiology. Medical supplies including laboratory reagents were not available enough in the market or in a doubtful quality. However, private health facilities keep better resources and continuous availability of services in line with needs of consumers.

Working in private health facilities especially in higher private healthcare facilities enables the transfer of skills to other junior colleagues. Better-experienced professionals working in either fulltime or part time from public health facilities or other private facilities have the

opportunity to share their knowledge and skill to others. The direction of skill transfer can be to either side of the sector.

6.3.3. Challenges in the healthcare delivery by private healthcare system

Uncomplimentary regulatory system pertaining to private health sector and lack of trainings and continuing education for health professionals were among the main challenges of private health facilities in the region. In addition, unavailability of enough health work force in the market and shortage of supplies to private facilities were mentioned. Healthcare professional employed in the private health facilities in the region were identified gaps like lack of training and continuing education opportunities, unfeasible regulation system and supply shortage.

Higher price of services were found main critics of users to access available healthcare services in the private sector. No pro-poor opportunities were set available to help access unaffordable healthcare services in the private sector. Community based health insurance or exempted services were not run by the private health sector in the region.

6.4. GUIDELINES TO ENHANCE HEALTH SERVICE DELIVERY IN THE PRIVATE HEALTH SECTOR

In order to further improve the health service delivery in the private health sector and increase its contribution to health outcomes in the region, the following guideline were originated from findings of this study and validated by well-experienced experts in the field. These are emanated from either challenges or opportunities found from the findings and not actually new but to extend their importance. These are:

Guideline 1: Increase accessibility of healthcare services for the poor through community based health insurance, fee waiver and exemption in the private health sector

Guideline 2: Increase facilitation to access regular updating trainings and continuing education for healthcare workers in the private health sector

Guideline 3: Increase facilitation for financial access to actors in the private health sector in the region

Guideline 4: Strengthen and support working for extended hours to promote user friendly health services

Guideline 5: Strengthen, enhance and scale up the capability of the existing association in the private health sector

6.5. RECOMMENDATIONS

The recommendations are directed towards the future and long-term plans for identification and management of the challenges and maximising use of available opportunities.

In order to make the private health sector best contribute to the national and regional a move towards UHC, consolidated efforts by responsible bodies in the health sector and beyond need to make integrated and focused better on the health priorities of the community. Participation of actors in the private health sector will further augment and compliment efforts done by the public health sector and other stakeholders.

The working documents of the government in the health sector also need to consider the current capacity of the healthcare institutions and anticipated services customers. Participation all stakeholders and implementers starting from the inception would get easy facilitation and support from the community. In addition, service cost should consider the capacity to pay of the community to be served and ensure its equivalence to services delivered. The regional health bureau and its partners should further work to build their capacity to the level of designing, managing and monitoring public private partnerships in the region. The region as well as the ministry of health need to provide regular update and inclusion of the private facilities in the regional program planning, training, supply distributions, monitoring and supervisions and include their inputs for the ongoing implementations and better collaboration and engagement of the sector. Focusing on

more technical mentoring and supervision than mere inspection might help the sector better until it becomes well integrated and established.

Healthcare supports from the government, different partners and stakeholders should equally distributed by targeting services users. It has to address clients and patients of private health facilities as they are the final beneficiaries of services delivered. Private health facilities needs to get chance of dealing with exempted services with concerned bodies. This would make sector to contribute better in the creation of sustainable and resilient healthcare system. The sector should have to get access for some selected equipment that have greater impact on the health services delivery and maintaining quality, low interest loans and land with minimum lease price. The price of services in the private healthcare sector need to be studied to compare with the price in public health facilities mainly to understand the gaps in between and main reasons behind. It will help to understand whether the price is in line with services provided or not and its consequences on family income and power of exposing for poverty.

The government, ministry of health and other stakeholder and partner institutions have to work with financial institutions to facilitate and increase access to finance for the private health sector. This will enable to create well capacitated and resilient private health sector that can perform well in line to the health standards and targets of the country. This can even be supplemented by organizing the sector in different associations and unions to work together than the current fragmented capacity.

All responsible bodies and stakeholders working in the health sector especially in relation to private health sector needs to work following the guidelines, the existing working rules and principles in the region. Based on the findings of this study, the researcher formulated some guidelines to be used by private health facilities, healthcare workers especially working in the private health sector, services consumers and health program administrators in the region. These are increasing facilitation for financial access to actors in the sector, increase facilitation to access regular updating trainings and continuing

education for healthcare workers, strengthen, enhance and scale up the capability of existing association in the private health sector, increase strengthen and support working for extended hours to promote user friendly services and accessibility of healthcare services for the poor through community based health insurance and exemption. The guidelines can also be used to decision makers, policy makers, researchers in the field and health program implementers.

6.6. LIMITATION OF THE STUDY

Limitation are matters and occurrences that arise in a study which are out of the researcher's control (Simon & Goes 2013:1). The study is a cross sectional survey conducted in the region and it can only point to statistical associations between variable, not about causality.

It was difficult to get facility owners, managers and healthcare providers for interview, as they were busy in other activities. Repeated visits were made with arranged appointments to decrease the nonresponse rate. Patients were also usually in hurry to return to their home. However, the researcher has strived a lot in order to make well understand the objectives of the study and wait comfortable until the interview ends. In addition, the researcher and study participants were in difficult to estimate incomes especially from the informal sector. Approximates were taken by considering annual earnings and harvest.

6.7 SUMMARY

This chapter presented the final conclusions and recommendations drawn from the findings of this study. The private health sector provide with more devotion on delivering profit driven health services. The contribution of private health sector in health services delivery in the region would be high if well supervised and supported. Appropriate guidelines and approaches should be applied to the ground to better make the private

health sector more creative and innovative. Lastly, the chapter included limitations of the study.

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ANNEXURE A: ETHICAL CLEARANCE FROM UINSA



**RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)**

1 February 2017

Dear Mr MA Woleli

Decision: Ethics Approval

HS HDC/590/2017
Mr MA Woleli
Student: 5855-950-7
Supervisor: Prof MC Matlakala
Qualification: D Litt et Phil
Joint Supervisor: -

Name: Mr MA Woleli

Proposal: The delivery of comprehensive healthcare service by private health sector in Amhara Region, Ethiopia.

Qualification: DPCHS04

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 1 February 2017.

The proposed research may now commence with the proviso that:

- 1) The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
- 2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*



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3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:

The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,



Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za



Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

ANNEXURE B: LETTER OF REQUEST SUPPORT FROM UNISA ETHIOPIA OFFICE TO APHI



03 MAY, 2018

UNISA-ET/KA/ST/29/03-05-18

Amhara Public Health Institute (APHI)

Bahir Dar

Dear Madam/Sir,

The University of South Africa (UNISA) extends warm greetings. By this letter, we want to confirm that Mr. Melkie Asefa Woleli (student number 58559507) is a doctoral student in the Department of Health Studies at UNISA. Currently, he is at the stage of data collection on his PhD research entitled "*The delivery of comprehensive healthcare service by private health sector in Amhara Region, Ethiopia*".

This is therefore to kindly request you to assist the student in any way that you can. Attached, please find the ethical clearance that he has secured from the Department of Health Studies. We would like to thank you in advance for all the assistance that you will provide to the student.

Sincerely,

Dr. Tsige GebreMeskel Aberra



Deputy Director – Academic and ICT Support



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ANNEXURE C: SUPPORT LETTER FROM APHI



በአማራ ብሔራዊ ክልላዊ መንግስት ጤና ጥበቃ ቢሮ
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Amhara Public Health Institute
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**To : All Zonal Health Department and Selected Private Health
Facilities in Amhara Region
Bahir Dar**

Subject: Provision of Support letter

Mr. Melkie Assefa Woleli has requested the institute to provide permission and write support letter to collect data from selected private health facilities in the region for his research to be conducted for the fulfilment of his doctoral study at the University of South Africa (UNISA), Department of Health Studies. Documents enclosed with his application indicate the university's Research Ethics Committee (REC) has provided ethical clearance for his research proposal entitled "The delivery of Comprehensive healthcare services by private health sector in Amhara Region, Ethiopia".

This is therefore to kindly request your health department to assist the student regarding the data collection in order to attain best results from the study. The student is expected to submit copies of the final paper to Amhara Public Health Institute research and technology transfer directorate.



Taye Zeru

Health Research and Technology

Transfer D/Director

☒ 477

Tell. 0582263223

Fax. 0582266701 : 0582263223

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ANNEXURE D: CONSENT FORM FOR PARTICIPANTS (HEALTH FACILITY OWNERS/MANAGERS, HEALTHCARE PROVIDERS AND CLIENTS/PATIENTS)

My Name is Melkie Assefa. I'm a PhD student at University of South Africa (UNISA). I'm assigned to collect data for the study on the topic 'The delivery of comprehensive health care service by private health sector in Amhara region, Ethiopia'. The study is aimed to identify the potentials and hidden challenges in the health care service delivery by private health sector in the region. This study has obtained Ethical clearance from the universities ethical board and the Amhara Public Health Institute granted permission to collect data from sites in the region. The study is being conducted by me (the student) and supervisor from UNISA, Professor Mokgadi C. Matlakala. Your participation is very important for the study.

I am seeking your views about the services provided in the facility. If you agree to participate in the study, I will ask you some questions and note your answer or choose options in my instrument paper.

The information you will give me will be kept strictly confidential, only the researcher will be allowed to see it. The information will not be used for any purpose other than this study. I will not take and use your name anywhere.

If you feel uncomfortable to answer any question, you have the right to refuse or stop interview anytime in between. Your refusal will not affect your treatment/work situation or cause any other problem. This study will not directly or immediately benefit you. However, it will benefit in the future when the decision makers use the results and recommendation generated from this study.

Participation in this study is voluntary. The interview will take about 30 minutes. You can raise any question and ask to repeat if you don't understand in between. You can refuse or ask to stop at any time. When the study is finalized it will be disseminated by different means that majority of beneficiaries can reach.

If you have any question before start interview, I'm happy to answer.

Contact address of the principal investigator:

Melkie Assefa Woleli

Mob: +251918779619

Email: 58559507@mylife.unisa.ac.za , assefamelkie@gmail.com

If you agree to participate with note taking;

Please sign here _____

(Oral consent may also be enough)

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□□□□□ 58559507@mylife.unisa.ac.za , assefamelkie@gmail.com

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ANNEXURE F: DATA COLLECTION TOOL FOR HEALTH FACILITY OWNERS/MANAGERS, HEALTHCARE PROVIDERS AND CLIENTS/PATIENTS

Data Collection Instrument

Facility code : _____

Interviewee Code : _____

Facility status – Facility owners or managers

(Date ___/___/___/(___/___) Telephone _____
dd/mm/yy/ (hh/ mm)

Sr No	Description	Options	Remark
1	Facility address	Town: _____ Kebele: _____	
2	Facility specialty	_____	
3	Level of facility	1. Hospital a)primary b) General 2. Specialty center ----- 3. Medium Clinic 4. Specialty clinic ---- 5. Primary Clinic 6. NGO Others, Specify _____	
4	Facility run by	1. Medical specialist 2. General practitioner 3. Health officer 4. BSc nurse 5. Nurse (Diploma) 6. Others, Specify _____	
5	Facility owned by	1. Medical specialist 2. General practitioner 3. Health officer 4. BSc nurse	

		5. Nurse (Diploma) 6. NGO 7. Share company 8. Others, Specify _____	
6	Building where services operated is	1. Built by the owner 2. rented 3. other _____ ----- blocks ----- Rooms If rented, how much you pay per month? - -----	
7	Established by (when)	_____ (e.g. September 1995)	
8	Number of patients seen per day (For any service) (See the previous day record if available)	_____ (Number)	
9	Number of staffs	Full time: _____ 1. Nurses: _____ 2. General Practitioners: _____ 3. Health officers: _____ 4. Specialists (all): _____ 5. Midwife ----- 6. Laboratory ---- 7. Others, Specify: _____ Part time work at least once per week: _____ 1. Nurses: _____ 2. General Practitioners: _____ 3. Health officers: _____ 4. Specialists (all): _____ 5. Midwife -----	

		6. Others, Specify: _____	
10	Opening hours of facility	Working days (Monday-Friday): Opened at: _____ Closed at: _____ Saturday: Opened at: _____ Closed at: _____ Sunday: Opened at: _____ Closed at: _____ Holidays: Opened at: _____ Closed at: _____	
11	What are service/s provided in this health facility?	1. OPD: OPD for what kind cases? a) Under 5 children b) adults c) both Services provided: a) ANC b) Delivery c) PNC d) FP e) EPI f) HIV test g) Radiology h) Other List all: _____ _____ 2. Inpatient 3. Others, specify _____	
12	Did you provide health education services to patients in team? (See the register)	1. Yes 2.No 3. One to one Have registered? 1. Yes 2. No If yes for how many for the last ONE WEEK? _____ For how many day? _____	
13	Does the facility provide special service different from others? (CT, MRI or any special service/s)	1. Yes 2. No If Yes, Specify _____ _____ _____	

14	Who did pay for patients present in emergency?	1. third person with receipts - payment facilitated by patients 2. third person – payment facilitated by health facility 3. Companions of patients 4. Others, specify ----- (should be listed as possible)	
15	Did the facility practiced back payment from any organization for the emergency cases served free	1. Yes 2. NO If Yes, Who coved? _____ If no, why? _____	
16	Who sets price for the services you are providing	1. Owner sets 2. Team established for this purpose 3. Share holders 4. Others, Specify _____ _____	
17	Does it (Cost list) communicated to the regulatory or any concerned body?	1. Yes 2. No If yes, to whom? _____ _____ Any feedback provided 1. Yes 2. No If yes, who provided? _____ What are comments? _____ are they comments corrected 1. Yes 2. No	
18	Do you call community representative/s during meetings or decision	1. Yes 2. No If Yes, who are they? ----- For what purpose you have practiced? _____	

	making practices made by the facility?	If no, why not? _____ _____	
19	Are there services prohibited to provide for patients contrary to your capacity? (Like EPI), if so, list:	1. Yes 2. No If yes, what are these services? 1. _____ 2. _____ (should be listed as possible)	
20	Is the facility participated in the external quality control system (EQA) at least for one specific program?	1. Yes 2. No If Yes, as 1. Participant 2. Controller What are programs you participated with? ----- -----	
21	Did you get feedback for the last previous quarter?	1. Yes 2. No	
22	Is the facility participated in the provision of public health programs? (prevention and control of HIV, TB, Malaria, FP, ...)	1. Yes 2. No If yes, please list _____ _____ _____ (should be listed as possible) If No, do you have interests on that? 1) Yes 2) No	
23	Did you get technical support at least for one program in the last quarter?	1. Yes 2. No If yes; Please list them all. _____ _____ _____	
24	Did the facility get financial/material support	1. Yes 2. No If Yes, who provided? _____	

	from government or other partners	With what programs? ----- If no, Do you have interests? _____ _____	
25	Did you get any loan for scaling up your healthcare services?	1. Yes 2. No If yes, who provide? _____ Interest rate _____ (%) Did you still in need of it _____	
26	How many staff members left the clinic in the last 6 months?	_____, Specify the number and profession ___ nurses (dip), ___ Nurses (BSc); ____, _____; _____, _____	
27	How many staff members did you hire in the last 6 months?	_____, Specify the number and profession ___ nurses (dip), ___ Nurses (BSc); ____, _____; _____, _____	
28	Which professional category is in shortage from the market?	1. Health Officers 2. Medical Doctors (GP) 3. Nurses 4. Laboratory professionals 5. Pharmacy technicians 6. Pharmacists 7. Others, Specify _____	
29	Have you report previous quarter to responsible body?	1. Weekly report 1.Yes 2. No 1. Monthly report 1.Yes 2. No 1. Quarterly report 1.Yes 2. No If yes, do they retain copy? 1. Yes 2.No	Please see the copies of reports
30	How do you prepare the following recording materials? 1.OPD abstract book -----		

		1. positively and tried to apply 2. Negatively and not action will be taken	
38	How do you see the supervision provided by government bodies?	1. V. good 2. Good 3. Acceptable 4. Poor 5. V. Poor	
39	How do you rate the working relationship with the government bodies?	1. V. good 2. Good 3. Acceptable 4. Poor 5. V. Poor	
40	How do you feel the trust up on you from the Gov't bodies in related to your services provision and importance for the community?	1. V. good 2. Good 3. Acceptable 4. Poor 5. V. Poor	
41	When was the facility inspected recently by (Town/Zonal/Regional) persons?	_____ (mm/yy) Did they provide written feedback? 1) Yes 2) No <u>If yes, See that</u> and record time and three main recommendations: 1) _____ 2) _____	
42	How do you rate health managers' experience in relation to lead the private sector?	1. Very satisfied 2. Satisfied 3. Neither 4. Dissatisfied 5. Very dissatisfied	
43	Does the facility review and use the data for improvement?	1. Yes 2. No	
44	Do you feel that the regulatory standards	1. Yes 2. No	

	commensurate with national resources and economic development	If no, what has to be made to improve health services in the region? 1. _____ — 2. _____ — 3. _____ — (should be listed as possible)	
45	What is the facility level from the evaluation conducted for the previous year?	1.Green 2.Yellow 3. Red	
46	Where do you get medical equipment that your facility needs?	1. Open market 2. Government 3. Other, Specify _____ If from open market, tell me about their quality of equipment 1.Poor 2.Fair 3.Good 4.Very Good 5.Excellent	
47	Do you have association or union that will help you in procuring or anything to reduce losses and maximize profit?	1.Yes 2.NO If yes, Name it _____ _____	
48	Is the facility member of Amhara Private Health Facilities Association?	1. Yes 2. No Do you believe benefited from the association? 1. Yes 2. No	?contribution of association
49	Did you believe that private association will	1.Yes 2.NO If Yes, In what area:	

	bring change to the private health sector?	1. _____ — 2. _____ — 3. _____ — If No, Reasons: 1. _____ — 2. _____ —	
50	What do you expect from Amhara Private Health Facilities and Professionals Association?	1. Legal advisor for members 2. Member of the inspection team 3. Promote the private sector 4. Represent the private sector in policy issues 5. Supervision on selected issues 6. Training 7. Others, Specify _____ _____ _____	
51	The government has exempted some services. Do you believe that it has impact on your health care delivery services?	1. Yes 2. No If yes, please specify the impact ----- ----- _____	Exempted services by GO are EPI, Delivery and ?Insura

			nce, TB Dx &Tx, HIV Dx & Tx and others
52	Involved in provision of health insurance?	<p>1. Yes</p> <p>2. No If no, why? _____</p> <p>_____</p> <p>Do you believe that It will have impact on the health market for private?</p> <p>1. Yes 2. No</p> <p>If Yes, specify -----</p>	
53	Have you engaged in some of philanthropic activities like helping some part of the community or individuals get free access or with lesser prices of services provided?	<p>1. Yes 2. No</p> <p>If yes, To whom? 1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>How many did you served in last one month? _____</p> <p>Reason to do this practice?</p> <p>1. Spritual purpose</p> <p>2. Social contribution</p> <p>3. Forced by others (including GOs)</p> <p>4. Promotion</p> <p>5. Others, Specify _____</p>	
54	Did you see main gaps and challenges in the management of private health sector?	<p>1. Yes 2. No</p> <p>If Yes, can you list some:</p> <p>1. _____</p> <p>—</p>	

		2. _____ _ (Health work force, Comprehensiveness of services, Cost of services, Supplies, regulation, trust, training (short & Long), Loan, Land, PPPH, Growth (Vision), institutionalize)	
--	--	---	--

Data Collection Instrument – Health Providers

Facility code : _____ Interviewee Code : _____

Health Providers - Socio-demographic/economic characteristics

(Date ___/___/___/(___/___) Telephone _____
dd/mm/yy/ (hh/mm)

Se No	Description	Options	Remarks
1	Sex	1. Male 2. Female	
2	Age	_____ year	
3	Profession	1. Specialist (Specify; _____) 2. General practitioner 3. Nurse Diploma 4. Nurse BSc 5. Health officer 6. Pharmacy (Including technician) 7. Laboratory (Technician/Technologist) 8. Others, Specify _____	
4	Upgrade or Generic	1. Generic 2. Upgrade from diploma	

		3. Upgrade from Health assistant 4. Others, Specify _____	
5	Birth place	1. Urban 2. Rural	
6	Religion	1. Orthodox Christian 2. Muslim 3. Protestant 4. Others, Specify _____	
7	Marital Status	1. Married 2. Single 3. Divorced 4. Separated 5. Widowed 6. Others, Specify _____	
8	Family number under you	Total _____ Children _____	
9	Are you living with your own family (closeness to family)	1. Yes 2. No if no, distance in KM _____ (Km)	
10	Years of Experience (total) _____ years	1. Current organization _____ 2. Others previous: Public _____ Private _____	
11	Graduated from	1. Public health institution:----- 2. Private health institution:----- 3. Both: -----	
12	When do you get job opportunity after graduation?	1. Immediately 2. After a month 3. Others, Specify _____ (Months)	
13	How many organizations did you work for (total)	_____ (Number)	
14	Your immediate past institution?	1. Public 2. Private 3. This is my first	

21	How do you feel about your job security?	1. V. Good 2. Good 3. Neutral 4. Bad 5. V. Bad	
22	Current status with in the facility	1. Owner/Share in the company 2. Manager 3. Technical person 4. Others, specify _____	
23	Do you get training opportunity while working in this facility? (CPD) (Including Financial management, Accounting, Mentoring)	1. Yes 2. No If yes, <u>what (Training name) and how long?</u> _____ _____ If no, reason -----	
24	Who provides the training or sponsored by?	1. Government 2. NGOs in collaboration with Gov't bureau 3. Others: Specify _____ _____	
25	Why are you working in private facility/sector?	1. _____ 2. _____ 3. _____	
26	How many hours working in a day? (only in this facility)	----- hours Starting at: _____ Ending at: _____	
27	Are you subjected to work for more hours in the past one week?	1. Yes 2. No If Yes, How Long? _____ Do you get additional pay for that? A) yes b) No c) changed in to leave	
28	Are you subjected to work in different jobs, not related to your profession?	1. Yes 2. No If Yes, What? _____	

29	Do you get other benefits other than regular salary?	1. Yes 2. No If yes, Specify (amount/month and source) _____ _____	
30	Did you absent from work (in this institution) in the last on week?	1. Yes 2. No If Yes, How Long? _____ (day/hour) Reason: _____	
31	Did you late from work in the last on week? (total time if you late twice or more)	1. Yes 2. No If Yes, How Long? _____ Reason: _____	
32	Who substitutes you during your <u>last absent or late</u> ?	1. Lower level health worker 2. Higher level health worker 3. Lower level health worker with special training 4. Higher level health worker with special training 5. Same level health worker 6. No body, it waits me 7. Phone call 8. Head will replace anybody	
33	Did you work substituting higher level health worker to work that you are not properly trained?	1. Yes 2. No 3. Informally trained If yes, reasons: _____ How did you get the result? 1. V. Good 2. Good 3. Neutral 4. Bad 5. V. Bad	

		Who provide you informal training? A) colleagues b) owner c) others _____	
34	Do you get enough job aids and reference procedures?	1. Yes 2. No If yes, where did you get them? _____ _____	
35	Are you commonly prescribe drugs in their brand or proprietary names?	1. Brand 2. Proprietary names 3. Not prescriber If in Brand names, Reason: _____ _____	
36	For the primary clinics : Did you prescribe?	1. Yes 2. No If yes, reason for passing the rule by new standard: _____ _____	
37	For the specialty clinics/Centers: Did you practice healthcare other that you have authorized to do by the new standard	1. Yes 2. No If yes, What are those practices? _____ _____ reason for passing the regulation by new standard: _____ _____ _____	
38	What are the differences of working in private than public? a) Yes b) No If yes, what are differences? ----- Can you list why these differences are? For owners: _____ _____ For Hired professional: _____ _____		

39	Do you perceive that working in private has better opportunity to learn more techniques and practices than working in public?	1. Yes 2. No If yes, what are those? 1. _____ 2. _____ 3. _____ 4. _____	
40	a) Anything you missed by working in the private?	1. _____ 2. _____ (should be listed as possible)	
	b) anything you got by working in the private	1. _____ 2. _____	
41	Level of Satisfaction by working in this private facility (Meeting own objective)	1.Very dissatisfied 4.Satisfied 2.Disatisfied 5.Very Satisfied 3.Unsure	
42	Level of Satisfaction by working in this private facility (compared to working in public)	1.Very dissatisfied 4.Satisfied 2.Disatisfied 5.Very Satisfied 3.Unsure	

43	<p>Any gaps/challenges you observed while working in private health sector to be improved for future?</p> <p>By the Government:</p> <ol style="list-style-type: none">1. _____2. _____3. _____4. _____ <p>By the private health sector itself:</p> <ol style="list-style-type: none">1. _____2. _____3. _____4. _____ <p>By patients:</p> <ol style="list-style-type: none">1. _____2. _____3. _____4. _____ (should be listed as possible)	
----	--	--

44	<p>Any recommendation you have for improvement?</p> <p>By the Government:</p> <ol style="list-style-type: none">1. _____2. _____3. _____4. _____ <p>By the private health sector itself:</p> <ol style="list-style-type: none">1. _____2. _____3. _____4. _____ <p>By patients:</p> <ol style="list-style-type: none">1. _____2. _____3. _____4. _____ (should be listed as possible)	
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Data Collection Instrument – Clients/Patients

Facility code: _____

Interviewee Code: _____

Card No at the facility: _____

Patients - Socio-demographic/economic characteristics

(Date ___/___/___/ (___/___) Telephone _____
 dd/mm/yy/ (hh/ mm)

Se No	Description	Options	Remark
1	Sex	1. Male 2. Female	
2	Age	_____ year	
3	Address (current address)	Woreda/Town _____ Kebele _____ Estimated distance (Km) _____ Time taken for transport _____ (Hrs) Transport cost (Birr) _____ (single trip)	
4	Residence	1. Urban 2. Rural	
5	Religion	1. Orthodox Christian 2. Muslim 3. Protestant 4. Others, Specify _____ _____	
6	Marital status	1. Married 2. Single 3. Divorced 4. Separated 5. Widowed 6. Others, Specify _____ _____	

7	Number of family member (Household size) (Total)	_____	
8	Number of children (≤ 15)	_____	
9	Occupation	1. Farmer 3. Gov't worker) 5. House wife 6. Others, specify _____	2. Merchant 4. Self-employed
10	Education	1. No educated 3. Secondary school 5. Degree and above	2. Primary school 4. Diploma
11	Average income level (Birr) (per Month)	-----	
Consumption of health care service:			
12	Have you visit other health facility before for this current illness	1. Yes 2. No If Yes, 1. Public health facility 2. Other private facility 3. This health facility (repeat) 4. Traditional healers 5. Holy water 6. Others ----- Reason for: -----	If no, go to no. 15
13	How do you rate services provided there?	1. Very Good 2. Good 3. Acceptable 4. poor 5. Very poor	
14	What are laboratory diagnosis done for this current illness (need to see the request)	1. _____ 2. _____ 3. _____ 4. (should be listed as possible)	
15	Other diagnostic machines or equipment used for	1. Yes 2. No If yes, what? _____	

	diagnosis like US, x-ray, CT-scan, pathology and others?	<p>_____</p> <p>_____</p> <p>(should be listed as possible)</p>	
16	Current diagnosis (self-reported) (if unclear, need to refer charts)	<p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>(should be listed as possible)</p>	
17	How much money did you spend for this illness for all services obtained in total still in this facility? _____ (Birr)		
18	How did you cover your expense for this healthcare cost?	<p>1. Self-deposited</p> <p>2. Self by selling A) cereals B) domestic animals C) house D)others specify; _____</p> <p>3. Borrowing from relatives, friends and other</p> <p>4. Private insurance will cover through my office (organization)</p> <p>5. Free help by the facility a) staff and family b) support those who can't pay</p> <p>6. Community based insurance</p> <p>7. Help by family (parents) or relatives</p> <p>8. Others, Specify: _____</p> <p>_____</p>	
19	Are you included in community health insurance? 1. Yes 2. No How much do you contribute? _____ Birr/year		
20	How many companions or supporters with you now to attend your health care service here?	<p>_____</p> <p>From Home _____ (including returned back)</p> <p>From this town _____</p>	

21	When did this illness started? (Duration) (dd/mm/yy)	___/___/___/ [___ (days)]	
22	When did you reach here at this facility? dd/mm/yy/hh/mm	___/___/___/ (___/___) dd/mm/ yy/ (hh/ mm)	
23	When did you get the required care (Treatment started) dd/mm/yy/hh/mm	___/___/___/ (___/___) dd/ mm/ yy/ (hh/ mm)	
24	If there is delay, Any reason for that?	1. _____ 2. _____ 3. _____ (should be listed as possible)	
25	Did you visit public health facilities for this illness?	1. Yes 2. No	
26	Who referred you here? (Hear about this healthcare service)	1. self 2. Relatives'/Friends' recommendations 3. Other patients who visited previously 4. Leaflets 5. Radio/TV spots 6. Others; Specify _____	
27	Reasons for choosing private healthcare facilities (Circle all that applies)	1. know experienced specialist 2. Saves time (long queue - other facilities) 3. expect experienced professionals at private 4. Better responsiveness 5. Cleanness of the facility 6. Better diagnostic equipment 7. Better cost 8. Better supply of drugs 9. Others: Specify _____	

28	Why are you coming here? Reason/s for choosing this facility?	1. _____ 2. _____ 3. _____ (should be listed as possible)	
29	Number of visits to any private health facility in the last one year? _____		
30	How much did you spend for health care per year for self and the family? (Av.)	_____ (Birr) (Self) _____ (Birr) (family)	
31	From where did you hear the service in this facility?	1. Informed relatives 2. Other patients 3. TV spots 4. Radio spots 5. Brochure/leaflets 6. Others, specify _____ _____	
32	Respect for the person: 1. How do you rate respect (dignity) provided by the staff in the facility?	1. V. good 2. Good 3. Acceptable 4. Poor 5. V. Poor	
	2. How do you rate the confidentiality kept (trust to be kept confidential) by the staff in the facility?	1. V. good 2. Good 3. Acceptable 4. Poor 5. V. Poor	
	3. How do you rate the provision of information you needed from the staff in the facility?	1. Very satisfied 2. Satisfied 3. Neither 4. Dissatisfied 5. Very dissatisfied	
33	Client orientation:		

	1. How do you rate prompt attention provided by the staff in the facility?	1. V. good 2. Good 3. Acceptable 4. Poor 5. V. Poor	
	2. How do you rate the provision of basic amenities (services) provided by the staff in the facility?	1. V. good 2. Good 3. Acceptable 4. Poor 5. V. Poor	
	3. How do you rate services provided was as per to your perceived choice to be	1. V. good 2. Good 3. Acceptable 4. Poor 5. V. Poor	
34	Any problem you observed in this private healthcare facility to be improved for future?	1. _____ 2. _____ 3. _____ (should be listed as possible)	Please note below and at the back if many
35	Any problem you observed in all private healthcare facility to be improved for future?	1. _____ 2. _____ 3. _____ (should be listed as possible)	
36	Level of Satisfaction you have in service delivery in this private facility	1. Very satisfied 2. Satisfied 3. Neither 4. Dissatisfied 5. Very dissatisfied	

37	Level of Satisfaction you have regarding the cost you spend in this private facility	1. Very satisfied 3. Neither 5. Very dissatisfied	2. Satisfied 4. Dissatisfied
38	Level of Satisfaction you have regarding outcome of services delivered in this private facility	1. Very satisfied 3. Neither 5. Very dissatisfied	2. Satisfied 4. Dissatisfied

ANNEXURE G: DATA COLLECTION TOOL FOR HEALTH FACILITY OWNERS/MANAGERS, HEALTHCARE PROVIDERS AND CLIENTS/PATIENTS (Amharic)

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13	<p>□□ □□□ □□□□ □□□□□</p> <p>□□□□ □□□□ □□□□□□</p> <p>□□□□? (CT, MRI or any special service/s)</p>	<p>1-□□ 2. □□□</p> <p>□□ □□□□□ -----</p> <p>-----</p> <p>-----</p> <p>-----</p>	
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29	□□□□ □□□□ □□ (□□□□/□□□□ □□□) □□□□ □□□□□□□ □□□ □□□□□□□□ □□ □□□□?	1-□□□□□□ □□□□ 1-□□ 2. □□□ 2-□□□□ □□□□ 1-□□ 2. □□□ 3-□□□ □□□ □□□□ 1-□□ 2. □□□ □□ □□□ □□□□ □□□□ □□ □□□□□ □□□□ □□ □□□□□□□□? 1-□□ 2-□□□	□ □ □ □ □
30	□□□□□□□ □□□□ □□□□□□□? (□□□□□ □□ □□□□ □ □□□□ □□□□ <u>□□□□□□/□□□□□</u>) 1-□□□□□□□ (OPD abstract) _____ 2-□□□□□ □□□□□ _____ 3-□□□□□□□ □□□□□ _____		

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32	<p>□□□□□□ □□□ □□□□□</p> <p>□□□□ □□ □□□□ □□□□</p> <p>□□□? (critically ill, can't pay, children, ...)</p>	<p>1-_____</p> <p>2-----</p> <p>-----3-----</p> <p>-----</p>	
33	<p>□□□ □□□□ □□□□</p> <p>□□□□ □□□ □□□</p> <p>□□□□□□ □□□□□□</p> <p>□□?</p>	<p>1-□□ 2-□□□</p> <p>□□ □□ □□□□□□□ -----</p> <p>-----</p> <p>-----</p> <p>-----</p>	
34	<p>□□□ □□□□□□</p> <p>□□□□ □□□ □□□</p> <p>□□□□□□ □□□□□□</p> <p>□□?</p>	<p>1-□□ 2-□□□</p> <p>□□ □□ □□□□□□□ -----</p> <p>-----</p> <p>-----</p> <p>-----</p>	
35	<p>□□□□ □□□□</p> <p>□□□□□□ □□□□?</p>	<p>1-□□ 2-□□□</p> <p>□□ □□ □□ □□□ □□□□□ □□□□ -----</p>	
36	<p>□□□□ □□□ □□□</p> <p>□□□ □□ □□□</p> <p>□□□□□ □□□ □□□□</p> <p>□□□□□□ □□ □□□□</p> <p>□□□□?</p>	<p>1-□□ 2. □□□</p> <p>□□ □□ □□□□ □□ -----</p> <p>□□□□ □□□ □□□□ □□□ □□ □□□? -----</p> <p>-----</p> <p>-----</p> <p>-----</p>	

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38	□□□□□ □□□□□ □□□□ □□□?	1-□□□ □□ □□ 2-□□ □□ 3-□□□ □□ 4-□□ □□□□ □□ 5-□□□ □□ □□□□ □□	
39	□□□□ □□ <u>□□□□□□ □□□□</u> <u>□□ □□□□□ □□□ □□ □□□□□</u> □□□□ □□□□□□?	1-□□□ □□ □□ 2-□□ □□ 3- □□□ □□ 4-□□ □□□□ □□ 5-□□□ □□ □□□□ □□	
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41	□□□□ □□□□□ □□□□ □□□□ □□□ □□ □□□? (□□□□/□□□□/□□□□)	_____ (□□/□□□) □□□□ □□□ □□□ □□□□□? 1- □□ 2- □□□ <u>□□</u> □□□ □□□□□ □□ □□ □□□□□ □□□□□□ □□ 1. ----- 2. -----	
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43	□□ □□□ □□□□ □□ (□□□) □□□□ □□□□□ □□□□□□ □□□□?	1. □□ 2. □□□	

44	<p>□□□□ □□□□□□ □□□□</p> <p>□□□□ □□□□□ □□□□□</p> <p>□□□□ □□□□ □□□□</p> <p>□□□□□ □□□□ □□□□□</p> <p>□□□ □□□?</p>	<p>1. □□ 2. □□□</p> <p>□□□ □□ □□ □□□ □□□□ □□ □□□?</p> <p>-----</p> <p>-----</p> <p>-----</p>	
45	<p>□□□□□□ □□□□ □□□□□ □2010 □□□□□</p> <p>□□□ □□□□ □□?</p>	<p>□) □□□/□□□□□ □) □□</p> <p>□) □□</p>	
46	<p>□□□□□ □□□□□/</p> <p>□□□□□□□□□</p> <p>□□□□□□□ □□□ □□?</p>	<p>1-□□□□ □□□□□ 2-□□□□□ □□□</p> <p>□□□□□</p> <p>3-□□ □□ □□□□ □-----</p> <p>□□□□ □□□□ □□□ □□□□□ □□□ □□□□□□?</p> <p>-----</p> <p>-----</p> <p>□□□□□□ □□□□ □□□- 1-□□ □□□□ 2-</p> <p>□□□□ □□□ 3-□□ □□□□ 4-□□□□ □□</p> <p>□□□□ 5-□□□ □□□ □□ □□</p>	
47	<p>□□□ □□□□□</p> <p>□□□□□□□□ □□□</p> <p>□□□□□/□□□□ □□□□□</p> <p>□□□□□ □□□□ □□□</p> <p>□□□□ □□?</p>	<p>1-□□ 2-□□□</p> <p>□□□□ □□ □□ □□□□□ □□□□□□ □-----</p> <p>-----</p>	
48	<p>□□ □□□ □□□□ □□□</p> <p>□□□ □□□□□ □□□□□□</p> <p>□□□□ □□□ □□?</p>	<p>1-□□ 2-□□□</p> <p>□□□ □□□□ □□□□□□□ □□□ □□□□? 1-</p> <p>□□ 2-□□□</p>	
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ANNEXURE H: Consent form for experts as participant in the study and proposed guidelines for validation

Title of the study: The delivery of comprehensive healthcare service by private health sector in Amhara region, Ethiopia

Dear -----

First, I thank you for your respected time dedicated to complete this questionnaire.

My name is Melkie Assefa, a PhD student at the University of South Africa. I am conducting a research on the title mentioned above as a requirement for fulfilment of the prospective degree.

The study was conducted in two phases, with phase 1 being collection for evidence for delivery of comprehensive healthcare service by private health sector and phase 2 as development of guidelines. From the findings of phase 1 of the study, the researcher proposed five guidelines for the identified challenges and opportunities in the private health sector in Amhara region, Ethiopia. The main purpose of proposed guidelines is to enhance the delivery of comprehensive healthcare especially in the private health sector in the region.

You are requested to validate the developed guidelines, using the questionnaire. You have been selected as a member of the panel of experts to validate the guidelines because of your experience as a senior health expert in the private health sector.

For this validation purpose, acceptability, feasibility, effectiveness, relevance and sustainability are the criteria to be used. Each proposed guideline should be validated in relation to the adjacent criteria. It has only two options, agree (value 1) and disagree (value 0). You are requested to put “x” on appropriate column. If your response is disagree, please put your comment on the space adjacent to it. The proposed guideline may not be new but to give high attention.

Your participation in the validation process is voluntarily and your name will not be required. Your responses will be kept with strict confidentiality and anonymity.

I thank you a lot for your participation and input for the fulfillment of this study and contribution for the improvement of the health system especially the private health sector in the region as well as in the country. For any information you need, please contact me on:

Melkie Assefa - +251 918 7796 19.

Thank you again for your participation!

Validation of individual guidelines by experts in the health sector

Guideline 1: Strengthen and support working for extended hours to promote user friendly services

Criteria	Agree (Value 1)	Disagree (Value 0)	Comments
Acceptability: the guideline is acceptable in terms of the physical, psychological and emotional support needs of working for extended hours the private health sector			
Applicability: The usefulness of the guideline as part of support system for private health sector to work for long hours			
Effectiveness: The guideline is able to achieve its objective as support means for the private health sector working for extended time in the context of the study.			

Feasibility: The implementation of the guideline is possible in terms of resources in the private health sector.			
Relevance: The guideline is ideal for application in relation to the private health sector working for extended hours			
Sustainability: The ability of the guideline to address the present and future emotional needs of the private health sector working for extended hours can be predicted.			

Guideline 2: Increase accessibility of healthcare services for the poor through community based health insurance, fee waiver and exemption in the private health sector

Criteria	Agree (Value 1)	Disagree (Value 0)	Comments
Acceptability: the guideline is acceptable in terms of the physical, psychological and emotional support needs of the private health sector			
Applicability: The usefulness of the guideline as part of a support system for the private health sector (Predicted applicable)			
Effectiveness: The guideline is able to achieve its objective as support means for the private health sector to provide free			

healthcare services through CBHI, fee waiver and exemption.			
Feasibility: The implementation of the guideline is possible in terms of resources in the private health sector.			
Relevance: The guideline is ideal for application in relation to the private health sector.			
Sustainability: The ability of the guideline to address the present and future emotional needs of the private health sector to provide free healthcare services through CBHI, fee waiver and exemption			

Guideline 3: Increase facilitation for financial access to actors in the private health sector in the region

Criteria	Agree (Value 1)	Disagree (Value 0)	Comments
Acceptability: the guideline is acceptable in terms of the physical, psychological and emotional support needs of accessing finance to the private health sector			
Applicability: The usefulness of the guideline as part of a support system for the			

private health sector to increase access to finance			
Effectiveness: The guideline is able to achieve its objective as support means for the private health sector to access finance to improve service delivery.			
Feasibility: The implementation of the guideline is possible in terms of resources in the private health sector.			
Relevance: The guideline is ideal for application in relation to the private health sector			
Sustainability: The ability of the guideline to address the present and future emotional needs of the private health sector access finance can be predicted.			

Guideline 4: Strengthen, enhance and scale up the capability of the existing association in the private health sector

Criteria	Agree (Value 1)	Disagree (Value 0)	Comments
Acceptability: the guideline is acceptable in terms of the physical, psychological and emotional support needs of the private health sector			

Applicability: The usefulness of the guideline as part of a support system for the private health sector (Predicted).			
Effectiveness: The guideline is able to achieve its objective as support means for the private health sector working together within the context of the study.			
Feasibility: The implementation of the guideline is possible in terms of resources in the private health sector.			
Relevance: The guideline is ideal for application in relation to the private health sector.			
Sustainability: The ability of the guideline to address the present and future emotional needs of the private health sector working together can be predicted.			

Guideline 5: Increase facilitation to access regular updating trainings and continuing education for healthcare workers in the private health sector

Criteria	Agree (Value 1)	Disagree (Value 0)	Comments
Acceptability: the guideline is acceptable in terms of the physical, psychological and			

emotional support needs of trainings and continue education in private health sector.			
Applicability: The usefulness of the guideline as part of a support system for the private health sector (Predicted)			
Effectiveness: The guideline is able to achieve its objective as support means for private health sector to trainings, continuing education within the context of the study.			
Feasibility: The implementation of the guideline is possible in terms of resources in the private health sector.			
Relevance: The guideline is ideal for application in relation to the private health sector.			
Sustainability: The ability of the guideline to address the present and future emotional needs of trainings and continuing education in private health sector can be predicted.			

Profession -

Occupation –

Work experience

