**ORGANIZATION STRUCTURE OF AMSH**

Contents

[I. INTRODUCTION 2](#_Toc194932512)

[Key Elements of Hospital Organizational Structure 3](#_Toc194932513)

[Types of Hospital Organizational Structures 3](#_Toc194932514)

[2.Situational Analysis: Organizational Structure of Emmanuel Hospital 7](#_Toc194932515)

[3.Hospital Organizational Structure: Comprehensive Analysis of Strengths and Weaknesses 9](#_Toc194932516)

[3.1. Organizational Strengths 9](#_Toc194932517)

[3.1.1. Structural Operational Excellence 9](#_Toc194932518)

[3.1.2 Strategic Leadership Innovation 9](#_Toc194932519)

[3.1.3. Human Resources Service Delivery 9](#_Toc194932520)

[3.1.4 .Performance Accountability 10](#_Toc194932521)

[3.2. Organizational Weaknesses 10](#_Toc194932522)

[3.2.1. Bureaucratic Delays in Decision-Making 10](#_Toc194932523)

[3.2.2.Lack of Defined Interdepartmental Relationships and Positional Interactions. 10](#_Toc194932524)

[3.2.3 Inflexible Resource Allocation Systems 11](#_Toc194932525)

[3.2.4 .Dysfunctional Human Resource Management 11](#_Toc194932526)

[4.The Rationale for Organizational Restructuring in Ethiopian Federal Hospitals. 11](#_Toc194932527)

[4.1.Strengthening Leadership, Governance, and Management 11](#_Toc194932528)

[4.2. Improving Healthcare Access, Affordability, and Equity 12](#_Toc194932529)

[4.3. Attaining and Sustaining Quality Service Standards 12](#_Toc194932530)

[4.4. Ensuring Managerial Autonomy and Decision-Making Efficiency 12](#_Toc194932531)

[4.5. Supporting Teaching and Research Centers 12](#_Toc194932532)

[4.6. Clarifying Roles, Responsibilities, and Accountability 12](#_Toc194932533)

[4.7. Integrating Health Professionals into Leadership 13](#_Toc194932534)

[4.8. Modernizing Infrastructure and Technology 13](#_Toc194932535)

[5.Recommendation for Hospital Organizational Structure 13](#_Toc194932536)

[5.1. Enhanced Integration of Health Professionals in Leadership Roles 13](#_Toc194932537)

[5.2.Strategic Involvement of Clinicians in Civil Service Commission 14](#_Toc194932538)

[5.3.Establishment of a Dedicated Academic and Research Directorate 14](#_Toc194932539)

[5.4.Flexible Qualification Standards: Relax overly stringent qualification 14](#_Toc194932540)

[5.5.Strategic Implementation of Public-Private Partnerships 14](#_Toc194932541)

[5.6.Financial Delegation for Clinical Directors. 15](#_Toc194932542)

[5.7.Establishment of Autonomous Legislative Authority 15](#_Toc194932543)

[6.Summary. 16](#_Toc194932544)

# I. INTRODUCTION

Hospitals, as complex healthcare delivery systems, require well-defined organizational structures to achieve their primary mission: providing quality patient care through optimal resource allocation and efficient operational management. The organizational framework of Ethiopian federal hospitals serves as the backbone for clinical service delivery, administrative functions, and strategic health system development.

This document presents a comprehensive analysis of the current organizational structure of Ethiopian federal hospitals, examining:

* Fundamental structural models in healthcare organizations
* The existing governance framework
* Identified strengths and weaknesses
* Recommendations for improvement

## Key Elements of Hospital Organizational Structure

A hospital's structure typically includes several key elements:

• **Executive Leadership**: The top tier of leadership responsible for setting policies, strategic direction, and overall management.

• **Clinical Departments**: Specialized units or departments, such as emergency care, surgery, internal medicine, and pediatrics, where patient care services are provided.

• **Support Services**: These include departments like human resources, finance, information technology, and facilities management, which ensure the hospital operates smoothly.

• **Administrative Functions**: This includes roles such as hospital directors, chief officers, and department heads, who oversee day-to-day operations.

• **Quality and Safety Teams**: Groups focused on ensuring high standards of care, patient safety, and adherence to regulations and protocols.Key Elements of Hospital Organizational Structure.

## Types of Hospital Organizational Structures

There are different hospital organizational structures including:

**1. Hierarchical (Bureaucratic) Structure**

Top-down decision-making with clear, vertical reporting lines (e.g., CEO → Department Heads → Staff).

A hierarchical organizational structure offers clear roles, accountability, and a well-defined chain of command, ensuring that responsibilities are explicitly assigned and decision-making follows a structured pathway. This stability fosters predictable operations, reducing ambiguity in workflows and enhancing overall efficiency. Additionally, this model aligns seamlessly with regulatory compliance requirements, making it particularly suitable for government-run hospitals and large healthcare institutions that must adhere to strict policies and standardized procedures.

While hierarchical structures provide stability, they often suffer from slow decision-making due to bureaucratic processes, as approvals must pass through multiple management levels. This rigidity limits flexibility and stifles innovation, making it difficult to adapt quickly to changes in healthcare demands or emerging technologies. Additionally, communication gaps between different hierarchical levels can lead to inefficiencies, misunderstandings, and delays in implementing critical improvements. These challenges can hinder a hospital’s ability to respond dynamically to patient needs and evolving medical practices.  
Ideal For: Large public hospitals (e.g., Ethiopian federal hospitals), traditional healthcare systems.

**2. Flat Structure**

Few or no middle-management layers; decentralized authority.  
A flat organizational structure offers significant advantages for hospitals, particularly in enabling faster decision-making and greater adaptability due to its streamlined management layers. This setup fosters strong teamwork and open communication across all levels, breaking down traditional hierarchical barriers. Additionally, it empowers employees by giving them more autonomy in their roles, making it especially suitable for smaller healthcare facilities like clinics or startup hospitals where flexibility is crucial. However, this structure also presents notable challenges: as the organization grows, role confusion can emerge due to the lack of clearly defined reporting lines. Staff members often take on broad responsibilities, which can lead to burnout and inefficiencies. Furthermore, the absence of specialized managerial roles may result in gaps in expertise, potentially affecting the quality of care in more complex medical environments. While ideal for small, agile healthcare settings, the flat structure may struggle to meet the demands of larger, more specialized hospital systems.

Ideal For: Small hospitals, private clinics, or urgent care centers.

3. **Functional Structure**

Departments grouped by expertise (e.g., Surgery, Radiology, Finance).  
The functional organizational structure offers significant advantages for hospitals by enabling high specialization and efficiency within departments, as staff focus on their specific areas of expertise, such as surgery, radiology, or administration. This specialization fosters clear career paths for employees, enhancing professional development and job satisfaction. Additionally, the functional structure allows for cost-effective resource allocation, as each department can optimize its budget and personnel for maximum productivity. However, this structure also has notable drawbacks: the formation of departmental silos can hinder cross-department collaboration, making it challenging to address complex, interdisciplinary patient needs. Duplication of efforts, such as separate administrative teams for each department, may lead to inefficiencies and increased operational costs. Furthermore, the rigid separation of functions can result in slower responses to situations requiring coordinated care across multiple specialties. While the functional structure excels in specialized settings, these limitations can impact overall hospital agility and patient-centered care.

Ideal For: Mid-sized hospitals with focused service lines.

4. **Divisional Structure**

Units divided by service lines (e.g., Pediatrics, Cardiology) or patient groups.  
The divisional organizational structure provides hospitals with distinct advantages, particularly in delivering tailored care for specific patient needs by organizing services into specialized units such as pediatrics, cardiology, or emergency care. Each division operates with autonomy in resource management, allowing for customized approaches to budgeting, staffing, and service delivery. This setup also simplifies performance tracking, as each division can be evaluated independently based on its unique goals and metrics. However, these benefits come with notable challenges: the duplication of resources across divisions—such as separate administrative teams or equipment—can drive up operational costs significantly. Additionally, the autonomy of divisions may foster internal competition for funding or staff, potentially undermining collaboration. Coordinating hospital-wide initiatives becomes more complex, as aligning the priorities of semi-independent divisions requires robust communication and leadership to ensure cohesive organizational outcomes. While effective for large, multi-specialty hospitals, this structure demands careful oversight to balance division-specific flexibility with overarching institutional objectives.

Ideal For: Large, multi-specialty hospitals (e.g., referral hospitals).

5. **Matrix Structure**

Dual reporting lines (e.g., a nurse reports to a department head and a project manager).  
The matrix organizational structure offers hospitals valuable advantages by enabling flexibility for cross-functional projects, such as medical research initiatives or pandemic response teams, where collaboration across specialties is essential. This model promotes efficient resource sharing, as staff and equipment can be dynamically allocated based on project needs rather than being confined to rigid departmental boundaries. Additionally, the interplay of diverse expertise in a matrix structure fosters innovation, encouraging creative solutions to complex healthcare challenges. However, this approach also presents significant drawbacks: the dual reporting lines inherent to matrix structures can lead to role conflict and power struggles between functional managers and project leaders, potentially creating workplace tension. Effective implementation requires robust communication systems to maintain clarity across intersecting chains of command, and without these, coordination may break down. Furthermore, staff members often face competing priorities from multiple managers, which can lead to overwhelm and decreased productivity. While the matrix structure is well-suited to academic medical centers or hospitals engaged in cutting-edge research, its success depends on careful management to balance its collaborative potential against these inherent complexities.

Ideal For: Academic hospitals, research institutions, or crisis-response teams.

# 2.Situational Analysis: Organizational Structure of Emmanuel Hospital

Ethiopia’s federal hospitals operate under a hierarchical yet decentralized governance model, designed to align clinical excellence, academic rigor, and administrative efficiency with national health priorities. This structure ensures accountability while enabling adaptability to Ethiopia’s evolving healthcare demands. Below is a formal breakdown of its core components:

**ቺፍ ኤክስኪዩቲቭ ዳይሬክተር**

**ዋናዳይሬክተር ጽ/ቤትኃላፊ**

**የአስተዳደርልማትዋናሥራአስፈጻሚ**

ህዝብግንኙነትናኮሚኒኬሽንስራአስፈፃሚ

ህግጉዳዮችስራአስፈፃሚ

ስትራቴጂክጉዳዮችስራአስፈፃሚ

የፋይናንስስራአስፈፃሚ

ስነምግባርመከታተያስራአስፈፃሚ

ብቃትናሰውሃብትአስተዳደርስራአስፈፃሚ

ግዢስራአስፈፃሚ

ውስጥኦዲትስራአስፈፃሚ

ሴቶቸችናማህበራዊጉዳዮችአካቶትግበራስራአስፈፃሚ

* የሴቶቸችናማህበራዊጉዳዮችአካቶተትግበራስራአስፈፃሚ
* ጉዳዮችአካቶተትግበራስራአስፈፃሚ
* ጉዳዮችአካቶተትግበራስራአስፈፃሚ
* የሴቶቸችናየሴቶቸችየሴቶቸችናማህበራዊጉዳዮችአካቶተትግበራስራአስፈፃሚ
* ናማህበራዊጉዳዮችአካቶተትግበራስራአስፈፃሚ
* ማህበራዊጉዳዮችአካቶተትግበራስራአስፈፃሚ

የህክምና ገቢስራአስፈፃሚ

ተቋማዊለውጥስራአስፈፃሚ

**የህክምና አገልገግሎት ጥራት ማሻሻያ ኢኖቬሽን ኮርፖሬት ዳይሬክቶሬት**

ምህንድስናስራአስፈፃሚ

ኢንፎርሜሽንኮሙዩኒኬሽንቴክኖሎጂስራአስፈፃሚ

**የጤናመረጃስርዓትዳይሬክተር**

የመሠረታዊ አገልግሎት ሥራ አስፈጻሚ

**ትምህርትናሥልጠናጥራት ዳይሬክተር**

**ህክምና አገልግሎት ጥራት ኢኖቬሽን ዳይሬክተር**

የታካሚቅብብሎሽናመረጃዳይሬክተር

ዲፓርትመንት

**ሜዲካል ዳይሬክተር**

የህክምናአገልግሎትማሳለጥዳይሬክተር

ላብራቶሪዳይሬክተር

ማህበረሰብአገልግሎትዳይሬክተር

ፋርማሲዳይሬክተር

የተሃድሶአገልግሎትዳይሬክተር

ህክምና ዲፓርትመንት

ባዮሜዲካልዳይሬክተር

የነርሲንግና ሚድዋይፈሪ ዳይሬክተር

1. **Federal Ministry of Health (FMOH)**

The FMOH serves as the strategic apex, providing policy direction, technical assistance, and resource allocation to federal hospitals. It establishes specialized units and appoints senior representatives to joint oversight committees, ensuring adherence to national healthcare standards and guidelines.

**2. Federal Hospital Boards**

Functioning at the strategic level, these boards:

Approve annual budgets, ensuring adequate funding for medical services, teaching, and research.

Monitor policy implementation and evaluate institutional performance quarterly.

Safeguard resource availability to maintain service continuity and quality.

**3. Chief Executive Director (CED)**

The CED acts as the operational linchpin, accountable for all hospital activities. Key responsibilities include:

Leading an empowered executive team (Chief Clinical, Academic, and Administrative Directors).

Maintaining a flattened management structure to decentralize decision-making while focusing on strategic goals.

Ensuring transparent, results-driven delivery of medical services, education, and research.

1. **ዋናዳይሬክተር ጽ/ቤት ኃላፊ**

The Chief of Staff serves as the CED's principal advisor and operational strategist, overseeing the Legal Office, Public Relations, and Internal Audit functions.

**5. Chief Administrative and Development Director (CADD)**

The CADD bridges operational and developmental functions by:

Coordinating workforce recruitment and retention to sustain hospital operations.

Drafting and implementing human resource development manuals.

Consolidating annual budgets for clinical, academic, and research activities.

**6. Medical Director (MD)**

The Medical Director ensures clinical and educational quality by:

Planning and coordinating departmental activities to deliver equitable, evidence-based care.

Implementing quality measurement tools and improvement programs.

Overseeing recruitment of skilled clinical staff.

**Clinical Services Directors**

These directors optimize service delivery by:

Monitoring efficiency and equity in patient care.

Addressing bottlenecks in real-time to uphold service standards.

**Departmental Heads**

Heads of departments (e.g., Surgery, Pediatrics) are frontline executors, responsible for:

Timely, patient-centered healthcare delivery.

Evidence-based medical education and ethical research.

**7.Medical Service Quality Innovation Directorate**

# 3.Hospital Organizational Structure: Comprehensive Analysis of Strengths and Weaknesses

## 3.1. Organizational Strengths

### 3.1.1. Structural Operational Excellence

• Service Organization: The clear categorization and segregation of services into clinical, financial, and administrative domains enhance efficiency and accountability.

• Unified Departments: Previously separate units have been consolidated into cohesive operational teams with well-defined roles, significantly improving coordination.

### 3.1.2 Strategic Leadership Innovation

• CEO Focus: The top leadership prioritizes long-term strategy, including growth and innovation, while delegating day-to-day operations to directors.

• Quality Innovation Directorate: This dedicated division drives continuous improvement initiatives, technology adoption, and the implementation of best practices.

• Adaptability: The establishment of new directorates, such as Community-Based Health Insurance,and rehabilitation service effectively addresses emerging healthcare needs.

### 3.1.3. Human Resources Service Delivery

• Staff Optimization: Strategic staffing and comprehensive training programs are in place to maximize workforce efficiency.

• Interdisciplinary Teams: Enhanced collaboration among various specialties leads to improved patient outcomes.

• Community Engagement: Robust public health initiatives and a strong preventive care infrastructure enhance accessibility and equity in healthcare.

### 3.1.4 .Performance Accountability

• Quality Metrics: Continuous monitoring of patient satisfaction, and regular audits ensures a commitment to service excellence.

• Clinical-Administrative Synergy: Director-level oversight of clinical services facilitates streamlined decision-making processes.

## 3.2. Organizational Weaknesses

### 3.2.1. Bureaucratic Delays in Decision-Making

Bureaucratic processes often lead to delays in decision-making, hindering timely responses to emerging challenges and opportunities.

### 3.2.2.Lack of Defined Interdepartmental Relationships and Positional Interactions.

One of the critical weaknesses in our current hospital organizational structure is the absence of a formal, documented framework that clearly delineates the nature of interactions and working relationships between various positions and departments. This deficiency manifests in several operational challenges:

**Unclear Reporting and Communication Channels**

* The lack of standardized protocols governing interdepartmental communication leads to inconsistent information flow between clinical units, administrative departments, and support services.
* Staff members frequently experience uncertainty regarding proper channels for collaboration or conflict resolution between different functional areas.

**Ambiguous Role Delineation**

* Without documented guidelines, overlapping responsibilities and authority gaps emerge between positions at similar hierarchical levels across departments. This ambiguity creates inefficiencies in decision-making processes and task execution.

**Coordination Difficulties**

* The absence of defined interaction protocols hinders effective coordination for emergency response situations requiring rapid interdepartmental mobilization

**Accountability Challenges**

Unclear relationship mapping makes it difficult to assign responsibility when:

* Service delivery breaks occur at departmental interface
* Resource allocation conflicts arise

### 3.2.3 Inflexible Resource Allocation Systems

• Desk Allocation (One-Size-Fits-All): Generic approaches fail to address the specialized needs of different departments, such as high-volume outpatient departments .

• Misaligned Position Placement: Critical roles are often situated away from service delivery points, leading to unnecessary workflow bottlenecks.

### 3.2.4 .Dysfunctional Human Resource Management

• Arbitrary Qualification Barriers: Rigid degree requirements (e.g., mandatory second degrees) exclude competent BSc professionals from contributing effectively.

• Inadequate Staffing: Staffing levels often do not align with service demands, resulting in operational inefficiencies.

# 4.The Rationale for Organizational Restructuring in Ethiopian Federal Hospitals.

Ethiopia's federal hospitals serve as critical pillars in the nation's healthcare system, yet evolving health demands, systemic inefficiencies, and gaps in service quality necessitate continues structural reforms.

## 4.1.Strengthening Leadership, Governance, and Management

Our currently face operational inefficiencies due to fragmented decision-making, unclear accountability, and bureaucratic delays. To address this, implementing a flattened hierarchy with empowered mid-level managers would enable faster responsiveness. This reform would enhance strategic oversight, streamline administration, and create a more agile healthcare system better equipped to meet patient needs.

## 4.2. Improving Healthcare Access, Affordability, and Equity

There is significant disparities in resource distribution among Hospitals. To address this, integrating community health units into hospital operations would ensure more equitable care delivery while reducing patient burdens through improved local service availability.

## 4.3. Attaining and Sustaining Quality Service Standards

Hospitals struggle with inconsistent adherence to clinical protocols and accreditation standards. To resolve this, creating dedicated Quality Assurance Departments to conduct regular audits and staff training would significantly improve compliance. This intervention would yield higher patient satisfaction, fewer medical errors, and alignment with international healthcare benchmarks.

## 4.4. Ensuring Managerial Autonomy and Decision-Making Efficiency

Excessive centralization in hospitals currently limits innovation and local decision-making capacity. The solution lies in granting greater financial and operational autonomy to hospitals.

## 4.5. Supporting Teaching and Research Centers

Amanuel hospitals currently face limited integration between academic and clinical functions, hindering optimal healthcare delivery. To address this, formal partnerships with medical schools and dedicated funding for residency programs should be established. This integration will enhance workforce training while promoting evidence-based care through stronger collaboration between education and practice.

## 4.6. Clarifying Roles, Responsibilities, and Accountability

A well-defined organizational structure with clear roles, responsibilities, and accountability mechanisms is essential for hospitals to function efficiently, deliver high-quality patient care, and achieve their strategic objectives. In complex healthcare environments, ambiguity in job functions, overlapping duties, and unclear reporting lines can lead to operational inefficiencies, communication breakdowns, and compromised patient outcomes

## 4.7. Integrating Health Professionals into Leadership

One of critical weakness in Ethiopian federal hospitals is the exclusion of clinicians from administrative roles, resulting in policy-clinic misalignment. Implementing mandatory dual-role appointments (like physician-administrators) would ensure management decisions reflect frontline realities while boosting staff morale through inclusive leadership.

## 4.8. Modernizing Infrastructure and Technology

Outdated technological systems in Ethiopian federal hospitals hinder data-driven decision-making and efficient healthcare management. To modernize operations, strategic investments in digital health platforms (including EHRs and telemedicine) and infrastructure upgrades are essential. This transformation will enable real-time patient monitoring and more scalable, responsive healthcare service delivery across all facilities

# 5.Recommendation for Hospital Organizational Structure

## 5.1. Enhanced Integration of Health Professionals in Leadership Roles

To strengthen decision-making processes, we recommend restructuring hospital leadership to systematically include qualified health professionals in all key administrative bodies. This reform would place clinicians in strategic roles such as deputy CEO positions, strategic planning committees, and legal/medico-legal units. Such integration ensures medical expertise directly informs policy development and resource allocation, addressing the current disconnect between administrative decisions and clinical realities.

5.2.Strategic Involvement of Clinicians in Civil Service Commission   
We propose establishing formal mechanisms for health professional participation in Civil Service Commission decisions affecting hospital operations. This includes creating a permanent Health Sector Advisory Panel to consult on staffing policies, performance evaluation criteria, and disciplinary matters involving clinical staff. Such involvement is critical to prevent non-clinical personnel from making medically uninformed HR decisions that negatively impact service delivery. The reform aims to improve staff retention and job satisfaction by aligning human resource policies with the operational realities of healthcare settings.

5.3.Establishment of a Dedicated Academic and Research Directorate

To advance Ethiopia's medical education and research capacity, we recommend creating a new directorate structure . This structural addition would address critical physician shortages through enhanced training programs while positioning federal hospitals as research hubs in alignment with Health Sector Reform.

5.4.Flexible Qualification Standards: Relax overly stringent qualification

requirements for certain roles. Allow BSc holders to qualify for key positions based on their skills and experience, ensuring that staffing needs are met even when higher-degree candidates are unavailable.

5.5.Strategic Implementation of Public-Private Partnerships.  
The proposed restructuring includes targeted public-private partnerships for non-core services and specialized care units. Diagnostic services (radiology and laboratories), non-clinical functions (laundry and catering), and some specialty centers represent ideal candidates for PPP arrangements. These partnerships would allow hospitals to focus resources on core clinical services while attracting private investment for technology upgrades. Implementation would incorporate strict safeguards, including retained clinical oversight in all contracts and capped profit margins for essential services to ensure accessibility.

## 5.6.Financial Delegation for Clinical Directors.

we recommend implementing targeted financial delegation for clinical service directors to streamline patient care operations. This reform would grant clinical leaders appropriate budget authority for essential medical expenditures, with spending thresholds based on department size, service volume, and clinical priority. The proposed system would establish expedited approval processes for critical needs including medical supplies, equipment maintenance, and emergency care while implementing robust accountability measures such as monthly expenditure reviews, clinical outcome audits, and cost-effectiveness analyses. By reducing bureaucratic delays in financial decision-making while maintaining appropriate oversight through transparent reporting requirements to hospital leadership and governing boards, this reform would significantly enhance the efficiency of clinical service delivery. Both recommendations are designed to create an optimal balance between operational flexibility and institutional accountability, enabling more responsive healthcare services while ensuring continued alignment with national health priorities. We suggest implementing these changes through carefully monitored pilot programs before institution-wide adoption, allowing for refinement based on operational experience and outcome measurements.3

## 5.7.Establishment of Autonomous Legislative Authority

we propose establishing autonomous legislative authority for the institution to enable dynamic self-governance. This empowerment would allow the hospital to continuously evaluate and adapt its organizational structure without being constrained by excessive external bureaucratic processes. The hospital would create an internal governance committee with delegated authority to approve structural modifications, develop policies aligned with national health objectives, and implement quality improvement initiatives, all while operating within parameters set by the Federal Ministry of Health to maintain compliance with national healthcare standards. This self-governance capability would position the institution to rapidly respond to emerging healthcare challenges, technological advancements, and evolving service delivery needs.

# 6.Summary.

This document provides a comprehensive analysis of the organizational structure of Ethiopian federal hospitals, with a particular focus on Amanuel Mental Specialized Hospital (AMSH). It underscores the critical importance of well-defined hospital structures in facilitating effective patient care and operational management. The report evaluates five prevalent organizational models.

A situational analysis of AMSH reveals a hybrid organizational structure characterized by hierarchical and decentralized elements. This structure exhibits several strengths, including clear categorization of services, a strong emphasis on leadership, and effective quality monitoring systems. However, it also presents significant weaknesses, such as bureaucratic delays, ambiguous interdepartmental relationships, inflexible resource allocation, and mismatches in staffing.

The rationale for restructuring the hospital is grounded in several needs including enhancing leadership capabilities, improving access to healthcare services, ensuring adherence to quality standards, increasing managerial autonomy, supporting academic and research initiatives, clarifying roles and responsibilities, integrating clinicians into leadership positions, and modernizing technological resources. To address these needs, seven specific recommendations are proposed: (1) fostering greater clinician involvement in leadership roles, (2) ensuring health professionals participate in civil service decision-making processes, (3) establishing an academic and research directorate, (4) implementing flexible qualification standards, (5) pursuing strategic public-private partnerships, (6) delegating financial authority to clinical directors, and (7) creating an autonomous legislative authority for the hospital.

The proposed reforms aim to cultivate a more agile, efficient, and patient-centered organizational model while ensuring alignment with national health priorities. It is recommended that implementation occur through phased pilot programs accompanied by robust evaluation mechanisms. This document serves both as an analytical framework and a practical roadmap for the restructuring of hospitals within Ethiopia's evolving healthcare landscape.