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PRIVATE SECTOR BRIEF
RWANDA HEALTH SYSTEM STRENGTHENING (RHSS) PROJECT

PRIVATE WING AT PUBLIC DISTRICT HOSPITALS

This private-sector brief examines the potential for establishing private wings at public district hospitals to improve the sustainability of Rwanda's health care system.

I. THE RWANDAN CONTEXT: PRIVATE WING

Rwanda's Ministry of Health is exploring and pursuing ideas and opportunities to strengthen district hospitals (DHs) by bringing a private-sector mindset to management and operations. Exploring the development of private wings at DHs has been proposed as a strategy for additional income generation toward their self-financing.

Private wing commonly refers to an official arrangement by which medical services are provided, on a fee-for-service basis, to inpatients and outpatients in an acute-care public hospital. This kind of arrangement is sought to improve the sustainability of services in public hospitals.

Rwanda is no stranger to such an arrangement. Examples exist at the King Faisal Hospital and at the University Central Hospital of Kigali. Private wings as an income-generating activity, however, have not been used systematically in Rwanda because of the lack of a formal legal framework. Currently, some DHs are investing time and resources to pursue this type of business model. For example, Gisenyi Hospital and Kigobora have developed the infrastructure for a private wing. And Kiziguro Hospital and Nyamata Hospital are in the process of building their respective private wings.

Pelonomi-Universitas Hospital Co-location Public-Private Partnerships

This 20-year agreement between the consortium Community Hospital Management (CHM) and the Free State Department of Health of South Africa started in 2003. The private partner (CHM) utilizes an empty ward at Universitas Hospital to operate a private hospital (known as Universitas Private Hospital). CHM injected capital (R20 million) towards upgrading a public medical ward, theaters, and intensive-care–unit blocks. In addition, the public sector receives a percentage of the turnover the private hospital generates, and the state retains ownership of all buildings after the concession period.

II. SUMMARY OF INTERNATIONAL LITERATURE REVIEW

The literature review identified two different models for private wings in public hospitals:

Co-location is a model "where a public agency allocates some of a public hospital's land and/or premises for sustained use by a private health care business in exchange for payment and specified benefits to the public hospital and public patients. The co-located facility may be held by an investor-owned (for-profit) or not for-profit entity. It may provide comprehensive or selected services. It may not only be physically located on premises leased from the public hospital; it may even comprise an additional floor of, or a separate pavilion within, the public facility. Co-location refers strictly to the physical proximity of the two facilities, not to any particular form of ownership or contractual relationship"[1] (see text box).

Photo Credit: http://features.healthdata.org/roux-prize-2015-winner

Public or Parastatal Private Service Model refers to a private wing in a public hospital that does not involve investor ownership at all but allows physicians to care for private patients in designated areas of the public facility (see the following text box). Physicians who are willing to work in the private wing sign a written contract with the hospital and are expected to rent offices. This contract dictates that physicians should be available in hospital premises for both the general and private-wing services. It ensures that quality of service in the general part should not in any

way be compromised by their involvement in the private wing. Any violation regarding the terms of agreement will result in termination of the contract. Physicians working in the private wing get paid per their consultations and procedures. The rest of the staff is assigned in the private wing with the employment of different criteria such as personal choice to work in the private wing, interview results, and an attitude appraisal. The nursing management in the private wing makes an effort to maintain the nursing standard of a minimum number of patients attended per nurse.[2]

Kenyatta National Hospital (KNH) Private Wing/Amenity Ward

Initiated in 1991 by the ministry of health and KNH in Kenya. The private wing offers the full range of inpatient and outpatient services 24/7, including laboratory, radiology, and other diagnostics. A management committee runs it, and the wing has its own finance head, property and procurement manager, and chief nursing officer.

The literature review revealed that establishing well-functioning private wings in public hospitals can bring various benefits: The most important benefits include the following:

- **Retention of staff**. Medical turnover is high in public hospitals in many African countries. A study discovered that the initiation of private wings in public hospitals contributed to motivation and retention of health professionals. Major benefits to private-wing staff include an increase in their skill use and better income.[3]

- **Increased client satisfaction.** Patients report a positive experience with private wings because of their extended hours of service, shorter wait times, better quality, and lower cost than private clinics.

- **Facility upgrades.** Along with access to new equipment by investors are another advantage.

- **Revenue flow.** If there is contractual agreement for revenue sharing, revenue flows to the public hospital. [4]

III. Summary of Recommendations for Decision-Makers

The legal framework in Rwanda allows only for developing the co-location model at district hospitals as a result of the amendments currently being made to the decentralization law.[5] The public or parastatal Private Service Model only will be possible once the decentralization law is further amended to provide public hospitals with budget, administration, and tariff autonomy.

Considering the potential benefits for establishing private wings in public hospitals, it is recommended that any selected model proceed only with the following:

1. **Diligent attention to regulatory detail.** A complete legal framework for the partnership is needed. Without it, the potential for continual conflict between the parties exists.

2. **Establishment of rigorous monitoring.** Contract compliance and performance results must be reported and reviewed continually. Bookkeeping, accounting, and reporting requirements need to be detailed and followed.

3. **Revenue distribution.** Private wings are most successful when the collected revenue is used to improve the quality of services for all. A formula for revenue distribution needs to be agreed upon that provides the needed incentive for clinician participation and retention - or a fair investor profit margin that also benefits the non-private patients with improved clinical services and better equipment and facilities.

4. **User fees.** Charges for services need to be regulated to ensure fairness and consistency.

Photo Credit: www.ubuzimabwacu.com

5. **Transparency and accountability**—These are critical for private wings to work and must be 100 percent.

1 Harding, April (2012). Co-Location PPP's in the Hospital Sector. World Bank Institute.
2 Louise Myers (2009). Ethiopia Federal Ministry Of Health—Operational Manual For Establishing Private Wings In Public Hospitals And Outsourcing Of Non-Clinical Services. Draft No 5.
3 Bogale Zewdie (2015). The Role of Private Wing set up in Public Hospitals in Reducing Medical Professionals' Turnover. Journal of Studies in Management and Planning.
4 Federal Ministry of Health Medical Services Directorate. "Assessment of Private Wings in Public Hospitals in Ethiopia". November 2011.
5 This process can take more than six months from the date this brief was developed. Source: Rwanda MOH Legal advisor.

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