

Hospital Autonomy in Zimbabwe

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Executive Summary

Introduction

This report is one of five case studies examining the experience of different developing countries to give financial, administrative or managerial autonomy to government-owned hospitals. It looks at experience with hospital autonomy in Zimbabwe. The issue of hospital autonomy has grown in importance in Zimbabwe as the government in 1995 announced its desire to decentralize hospital financing and to promote privatization of selected hospital functions.

The Government of Zimbabwe has organized the public health facilities and most non-government health facilities into a national four-tiered system for delivering health services. The upper tier consists of six central hospitals. Among the six, Parirenyatwa Hospital has been granted a degree of autonomy that other government hospitals do not have. Parirenyatwa Hospital is a 987 bed hospital in central Harare. In 1995, it provided 272,330 days of care and 231,531 outpatient visits. It is the principal teaching hospital for the University of Zimbabwe School of Medicine and a major referral center. The principal focus of this study is comparison of the governance and operation of Parirenyatwa Hospital to that of other central hospitals.

In addition to this principal case, two other cases are examined -- Wankie Colliery Hospital in Hwange and Avenues Clinic in Harare.

Parirenyatwa Hospital

History of Parirenyatwa Hospital

In pre-independence Zimbabwe, hospital services were segregated. In the early 1970s, a decision was made to create a major teaching hospital for white patients. The Andrew Fleming Hospital opened in 1974. The next year, governance of this hospital and three other hospitals, including the black Harare Central Hospital, was vested in a new body, the Salisbury Hospitals Board of Governors. The Board had authority to administer the property of the hospitals, to manage and control the hospital, to control the funds received by the hospital from patients, and, subject to conditions established by the Minister of Health and some other restrictions,

appoint medical staff, clinical teaching staff, and residents. The Minister of Health was to consult with the Board prior to appointing the Medical Superintendent of the Hospitals and other nonmedical staff. Funds were provided by the Ministry of Health as a block grant.

Following independence, the new government took steps to reduce the autonomy of the hospital. The apparent motive was to gain control over an elite white institution and expand access to care at the hospital to the black population. In 1981, the legislation creating the Board of Governors was amended to reduce the size of the Board of Governors and change its composition, eliminate the requirement that the Minister of Health consult with the Board prior to the appointment of a Medical Superintendent or other staff or the removal of non-medical staff, and expand the authority of the Minister of Health relative to the Board by making the Minister's direction binding on the Board. The legislation also removed Harare Central Hospital from the control of the Board. The next year, the Andrew Fleming Hospital was renamed the Parirenyatwa Hospital in honor of the first black Zimbabwean to qualify in medicine.

Throughout the 1980s, the MoHCW maintained substantial interest in decision making at Parirenyatwa Hospital. In 1992, the Board resigned or was forced to resign following a series of press reports on the hospital's substantial deficit, and alleging mismanagement and economic discrimination in access to the hospital. A committee of MoHCW officials was appointed to run the hospital and review the issues in the management and governance of the hospital. It presented a report in 1993 calling for the upgrading of the hospital and its continued operation as an autonomous institution. The MoHCW official who was lead author of the report was appointed Medical Superintendent. The Board was reconstituted in 1995. Shortly after the field work on this study was completed, the Medical Superintendent was forced to resign because of personal use of a hospital ambulance.

The Scope of Autonomy at Parirenyatwa Hospital

Formal MoHCW supervision of government hospitals in Zimbabwe is highly centralized. Senior officials are appointed by the Ministry of Health and all employees are civil servants. Hospitals are allocated line-item budgets for inputs such as salaries, supplies and provisions based on historic levels of spending. Purchasing is controlled. Medical supplies and drugs must be obtained by requisition through the Government Medical Stores (GMS). Other purchases are made by issuing requisitions to government-approved vendors. The requisitions are submitted to Treasury for payment, and are eventually debited against the appropriation for the hospital. Capital funds are provided by MoHCW for government owned hospitals. Maintenance of plant is the responsibility of the Ministry of Construction and Housing, and maintenance of vehicles is the

responsibility of the Ministry of Transport. The Ministry of Health and hospital staff share responsibility for equipment maintenance. Hospitals are expected to bill patients insured through Medical Aid Societies and patients whose monthly incomes exceed Z\$400 according to a Ministry of Health and Treasury-established fee schedule, but any funds recovered through billing revert to Treasury. Within this system, the Medical Superintendent and senior staff of the hospital make day to day operational decisions.

Placed within the context of other hospitals, the autonomy of Parirenyatwa Hospital is limited. Senior staff have been appointed by the MoHCW without Board approval or consultation. Staff are civil service. Budgets, while block grants, are also determined based on historic levels. The hospital must follow the same tender process as other hospitals, and maintenance procedures are the same. The hospital must adhere to the MoHCW fee schedule.

The principal areas of autonomy are the following. First, fee income can be retained. Furthermore, unlike other hospitals, Parirenyatwa is authorized to bill the government for patients eligible for free care because their incomes are less than Z\$400 per month. It should be noted, however, that while fee income can be retained, fee levels established by the MoHCW have traditionally been set below cost. This policy creates a structural deficit that can only be met through public appropriations.

Second, the hospital receives its funds as a block grant, and can construct its own internal budget without regard to MoHCW or Treasury allocations to specific line items. However, the autonomy of internal budgeting is limited because employees are civil servants and the Public Service Commission has restricted the ability of the hospital to redefine its staffing needs and hire or lay off workers in response to those needs.

Third, while the Board of Governors' role has been diminished by the 1981 amendments and subsequent actions of the MoHCW, it has some potential to foster the independence of the hospital. Nonetheless, autonomy is constrained by continued MoHCW efforts to directly influence the scope of services and operation of the hospital, and by limited initiative and leadership within Parirenyatwa Hospital.

If the autonomy of Parirenyatwa Hospital is limited, it is also the case that in the past several years, actual supervision of other hospitals by MoHCW has been less than is suggested by the formal description presented above. Personnel costs and employment have been strictly enforced by the Public Service Commission but often budget limits have not been tightly administered. Some hospitals made purchases substantially in excess of budgeted amounts, which have simply been paid at the start of the next fiscal year and debited against the new year's appropriation. Parirenyatwa Hospital has done the equivalent, i.e., withheld payment until it had the funds to pay. Vendors have seemed willing to extend credit both to the government and Parirenyatwa, thus reducing the discipline of a fixed budget.

Likewise, when GMS is out of stock, both Parirenyatwa and other hospitals were authorized to use standard tender processes to obtain needed supplies in the outside market.

MoHCW supervision of its hospitals has also been limited by the way in which expenditure data and utilization statistics are separately collected and maintained. It has proven extremely difficult to construct estimates of unit costs either over time in the same hospital or comparatively across hospitals. Without such data, it is hard to establish reasonable expectations for hospital managers.

Managerial and Organizational Responses to Autonomy

As autonomy is limited, so are modifications to the management, organization and systems in place at Parirenyatwa Hospital. The management structure of the hospital is similar to that of other central hospitals, but the Medical Superintendent at the time of our study was seeking to upgrade his senior accounting staff and add a position of Technical and Estates Executive in the expectation that the hospital would gain responsibility for maintaining its own plant, equipment and vehicles.

Given the hospital's opportunities to retain fee income, it might be expected that its accounting and billing functions would be well developed, as gains in this area might pay for themselves. Parirenyatwa Hospital does a better job of collection than other central hospitals. In 1994, for example, it reported collecting 18.2 percent of its expenditures, compared to 6.4 percent for Harare Central. While better than other hospitals, the billing and collection process at Parirenyatwa Hospital has been poor. In 1993, it was estimated that bills were produced six to 12 months after discharge, and it was estimated there was a 14-month backlog in billing.

The problems in the billing area have been attributed to two factors -- failure to computerize this function and civil service restrictions on staffing and hours. A more general factor contributing to the billing problem was lack of management focus on the issue. This may have reflected an orientation during the 1980s toward expanding access and reliance on MoHCW direction and appropriations.

Impacts of Autonomy on Operational Performance

The study compares the performance of Parirenyatwa Hospital and Harare Central Hospital for evidence that the autonomy of Parirenyatwa has contributed to a higher standard of performance. Such comparisons are difficult, however, because Parirenyatwa has historically been funded at a much higher level than Harare Central and Harare Central serves a poor area, and differences may be attributable to differences in resources or case mix, rather than autonomy. Overall, few differences are observed.

With respect to overall financial management and cost control, evidence of superior performance by Parirenyatwa Hospital is mixed. For the three years (1993-1995) for which comparable data are available, the nonpersonnel expenses at Parirenyatwa grew substantially more slowly than at Harare Central but Harare Central started and ended the period with costs per day lower than those at Parirenyatwa. Parirenyatwa may have better controlled its costs during this period, but it also had greater room for maneuver. Ratings of the two hospitals in the area of financial management and cost control in the 1992 and 1995 Best Central Hospital Competitions were comparable.

With respect to individual areas of hospital operations, performance appears comparable or associated with the budget levels for the function. *Personnel* functions are comparable at the new institutions. *Drugs and Supplies* are purchased using the same systems and sources, and staffs in both hospitals report overspending in recent years. When drugs are not available through GMS, Parirenyatwa reports sometimes going to outside vendors; Harare Central to having patients or their families buy drugs and bring them to the hospital. This may reflect the difference in funding levels between the two institutions. *Food service* is one area of identified difference between the two institutions, with outside sources rating the Parirenyatwa Hospital food service as superior to that at Harare Central. This may, however, reflect the higher level of spending on provisions per day at Parirenyatwa, Z\$16 in 1995 compared to Z\$10 at Harare Central. *Maintenance and Equipment Repair* is handled similarly at both hospitals. Severe shortages of staff and supplies were reported at Harare Central, however. Both hospitals report problems with respect to the responsiveness of the non-MoHCW Ministries responsible for maintaining plant and vehicles. The process of *Equipment Purchase* is similar at both hospitals. The principal difference is that the equipment budget at Parirenyatwa Hospital is fixed internally, while that at Harare Central is based on its appropriation for equipment. Over the past several years of tight budgets, donor funds have been the principal source of financing for new equipment and these have been administered through the MoHCW for both Parirenyatwa and Harare Central.

Few measures of overall quality are available. Ratings of the two hospitals in the Best Central Hospital Competitions of 1992 and 1995 are slightly higher for Parirenyatwa Hospital, but the differences are small. Mortality rates at Parirenyatwa are lower than at Harare Central, but these differences could reflect case mix differences, the higher poverty level in the population treated by Harare, or the greater resources available at Parirenyatwa, rather than management differences. Mortality rates rose between 1989 and 1995 at Parirenyatwa in both maternity and nonmaternity services, but this may reflect declines in the economy in Zimbabwe or the growing burden of HIV/AIDS.

Wankie Colliery Hospital

The Wankie Colliery Hospital is located close to the coal mines of the Wankie Colliery in Hwange in western Zimbabwe. The hospital has more than 150 beds, and is well equipped and well staffed. The hospital is an operating department of the colliery, originally established to provide care to company employees and their families. Annual budgets and a five year equipment plan are submitted by the hospital to colliery officials, who set the final budgets. The colliery purchasing department handles procurement for the hospital.

The colliery contracts with several large regional employers to provide hospital services to their employees. Reimbursement is on a negotiated fee schedule. The negotiated fees are cost-based and the hospital has implemented internal cost accounting and computerized billing systems to support this process. This illustrates the potential for the implementation of such systems at other hospitals in Zimbabwe.

The hospital also contracts with the Ministry of Health to provide district hospital-level services under a similar cost-based negotiated fee schedule. This relationship has become strained for several reasons. First, the costs at the colliery hospital are higher than at MoHCW district hospitals, and the MoHCW Provincial Health Officer has therefore encouraged patients to go to other hospitals. The hospital has complained that without a predictable flow of patients from the MoHCW, it has been hard to staff appropriately. There have also been conflicts over the hospital's billing the government for patients with incomes greater than Z\$400 who come to the hospital with referral letters from district health clinics. Similar conflicts might emerge with respect to other hospitals if the government grants hospitals greater autonomy and shifts its payment from line-item or block grants to fee-for-service for eligible patients.

Avenues Clinic

Avenues Clinic is one of the few private general hospitals in Zimbabwe. It has one hundred forty-eight beds and is located within a short walk from Parirenyatwa Hospital. The hospital describes itself as operating much as a nonprofit and has applied for nonprofit status. The stated philosophy is to keep fees as low as possible, consistent with paying the recurrent costs and providing for equipment and upgrading.

More than 80 percent of the patients are members of Medical Aid Societies. Most of the rest are either foreign insured patients or cash paying patients. The hospital charges for care on a fee-for-service basis. It has implemented computerized cost accounting and billing systems, using the same software as the Wankie Colliery Hospital. The hospital illustrates the potential for fee-supported hospital care in Zimbabwe and that systems are available within the country to effectively manage in such an environment.

Lessons and Implications of the Zimbabwe Cases

The motivation for creating Parirenyatwa Hospital as an autonomous hospital in the pre-independence period is not entirely clear. In the post-independence period, the MoHCW sought to restrict the limited autonomy originally established. In the past year, the government of Zimbabwe has expressed interest in decentralizing hospital management and expanding autonomy not just at Parirenyatwa Hospital but at hospitals throughout the country.

Several lessons emerge from the experience of Parirenyatwa Hospital, Wankie Colliery Hospital, and Avenues Clinic for implementing effective efforts to decentralize hospital management and increase hospital autonomy. **First**, hospital leadership must be appointed that is committed to implementing expanded autonomy and can effectively articulate a vision of autonomy to the hospital staff and other hospital constituencies. The hospital leadership must be able to gain the confidence and cooperation of the hospital staff. **Second**, the financial and managerial accounting and billing systems currently in place in hospitals are not adequate to allow hospitals to effectively price their services, bill in a timely fashion, budget, manage against budget, or adjust budgets in real time to reflect changing demand or economic circumstances. Upgrading these systems and the staff administering them will be a critical element in implementing any policies that put hospitals at risk for balancing revenues and expenditures. **Third**, control must be ceded by Ministry of Health. In a decentralized hospital system the MoHCW must be willing to relinquish authority over senior appointments, staffing, service offerings, and operational management of the hospitals.

There are several critical transitional issues that MoHCW must resolve if it will move toward decentralized financing and management. **First**, it must resolve the question of whether hospital employees will remain civil servants. **Second**, a new basis for flowing funds to hospitals must be articulated and implemented. If hospitals are to be expected to generate their funds from fee income, then the payment rates must be more closely aligned with costs. This will require prices substantially higher than the current fee schedule for the central hospitals. A strategy may also have to be developed to reduce the current disparities in payment among comparable hospitals. **Third**, a system of hospital financing that is based upon uninsured individuals with incomes greater than Z\$400 being fully responsible for their own bills has the potential of confronting hospitals with structural shortfalls in payment. Attention should be paid to developing financing mechanisms that prevent this. **Fourth**, currently hospitals determine whether individuals are above or below the Z\$400 cutoff for free care. Most make these decisions without a direct financial incentive in the decision. To the extent the government seeks to shift funding of hospitals to fee-for-service while a sizable portion of the population remains without coverage, both individuals and hospitals will have an incentive to qualify patients for government assistance. The MoHCW needs to identify systems

and mechanisms for assuring that appropriate decisions on qualification are made. **Finally**, even as the MoHCW role in operational management of hospitals shrinks, MoHCW roles in the areas of financing, monitoring and quality assurance are likely to grow in importance. Systems must be developed to allow the Ministry to effectively carry out these new or expanded roles.

1. Introduction

The Data for Decision Making (DDM) Project at Harvard University has been commissioned to undertake five individual case studies on the experiences in different developing countries with efforts to give greater financial, administrative and managerial autonomy to public hospitals. This report looks at experience with hospital autonomy in Zimbabwe. The issue of hospital autonomy has grown in importance in Zimbabwe as the government in 1995 announced its desire to substantially decentralize hospital financing in the country and to promote privatization of selected hospital functions. (Ministry of Health and Child Welfare 1995; Ministry of Health and Child Welfare 1995)

The Government of Zimbabwe has organized the public health facilities and most non-government health facilities into a national four-tiered system for delivering health services. The upper tier consists of six central hospitals. Among the six, Parirenyatwa Hospital has been granted a degree of autonomy that other government hospitals do not have. The principal focus of this study is a comparison of the nature and impact of autonomy at Parirenyatwa Hospital in contrast to that of other central hospitals. Specific comparison is made to the Harare Central Hospital.

In addition to this principal case, two other cases are examined. One is that of an industrially-owned private hospital -- Wankie Colliery Hospital in Hwange -- and the second is of a private hospital -- Avenues Clinic -- in Harare. These two cases provide additional insight into the potential impacts of hospital autonomy in Zimbabwe.

The study addresses five broad questions: 1) What are the nature and extent of the autonomy of the hospitals studied? 2) What is the process by which autonomy has been extended to these hospitals and how has autonomy changed over time? 3) How have the hospital management, organization, internal systems and practices been structured or changed to reflect the hospital's level of autonomy? Is there a mismatch between management, organization, systems or practices and the demands imposed by autonomy? 4) What has been the impact of autonomy? 5) What issues emerged in implementation of hospital autonomy and what lessons have been learned about implementing a policy of autonomy?

The information to address these questions was obtained in interviews, review of relevant documents, and the collection and analysis of available data regarding hospital utilization, budgets, revenues and expenditures. The study was conducted

in accordance with methodological guidelines developed by DDM. (Berman and Chawla 1995) This guidance was modified as appropriate in the field to reflect the available data and issues that were most salient in the Zimbabwe cases.

1.1 Zimbabwe Economic Context

Zimbabwe is a country of approximately 11 million people in southern Africa. Population growth has averaged in excess of 3 percent over the past decade. Eighty percent of the population lives in rural areas.

In the decade following independence in 1980, government revenues as a proportion of GDP rose from 25 percent to 38 percent, while government expenditures increased from 33 percent of GDP to 49 percent. (Schwartz and Zwizwai 1995) In 1991, the Government of Zimbabwe began an Economic Structural Adjustment Program (ESAP) with the support of the World Bank and International Monetary Fund. During 1991-1992, Zimbabwe also experienced a severe drought, and the combined effects of the drought and ESAP contributed to a decline of real GDP per capita between 1991 and 1994. This was also a period of extensive inflation, with nominal prices more than doubling. Inflation in the medical sector was even higher.

Between 1989 and 1994, because of the ESAP, Ministry of Health and Child Welfare (MoHCW) spending as a proportion of government expenditure declined from 6.0 percent to 5.1 percent, and as a proportion of GDP declined from 3.1 percent to 2.2 percent. When the decline in GDP and population growth are taken into account, it has been estimated that real per capita recurrent expenditures by MoHCW fell 39 percent between 1991 and 1995. (Chisvo and Munro 1994 cited in; Schwartz and Zwizwai 1995) MoHCW-announced policy was to protect primary care spending and allocated cuts disproportionately to the central hospitals.

Much of the data available for this study are from the 1989-1995 period, and interviewing focused on this period. The economic situation provides the context within which hospital experience was analyzed.

1.2 The Health Sector in Zimbabwe

The health sector in Zimbabwe is made up of central government hospitals, mission hospitals, and municipal hospitals and clinics, as well as private hospitals and hospitals and clinics owned by industrial, mining and agricultural enterprises for their employees and their families. (McLoughlin 1995) At independence, the government adopted a primary care orientation and organized public and mission facilities into a four-tier system, with primary care in the first level, district hospitals and health services at the second, provincial facilities in the third tier and six central hospitals in the quaternary level. In principal, individuals are not supposed to go to higher level facilities without being referred from a lower level.

By-passing lower levels is very common, however, and the referral system is acknowledged not to work well. (Adamchak 1995) As a result, central hospitals such as Parirenyatwa and Harare Central see a mix of highly specialized and routine cases that could be treated at lower levels.

The system of public and mission health services are funded through several sources. Direct grants or budgets from the MoHCW are the principal source of funds. Donor funds may augment government appropriations. Fees to patients are a second source of funds, although in virtually all cases, receipts revert to the Treasury. Patient-based fees are paid from three sources. The first are Medical Aid Societies. Approximately 700,000 people are members of these societies. (Schwartz and Zwizwai 1995) The second source is self-pay patients. While government supported hospitals are expected to provide care at no charge to individuals earning less than Z\$400, those with incomes above that level are to be held liable for their hospital bills. The third source is the Social Dimensions Fund. This fund was created at the time the ESAP was adopted in recognition that reductions in government subsidies could have devastating effects on the poorest segment of the population, defined as those earning less than Z\$400 per month. Parirenyatwa Hospital and the municipal hospitals are permitted to bill this fund for qualifying patients. All billing is based on a government-established fee schedule. The schedule, recently revised, establishes charges that are believed to be below cost. (Hecht, Overholt et al. 1992) A comparison of the 1992 Parirenyatwa charges to those of private hospitals are presented in Table 1.

Table 1
Comparison of Parirenyatwa and Private Hospital Fees (Z\$)

	<i>Parirenyatwa</i>	<i>Avenues</i>	<i>St. Anne's</i>	<i>Montagu</i>	<i>Martarde</i>	<i>CASU</i>	<i>Gerfand</i>	<i>Triangle</i>
Ward Fees/day								
Private	\$60.00	\$300.00	\$93.50-100.00	na				
2 Bed	na	\$158.00	\$80.00	\$132.00		\$120.00	\$125.00	\$70.00
General	\$5.00-35.00	\$24.00-142.00	\$72.50	\$102.00	\$92.00	\$110.00	\$110.00	\$50.00
Maternity Charges	\$20.00-30.00	\$158.00+ Room	na					
ICU	\$20.00-80.00	\$330.00	na					
Surgery Charges	\$20.00-80.00	\$46.00/15 min.	\$50.00/15 min.					
Recovery Room	none	\$20.00	\$12.00					
General	\$24.00/1st 15	\$92.00/1st 15	\$50.00/1st 15					
Anaesthesia	\$12.00/sbq. 15	\$46.00/sbq. 15	\$25.00/sbq. 15					
Pharmacy Charges	Wholesale cost+50%	Wholesale cost+50%+ Pharm. fee	Wholesale cost+50%+ Pharm. fee					

*Parirenyatwa fees are used for comparison since they are highest of the public sector fees.
na=Not available at this hospital

Source: Hect, Overholt, and Holmberg, 1992.

2. Parirenyatwa Hospital

2.1 Description of Parirenyatwa Hospital and Other Central Hospitals

Parirenyatwa Hospital is a 987 bed hospital in central Harare. In 1995, it expended Z\$154 million providing 272,330 days of care and 231,531 outpatient visits. It is the principal teaching hospital for the University of Zimbabwe School of Medicine and a major referral center. It is located in central Harare.

Parirenyatwa Hospital is one of six Central Hospitals, Four are general hospitals, two are psychiatric hospitals. The other general central hospital in Harare is Harare Central Hospital. This is an 1115 bed hospital on the north side of Harare, which is a poorer community than that in which Parirenyatwa is located. Harare Central provided 357,837 days of inpatient care and 292,017 outpatient visits in 1995, and its expenditures were approximately 60 percent of those by Parirenyatwa. It is also a teaching hospital for the University of Zimbabwe School of Medicine.

Table 2 provides information on patient volumes and expenses at both hospitals.

2.2 History of Parirenyatwa Hospital

In pre-independence Zimbabwe, hospital services were segregated. Several factors contributed to the creation of a new major teaching hospital for white patients in the early 1970s. A medical school had opened in 1967, using facilities at Harare Hospital. There was a desire to make the benefits of the expertise at the medical school accessible to white patients. Private practitioners, including many specialists attracted by the medical school, wanted more beds for private patients. The war in the country increased the need for hospital services. The Andrew Fleming Hospital, built in response to these needs, opened in 1974.

The next year, governance of this hospital and three other hospitals, including the black Harare Central Hospital, was vested in a new body, the Salisbury Hospitals Board of Governors. The Board had authority to administer the property of the hospitals, to manage and control the hospital, to control the funds

received by the hospital from patients, and, subject to conditions established by the Minister of Health and some other restrictions, appoint medical staff, clinical

Table 2
Comparative Operating Statistics for Parirenyatwa and Harare Central Hospitals

	Year						
	1995	1994	1993	1992	1991	1990	1989
<i>Parirenyatwa Hospital</i>							
Beds	987	1,007	1,083	1,083	1,083	1,043	988
Discharges	47,669	42,249	38,673	34,574	34,964	34,356	38,534
Days	272,330	251,719	257,335	259,062	297,957	306,567	304,492
Length of Stay	5.71	5.96	6.65	7.49	8.52	8.92	7.90
Outpatient Visits	231,531	222,648	226,263	203,953	234,971	NA	191,765
Expenses	153,793,70	117,904,39	90,427,016	74,461,463	63,141,813	52,896,621	40,131,682
Expenses Excluding Personnel	83,803,164	66,497,685	46,406,262	38,521,663	30,566,787	26,974,216	18,873,581
<i>Harare Central Hospital</i>							
Beds	1,115	1,115	1,087	1,087	1,131	1,155	1,176
Discharges	72,842	66,458	60,478	65,887	64,710	60,642	57,335
Days	357,837	339,704	342,195	322,981	361,092	341,789	386,400
Length of Stay	4.91	5.11	5.66	4.90	5.39	5.39	6.35
Outpatient Visits	292,017	211,000	235,559	212,302	258,188	305,472	303,355
Expenses Excluding Personnel	51,546,473	37,951,694	17,364,741	NA	NA	NA	NA

Sources: Medical Records Department and Accounts Department, Parirenyatwa Hospital
 Medical Records Department and Accounts Department, Harare Central Hospital

Note: Expenses for Parirenyatwa Hospital include Public Health Laboratory
 Outpatient visits for Parirenyatwa Hospital not available for 1990

teaching staff, and residents. The Minister of Health was to consult with the Board prior to appointing the Medical Superintendent of the Hospitals and other nonmedical staff. Funds were provided by the Ministry of Health as a block grant (Rhodesia 1975). The reasons for establishing this governance structure in 1975 are not clear. One explanation offered is that the creating a Board of Governors and devolving authority from the Ministry may have been a rational response to the managerial challenges of establishing a new elite institution and integrating the needs and interests of the medical school and private practitioners in treatment, teaching and research. An alternative explanation is that this governance structure reflected the efforts of the medical school faculty and most powerful private practitioners in the country to exercise control over their clinic facilities. It was

suggested by some interviewees that, with the recognition that majority rule was increasingly likely, this governance arrangement was viewed as a possible path to preserving control in a post-independence state.

Following independence, the new government took steps to reduce the autonomy of the hospital. The apparent motive was to gain control over an elite white institution and expand access to care at the hospital to the black population. In 1981, the legislation creating the Board of Governors was amended to reduce the size of the Board of Governors and change its composition (see Table 3), eliminate the requirement that the Minister of Health consult with the Board prior to the appointment of a Medical Superintendent or other staff or the removal of non-medical staff, and expand the authority of the Minister of Health relative to the Board by making the Minister's direction binding on the Board. The legislation also removed Harare Central Hospital from the control of the Board. Language was added to the Act to make "the equitable distribution of health resources irrespective of race or creed and in the interests of social justice...." a purpose of the hospital equal in importance to treatment, teaching and research. (Zimbabwe 1981) In

Table 3**Composition of Parirenyatwa Hospital Board Under 1975 Act and 1981 Amendments**

Category	1975 Board	1981 Amendment
One person not practicing medicine for gain	Chair	Chair
Medical Superintendent ex officio	1	1
Persons who are not medical practitioners appointed by Minister	5	4
Officers of the MOH	2	1
Members appointed by the Minister from a panel submitted by the Council of the University of Rhodesia/Zimbabwe	3 of 5	1 of 3 from panel of Faculty of Medicine 1 of 3 from panel of Council not in Faculty of Medicine
Members of clinical teaching staff appointed by Minister from panel elected by clinical teaching staff	3 of 5	2 of 4
Medical practitioners appointed by Minister from panel submitted by medical association	3 of 5, at least 2 consultants	1 of 3
Honorary consultant appointed to Fleming Hospital to be appointed by Minister from panel submitted by honorary consultants	1 of 2	1 of 2
Member appointed by Minister from panel submitted by governing body of Zimbabwe Nurses Association		1 of 3
Total	19	14

1982, the Andrew Fleming Hospital was renamed the Parirenyatwa Hospital in honor of the first black Zimbabwean to qualify in medicine.

Throughout the 1980s, the MoHCW maintained substantial interest in decision making at Parirenyatwa Hospital. Tensions emerged over the conflict between the interests of established practitioners to admit their private patients to the hospital, the MoHCW desire to expand access to this premier institution by the poor, and the problem of paying for the expanded access of poor populations. In 1992, the Board resigned or was forced to resign following a series of press reports on the hospital's substantial deficit, and alleging mismanagement and economic discrimination in access to the hospital.

A committee of MoHCW officials was appointed to run the hospital and review the issues in the management and governance of the hospital. It presented a report in 1993 calling for the upgrading of the hospital and its continued operation as an autonomous institution. The committee also called for changes in the Act that would strengthen the hospital's autonomy by providing more independent authority over personnel, purchasing, maintenance and finance. (Ministry of Health and Child Welfare Technical Committee 1993) The MoHCW official who was lead author of the report was appointed Medical Superintendent. The Board was reconstituted in 1995, with a former mayor of Harare appointed the chair. Shortly after the field work on this study was completed, the Medical Superintendent was removed from his position because of personal use of a hospital ambulance.

2.3 The Scope of Autonomy at Parirenyatwa Hospital

Formal MoHCW supervision of government hospitals in Zimbabwe is highly centralized. Senior officials are appointed by the Ministry of Health and all employees are civil servants. Hospitals are allocated line-item budgets for inputs such as salaries, supplies and provisions based on historic levels of spending. Purchasing is controlled. Medical supplies and drugs must be obtained by requisition through the Government Medical Stores (GMS). Other purchases are made by issuing requisitions to government-approved vendors. The requisitions are submitted to Treasury for payment, and are eventually debited against the appropriation for the hospital. Capital funds are provided by MoHCW for government owned hospitals.

Maintenance of plant is the responsibility of the Ministry of Construction and Housing, and maintenance of vehicles is the responsibility of the Ministry of Transport. The Ministry of Health and hospital staff share responsibility for equipment maintenance, with many large items purchased with maintenance contracts from the vendors. Hospitals are expected to bill patients insured through Medical Aid Societies and patients whose monthly incomes exceed Z\$400 according to a Ministry of Health and Treasury-established fee schedule, but any funds

recovered through billing revert to Treasury. Within this system, the Medical Superintendent and senior staff of the hospital make day to day operational decisions.

Placed within the context of other hospitals, the autonomy of Parirenyatwa Hospital is limited. Senior staff have been appointed by the MoHCW without Board approval or consultation. Staff are civil service. Budgets, while block grants, are also determined based on historic levels. The hospital must follow the same tender process as other hospitals, and maintenance procedures are the same. The hospital must adhere to the MoHCW fee schedule.

A comparison of degree of autonomy of Parirenyatwa Hospital and other central hospitals is presented in Table 4. The principal areas of autonomy are the following. First, fee income can be retained. Furthermore, unlike other hospitals, Parirenyatwa is authorized to bill the Social Dimensions Fund. In principal, if the hospital were billing and being reimbursed for care by the Medical Aid Societies and the Social Dimension Fund, and some portion of those with incomes above Z\$400 per month, the need for a government block-grant would be substantially reduced. As noted above, however, fee levels are established by the MoHCW and these have traditionally been set below cost. The Medical Aid Societies have refused to pay more than the government-set fee schedules, although their own standard fee schedule is higher. The effect of these policies is to create a structural deficit that can only be met through public appropriations.

Second, the hospital receives its funds as a block grant, and can construct its own internal budget without regard to MoHCW or Treasury allocations to specific line items. The hospital has its own bank account and its funds are nominally managed by the Board. The internal budgeting process is sharply limited by the civil service nature of the workforce. Personnel is the largest element of the budget and the Public Service Commission has restricted the ability of the hospital to redefine its staffing needs and hire or lay off workers in response to those needs. It reimburses the Public Service Commission for salaries of employees.

Third, while the Board of Governors' role has been diminished by the 1981 amendments and subsequent actions of the MoHCW, it has some potential to foster the independence of the hospital. The new Board was characterized as "feeling its way" but was also described as looking at the management plan and reviewing various aspects of hospital management. It may also become active on a recent issue regarding the development of a prison maternity service at Parirenyatwa Hospital, a proposal being pushed by the MoHCW. Nonetheless, autonomy is constrained by continued MoHCW efforts to directly influence the scope of services and operation of the hospital, and by limited initiative and leadership within Parirenyatwa Hospital. The response to several questions by Parirenyatwa Hospital staff about referring issues to MoHCW was "It's still a state institution."

If the autonomy of Parirenyatwa Hospital is limited, it is also the case that in the past several years, actual supervision of other hospitals by MoHCW has been less than is suggested by the formal description presented above. Personnel costs and employment have been strictly enforced by the Public Service Commission but often budget limits have not been tightly administered. Because of the requisition system and the limited ability of Treasury to monitor purchases against budget, some hospitals made purchases substantially in excess of budgeted amounts. When this occurred, Treasury has held payment until the start of the next fiscal year, and then debited the excess purchases against the next year's appropriation. Parirenyatwa Hospital has done the equivalent, i.e., withheld payment until it had the funds to pay. Vendors have seemed willing to extend credit both to the government and Parirenyatwa, thus reducing the discipline of a fixed budget.

Table 4
Comparison of Degree of Autonomy at Harare Central and Parirenyatwa Hospitals

<i>Area</i>	<i>Harare Central</i>	<i>Parirenyatwa</i>	<i>Comments</i>
<i>Administration</i>			
Board	None	Appointed by MOH	Parirenyatwa board suspended by MOH in 1992. Reestablished in 1995.
Medical Superintendent	Appointed by MOH from officers of the Ministry	Appointed by MOH from officers of the Ministry	Provisions in original 1975 statute called for appointment "after consultation with the Board." The consultation requirement was repealed in 1981.
	Reports to MOH	Reports to MOH	Parirenyatwa Medical Superintendent has close ties to MOH.
Community Input	Hospital Advisory Board	Hospital Advisory Board	Parirenyatwa HAB not active 1992-Present
<i>Revenues, Budget and Expenditures</i>			
Allocation of Government Resources to Hospital	Treasury and MOH Line Item Budget	Treasury and MOH Block grant	Parirenyatwa submits line item budget to MOH as part of process of establishing grant level for year.
Fee Income	Fees set by MOH and Treasury Hospital bills for service Reverts to Treasury	Fees set by MOH and Treasury Hospital bills for service Retained by Hospital	Both hospitals are subject to MOH and Treasury guidance on fee levels and patients exempt from paying fees.
Donor Funds	Treasury and MOH	Treasury and MOH	
Retention of Surplus/ Responsibility for Loss	MOH	Hospital Board	Statute states: "In the exercise of its functions, it shall be the object of the Board to ensure that all its income, taking one year with another, is not less than sufficient to enable the Board to meet its expense.
Line Item Budgeting	Treasury and MOH	Hospital Board	Opportunities for hospitals under line item budget to request shifts of funds across accounts.
Accounting Procedures	Government	Government	
External Audit	Auditor General	Auditor General	

Table 4**Comparison of Degree of Autonomy at Harare Central and Parirenyatwa Hospitals (Continued)**

<i>Area</i>	<i>Harare Central</i>	<i>Parirenyatwa</i>	<i>Comments</i>
<i>Personnel</i>			
Hiring and Firing	Public Service Commission	Public Service Commission	Hospitals staffing establishment schedule must be approved by MOH, PSC, Treasury Parirenyatwa can recruit medical personnel (nurses, technicians, etc.) without referral to MOH if in vacant slot not frozen Parirenyatwa reimburses Public Service Commission for personnel costs.
Appointing Medical Staff	MOH	Board, subject to approval of MOH	
Salaries and Benefits	Public Service Commission	Public Service Commission	
<i>Procurement</i>			
Drugs	Hospital via government requisition through Government Medical Stores	Hospital via direct billing through Government Medical Stores	If items not available, both hospitals have authority to seek quotations and buy direct from private sector
Supplies	Hospital via government requisition through Government Medical Stores	Hospital via direct billing through Central Stores	If items not available, both hospitals have authority to seek quotations and buy direct from private sector
Food	Hospital via government requisition using tender process	Hospital via direct billing using tender process	Parirenyatwa uses government tender process but is responsible for paying own bills. Harare bills paid directly by Treasury
Equipment	Hospital and MOH	Hospital	Because budgets have been tight and donors have contributed funds for equipment, Parirenyatwa has received equipment allocated by MOH
<i>Maintenance</i>			
Medical Equipment	Hospital and MOH	Hospital and MOH	Most procurement contracts include maintenance agreements. MOH has done maintenance and repairs outside of hospital grant.
Other Movable Equipment	Hospital and MOH	Hospital and MOH	
Plant and Fixed	Ministry of Construction and National Housing	Ministry of Construction and National Housing	
Vehicles	Ministry of Transport	Ministry of Transport	

Likewise, when the GMS is out of stock, both Parirenyatwa and other hospitals were authorized to use standard tender processes to obtain needed supplies in the outside market.

MoHCW supervision of its hospitals has also been limited by the way in which expenditure data and utilization statistics are separately collected and maintained. It has proven extremely difficult to construct estimates of unit costs either over time in the same hospital or comparatively across hospitals. Without such data, it is hard to establish reasonable expectations for hospital managers.

2.4 Managerial and Organizational Responses to Autonomy

As autonomy is limited, so are modifications to the management, organization and systems in place at Parirenyatwa Hospital. The management structure of the hospital is similar to that of other central hospitals, but the Medical Superintendent at the time of our study was seeking to upgrade his senior accounting staff and add a position of Technical and Estates Executive in the expectation that the hospital would gain responsibility for maintaining its own plant, equipment and vehicles.

Given the hospital's opportunities to retain fee income, it might be expected that its accounting and billing functions would be well developed, as gains in this area might pay for themselves. Parirenyatwa Hospital apparently does a better job of collection than other central hospitals. For example, it reported to us that it collected Z\$21.5 million in 1994 or 18.2 percent of its expenditures, compared to the Z\$2.4 million (6.4 percent) reported by Harare Central.

There is conflict in available data on the rate of billings and collections by Parirenyatwa and other hospitals. Table 5 compares data on collections by Parirenyatwa and Harare Central Hospital. The data come from two sources and there is an overlap in reported years only for Parirenyatwa for 1989 and 1990. The data for those two years are markedly different across sources. Hecht, Overholt and Holmberg (1992) report collections that represent 8 to 10 percent of expenses for the hospital. The data provided by the hospital to our team report collections in the range of 19 to 26 percent of expenses. HOH cite the Parirenyatwa and MoHCW data systems as their source. These differences not only have consequences for judgments about collection efficiency and efforts, but also profitability.

Regardless which set of numbers one accepts, collections as a proportion of expenses at Parirenyatwa are down substantially from the early days of the hospital, where the proportion was estimated at 60 percent or more. The difference is unlikely to be solely the result of changes in billing efficiency or effort. One of the goals of the government has been to democratize access to Parirenyatwa Hospital. The language added to the act by the 1981 amendments was cited earlier, and is cited in the review of the policy options for the hospital. (Ministry of Health and Child Welfare Technical Committee 1993) Issues of differential access, and

Table 5
Reported Collections by Parirenyatwa and Harare Central Hospitals, Selected Years

Year	Parirenyatwa Hospital				Harare Central			
	Reported by HOH		Reported by Parirenyatwa		Reported by HOH		Reported by Harare	
	Collections	As % of Expenses	Collections	As % of Expenses	Collections	As % of Expenses	Collections	As % of Expenses
1986	2,246,000				296,375			
1987	2,388,000				361,418			
1988	3,318,000				480,486			
1989	3,808,000	9.97%	10,425,634	25.98%	456,783	1.80%		
1990	3,943,000	7.89%	7,472,597	18.62%	449,783	1.32%		
1991			8,911,467	16.85%				
1992			11,603,942	15.58%				
1993			12,310,552	13.61%				
1994			21,491,548	18.23%			2,422,9688	6.38%
1995			27,764,190	18.05%				

Sources: HOH: Hecht, Overholt and Holmberg, 1992. Reporting data from MOH for Harare and Parirenyatwa for Parirenyatwa
 Parirenyatwa: Data provided by Parirenyatwa Accounts Department to study team.
 Harare Central: Data provided by Harare Central Accounts Department to study team

Note: Expenses used for Parirenyatwa Hospital include expenses of Public Health Laboratory
 Data for years not shown was not available

separation of private and public patients, have periodically emerged through the hospitals post-independence history. They contributed to the departure of the Board in 1992 and have been an recent issue in decisions about the future governance of the Mbuya Nehanda Maternity Hospital within the Parirenyatwa complex.

Given the opening of the hospital to those of lower income, it is not surprising that the proportion of expenditures covered by collections has declined.

The differences in the relative wealth of the patient populations at Parirenyatwa and Harare Central may also contribute to the differences observed in collection experience at these two hospitals. Likewise, some of the differences observed in the time series of collections at Parirenyatwa, in which collections declined between 1989 and 1993 and then began rising again may reflect the economic downturn of the early 1990s in Zimbabwe.

The assessment of knowledgeable observers within and outside the hospital is that the billing and collection process at Parirenyatwa Hospital has been poor. Hecht, Overholt and Holmberg observed in 1992 "None of the [central] hospitals can produce timely patient accounts, with delays ranging from 2-9 months." (Hecht, Overholt et al. 1992) The MoHCW Technical Committee commented "Billing and the collection of debts system is very poor due to the computerized system currently in operation being linked to the Central Computer Bureau. It is common knowledge that the bills are produced after 6 to 12 months, when it is difficult or impossible to

trace the debtors." (Ministry of Health and Child Welfare Technical Committee 1993) In our interviews, it was estimated there was a 14-month backlog in billing.

The problems in the billing area have been attributed to two factors. First, the function has not been computerized and the hospital has appeared to look to the MoHCW for funds and authority for computerizing. In the past year, the hospital was given authority by the MoHCW to spend up to Z\$6 million for a computer system. Rather than move quickly to adopt a system, officials from Parirenyatwa and the Ministry of Finance began planning an extended trip to examine systems in place in India and elsewhere prior to making a decision.

Second, civil service restrictions on staffing and hours have constrained the hospital. When the hospital sought last year to use overtime to address the backlog, it was prevented from doing so by the Public Service Commission. After negotiation, it was allowed to hire casual (temporary) workers to address the backlog.

A more general factor contributing to the billing problem was lack of management focus on the issue. This may have reflected an orientation during the 1980s toward expanding access and reliance on MoHCW direction and appropriations.

2.5 Impacts of Autonomy on Operational Performance

The study compares the performance of Parirenyatwa Hospital and Harare Central Hospital for evidence that the autonomy of Parirenyatwa has contributed to a higher standard of performance. Such comparisons are difficult, however, because Parirenyatwa has historically been funded at a much higher level than Harare Central and Harare Central serves a poor area. Differences may be attributable to differences in resources or case mix, rather than autonomy. Overall, however, few differences are observed.

With respect to overall financial management and cost control, Parirenyatwa Hospital costs increased at substantial rates between 1989 and 1995, but when inflation is taken into account, the range of year to year increases in real spending vary from -11.3 percent to +32.5 percent. (Table 6 presents accounts in nominal dollars, Table 7 in real dollars adjusted for the CPI inflator.) For the three years for which comparable data (1993-1995) are available, the nonpersonnel expenses (data on personnel expenses was not available for Harare Central) at Parirenyatwa grew substantially more slowly than at Harare Hospital. Harare Central's nonpersonnel expenses, which in 1989 were only three-eighths those of Parirenyatwa despite its higher inpatient and outpatient volume) at the end of this period were still only three-fifths those at Parirenyatwa Harare Central's costs per adjusted day (with an outpatient visit weighted at one-quarter of an inpatient day) were 37 percent of Parirenyatwa's in 1993 and 58 percent in 1995. (Table 8) Differences in costs were comparable for selected areas of recurrent cost -- medical

and surgical supplies, provisions, and linens, beddings and related expenses. (Table 9)

Parirenyatwa may have better controlled its costs during this period, but it also had greater room for maneuver. In both hospitals, losses occurred in most years, but the losses were greater at Harare Central. Ratings of the two hospitals in the area of financial management and cost control in the 1992 and 1995 Best Central Hospital Competitions¹ were comparable.

Table 6

Expenses, Revenues, Gains and Losses for Parirenyatwa and Harare Central Hospitals, Nominal Dollars

	Year						
	1995	1994	1993	1992	1991	1990	1989
<i>Parirenyatwa Hospital</i>							
Expenses	153,793,700	117,904,395	90,427,016	74,461,463	63,141,813	52,896,621	40,131,682
Expenses Excluding Personnel	83,803,164	66,497,685	46,406,262	38,521,663	30,566,787	26,974,216	18,873,581
Vote (Appropriation)	115,250,000	95,500,000	82,300,000	60,200,000	51,700,000	44,000,000	37,915,000
Retained Fee (HOH)						3,943,000	3,808,000
Retained Fee (Hospital)	27,764,190	21,491,548	12,310,552	11,603,942	8,911,467	7,472,597	10,425,634
Gain/Loss (Using HOH)						(4,953,621)	1,591,318
Gain/Loss (Using Hospital)	(10,779,510)	(912,847)	4,183,536	(2,657,521)	(2,530,346)	(1,424,024)	8,208,952
% Change Exp Excluding Personnel Over Prev. Year	26.02%	43.29%	20.47%	26.02%	13.32%	42.92%	
<i>Harare Central Hospital</i>							
Expenses Excluding Personnel	51,546,473	37,951,694	17,364,741	NA	NA	NA	NA
Vote (Appropriation)	26,706,100	20,021,100	11,654,500				
Gain/Loss	(24,840,373)	(17,930,594)	(5,710,241)				
%Change Exp Excluding Personnel Over Prev. Year	35.82%	118.56%					

Source: Accounts Department, Parirenyatwa Hospital and Hecht, Overhot and Homberg, 1982
Accounts Department, Harare Central Hospital

Note: Expenses for Parirenyatwa Hospital include Public Health Laboratory

1/ In 1992 and 1995, NGOs conducted competitions among the central hospitals, as they had previously done among district hospitals. The competitions were designed "to be a positive review rather than a critical audit of Central Hospital shortcomings." Rating was done by a team of six health specialists drawn from the MoHCW, provincial and municipal health officials, and NGOs. Each hospital was rated on an extensive in-depth check list that focused on operations, but not outcomes.

Table 7

Expenses, Revenues, Gains and Losses for Parirenyatwa and Harare Central Hospitals, Real Dollars

	Year						
	1995	1994	1993	1992	1991	1990	1989
<i>Parirenyatwa Hospital</i>							
Expenses	47,034,943	43,125,236	40,441,420	42,500,835	51,209,905	52,896,621	43,302,605
Expenses Excluding Personnel	25,629,639	24,322,489	20,754,142	21,987,251	24,790,582	26,974,216	20,364,839
Vote (Appropriation)	35,247,069	34,930,505	36,806,798	34,360,731	41,930,251	44,000,000	40,910,776
Retained Fee (HOH)						3,943,000	4,108,881
Retained Fee (Hospital)	8,491,161	7,860,844	5,505,614	6,623,255	7,227,467	7,472,597	11,249,394
Gain/Loss (Using HOH)	(3,296,713)	(333,887)	1,870,991	(1,516,850)	(2,052,187)	(1,424,024)	8,857,566
Gain/Loss (Using Hospital)	5.37%	17.19%	-5.61%	-11.31%	-8.10%	32.45%	
%ChangeExp Excluding Personnel Over Prev Year							
<i>Harare Central Hospital</i>							
Expenses Excluding Personnel	15,764,530	13,881,380	7,765,984	NA	NA	NA	NA
Vote (Appropriation)	8,167,564	7,323,007	5,212,209				
Gain/Loss	(7,596,966)	(6,558,374)	(2,553,775)				
%Change Exp Excluding Personnel Over Prev Year	13.57%	78.75%					
CPI Deflator	327.0	273.4	223.6	175.2	123.3	100.0	92.7

Source: Accounts Department, Parirenyatwa Hospital and Hecht, Overhot and Homberg, 1982
Accounts Department, Harare Central Hospital
CPI Deflator, 1990-1994: Schwartz and Zwizwai, 1995
CPI Deflator 1989,1995 estimated from MOH Health Information Unit, Health Expenditure Annual Report 1994/95

Note: Expenses for Parirenyatwa Hospital include Public Health Laboratory

With respect to individual areas of hospital operations, performance appears comparable or associated with the budget levels for the function. *Personnel* functions are comparable at the new institutions, with Public Service Commission rules governing hiring, compensation, promotion, discipline and firing. Both hospitals report being understaffed with many posts frozen or abolished.

The problems of Parirenyatwa in expanding its billing function were cited above. Other problems are cited in the 1993 Technical Committee report, including: "Delays in approving posts and filling them...These are processed by the PSC through the MOH&CW. For example certain facilities like the Burns Unit and some theatres are not being used due to lack of staff." (Ministry of Health and Child Welfare Technical Committee 1993)

Numerical scores were provided in the 1995 report but not the 1992 report. In neither year did Parirenyatwa or Harare Central win the competition. [Ministry of Health and Child Welfare, 1992 #12; Ministry of Health and Child Welfare, 1995 #13]

Table 8
Expenses per Adjusted Day for Parirenyatwa and Harare Central Hospitals

	Year						
	1995	1994	1993	1992	1991	1990	1989
<i>Parirenyatwa Hospital</i>							
Days	272,330	251,719	257,335	259,062	297,957	306,567	304,492
Outpatient Visits	231,531	222,648	226,263	203,953	234,971	213,368	191,765
Expenses Excluding Personnel	68,828,964	53,417,253	35,650,370	28,959,360	24,612,375	22,759,771	15,765,966
Expenses/Adj Day	208	174	114	93	69	63	45
Change in Exp/Adj Day	19.9%	53.0%	21.6%	35.4%	9.1%	41.4%	NA
Real Exp/Adj Day							
Change in Real Exp/Adj Day							
<i>Harare Central Hospital</i>							
Days	357,837	339,704	342,195	322,981	361,092	341,789	386,400
Outpatient Visits	292,017	211,000	235,559	212,302	258,188	305,472	303,355
Expenses Excluding Personnel	51,546,473	37,951,694	17,364,741	NA	NA	NA	NA
Expenses/Adj Day	120	97	43	NA	NA	NA	NA
Change in Exp/Adj. Day	23.7%	123.4%					
Real Exp/Adj Day	37	35	19	NA	NA	NA	NA
Change in Real Exp/Adj. Day	3.4%	82.7%					

Source: Medical Records Department and Accounts Department, Parirenyatwa Hospital
 Medical Records Department and Accounts Department, Harare Central Hospital

Notes: Expenses for Parirenyatwa Hospital exclude Public Health Laboratory
 Outpatient visits for Parirenyatwa Hospital not available for 1990. Average of 1989 and 1990 visits used.

Adjusted days estimated as Days+(Outpatient Vists*.25): 14,974,200 13,080,432, 10,755,892, 9,562,303, 5,954,412, 4,214,445, 3,107,615 68,828,964, 53,417,253, 35,650,370, 28,959,360, 24,612,375, 22,759,771, 15,765,966

CPI Deflator: 327.0 273.4 223.6 175.2 123.3 100.0 92.7

Drugs and Supplies are purchased using the same systems and sources. Staffs in both hospitals monitor spending against budget and both report overspending in recent years. Both hospitals report that drugs are often not available and that availability through GMS has gotten worse over the past few years. Parirenyatwa reports sometimes going to outside vendors; Harare Central to having patients or their families buy drugs and bring them to the hospital. This may reflect the difference in funding levels between the two institutions.

Table 9**Comparison of Selected Expenses per Day or Adjusted Day, Parirenyatwa and Harare Central Hospitals**

	Year					
	1995	1994	1993	1992	1991	1990
<i>Parirenyatwa Hospital</i>						
MedSurg Exp/Adj Day	141	119	70	64	45	41
% Change Over Prior Year	18.49%	70.00%	9.38%	42.22%	9.76%	51.85%
Provisions/Day	16	13	14	10	9	6
% Change Over Prior Year	23.87%	-8.26%	30.57%	20.28%	37.15%	22.07%
Linens,bedding& other/Adj Day	37	32	23	13	11	10
% Change Over Prior Year	14.59%	40.23%	77.34%	13.68%	11.36%	45.93%
Salaries/Adj Day	212	167	140	116	91	72
% Change Over Prior Year	26.74%	19.26%	20.98%	26.93%	26.79%	19.41%
<i>Harare Central Hospital</i>						
MedSurg Exp/Adj Day	87	75	27	NA	NA	NA
% Change Over Prior Year	15.97%	175.45%				
Provisions/Day	10	5	5	NA	NA	NA
% Change Over Prior Year	80.43%	0.38%				
Linens,bedding& other/Adj Day	18	14	9	NA	NA	NA
% Change Over Prior Year	28.05%	48.88%				

Source: Medical Records Department and Accounts Department, Parirenyatwa Hospital
 Medical Records Department and Accounts Department, Harare Central Hospital

Note: Outpatient visits for Parirenyatwa Hospital not available for 1990. Average of 1989 and 1990 visits used.
 Adjusted days estimated as Days+(Outpatient Vists*.25)

Food service is one area of identified difference between the two institutions, with the Parirenyatwa Hospital food service rated superior to that at Harare Central in the Best Hospital Competition. This may, however, reflect the higher level of spending on provisions per day at Parirenyatwa, Z\$16 in 1995 compared to Z\$10 at Harare Central.

Maintenance and Equipment Repair is similar at both hospitals. In-house staff does cleaning and small scale maintenance. Equipment repair is done by in-house staff, MoHCW staff, or under maintenance contracts. Physical plant repairs and renovations are the responsibility of the Ministry of Construction and Housing and vehicle maintenance is the responsibility of the Ministry of Transport. Severe shortages of staff and supplies were reported at Harare Central. Similar problems were reported with respect to the responsiveness of the two non-MoHCW Ministries.

The process of *Equipment Purchase* is similar at both hospitals. Departments submit needs to the hospital administration. These are prioritized. Small purchases are made by the hospital directly following government tender regulations. Purchases in excess of Z\$150,000 go through the external government Tender Board. The principal difference is that the equipment budget at Parirenyatwa Hospital is fixed internally, while that at Harare Central is based on its appropriation for equipment. Over the past several years of tight budgets, donor funds have been the principal source of financing for new equipment and these have been administered through the MoHCW for both Parirenyatwa and Harare Central.

Few measures of overall quality are available. Ratings of the two hospitals in the Best Central Hospital Competitions of 1992 and 1995 are slightly higher for Parirenyatwa Hospital, but the differences are small. In 1995, the overall score for was 2.53 on a scale of 1 to 4 for Parirenyatwa Hospital and 2.16 for Harare Central. The range for the five central hospitals rated was 2.16 to 2.68. (Ministry of Health and Child Welfare 1995)

Mortality rates at Parirenyatwa are lower than at Harare Central (Table 10), but these differences could reflect case mix differences, the higher poverty level in the population treated by Harare, or the greater resources available at Parirenyatwa, rather than management differences. Mortality rates rose between 1989 and 1995 at Parirenyatwa in both maternity and nonmaternity services, but this may reflect declines in the economy in Zimbabwe or the growing burden of HIV/AIDS.

2.6 Future Directions for Autonomy at Parirenyatwa Hospital

The degree of autonomy at Parirenyatwa Hospital has been limited and further restricted by MoHCW efforts to maintain control over the premier hospital in the country and hospital leadership that has not sought to expand the range of autonomy. In 1993, a technical committee of MoHCW officials laid out an extensive proposal to expand the autonomy of Parirenyatwa Hospital and strengthen its management to more fully exercise that autonomy. The key elements of that proposal were: provide more financial control and autonomy to the hospital by giving it the authority to fix its own fee schedule, appoint and remunerate its own staff, and own and control its own assets; reduce the formal authority of the

Table 10
Comparison of Mortality Rates in Parirenyatwa and Harare Central Hospitals, Selected Years

	<i>Year</i>						
	<i>1995</i>	<i>1994</i>	<i>1993</i>	<i>1992</i>	<i>1991</i>	<i>1990</i>	<i>1989</i>
<i>Overall Mortality Rate</i>							
Parirenyatwa	5.93%	5.89%	6.19%	5.74%	5.01%	4.66%	3.39%
Harare Central	7.70%	7.53%	7.23%	NA	NA	NA	NA
<i>Mortality Rate in Maternity Service</i>							
Parirenyatwa	0.06%	0.04%	0.03%	0.02%	0.00%	0.00%	0.02%
Harare Central	0.18%	0.19%	0.15%	NA	NA	NA	NA
<i>Mortality Rate in Service Other Than Maternity</i>							
Parirenyatwa	7.50%	7.10%	7.44%	6.95%	6.09%	6.02%	4.02%
Harare Central	11.80%	11.86%	11.18%	NA	NA	NA	NA

Source: Calculated from deaths and discharges provided by Medical Records Departments in each hospital

MoHCW over hospital appointments and operations; reorganize clinical services to reduce the distinctions between medical school appointees and other clinical staff, teaching and non-teaching wards, and private and public patients; restructure internal management; and restructure the Board to provide for direct appointment of Board members by nongovernment entities, such as the medical school, medical association, and nursing association.

Concrete steps toward realizing this vision were, at the time of the fieldwork two years after it was articulated, extremely limited. A new Board and Medical Superintendent had been appointed. A search was underway for a senior financial officer. Amendments to change the Board structure had been presented to Cabinet, but no action was expected on these for at least two years. Changes in hospital finance were being discussed in the Ministry, but in terms of general decentralization and reform.

3. Wankie Colliery Hospital

One of the features of the Zimbabwe health care system is hospitals and clinics owned by industrial entities to provide care to employees that are managed independent of the government. The operation of one such hospital, the Wankie Colliery Hospital, provides additional insight into the possibilities and issues raised by hospital autonomy in Zimbabwe.

The Wankie Colliery Hospital is located close to the coal mines of the Wankie Colliery in Hwange in western Zimbabwe. The hospital has more than 150 beds, and is well equipped and well staffed. The closest comparable facility is in Bulawayo, although there is a small government district hospital in Victoria Falls, 100 kilometers away, and a mission hospital half-way to Bulawayo.

The hospital is an operating department of the colliery, which provides the funds to operate. An annual budget submitted by the Medical Superintendent is reviewed and approved by colliery officials. The hospital has also developed a five-year equipment plan which is approved by the colliery. Procurement is carried out by the colliery purchasing department.

The colliery contracts with the ZESA, the national electric utility, and the railroad, two organizations with many employees in the region, to provide hospital services to their employees. Reimbursement is on a negotiated fee schedule. The negotiated fees are cost-based and the hospital has implemented internal cost accounting and computerized billing systems to support this process. This illustrates the potential for the implementation of such systems at other hospitals in Zimbabwe.

The hospital also contracts with the Ministry of Health to provide district hospital-level services under a similar cost-based negotiated fee schedule. This relationship has become strained for several reasons. First, the costs at the colliery hospital are higher than at MoHCW district hospitals, and the reimbursement required is therefore higher on a per case basis. The MoHCW Provincial Health Officer has therefore encouraged patients to travel to Bulawayo, and the hospital has complained that without a predictable flow of patients from the MoHCW, it has been hard to staff appropriately. There have also been conflicts over the hospital's billing the government for patients with incomes greater than Z\$400 who come to the hospital with referral letters from district health clinics. The Ministry believes the hospital should collect from these patients directly. The hospital argues that it can't go chasing data all over the country and that the government should be doing the financial screening before it provides a referral letter. These two conflicts might emerge with respect to other hospitals if the government grants hospitals greater autonomy and shifts its payment from line-item or block grants to fee-for-service for eligible patients.

4. Avenues Clinic

Avenues Clinic is one of the few private general hospitals in Zimbabwe. It has one hundred forty-eight beds and is located within a short walk from Parirenyatwa Hospital. Built shortly after independence, it is owned as by a private company whose shareholders include farming families for whom stock ownership provides a guarantee of admission. The company does not pay dividends and many owners have written off the investment. The hospital describes itself as operating much as a nonprofit and has applied for nonprofit status. The stated philosophy is to keep fees as low as possible, consistent with paying the recurrent costs and providing for equipment and upgrading.

More than 80 percent of the patients are members of Medical Aid Societies. Most of the rest are either foreign insured patients or cash paying patients. The hospital charges for care on a fee-for-service basis. It has implemented computerized cost accounting and billing systems, using the same software as the Wankie Colliery Hospital.

The hospital illustrates the potential for fee-supported hospital care in Zimbabwe and that systems are available within the country to effectively manage in such an environment.

5. Lessons and Implications of the Zimbabwe Cases

The motivation for creating Parirenyatwa Hospital as an autonomous hospital in the pre-independence period appears to be related to efforts by the medical staff and medical school faculty to control their clinical facilities, and stands in contrast to reasons being advanced today for increased autonomy, notably resource mobilization, improved efficiency, or separation of financing and delivery. In the post-independence period, the MoHCW sought to rein in the hospital, in order to establish control over a large and prestigious national institution, assure adherence to government policies, and to expand access to the facility for the poor and black population, issues of both symbolic and substantive importance.

In the past year, the government of Zimbabwe has expressed interest in decentralizing hospital management and expanding autonomy not just at Parirenyatwa Hospital but at hospitals throughout the country. This interest is reflected in plans to promote contracting out by hospitals of security, grounds maintenance, internal cleaning, and laundry, which would have the effect of reducing the civil service employment at the hospitals. It is also reflected in concept papers released by the MoHCW regarding the creation of a social insurance program in Zimbabwe and shifting funding for provincial and central hospitals from grants to fee-for-service payments by district health systems, central government and the University. (Ministry of Health and Child Welfare 1995) And it is reflected in concept papers regarding turning ownership and management of hospitals to district boards or hospital boards. (Ministry of Health and Child Welfare 1995) Part of the infrastructure needed to implement these proposals, such as improved cost accounting, is being tested in selected hospitals.

5.1 Lessons

Several lessons emerge from the experience of Parirenyatwa Hospital, Wankie Colliery Hospital, and Avenues Clinic for implementing effective efforts to decentralize hospital management and increase hospital autonomy.

Cultivating Hospital Leadership

Hospital leadership must be appointed that is committed to implementing expanded autonomy and can effectively articulate a vision of autonomy to the hospital staff and other hospital constituencies. The hospital leadership must be able to gain the confidence and cooperation of the hospital staff.

The Need for Upgraded Financial and Billing Systems

The financial and managerial accounting and billing systems currently in place in hospitals are not adequate to allow hospitals to effectively price their services, bill in a timely fashion, budget, manage against budget, or adjust budgets in real time to reflect changing demand or economic circumstances. This is apparent in the case of Parirenyatwa Hospital. Upgrading these systems and the staff administering them will be a critical element in implementing any policies that put hospitals at risk for balancing revenues and expenditures. The evidence from within Zimbabwe at the private hospitals and presence of appropriate systems in other African teaching hospitals suggests that these needs can be quickly addressed if the commitment to doing so is present.

Control Must Be Ceded by Ministry of Health

In a decentralized hospital system the MoHCW must be willing to relinquish authority over senior appointments, staffing, service offerings, and operational management of the hospitals. Without clear signals that MoHCW management has been irrevocably restricted, there is a risk that hospital executives and staffs will move slowly to assume responsibility but will instead continue to look to MoHCW for direction. Board and governance structures for the hospitals must be created that will have effective control and make it difficult for the MoHCW to reassert operational authority over autonomous hospitals. At the same time, the process of appointing Boards must be such that the government will retain confidence in the Boards and their capacity to oversee the hospitals.

5.2 Transition Issues

There are several critical transitional issues that MoHCW must resolve if it will move toward decentralized financing and management.

Hospital Employees and the Civil Service

One of the critical issues to be resolved is the question of whether hospital employees should remain civil servants. From the hospital perspective, this issue is important because it affects the ability to flexibly staff and adjust staffing to

changing demands, and to exercise supervision and control over staff through the ability to hire, fire, promote and discipline. From the employee perspective, the issue is critical because it affects job security and tenure in an economy in which unemployment is very high.

Whatever is done should be done with sensitivity to the impact of uncertainty and change on hospital worker productivity and morale. The announced proposal to promote contracting out of selected hospital functions has lowered morale at Parirenyatwa Hospital. This by itself is not a justification for not moving forward, but it does underscore the need to consider how a transition should be announced and implemented.

Creating a New Basis for Funding

Neither the line-item budgeting system standard in MoHCW-hospitals nor the mixed funding system at Parirenyatwa Hospital are working well. The line-item budgeting system is not effective for two reasons. First, because of the requisition process, hospitals have been able to overspend their allocations. While steps were taken this year to control this by placing monthly caps on requisitions, it is not clear that this will be effective. Furthermore, because budgets and the budgeting process do not link appropriated amounts and the volume of services, there is little basis for effective dialog between hospitals and MoHCW over appropriate amounts to be spent, either during the budgeting process or in reviewing actual spending levels during the year. Indeed, because funding levels are historically-based, there are widespread disparities in the funding of hospitals with similar missions and case loads.

The mixed funding system for Parirenyatwa Hospital -- block grant for much of its budget, fee retention for the balance, with the right to bill the Social Dimensions Fund for patients whose monthly income fall below Z\$400 per month -- has proven to have several flaws. First, because the hospital must bill to the government-established fee schedule, it is recovering less revenue than it could from the Medical Aid Societies. Second, since the government-established fee schedule provides for prices that are below cost, even if all patients were paid for fully under the fee schedule, there would be a structural deficit. Third, the Social Dimensions Fund has been an unreliable payer. Fourth, uninsured patients with monthly incomes over Z\$400 are expected to pay for their own care. For patients with incomes just over this line, this can prove difficult.

To implement the decentralization envisaged by the MoHCW, a new basis for flowing funds to hospitals must be articulated and implemented. If hospitals are to be expected to generate their funds from fee income, then the payment rates must be more closely aligned with costs. This will require prices substantially higher than the current fee schedule for the central hospitals. If the basis for payment is to shift

to formula funding that generates comparable revenues for similarly situated hospitals, provisions will have to be made for easing the transition of hospitals receiving high levels of funding under the current budgeting regime.

Eligibility Determination for Government Assistance. Currently hospitals determine whether individuals are above or below the Z\$400 cutoff for free care. Most make these decisions without a direct financial incentive in the decision. To the extent the government seeks to shift funding of hospitals to fee-for-service while a sizable portion of the population remains without coverage, both individuals and hospitals will have an incentive to qualify patients for government assistance. The MoHCW needs to identify systems and mechanisms for assuring that appropriate decisions on qualification are made.

Preparing MoHCW to Carry Out Its New Responsibilities. Even as the MoHCW role in operational management of hospitals shrinks, MoHCW roles in the areas of financing, monitoring and quality assurance are likely to grow in importance. Systems must be developed to allow the Ministry to effectively carry out these new or expanded roles.

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Appendix 1: List of Interviewees

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Medical Superintendent
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Mr. R. B. Nyenya
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Mr. M. Chaora
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Dr. Ternouth
Government Consultant
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Dr. Ali
Medical Superintendent
Harare Central Hospital
P.O. Box ST 14
Southerton, Harare

Mr. Kalwett
Avenues Clinic
P.O. Box 4880
Harare

Mr. J. Fleming
Board Member - Parirenyatwa Board of Governors
J.B.M. Fleming Consulting Rooms
52 Baines Avenue
Harare

Dr. Makoni
Medical Officer
Wankie Colliery Hospital
Hwange

Parirenyatwa Group of Hospitals

Mr. Mtwalo	Finance Officer
Mrs. Marufu	Deputy Matron
Mr. Goredema	Medical Records Officer
Mr. Mukwada	Stores Officer
Mrs. Chiwereza	Equipment Officer
Mr. Matsikire	Provisions Officer
Mrs. Togarepi	Pharmacist
Mr. Tangawafunga	Food and Cleaning Unit
Mr. Tabvemhiri	Workers' Committee Member

Harare Central Hospital

Mr. Nhorwo	Hospital Equipment Officer
Mrs. Gandiya	Equipment Technician
Mr. Whiza	Stores Officer
Mr. Mharadzirwa	Maintenance Officer
Mrs. Ali	Principal Matron
Mrs. Zvawamwe	Pharmacist
Mr. Kahla	Food Supplies Officer
Mrs. Musonza	Staffing Officer
Mr. Faranera	Medical Records Officer
Mr. Garatsa	Accounts Officer

Appendix 2: Salisbury Hospitals Act, 1975



RHODESIA

ACT

To establish the Salisbury Hospitals Board of Governors to manage and control the Salisbury Group of Hospitals and to provide for its *functions*, relating to the care and treatment of the sick and medical education and research, and its powers; to provide for the transfer of certain movable assets and certain liabilities to the Salisbury Hospitals Board of Governors and to regulate the financial affairs thereof; to provide for the staffing of such Hospital; and to provide for matters incidental to or connected with the foregoing.

ARRANGEMENT OF SECTIONS

PRELIMINARY

Section

1. Short title and date of commencement.
2. Interpretation of terms.

PART 1

SALISBURY HOSPITALS BOARD OF GOVERNORS

1. Establishment of Salisbury Hospitals Board of Governors.
2. Composition of Board.
3. Conditions of office of members.
4. Appointment of members where provisions of section 4 not followed

Section

7. Disqualification for appointment or election as member.
8. Vacation of office of members.
9. Minister may require member to vacate office or suspend him.
10. Filling of vacancies on Board.
11. Meetings and decisions of Board.
12. Committees of Board.
13. Executive Committee
14. Finance Committee.
15. Medical Appointments Committee.
16. Restrictions relating to member with interest or candidate for appointment.
17. Validity of decisions and acts of Board.
18. Contracts and instruments of Board.

PART II
FUNCTIONS, POWER AND DUTIES OF BOARD AND
OF ASSETS

19. Functions of Board.
20. Powers of Board.
21. By-laws of Board.
22. Transfer of certain assets, rights, liabilities and obligations to Board and construction of future donations to Ministry, etc.

PART III
FINANCIAL PROVISIONS OF BOARD

23. Conduct of financial affairs of Board.
24. Funds of Board.
25. Accounts and reserves of Board.
26. Audit of accounts of Board.

PART IV
STAFF OF HOSPITALS

27. This Part does not derogate from laws relating to Public Service.
28. Appointment, functions and powers of Medical Superintendent and Deputy Medical Superintendent.
29. Persons to be provided by Minister.
30. Staff may be appointed by Board.
31. Powers of Board in respect of persons provided by Minister.

PART V
GENERAL

Section

- 32. Limitation of liability of Board.
- 33. Actions in delicate to be taken against State.
- 34. Proceedings on failure of Board to comply with Act.
- 35. Board not bound by certain laws.
- 36. Use of patented inventions by Board.
- 37. Amendment of First Schedule.
- 38. Regulations.

FIRST SCHEDULE: Salisbury Group of Hospitals.
SECOND SCHEDULE: Powers of Board.

BE IT ENACTED by the President and the Parliament of Rhodesia, as follows:-

PRELIMINARY

1. (1) This Act may be cited as the Salisbury Hospitals Act, 1975.

Short title and date of commencement.

(2) This Act shall come into operation on the 1st July.

2. In this Act-

Interpretation of terms.

"Association member" means a member appointed in terms of paragraph (f) of subsection (1) of section *four*;

"Board" means the Salisbury Hospitals Board of Governors established by section *three*;

"Chairman" means the chairman of the Board appointed in terms of paragraph (a) of subsection (1) of section *four*;

"clinical teaching staff" means staff appointed to any of the Hospitals in terms of paragraph (c) of section *thirty*;

"clinical teaching staff member" means a member appointed in terms of paragraph (e) of subsection (1) of section *four*;

"consultant member" means the member appointed in terms of paragraph (g) of subsection (1) of section *four*;

"dental surgeon" means a dental surgeon registered as such in terms of the Medical, Dental and Allied Professions Act, 1971 (No. 24 of 1971);

"Deputy Medical Superintendent" means the Deputy Medical Superintendent of the Hospitals appointed in terms of paragraph (b) of subsection (1) of section *twenty-eight*;

ex officio member" means the member referred to in paragraph (b) of subsection (1) of section *four*;

"Executive Committee" means the committee established in terms of paragraph (a) of subsection (1) of section *twelve*;

- "Finance Committee" means the committee established in terms of paragraph (b) of subsection (1) of section *twelve*;
- "financial year" means the period commencing on the fixed date and ending on the 30th June next following that date and thereafter the period of twelve months ending on the 30th June each year;
- "fixed date" means the date on which this Act comes into operation;
- "honorary consultant" means a medical practitioner or dental surgeon appointed to any of the Hospitals in terms of paragraph (b) of section *thirty*;
- "Hospitals" means the Salisbury Group of Hospitals specified in the First Schedule;
- "lay member" means a member referred to in subparagraph (i) of paragraph (c) of subsection (1) of section *four*;
- "Medical Appointments Committee" means the committee established in terms of paragraph (c) of subsection (1) of section *twelve*;
- "*medical* practitioner" means a medical practitioner registered as such in terms of the Medical, Dental and Allied Professions Act, 1971 (No. 24 of 1971);
- "Medical Superintendent" means the Medical Superintendent of the Hospitals appointed in terms of paragraph (a) of subsection (1) of section *twenty-eight*;
- "member" means a member of the Board referred to in subsection (1) of section *four*;
- "Minister" means the Minister of Health;
- "Ministry member" means a member referred to in sub-paragraph (ii) of paragraph © of subsection (1) of section *four*;
- "University member" means a member appointed in terms of paragraph (d) of subsection (1) of section *four*.

PART I

SALISBURY HOSPITALS BOARD OF GOVERNORS

Establishment of Salisbury Hospitals Board of Governors.

3. There is hereby established a board, to be known as the Salisbury Hospitals Board of Governors, which shall be a body corporate and shall in its corporate name be capable of suing and being sued and, subject to the provisions of this Act, of performing all such acts as bodies corporate may by law perform.

Composition of Board.

4. (1) Subject to the provisions of section *six*, the Board shall consist of nineteen members, of whom-
- (a) one shall be a person who is not practicing medicine for gain appointed as chairman by the Minister after consultation with the Council of the University of Rhodesia; and

- (4) If at a meeting of the Finance Committee the chairman of that committee is absent, one of the lay members shall preside at that meeting or, if no lay member is present, the members present shall appoint one of their number to preside at that meeting.
- (5) All acts, matters or things authorized or required to be done by the Finance Committee shall be decided by a majority vote at a meeting of that committee at which a quorum is present.
- (6) At all meetings of the Finance Committee each member of that committee present shall have one vote on a question before that committee and, in the event of an equality of votes, the person presiding at the meeting shall have, in addition to a deliberative vote, a casting vote.

15. (1) The Medical Appointments Committee shall consist of-

- (a) the *ex officio* member or his alternate who shall be the chairman; and
- (b) the two Ministry members; and
- (c) one University member; and
- (d) one clinical teaching staff member; and
- (e) one Association member; and
- (f) the consultant member.

Medical Appointments Committee.

- (2) Meetings of the Medical Appointments Committee shall be held as often as may be necessary for the proper conduct of the business of that committee.
- (3) At any meeting of the Medical Appointments Committee the chairman and three members, of whom at least two shall be medical practitioners, shall form a quorum.
- (4) All acts, matters or things authorized or required to be done by the Medical Appointments Committee shall be decided by a majority vote at a meeting of that committee at which a quorum is present.
- (5) At all meetings of the Medical Appointments Committee each member of that committee present shall have one vote on a question before that committee and, in the event of an equality of votes, the person presiding at the meeting shall have, in addition to a deliberative vote, a casting vote.

Restriction relating to member with interest or candidate for appointment.

16. (1) If a member or his spouse-

- (a) tenders for, acquires or holds a direct or indirect pecuniary interest in a contract with the Board; or
- (b) holds a direct or indirect pecuniary interest in a company or firm which results in his private interests coming or appearing to come into conflict with his duties as a member;

the member shall forthwith disclose the facts to the Board and the Minister.

- (2) A member referred to in subsection (1) shall absent himself during the consideration of or vote on any question before the Board or a committee which relates to a contract or interest referred to in that subsection.
- (3) Where a member or his spouse is a candidate for an appointment in terms of section thirty, the member shall absent himself from any meeting while the appointment is being considered or voted on.

Validity of decisions and acts of Board.

17. No decision or act of the Board or a committee or act done under the authority of the Board or a committee shall be invalid by reason only of the fact that-
- (a) the Board or the committee, as the case may be, did not consist of the full number of members for which provision is made in this Part; or
- (b) a disqualified person sat or acted as a member of the Board or the committee, as the case may be, at the time the decision was taken or the act was done or authorized.
18. An agreement, contract or instrument may be entered into or executed on behalf of the Board by any person or persons generally or specially authorized by the Board for that purpose.

PART II

FUNCTIONS, POWERS AND DUTIES OF BOARD AND TRANSFER OF ASSETS

Functions of Board.

19. Subject to the provisions of this Act and the directions of the Minister, the functions of the Board shall be to manage and control the Hospitals for the purpose of providing-
- (a) for the care and treatment of patients at the Hospitals; and
- (b) facilities for the teaching and training of medical practitioners, medical students, nurses and other personnel; and
- (c) facilities for medical research.

Powers of Board.

20. Subject to the provisions of this Act and any directions of the Minister, the Board shall, for the better exercise of its functions, have power to do or cause to be done, either by itself or through its agents, all or any of the things specified in the Second schedule, either absolutely or conditionally and either solely or jointly with others.

By-laws of Board.

21. (1) Subject to the provisions of subsection (3), the Board may make by-laws for the administration and management of the Hospitals.
- (2) By-laws made in terms of subsection (1) may relate to-

- (a) the safe-keeping of and responsibility for the belongings of patients and controlling the conduct of patients;
 - (b) the conditions under which patients may be visited and the conduct of visitors;
 - (c) the duties, responsibilities and conduct within the Hospitals of staff referred to in section *thirty*;
 - (d) the control of and access to the grounds and buildings of the Hospitals;
 - (e) the control of vehicular traffic and parking in the grounds of the Hospitals, including the fixing of fees for the parking of vehicles.
- (3) By-laws made by the Board in terms of subsection (1)-
- (a) may provide for the imposition of penalties for breaches thereof and for different penalties in the case of successive breaches but no penalty shall-
 - (i) in the case of a first conviction, exceed a fine of one hundred dollars or, in default of payment, imprisonment for a period of one month;
 - (ii) in the case of a second or subsequent conviction, exceed a fine of two hundred dollars or, in default of payment, imprisonment for a period of three months;
 - (iii) in the case of a continuing offence, exceed a daily penalty of ten dollars;
 - (b) and shall not have effect unless and until they have been approved by the Minister and published in the *Gazette*.

22. (1) The assets and rights of the State connected with the services provided by the Ministry of Health in the Hospitals, including any endowment, together with the liabilities and obligations attached thereto, which were subsisting immediately before the fixed date and are specified by the Minister, after consultation with the Minister of Finance, shall be transferred with effect from the fixed date to the Board:

Transfer of certain asset rights, liabilities and obligations to Board and construction of future donations to Ministry, et

Provided that no immovable property shall be transferred to the Board.

- (2) All charges, agreements, contracts, instruments and working arrangements creating, giving rise to, relating to or connected with an asset, right, liability or obligation referred to in subsection (1) which were subsisting immediately before the fixed date, including any contract entered into before the fixed date for the supply of equipment for the Hospitals, shall, subject to the provisions of subsection (4), be of as full force and effect against or in favor of the Board and enforceable as fully and effectively as if, instead, of the State or a representative of the State, the Board had been named therein and had been a party thereto.
- (3) A proceeding or cause of action relating to or connected with an asset, right, liability or obligation referred to in subsection.

- (1) or arising out of a charge, agreement, contract, instrument or working arrangement referred to in subsection (2) which was pending or existing immediately before the fixed date by or against the State may, subject to the provisions of subsection (4), be continued or enforced by or against the Board as it might have been by or against the State if this Act had not come into operation.
- (4) The provisions of subsections (2) and (3) shall not apply to a proceeding or cause of action pending or existing immediately before the fixed date between the State and a person employed by the State.
- (5) Any money or other movable property which is donated or bequeathed on or after the fixed date to the Minister, the Secretary for Health or the Ministry of Health for the benefit of any of the Hospitals or the staff or patients thereof shall be deemed to have been donated or bequeathed, as the case may be, to the Board and any terms or conditions attached thereto shall be construed accordingly.
- (6) In this section-
"endowment" means any money or other movable property which has been donated or bequeathed before the fixed date for the benefit of any of the Hospitals or the staff or patients thereof and, immediately before the fixed date, is held by the Minister, the Secretary for Health or the Ministry of Health.

PART III

FINANCIAL PROVISIONS OF BOARD

Conduct of financial affairs of Board.

23. In the exercise of its functions it shall be the object of the Board to ensure that all its income, taking one year with another, is not less than sufficient to enable the Board to meet its expenses.

Funds of Board.

24. (1) The funds of the Board shall consist of-
- (a) the fees and charges fixed in terms of paragraph 9 of the Second schedule; and
 - (b) such grants, donations, bequests and subscriptions as may be payable to the Board; and
 - (c) such moneys as may be payable to the Board from moneys appropriated for the purpose by the Legislature; and
 - (d) such other moneys or assets as may vest in or accrue to the Board, whether in the course of its operations or otherwise.
- (2) Moneys referred to in paragraph (b) of subsection (1)-
- (a) may, subject to the provisions of paragraph (b) and of any terms and conditions under which such moneys are payable to the Board, be used for such purposes as the Board thinks fit; and

- (b) shall not be used for any purposes which will involve any payments from moneys referred to in paragraph (a), (c) or (d) of subsection (1) unless the approval of the Minister has been obtained.
- (3) The funds of the Board shall not be regarded as public moneys for the purposes of the provisions of the Audit and Exchequer Act, 1967 No. 28 of 1967), other than the provisions of Part II of that Act.
25. (1) The Board shall keep proper accounts and other records relating to all its operations and property, including such particular accounts as the Minister may direct. **Accounts and reserves of Board.**
- (2) The Board shall prepare. and submit to the Minister a statement of accounts in respect of each financial year or such other period as the Minister may direct.
- (3) The Board may establish a general reserve and may credit thereto such sums as may be approved by the Minister and the Minister of Finance.
26. (1) The accounts of the Board kept in terms of sub-section (1) *twenty-five* shall be audited by the Comptroller and Auditor-General not less than once in each financial year. **Audit of accounts of Board.**
- (2) The Comptroller and Auditor-General shall make a report to the Board on the statement of accounts prepared in terms of subsection (2) of section *twenty-five* and such report shall state whether or not, in his opinion, the statement of accounts gives a true and fair view of the state of the financial affairs of the Board.
- (3) In addition to, the report referred to in subsection (2), the Minister may require the Board to obtain from the Comptroller and Auditor-General such other reports, statements or explanations in connection with the operations and property of the Board as the Minister may consider expedient.
- (4) If, in the opinion of the Comptroller and Auditor-General-
- (a) he has not obtained the information and explanations he requires; or
- (b) the accounts and records referred to in subsection (1) of section *twenty-five* have not been properly kept; or
- (c) the Board has not complied with the provisions of this Part;
- he shall include in the report made in terms of subsection (2) or (3), as the case may be, statements to that effect.

PART IV

STAFF OF HOSPITALS

26. Nothing in this Act shall derogate from the provisions of the laws relating to the Public Service which shall continue **This Part not to derogate from laws relating to Public Service.**

apply in relation to members of staff referred to in paragraph (a) of section *thirty* as though their service with the Board were service in the Public Service.

- Appointment functions and powers of Medical Superintendent and Deputy Medical Superintendent**
28. (1) The Minister shall, appoint to the Hospitals from persons to be known as-
- (a) the Medical Superintendent of the Hospitals; and
 - (b) the Deputy Medical Superintendent of the Hospitals.
- (2) The Medical Superintendent shall, subject to the directions of the Board, be responsible for the day to day running of the Hospitals, including the control of the staff referred to in section *thirty*.
- (3) The Medical Superintendent shall have such powers as may be necessary for or incidental to the performance of his functions.
- (4) The Deputy Medical Superintendent shall-
- (a) assist the Medical Superintendent in the performance of his functions; and
 - (b) act for the Medical Superintendent in his absence.
- Persons to be provided by Minister.**
29. (1) The Minister shall, provide for appointment to the Hospitals from the establishment of the Ministry of Health such persons as he may consider reasonably necessary to enable the Board to exercise its functions and powers.
- (2) The Minister may, remove from the service of the Board a person appointed to any of the Hospitals in terms of paragraph (a) of section *thirty*.
- Staff may be appointed by Board.**
30. The Board may appoint to any of the Hospitals-
- (b) any person provided by the Minister in terms of section twenty-nine and the person so appointed shall be in the service of the Board until he dies, resigns, retires or is discharged from the Public Service or is removed in terms of subsection (2) of section twenty-nine;
 - (b) on such terms and conditions as the Minister may approve, medical practitioners and dental surgeons as honorary consultants;
 - (c) with the approval of the Council of the University of Rhodesia, on such terms and conditions, including the payment of such allowances, as the Minister may approve, members of the staff of the University of Rhodesia as clinical teaching staff;
 - (d) on such terms and conditions, including the payment of remuneration and allowances, as the Minister may approve, persons as resident medical or dental staff;

(e) such other staff on such terms and conditions as the Minister may approve.

31. The Board may, in respect of a person appointed to any of the Hospitals in terms of paragraph (a) of section *thirty*, request the Minister-

(a) to remove that person in terms of subsection (2) of section *twenty-nine*; or

(b) to investigate an allegation of misconduct against that person in terms of the laws relating to the Public Service;

and the Minister shall cause an inquiry to be conducted and thereafter, if he considers such action justified, remove the person or prefer a charge of misconduct against him, as the case may be.

Powers of Board in respect of persons provided by Minister.

PART V

GENERAL

32. Without prejudice to any defense or limitation which might be available in terms of any law, no liability shall attach to any member or member of a committee of the Board in respect of any loss or damage sustained by any person as a result of the exercise or performance or purported exercise or performance of or the omission to exercise or perform any power or duty conferred or imposed on the Board or the committee by or in terms of this Act unless the act or omission to act in question was in bad faith or negligent.

Limitation of liability of Board.

33. Any delictual liability of the Board shall be deemed to be that of the State and any proceedings in connection therewith shall be taken against the Minister.

Actions in delict to be taken against State.

34. (1) If at any time the Minister is satisfied that the Board has failed to comply with the provisions of this Act, he may, by notice in writing, require the Board to make good the default within a specified time.

Proceedings on failure of Board to comply with Act.

(2) If the Board fails to comply with a notice issued in terms of subsection (1), the Minister may apply to the General Division for an order compelling the Board to remedy the default and the General Division may make such order on the application as it thinks fit.

35. The Board shall not be bound by any law which does not bind the State:

Board not bound by certain laws.

Provided that the provisions of the Workmen's Compensation Act (*Chapter 248*) shall bind the Board in respect of employees of the Board, other than those referred to in paragraph (a) of section *thirty*.

36. The Board shall be deemed to have been authorized in writing in terms of subsection (1) of section 34 of the Patents Act, 1971 (No. 26 of 1971) to make, use or exercise any invention

Use of patented inventions by Board.

disclosed in any specification lodged at the Patent Office in connection with any services provided at the Hospital or any one or more of them.

Amendment of First Schedule.

37. The Minister may, after consultation with the Board, by notice in the *Gazette*, amend, add to or replace the First Schedule.

Regulations.

38. (1) The Minister may make regulations prescribing any thing which, in his opinion, is necessary or convenient to be prescribed for carrying out or giving effect to "he provisions of this Act.

(2) Regulations made in terms of subsection (1)-

- (a) may provide for any matter in respect of which the Board may, in terms of section *twenty-one*, make by-laws; and
- (b) if inconsistent with any by-laws made in terms of section *twenty-one*, shall repeal and substitute those by-laws to the extent that they are so inconsistent.

(3) Regulations made by the Minister in terms of sub-section (1) may provide for the imposition of penalties for breaches thereof and for different penalties in the case of successive breaches but no penalty shall-

- (a) in the case of a first conviction, exceed a fine of one hundred dollars or, in default of payment, imprisonment for a period of one month;
- (b) in the case of a second or subsequent conviction, exceed a fine of two hundred dollars or, in default of payment, imprisonment for a period of three months;
- (c) in the case of a continuing offence, exceed a daily penalty of ten dollars.

FIRST SCHEDULE (Section 2)

SALISBURY GROUP OF HOSPITALS

1. Andrew Fleming Hospital, including the hospital previously known as the Salisbury Central Hospital and its annexes.
2. Lady Chancellor Maternity Home
3. Princess Margaret Hospital
4. Harari Central Hospital.

SECOND SCHEDULE (Section 20)

POWERS OF BOARD

1. To acquire movable property by purchase, loan, hire or exchange.
2. To maintain, alter or improve the property of the Board.
3. To sell, exchange, lease, pledge, dispose of, turn to account or otherwise deal with any property of the Board for such consideration as the Board may determine.

4. To borrow money in such amounts, on such terms and conditions and for such purposes as may be approved by the Minister and the *Minister of Finance*.
5. To insure against any loss, risk or liability which the Board may incur or any damage which the Board may suffer.
6. To enter into agreements and to modify or rescind such agreements: Provided that the Board shall not enter into agreements of suretyship or guarantee without the approval of the Minister and the Minister of Finance.
7. To draw, make, accept, endorse, discount, execute and issue, for the purpose of the business of the Hospitals, promissory notes, bills of exchange, securities and other negotiable and transferable instruments.
8. To invest moneys not immediately required.
9. (1) To fix the terms and conditions, including fees, subject to which patients are admitted to, accommodated and treated in and discharged from the hospitals and to fix different terms and conditions for different classes of patients by race or otherwise:

Provided that in fixing the fees in terms of this subparagraph the Board shall do so subject to the directions of the Minister and the Minister of Finance.

- (2) Subject to the directions of the Minister and the Minister of Finance, to provide-
 - (a) that no fees shall be paid by a specified patient or class of patients; and
 - (b) for the remission of fees paid by a specified patient or class of patients.

10. To accept a grant, donation or bequest of movable property, including money, made to the Board or for the Hospitals:

Provided that, if a grant, donation or bequest referred to in this paragraph-

- (a) is made subject to any conditions; or
 - (b) would involve additional or recurrent expenditures on the part of the Board; the Board shall not accept the grant, donation or bequest without the consent of the Minister.
11. Generally, to do all such things as are incidental or conducive to the exercise of the functions or the performance of the duties of the Board or which are incidental to the powers specified in this Schedule or which are calculated, directly or indirectly to enhance the value of, or to develop, the services provided at the Hospitals.

Appendix 3: Salisbury Hospitals Amendment Act, 1981

SALISBURY HOSPITALS AMENDMENT

PRESENTED BY THE MINISTER OF HEALTH

BILL

To amend the Salisbury Hospitals Act 1975.

ENACTED by the President and the Parliament of Zimbabwe.

- | | | |
|----|---|--|
| 5 | 1. This Act may be cited as the Salisbury Hospitals Amendment Act, 1981. | Short title. |
| 10 | 2. Section 2 of the Salisbury Hospitals Act, 1975 (hereinafter called the principal Act); is amended- | Amendment of section 2 of Act No. 16 of 1975 |
| 15 | <p>(a) in the definition of "Association member" by the insertion after "paragraph (f)" of "or (h)";</p> <p>(b) by the repeal of the definition of "Medical Appointments Committee" and the substitution of "Medical Advisory Committee on Appointments" means the committee established in terms of paragraph (c) of subsection (1) of section <i>twelve</i>;"</p> <p>(c) by the insertion of the following definitions-</p> <p>"Zimbabwe Medical Association member" means a member appointed in terms of paragraph (f) of subsection (l) of section <i>four</i>;</p> | |

'Zimbabwe Association member" means a member appointed in terms of paragraph (h) of subsection (1) of section *four*."

3. Section 4 of the principal Act is amended by the repeal of subsection (1) and the substitution of-

5

"(1) Subject to the provisions of section six, the Board shall consist of fourteen members, of whom-

(a) one shall be a person who is not practicing medicine for gain appointed as chairman by the Minister; and

10

(b) one shall be the Medical Superintendent *ex officio*; and

(c) five shall be appointed by the Minister, of whom-

(i) four shall be persons who are not medical practitioners; and

(jj) one shall be an officer of the Ministry of Health; and

15

(d) two shall be appointed by the Minister, of whom-

(i) one shall be selected from a panel of three persons who are staff members of the Faculty of Medicine whose names have been submitted by the Council of the University of Zimbabwe; and

20

(ii) one shall be selected from a panel of three persons who are not staff members of the Faculty of Medicine whose names have been submitted by the Council of the University of Zimbabwe; and

25

(e) two shall be members of the clinical-teaching staff appointed by the Minister from a panel of four persons, all of whom shall be full-time staff members of the Faculty of Medicine at the University of Zimbabwe, elected by the clinical teaching staff in the manner fixed in terms of subsection (3); and

30

(f) one shall be a medical practitioner appointed by the Minister from a panel of three persons whose names have been submitted by the governing body of the Zimbabwe Medical Association; and

35

(g) one shall be an honorary consultant appointed by the Minister from a panel of two persons whose names have been submitted by the honorary consultants;

(h) one shall be a nurse appointed by the Minister from a panel of three persons whose names have been submitted by the governing body of the Zimbabwe Nurses Association."

40

4. Section 5 of the principal Act is amended in subsection (1)-

(a) in paragraph (a) by the deletion of “five” and the substitution of “three”;

(b) in paragraph (c)—

(i) by the deletion of “three” and the substitution of “two”;

(ii) by the repeal of the proviso.

5. Section 6 of the principal Act is amended by the repeal of subsection (1) and the substitution of—

Amendment of section 6 of Act No. 16 of 1975.

“(1) If the Council of the University of Zimbabwe, the 10 clinical teaching staff, the Associations referred to in paragraphs (1) and (h) of subsection (1) of section *four* or the honorary consultants fail, neglect or refuse to submit the names of or elect the panel of persons referred to in paragraphs (d), (e), (f), (g) or (h) of subsection (1) of section four, as the case may be, the Minister may in terms of the appropriate paragraph appoint any person, whether that person is a staff member of the Faculty of Medicine, a member of the clinical teaching staff, a medical practitioner, an honorary consultant or a nurse, as the case may be; or not, whom he thinks fit to be a member.”

6. Section 10 of the principal Act is amended in subsection (1)—

Amendment of section 10 of Act No. 16 of 1975.

(a) by the deletion of “or (g)” and the substitution of “(g) or (h)”;

(b) by the repeal of proviso (ii) and the substitution of—

“(ii) the reference in paragraph (e) of subsection (1) of section *four* to a panel of four persons shall, for the purposes of this subsection, be read and construed as a reference to a panel of three persons.

7. Section 11 of the principal Act is amended—

Amendment of section 11 of Act No. 16 of 1975.

(a) in subsection (2) by the deletion from paragraph (b) of “five” and the substitution of “four”; (b) by the repeal of subsection (3) and the substitution of—

“(3) At any meeting of the Board six members, of whom—

(a) one shall be the *ex officio* member or his alternate; and

(b) two shall be lay members; and

(c) one shall be the Ministry member; and

(d) one shall be either a University member or a clinical teaching staff member; and

(e) one shall be either the Zimbabwe Medical

12. Section 19 of the principal Act is amended by the insertion after paragraph (c) of the following paragraph and
- 5 (d) the equitable distribution of health resources irrespective of race or creed and in the interests of social justice.”
13. Section 28 of the principal Act is amended in subsection (1) by the deletion of “after consultation with the Board.”
14. Section 29 of the principal Act is amended in subsections (1) and (2) by the deletion of “after consultation with the Board,” wherever it occurs.
15. Section 34 of the principal Act is amended in subsections (1) by the insertion after “Act” of “or the directions of the Minister.”
16. Section 37 of the principal Act is repealed and the following is substituted—
- Amendment of First Schedule and traditional provisions.
- 20 “37. (1) The Minister may, by notice in the *Gazette*, amend, add to or replace the First Schedule.
- 25 (2) Notwithstanding the provisions of this Act, provisions.” where, as a result of an amendment to the First Schedule, any hospital is removed from the Salisbury ; Group of Hospitals, the Minister may direct the Board to continue to manage and control that hospital to such extent and for such period as he may specify and the Board shall comply with the Minister’s directions and have the authority and power to act in accordance with those directions.”
17. The First Schedule to the principal Act is amended by the deletion of item 4.
18. The provisions of the Act specified in the first column of the Schedule are amended to the extent specified opposite thereto in the second column of the Schedule.

Amendment of section 1 of Act No. 16 of 1975.**Amendment of section 2 of Act No. 16 of 1975.****Amendment of section 2 of Act No. 16 of 1975.****Amendment of section 3 of Act No. 16 of 1975.****Amendment of section 3 of Act No. 16 of 1975.****Amendment to First Schedule to Act No. 16 of 1975****Minor amendments**

SCHEDULE (Section 18)

MINOR AMENDMENTS

35	<i>Provision</i>	<i>Amendment</i>
	Sections 7 (b) (i) and (ii) and 30(c)	By the deletion of “Rhodesia” wherever it occurs and the substitution of “Zimbabwe.”

SALISBURY HOSPITALS AMENDMENT BILL 1981

MEMORANDUM

Clause 2

This clause makes amendments to the definition of "Medical Advisory Council" which becomes the "Medical Advisory Committee on Appointments." Two new definitions are added consequent upon amendments in clause 3.

Clause 3

This clause alters the composition of the Board, reducing its membership from nineteen to fourteen and providing for the appointment of a nurse as a Board member.

Clause 4

This clause alters the tenure of office of the various Board members.

Clause 5

This clause provides for the appointment of Board members where the provisions of clause 3 are not followed.

Clause 6

This clause is an amendment consequent upon the provision for the appointment of a nurse to the Board. The proviso relates to the appointment of a member of the clinical teaching staff following a vacancy.

Clause 7

This clause details the composition and numbers for a quorum of the Board, which formerly stood at nine.

Clause 9

This clause sets out the composition of the Executive Committee.

Clause 10

This clause relates to the composition of the Finance Committee.

Clause 11

This clause sets out the composition of the Medical Advisory Committee on Appointments. Clause 8 is a concomitant amendment.

Clause 12

This clause adds to the functions of the Board.

Clauses 13 and 14

These clauses remove the requirement that the Minister consult with the Board in the appointment of the Medical Superintendent or administrative personnel.

Clause 15

This clause amends the section relating to the failure of the Board to comply with a provision of the Act. The amendment is intended to clarify the section.

Clause 16

This clause enables the Minister to amend the composition of the Salisbury Group of Hospitals. The Minister may give directions to the Board to ensure the continuity and management of any hospital removed from the Group.

Clause 17

This clause removes the Harari Central Hospital from the Salisbury Group of Hospitals.

Clause 18

This clause makes minor amendments.