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POLICY IMPLEMENTATION & ECONOMIC GROWTH

IN THIS ISSUE

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FROM THE EDITOR

As previous issues tried to do, this Bulletin attempted to present timely and important issues in a non-technical manner. Two themes figured prominently in this issue. One addresses the need, the requirement and the role of policy implementation in a country's development endeavour. Arguably, the appropriateness and the efficiency with which a given policy is implemented are the two most important determinants of economic performance. That is, the proposition that one or the other alone cannot ensure economic growth is explored in these papers. Most of these papers were presented in the last bi-monthly round table discussion organised by the Association.

The second set of papers focuses on the seemingly unrelated health sector issues. One of the papers explores the economics and particularly the extent and the mechanics of financing health care provisions in this country. This issue is likely to take a centre-stage in the economic agenda of the country (if it has not already) as the demand for health care provision increases dramatically in competition with other social provisions for the limited national social sector budget. The second paper attempts to examine the socio-economic impacts of HIV/AIDS on the economic health of the country. HIV/AIDS, besides its challenge to medical researchers, has also emerged as an issue which combines the unique feature of being a primary social, economic and political (at least internationally) agenda all at the same time. Among these, the economic dimension of HIV/AIDS is explored in this issue.

It is therefore hoped that the ideas contained in this issue will serve as a starting point for further discussion and rigorous research, and ultimately generate kin interest among policy makers. Failing to address these issues in a comprehensive, effective and resolute manner might be tantamount to failing in both the economic and social arena.

QUOTABLE QUOTES

Citizens are not born, but made.

Bauch (Benedictus de) Spinoza
Tractatus Politicus, 1676

He who would not wish his own country to be bigger or smaller, richer or poorer, would be a citizen of the universe.

Voltaire "Patrie"
Dictionnaire philosophique, 1764

A strict observance of the written laws is doubtless one of the high virtues of a good citizen, but it is not the highest. The laws of necessity, of self-preservation, of saving our country when in danger, are of higher obligation.

Thomas Jefferson
letter to John B. Colvin
Sep 20, 1810

Whatever makes men good Christians, makes them good citizens.

Daniel Webster
speech in Plymouth,
Massachusetts
Dec 22, 1820

Before men made us citizens, great Nature made us men.

James Russel Lowell
"On the Capture of Fugitive Slaves near Washington"
1845

Everyone who receives the protection of society owes a return for the benefit.

John Stuart Mill
On Liberty, 1859

Without a home there can be no good citizen. With a home there can be no bad one.

Andrew Johnson
quoted by George L. Tappan
Andrew Johnson, Not Guilty
May, 1872

ECONOMIC PERFORMANCE AND THE QUALITY OF THE PUBLIC SECTOR

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Economic Commission for Africa

I. INTRODUCTION

The conventional wisdom is that the quality of the public sector in Ethiopia needs to be improved substantially.[1] There is also sufficient anecdotal evidence, including the pronouncements of government officials, suggesting that bad service and corruption are not uncommon. Indeed, it appears that very few service-providing public sector organisations are considered well-functioning by the public.

Should this state of affairs be a concern? The unequivocal answer is yes, it should be. How good the public sector is in discharging its functions impacts on the efficiency and welfare achieved in an economy. Broadly speaking, the sector critically affects the design and implementation of economic policies and through them the development and efficiency of the economy in general, and that of the private sector, in particular. For example, speedy licensing and low corruption are viewed as important considerations to domestic as well as foreign private investors. Similarly, the welfare of the public in part depends on how effectively and equitably public services (such as health and education) are delivered. It also depends on how consistently and uniformly rules and regulations are applied. In this regard, distorted provision of public services and biased or arbitrary application of rules and regulations can be particularly detrimental to the well being of the poor.

Despite the significance of these issues, to my knowledge, little systematic empirical work has been done on the efficiency of the Ethiopian public sector. Consequently, this note cannot report on findings specific to Ethiopia. Instead, it addresses the issues in general terms. Its aim is to highlight the significance of a high-quality public sector, thereby raising research interest in issues of public sector performance and reform. The rest of the note is organised as follows. Section II and Section III respectively consider, briefly and rather informally, the economic role of the state and the quality of the public sector, and the determinants of the quality of the public sector. Section IV examines measurement issues and reports some empirical evidence on the determinants of the quality of the public sector and the link between that quality and economic performance. Section V concludes.

II. ECONOMIC ROLE OF THE STATE AND THE QUALITY OF THE PUBLIC SECTOR

Obviously, how good the public sector is needs to be assessed against the primary functions it is expected to perform. Essentially, these functions originate in the economic role of the state in a market economy. Hence, the quality of the public sector can only be evaluated relative to the role of the state.

Economic role of the state

A number of basic economic functions are attributed to the state in a market economy (Stiglitz (1996), World Bank (1997), and Tanzi (2000)). Specifically, the state needs to: maintain law and order (the rule of law) by, among others, establishing rules and institutions aimed at the enforcement of contracts and the protection of property rights; maintain macroeconomic stability and ensure an incentives-compatible microeconomic environment; allocate resources to correct market failures[2] including provision (not necessarily production) of public goods (defence, infrastructure), dealing with externalities (education, health, pollution), invest in basic social services (health and education) and infrastructure (transport and communications networks); promote equity by helping the poor and protecting and targeting the vulnerable (such as the less-well endowed and victims of natural disasters); promote growth and employment; and protect the environment.

The public sector is the institutional apparatus through which the state performs its functions. As such, it can facilitate or impede the formulation and implementation of government policies. In other words, the quality of the public sector is a major determinant of the ease with which the state plays its economic role.

Quality of the public sector

It is thus logical to define the quality of the public sector in terms of its ability to allow the state accomplish its objectives as efficiently as possible. Tanzi

(2000) argues that ideally the public sector should enable the state to perform its tasks with the minimum degree of distortion of the market, the lowest burden of taxation on taxpayers, the smallest number of public employees, the lowest absorption of economic resources, and the maximum degree of accountability and transparency in the relevant processes and outcomes. More specifically, the public sector should have the ability to: provide appropriate policy advice (including relevant information); implement polices and enforce rules (both within itself and in the society at large); and provide good quality services to the public. It should also perform these tasks in an efficient (i.e., cost effective), transparent, accountable and co-ordinated manner. Therefore, the extent to which these characteristics are possessed by the public sector can be used as the yardstick in assessing its quality.

In this regard, it is important to make a distinction between the quality of the public sector and the quality of economic policy. The two are likely to be positively correlated since a high-quality public sector will help in designing good economic policies and facilitate their effective implementation (Tanzi (2000) and World Bank (1997, 2000b)). However, the goals of the state must be feasible in the sense of being a sufficiently realistic reflection of the economy's capabilities. Even a very efficient public sector will be unable to cope with unrealistic goals. One major implication of this distinction is that, in explaining unsatisfactory outcomes, it is necessary to examine both the appropriateness of policies and the effectiveness of the agencies implementing them. One or the other or both could be the culprit(s).

III. DETERMINANTS OF THE QUALITY OF THE PUBLIC SECTOR

The consensus is that a high-quality public sector is an asset to society. The obvious corollary is that wherever the quality of the public sector is low, the necessary effort should be exerted to raise it. An effective strategy to achieve the latter requires, among others, a clear understanding of what determines the quality of the public sector. A number of recent studies explored these determinants (see for instance, Manning, Mukherjee and Gokcekus (2000), Rauch and Evans (2000), Tanzi (2000), World Bank (2000a,b)). Their findings are summarised below.

1. The quality of the public sector depends on its institutional environment. The latter is composed of formal constraints and informal constraints to which public sector institutions are subject. Formal constraints are comprised of formal rules which articulate government policy broadly or narrowly, as appropriate. These rules are laid down in constitutions, laws (including budget documents), and specific regulations (such as decrees, directives, and operational manuals). Informal constraints, on the other hand, are norms of behaviour, conventions, and codes of conduct. They generally reflect the interrelated historical, socio-economic and cultural circumstances of communities.

   The quality of the public sector is augmented by laws that are stated clearly and cover all the relevant areas, that do not lead either the public or public officials to conflicting interpretations, that are not conflicting among themselves, and whose number is as small as feasible. It is also important that rules and policies are credible and resources are (relative to tasks) adequate and predictable.

2. The overall quality of the public sector is significantly determined by its institutional composition (which institutions exist within it and which relevant ones are missing), by the effectiveness of the interaction among its institutional elements, and by the performance and efficiency of the individual institutions (or agencies).

   The public sector is a system composed of various organisations with many functions. Its efficiency as a system therefore partly depends on how its constituent parts interact among themselves. These interactions generate what can be referred to as inter-institutional externalities, which can be positive or negative. A weak link in the system may constrain the performance of the entire sector. This feature should thus be recognised and dealt with in any attempt at enhancing the quality of the public sector.

   The performance of individual public agencies depends on: their tradition and reputation; the resources available to them and the discretion over their use; the clarity of their mandate; their organisation; the incentives that they face; the quality of their leadership and staff; and the freedom they have over reorganisation matters.

   Clearly, all these factors influence the performance of individual employees. This performance, in turn, is a major determinant of efficiency at the level of institutions. A number of specific factors were found to be influential at the individual level. These include merit-based recruitment and promotion, monetary incentives, security of tenure, long-term career possibilities, job satisfaction and professional achievements, and the opportunity to realise socially desirable objectives.

3. The quality of the public sector also depends on the existence of controls and enforcement mechanisms.[3] Controls and enforcement characteristics express the manner in which and the extent to which the two aforementioned sets of constraints are enforced. Within

the public sector itself, it is critical to have regular and efficient internal audit, audit by a central audit agency, merit-based reward and punishment procedures, systematic record management, and effective performance appraisal.

It is also important to institute systems of evaluation located outside the public sector. This is particularly significant in the light of the monopolistic position of many public sector agencies. External control and enforcement mechanisms include regular and systematic elicitation of the reactions and preferences of citizens and civil society with respect to the services rendered by the public agencies, effective parliamentary supervision, and a fair and speedy court system.

Briefly, the quality of the public sector depends on a complex set of factors. Consequently, enhancing that quality requires a holistic approach. In diagnosing relevant problems and working-out appropriate solutions, it is imperative to examine the institutional environment, inter-institutional externalities, incentives, and enforcement mechanisms. One important fact is commonly not fully appreciated, in this regard: immoral behaviour on the part of some public sector employees is, at most, part of the problem and mitigating such behaviour through punishment only part of the solution.

IV. SOME EMPIRICAL EVIDENCE

As noted above, the role of the public sector in determining economic outcomes has been subject to some empirical analysis.[4] Two major and closely related lines of research can be identified. The first, and slightly earlier, strand focuses on the impact of 'institutional quality' (such as bureaucratic quality and corruption in government) on economic growth (Knack and Keefer (1995) and Mauro (1995)). The second line concentrates on measuring the performance of the public sector and identify the relevant determinants of that performance (Manning, Mukherjee and Gokcekus (2000), Rauch and Evans (2000), Tanzi (2000), World Bank (2000a,b)). The following few paragraphs report on both strands by considering measurement issues and empirical findings.

Measurement issues

As can be surmised from the discussion above, both the quality of the public sector and its determinants are multidimensional and rather difficult to measure. Despite the difficulties, a verity of measures have been developed and employed. Some are outcome indicators which serve as proximate measures of the quality of public institutions. Others attempt to directly measure elements of that quality.

World Bank (2000b) classifies the measures into two types–*descriptive* measures and *evaluative* measures. As the name indicates, descriptive measures describe prevailing public sector circumstances with little normative content. Examples include number of civil servants, civil service pay, turnover rates for civil servants, aspects of organisational structure, revenue predictability, and deviation between budget appropriations and actual spending. In contrast, evaluative measures are normative involving judgements about quality. These measures are in turn divided into three subtypes:

a. *Objective fact-based measures* such as waiting time for telephone lines and budget variability. A rather limited number of such measures are currently available. However, a lot of effort is being made to increase both the number and coverage of this type of measures.

b. *Participant survey-based measures* such as elements of the Global Competitiveness Index (by the World Economic Forum). The surveys, usually conducted by country rating agencies, cover citizens, entrepreneurs, foreign investors, and public officials. Thus, the measures based on these surveys reflect the views and perceptions of their respondents.

c. *Expert opinion-based measures* such as the Corruption Perceptions Index (by Transparency International) and the index of Bureaucratic Quality (by International Country Risk Guide). These indicators are derived from the responses of experts who are asked to rate the quality and effectiveness of public institutions.

Given the paucity of hard-data on the quality of the public sector, the last two subtypes are quite useful. To put things in perspective, however, it is essential to mention some of their shortcomings. Being largely subjective, these indicators can be biased and difficult to compare with one another even when they claim to measure the same phenomenon. They may also fail to accurately reflect the concerns and perceptions of actual stakeholders (this may be particularly true of those based on expert opinions). In order to alleviate these and other measurement problems, a substantial amount effort is being exerted towards standardisation (see, for instance, Knack and Manning (2000) and World Bank (2000b)).

Empirical findings

There is a growing number of studies which empirically explore the determinants of the performance of the public sector and the impact of that performance on economic outcomes. Given space limitation, it is possible to only briefly report some of the major findings.[5]

a. Manning, Mukherjee and Gokcekus (2000) identify three dimensions of the performance of public sector institutions – result focus, accountability, and employee morale. ***Result focus*** covers attainment of or-

ganisational objectives, efficiency, and merit-based reward and punishment. *Accountability* captures enforceability of regulations (including record management, project evaluation, internal audit, and performance appraisal), extent of delegation, and answerability to society (including to citizens, civil society, and parliament). *Employee morale* essentially refers to the satisfaction of staff. They also identify elements of the institutional environment within which public sector agencies operate. These include: the existence and nature of rules of recruitment, evaluation, training, and recording; perceived fairness of treatment; predictability of career path, the degree of policy consistency; effectiveness of communication regarding policies; the extent of employee support to policies adopted; the degree of political interference and/or micro-management; and the predictability of resource availability.

Using survey data, Manning, Mukherjee and Gokcekus (2000) estimate the impact of the specified elements of the institutional environment on public sector performance. They find that the result focus of agencies is positively and significantly influenced by the existence of rules in evaluation and recording as well as employee support to adopted policies. Similarly, their results indicate that accountability of public sector institutions is positively and significantly affected by existence of rules in evaluation, training, and recording; predictability of career path; the degree of employee support for adopted policies; and limits to political interference and/or micro-management. Furthermore, they find that existence of rules in recruitment, evaluation, and recording; perceived fairness of treatment; predictability of career path; policy consistency; the degree of employee support for adopted policies; and limits to political interference and/or micro-management are positive and significant determinants of employee morale.

b. Rauch and Evans (2000) find that, in their sample, meritocratic recruitment (recruitment on the basis of a civil service examination or university education) is empirically the most important determinant of bureaucratic quality. To a lesser extent, their findings also suggest that internal promotion and career stability are also important.

c. Knack and Keefer (1995) find that corruption in government and bureaucratic delays reduce GDP growth, while bureaucratic quality raises it.

d. Mauro (1995) also finds that corruption and bureaucratic red tape reduces growth in per capita GDP, while Mauro (1997) shows that corruption leads to lower public expenditure on health and education.

e. Rahman, Kisunko and Kapoor (1999) find that corruption is detrimental to growth, investment, and foreign direct investment.

In short, there is sufficient evidence to establish that a high-quality public sector promotes good economic outcomes; and that the quality of the public sector, in turn, depends on the 'quality' of its institutional environment, the appropriateness of the constraints and incentives facing individual agencies and their employees, and the existence of effective control and enforcement mechanisms.

V. CONCLUSION

In a poor country like Ethiopia, in which the private sector and the market are still weak and poverty is extensive, the economic role of the state is considerable in both scope and significance. The findings reported above clearly indicate that a high-quality public sector helps the state play this considerable role effectively. It appears that the quality of the public sector in Ethiopia leaves a lot to be desired. The necessary effort, therefore, should be exerted to raise that quality. It is also important to recognise that the government, the private sector, civil society, and individual citizens can and should constructively contribute to that effort.

An effective strategy to improve the effectiveness of the public sector requires, among others, a clear understanding of what determines the quality of that sector. Public sector agencies have a number of distinctive features which include multiple principals, multiple goals, and lack of competition (Dixit (2000). Moreover, the specific institutional, socio-economic, and historical context imparts a degree of specificity to these agencies and their functioning. These features need to be taken into account in evaluating the performance of the public sector and in designing reform programmes aimed at enhancing that performance.

These considerations suggest that the rigorous economic analysis of the performance of the Ethiopian public sector and its determinants is a priority area of research. Public agencies themselves, professional associations such as the Ethiopian Economic Association, the private sector, and individuals should engage in this line of research actively and without delay.[6]

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* This note is a revised version of a talk given to the Round Table on "Policy Implementation and Economic Growth" organised by the Ethiopian Economic Association.

[1] For the purpose of this note, the public sector consists of the civil service and government institutions delivering services, such as education and health, to the public.

[2] It is important to note that government failures also exist and can be as common as market failures. The desirable objective is to nurture effective complementarities between the market and the state. The state needs to promote the development of the market, appropriately regulate its operations, and correct for its socially undesirable outcomes.

[3] It is possible to consider these mechanisms as elements of the institutional environment described in item (1) above. The separate treatment is intended to further underscore their importance.

[4] That interest is in part motivated by the drive for what are called second-generation reforms in developing countries. The World Bank has initiated the bulk of this work.

[5] For a discussion of the channels through which these effects operate, see the papers cited below. Also, consult World Bank (2000a,b) and the references therein.

[6] There are encouraging signs that this is being recognised. One such indication is the up-coming conference organised by the Ethiopian Civil Service Commission.

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MAJOR PROBLEMS IN POLICY IMPLEMENTATION

Kebur Gena
President, Addis Ababa Chamber of Commerce

INTRODUCTION

Thank you for the invitation and for the opportunity offered to me to discuss what is, I believe, an important topic–improving government performance.

The literature concerning policy-making is rife with disagreement. A number of authors suggest that the reason for this disagreement is that conceptually, there is lack of agreement on the meaning of the term 'policy', which is often defined either too broadly, in terms of a set of goals or in a statement of belief, or too narrowly, in terms of a detailed specification of a course of action to be followed or a set of rules and procedures.

However, if one examines the literature more carefully, it becomes clear that the root of the difficulty for most of the writers in the discipline is in developing an acceptable phrase that precisely captures the essence of policy.

I thought it best at this stage to define the term 'policy' in order to provide the basis for discussions around the nature of effective policy and the conditions for effective policy implementation.

For tonight's discussion I will adopt Caldwels definition that " a policy is a set of guidelines which provides a framework for action in achieving some purpose on a substantive issue...they imply an intention and a pattern for taking action". Therefore, "a policy is established to achieve some purpose, which invariably reflects a set of beliefs or values or philosophy on the issue concerned" Policy, it seems in the Ethiopian context, has been traditionally viewed as those decisions made by individuals in power to exercise control over those who must obey.

However, this traditional view of clear lines between policy decision and action is largely imaginary. In reality, there are no clearly-cut distinctions between the policy framers and the policy implementers. In fact, those who make policies are very often the people who must implement and even obey them.

In any case, one can glean key words and phrases which appear to capture the essence of policy and combine them to synthesise an effective definition of policy. Words and phrases such as "value statements", "communication", "efficient public service", "decisions", and "choices" speak to various aspects of policy making.

Thus, policy may be defined as those general regulations made by governing or administrative bodies that communicate value statements which are intended to give acceptable choices for decision making especially in problem or controversial areas.

Now, having established a certain common ground on the term 'policy', I will go straight to the main theme of the discussion–policy implementation. We all know that policies are not self-executing. Simply because legislators or policy enactors express explicit intentions in policy does not guarantee those aims will be preserved. If that were the case we would not have been here tonight.

Policy implementation implies bringing technical knowledge, skills and abilities to the implementation of public policy and to the everyday running of the government.

THE CHARACTERISTICS OF EFFECTIVE POLICY

If one can assume that all policies are not created equal and that some policies are "better" or more effective than others, one must examine those policies considered to be effective in changing target group behaviour in order to describe the characteristics of effective policy. There are some characteristics common to effective policies that one can identify to make policy framing more scientific and precise, and more likely to be successful in achieving desired behaviours.

One characteristic of effective policy is the size or magnitude of the change in behaviour targeted by the policy itself. Charles Lindblom (1979), in his exploration of what he calls the "science" of muddling through, suggests that "incrementalism ... [or] political change by small steps" (p. 517) is the key to effective policy. The crux of his argument is that "no person, committee, or research

team, even with all the resources of modern electronic computation, can [effectively] complete the analysis of a complex problem [like those before today's policy makers]" (p. 518). Therefore, the range of possible decisions in almost any worthy policy area is too broad to be addressed by sweeping policy changes. He postulates, then, that effective policy consists of "a fast-moving sequence of small changes [which] can more speedily accomplish a drastic alteration of the *status quo* than can an only infrequent major policy change" (p. 520).

Another aspect of effective policy is the type of directive contemplated and its potential effect on the organisation. In this regard one can identify four types of policy directives.

(a) vague, but provide clear financial support;
b) specific, and provide clear financial support;
(c) vague, but provide no clear financial support; and
(d) specific, but provide no clear financial support .

There is also a suggestion that most policy implementation problems are due to "intra-organisational" conflicts. Therefore, effective policies avoid intra-organisational implementation problems by establishing a specific mandate and providing sufficient resources.

A policy may be considered effective, therefore, if it successfully effects a change in target-group behaviour with a minimum of resistance. Further, it must be specific enough to clearly delineate expected behaviour without being so rigid that it does not allow local implementation flexibility. It must make sense within the context of other policies that are in effect, and it must be practical in terms of implementability. Finally, it must be appropriate, for it scarcely matters what size hammer one has when one is faced with a screw.

MAJOR PROBLEMS IN POLICY IMPLEMENTATION

Everyone Loves Policy and No One Loves Implementation.

Here are some of the major implementation problems:

Lack of capacity–the expertise, organisational routines and resources available to support planned change efforts are not there; and in fact the problems I will go over tonight are basically the results due mostly to lack of skills and proper knowledge.

For example, let's take housing–a problem we don't seem to be able to address. The private sector could have benefited from the right kind of environment had the structures of state were geared to mobilising funds from, say, the pension fund. The job creating potential of such housing programmes and co-ordinated public works programmes would have helped the creation of more than 500,000 jobs through public works. I believe the problem here is lack of government capacity.

Will–The will or the motivation to embrace the policy objectives is not there;
How many times have you come across the statement–we are not authorised to do that...That's somebody else's job. The fact is most people in the public, including most very well educated and concerned don't care to see things work.

Authority–As a tradition in this country we really like authority very much! Many of the things the government does have to do with authority over people. The people seem to have accepted it.

In Ethiopia, power is concentrated on the Executive. Policies are made within a tight group of people who know each other. It is in fact more and more dangerously supported by select ethnic-rooted groups, excluding other classes. True, a representative democracy is tolerated since it can be manipulated. The legislative is dependent on the Executive for most policy issues even to elect its own representatives. The consequences are a recess of civil life and no chance for social organisation and local leadership. Under such conditions large conglomerates of enterprises are formed and that makes private and oligopolic the most profitable sectors of economy. In the cultural life, authoritarianism appears in the way the means of communication are controlled and used.

Complexity–Don't be surprised if someone insists that those people in the parliament should not be allowed to change or vote for a law until they have read it; that is to say policy are adopted without proper analysis and review of options.

For one thing the people don't tend to focus on the concept of implementation long enough. It is long and complicated, because there are many people at many levels in many parts of the government agencies.

Lack of leadership–leadership is needed to confront all the social and economic harm people face. Perhaps it's important I list the most commonly associated skills of leadership–vision, direction, persuasion, development (providing professional growth) and appreciation (recognising with gratitude the contribution); in many instances these are lacking;

Unreasonable level of secrecy–we go from one surprise to another. The concept of a Green Paper, offering options and encouraging questions for government to formulate policy is unheard of.
So where do we stand in terms of policy formulation and implementation in the state of the union? Are we meeting the challenges? Do we have a winning plan of action to meet that challenge, to lead our people to the new world

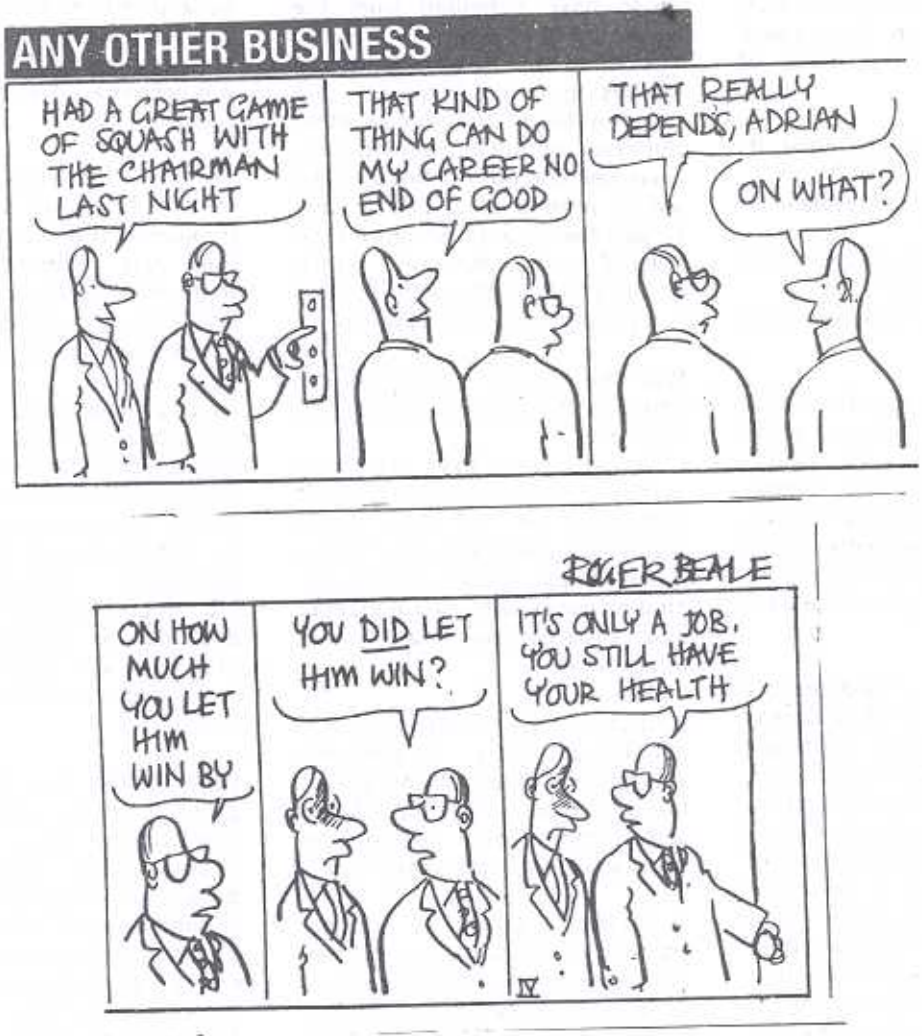
of the 21st century?

Let's be honest. Yes, governing Ethiopia is no easy task but at the end of ten years of the present government we don't have much to be thankful for. Economic decline and famine are still with us. I don't see much optimism around. Do you? All for the wrong policies or the poor implementation of the right policies.

Can we really say that Ethiopia today is strong? Are we rising to make our nation better. Are we seizing the occasion for the new promise of the global economy? I think not. I don't see us shaping events. I don't see us acting, grabbing the best possibilities of our future.

And yet we have everything going for us. Save our own inaction. I believe this government lost a great occasion this past September to issue a call to action for the New Year and right after the victory against Eritrea.

This was a good opportunity for launching policy actions to prepare the people of Ethiopia for the 21st century. Actions to revitalise our economy and our young democracy for all our people; action to strengthen education and harness the forces of technology and science; actions to build stronger families and communities; and above all, the spirit to build a more harmonious union here at home. ■



Financial Times, July 10, 2000

POLICY IMPLEMENTATION AND ECONOMIC GROWTH

Dawit Yohannes
Speaker of the House of people's Representatives

As the topic of discussion already points to issues of policy implementation, I will not dwell on the substantive issues of policy formulation and articulation. This means that I will presume that there are agreements on such fundamental issues of state involvement in the economy and government led initiatives in certain sectors of the national economy.

By concentrating on implementation related issues, we will assist policy makers to be sensitive on the actual effect of a government endorsed policy and the obstacles it faces in actual implementation.

I think it is common sense that a sound economic policy will have effective implementation if three conditions are met:

I. The economic actors have the sufficient maturity to implement declared policy.

II. The government bureaucracy is efficient and productive.

III. The public at large supports the economic policy.

I. The economic actors have the sufficient maturity to implement declared policy.

In Ethiopia today no sound economic policy will bear fruit unless the stakeholders in the declared policy have the capacity and the needed organisational structure to take effective advantage presented. As you all know, the market forces in Ethiopia are weak and fragmented. Individual entrepreneurship is the dominant form of doing business as opposed to corporate, partnership and other forms of doing business. This deficiency will incapacitate the market forces from having the necessary impact in both the articulation of national economic policies and its implementation.

For example, the implementation of any tax policy depends on the taxpayer's perception of its responsibility and in fact in its own interest to avoid corruption. Many a government policy fails as the individual businessman conceives taxes as net losses to his income.

II. The government bureaucracy is efficient and productive.

The need to re-orient the government bureaucracy towards the concept of public service as opposed to the notion of a governing body of public affairs is the crucial determinant for effective policy implementation. This will require a fundamental re-organisation of the civil service with transparent and simplified administrative rules and procedures. The ethical standard required of public employees must be of a higher standard. Government must make sure that public employees are not underpaid to avoid challenges into corruption.

III. The public at large supports the economic policy.

In an aspiring democracy such as the one we have in Ethiopia today, no national policy will be successfully implemented unless wide public support is secured. A policy designed and articulated to assist development will directly affect the public who will take part in its implementation without reserve. A conscious public will fight for transparency and will not encourage and tolerate corruption. ■

GROWTH POLICIES AND THE EXPERIENCE OF AFRICAN ECONOMIES: SOME REFLECTIONS

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1. INTRODUCTION

Arguably, more than any other factor, Africa is a victim of ill-designed policies (both domestic and foreign). These inappropriate policies at the macro-economic level include: high fiscal deficits, misalignment of the real exchange rate, and distorted price policies in general. These factors could be grouped as incentive incompatible policy stances that distorted price signals which hindered individual initiatives in favour of bureaucratic red tape and inefficiency.

As many argue, passing through the colonial experience has also robed Africa of its creative initiative and confidence. But this thesis seems to have lost its status by both the performance of other countries which were in similar circumstances and its performance in the last four decades or so. That is, whatever the potency of this argument in explaining Africa's economic performance until the end of the Colonial era, it fails to explain the history of Africa's economic performance during the post-colonial era. Some argue, the institutional and cultural legacies of colonialism lingered and contributed to the weak performance even today, but this, even if accepted, cannot explain the whole story.

The current prominent thesis in explaining Africa's poor economic performance focuses on ill-designed polidies and lack of implementation, but still without fully articulating the latter. The ill-designed policies range from poor imitation of western experiences (like the Marshall Plan) which was meant to fill the saving gap, to imposing superficial supra-structures without paying significant attention to the infra-structure in what is conventionally termed as import-substitution led growth strategy. We know now aid did not fill the saving gap and that imports have not been substituted and exports have not been diversified.

On the socio-political side, the supra-structure included a bureaucratic structure and an education system which were by and large cheap imitations of western countries. Cheap imitations because the bureaucracy has not incorporated the appropriate incentive-compatible procedures and the education system, not only has it not been expanded, but was not designed to produce effective human capital either–to use the growth jargon.

In short, as all the economic indicators testify (lower GDP per capita today compared to the 1960s, for instance), Africa seems to go more to the south (the land of poverty) as all other regions go North where it seems progress and wealth have permanently located their residence.

This state of affairs forces one to raise the non-retiring but tiring questions of: What really went wrong? What lessons have we learned in studying growth theories for good 50 years or so? And finally, what makes these policies ineffective in Africa?

As an attempt to answer these questions, this short note will focus on addressing the following questions: First, what does the accumulated wisdom of growth theories tell us about growth strategy? Second, what lessons could we learn from countries that have succeeded in transforming their economies in a relatively short period of time? And third, based on what we know from the accumulated theoretical wisdom and country experiences, what is the role of policy implementation in the growth process?

2. LESSONS FROM GROWTH THEORIES

2.1. The Financing-Gap Model

After the collapse of the colonial era, the dominant growth strategy was designed along the lines of the then contemporary theories that focused on saving mobilisation (summarised in what is called the Harrod-Domar Model). This paradigm suggested that counties with a savings gap should be given aid to fill the gap following the experience of European countries under the Marshall plan. This was rationalised as follows. Since the main binding constraint to growth was be-

lieved to be a financing gap (which later was modified to include other gaps namely the exchange rate and the fiscal gap), these models were used to forecast future economic growth using the rate of investment and the incremental capital output ratio or ICOR (I/ICOR = output growth).

We now know saving mobilisation by itself is not the panacea it was hoped to be. Let me cite some evidence to support this statement: (i) expansion of aid to fill the financing gap increased from $5 billion in 1960 annually to $45 billion in the 1990s (in constant dollars) with a cumulative sum of one trillion world wide (in the 1990s). According to the financing gap model, aid should have increased investment one for one, but only 6 out of 88 countries invested as the model predicted. What is more, the relationship between short run growth and investment only held as predicted by the model in only 5 out of 138 countries; and (ii) to give a specific African example, given the level of aid that came to Zambia, the model would predict that income per capita would be $20,000 by 1994, but actual figure was only around $600.

Despite such failures of the model, it is surprising that one still finds the growth predictions and policy advice coming from international financial institutions are, in many cases, based on this model - using the ICOR to project growth and calculate the financing gap. This is even surprising noting that the inventor of the theory himself refuted the idea a year after he suggested it as a strategy of long term growth.

2.2. Growth and Technical Progress

For reasons outlined above and others, the saving gap model lost its prominent status in the academic circle (though not necessarily by practitioners, as noted above) and was replaced by the hypothesis that economic growth is determined by increases in Human and physical capital and technical progress.

The core idea of this hypothesis is that economic growth is determined by technological change and not by saving or investment - due to what is called in the jargon diminishing returns to capital (or investment).

The accumulated evidence to date suggests that both cross country and across time growth differences could not be explained by capital accumulation (or level of investment) alone-because physical capital only explains about 25% of variations in growth rates between countries and over time. Based on reliance on physical capital, the dominant growth strategy of many LDCs in general and that of African countries in particular, in the 1960s and 1970s was what is termed an inward looking or import-substitution - which relied on relatively massive importation of physical capital. To highlight the point, in 1960-1975 Zambia had an average investment rate of over 35% of GDP but its GDP per capita grew at an average of 0.4% only, while South Korea had (during the same period) an investment rate of 19% of GDP but its GDP per capita grew by 6%. This and similar evidences clearly suggest that accumulation of physical capital alone is not a sufficient condition for economic growth. The main weakness of the above theory is that it ignores the impact of policy on total factor productivity or technological change as the new growth theories clearly demonstrate.

2.3 The Structural Adjustment Decade of the 1980s

As an attempt to revive LDC economies after the economic failures of the previous decades, both foreign sponsored and in rare cases domestically initiated, many countries have been engaged in what is referred to as structural adjustment programs.

Since many African countries engaged themselves in the process of this structural change and stabilisation polices (albeit at different degrees), professional economists have not wasted their time to evaluate the impact of these policies on the economic performance of African economies. With some variation, the early 1990s economic indicators suggested some positive changes in many African countries which led to some optimism (even some authors go as far as calling it the 'African Renaissance'). In the late 1990s however, the consensus (with some variation again) regarding the economic performance of many African countries seems to t be that the positive signals more often than not have disappeared, and even if they exist they are weak and fragile.

To cite an example from the first recipients of adjustment loans, Zambia received 10 adjustment loans between 1982 and 1992 from International financial institutions, and Kenya received 15 adjustment loans around the same period. But inflation in Zambia hit all time high of 192% in 1992 and the budget deficit in Kenya averaged around 8% of GDP over the same period. It should be noted that the failures are not confined to only such macroeconomic imbalances or specific countries, but one can add a host of countries and failed adjustment initiatives (privatisation for instance) to show how by in large the structural adjustment failed to adjust the economies and to bring economic growth.

This is of course, without even adding the issue of income distribution or poverty reduction which seems to have gained recognition by the architects of the adjustment programs.

William Easterly argues that the reason why structural adjustments failed is because in many cases they have not been implemented fully; and the reason why governments failed to implement

the adjustment policies fully and the International financial institutions failed to require full implementation (before disbursing the loans) is because they both lack incentives to do so.

In summary, therefore, all the above cited attempts to help African economies grow seem to have delivered a less than adequate economic performance, to say the least. At the risk of simplicity, the reasons why the attempts have failed could simply be put as follows: they all focused on the necessary (saving, investment, macroeconomic imbalances) but not the sufficient conditions of incentive compatible environment created by efficient institutions and competent government that are required to implement policy efficiently.

As the new growth literature shows, to escape from the "vicious circle" (or "poverty trap") to a "virtuous circle", well designed government policies and a commitment to implement them are essential requirements (and not optional choices) for economic growth. That is, the appropriateness of policy by itself never ensures anything. In fact, the outcomes of poorly implemented appropriate and inappropriate polices may not differ from each other.

This raises the fundamental question of how other regions succeeded in achieving impressive economic growth in the last few decades. More importantly, are there lessons to be learned? In what follows a brief summary of that experience will be outlined.

3. COMMON FEATURES OF THE EAST ASIAN COUNTRIES GROWTH EXPERIENCE

It has to be noted from the outset that the growth experience of East Asian countries vary. Given the variation in specific country experience(s), therefore, what is attempted here is to focus on two aspects of their experiences: First on what seem to be common to all countries, and second on what are likely to be directly relevant for Africa. In line with the above selection criteria, therefore, here are some of the common features of East Asian growth strategy.

a) All countries focused on export as an engine of economic growth. As Krueger put it, "No observer of the success of the East Asian exporters can doubt that exports played a key role in accelerating growth...[In contrast] The South Asian countries that adopted policies of import substitution and industrialisation behind high walls of protectionism failed to adopt policies conducive to rapid economic growth."

b) At varying degrees, governments played a significant role in both identifying the growth strategy and by creating a conducive environment to operate effectively. To quote Park (1990), "it is difficult to believe that the private sector alone could have launched and sustained the export drive without the direct government intervention in Korea in the 1960s". And Krueger (1990) adds that, "government policies in the super-exporters were clearly set within the context of a commitment to growth through exporting".

c) But the above factors may not have been sufficient by themselves. A host of other factors also contributed to growth. As Krueger (1990) noted, "educational attainments were quite high; government services, including transport and communications, were reasonably efficient".

d) And the attainment of high education and efficient government enabled them to adapt technology easily. All the countries not only have they methodologically and selectively sought to integrate foreign technologies, but they were also successful in adapting them starting form a low industrial base in the 1960s.

e) In addition to efficiency of government and expanding human capital and infrastructure, however, stable environment in general and policy stability in particular also significantly contributed to their growth.

f) All countries let incentive-driven policies influence economic activity.

The question is, what lessons could we learn from the East Asian Experience?

Clearly all growth theories and country experiences suggest that the growth ingredients listed above (except, arguably, the specific export led growth strategy) are both time or place invariant. They are, therefore, relevant experiences that other countries could learn from and directly incorporate in their growth strategy. However one has to raise one issue regarding the replicability of exports as a growth strategy in the context of globalisation and the mushrooming of regional integration arrangements. That is, the replicability of relying on exports as an engine of growth may not be time invariant.

There are two reasons for this concern: first the political economy of international trade has changed; and second if indeed globalisation is taking (or will take) place, the competition game will likely assume a radically different form than what faced East Asian countries in the 1960s and 1970s.

Based on the casual evidence (the amount of aid and the market access given to countries like South Korea, for instance), I suggest that international trade was probably at times used as a deterrent to Eastern influences due to the political environment that prevailed in the 1960s and 1970s (the Cold War era). And most of

these countries were bordering such influences and relatively were more pro-western democracies, which dominated world trade then and still do. Therefore, the access to technology (and the tolerance for piracy) and export markets was much relaxed for such countries at the time. And these advantages are most likely to disappear in the post-cold-war era thereby limiting the window of opportunity that the East Asian countries enjoyed in the 1960s and 1970s when engaged in export led growth.

Second, the trade environment that faced East Asian tigers in the 1960s and 1970s is probably different from what is facing African countries today. East Asia was alone in being low cost producer of primary manufactures in a world where protectionism was the dominant trade policy; today if indeed globalisation takes place, Africa must operate in the context of globalisation which implies competition with similar low cost countries, which in turn implies facing a more cautious western markets that would work hard to protect their markets and employment from the potentially multidirectional competition (as practised in the agricultural sector). Therefore, trade as a growth strategy has to be re-evaluated carefully before directly imitating the East Asian experience. It is true that, in principle an expansion of trade world wide opens an opportunity to trade more as is implied by globalisation. But it could also lead to marginalisation in the case of small countries in Africa which operate under very low increasing returns and with a narrow export base. At this early stage of globalisation, the preliminary evidence seems to indicate the latter and not the former.

All the above analysis also suggest that it is not following an appropriate policy per se that ensures growth. But equally, how efficiently, effectively and fully such policies are implemented is crucial in determining economic performance. Arguably, on balance, Africa's failure to achieve satisfactory economic performance is likely to be explained by inadequate political, infrastructural, institutional and other political economy variables that hindered implementation rather than appropriateness (or lack there) of policy.

Accordingly, the most important lesson economic policy makers in Africa seem to have failed to recognise is the following: while spending so much energy on fine-tuning the designs of what they considered to be appropriate economic policies, they have neglected to identify and put in place the conditions necessary for such a policy to be effectively implemented. That is, they failed to incorporate the institutional, human resource and cultural ingredients necessary to implement such policies. Or in their jargon they assumed away such conditions by invoking the famous "other things being equal" clause when prescribing policies.

What exactly are these necessary conditions?

In general, successful implementation of a policy requires institutions that are conducive for an implementations of the policy chosen, trained work force and a bureaucracy structured in such a way that it incorporates three ingredients: responsibility, accountability, and incentive compatibility.

First, as noted above, the institutions found in many African countries are poor imitations of western countries short of the necessary work environment in these countries. Invariably, they are centralised where authority is not appropriately delegated downwards. Such an institutional structure lends itself to an inefficient bureaucratic chain with potential loopholes for abuse (due to the concentration of authority in few hands). Suffice it to say, the paper trails one has to follow to accomplish a simple thing is enough evidence to validate this observation.

Second, both the quantity and quality of education prevalent in many African countries falls short of creating the environment that fosters adaptation of technology and creation of new ideas. As Paul Romer (1999) put it, one of the safest predictions is that, "the country that takes the lead in the twenty-first century will be the one that implements an innovation that supports production of commercially relevant ideas." In the case of African countries, the minimum prerequisite to catch up is to at least develop the ability to adapt, if not to create new ideas. But as casual observation indicates African governments failed to both produce quality workforce and fully exploit that exist. The concentration of authority in the hands of politically favoured bureaucrats (instead of trained professionals) and the exodus of professionals to western countries is an indicator of this fact (i.e. these at lest partly serve as push factors even though there are also pull factors that will explain the exodus).

And, third, arguably the most important factor that affected the efficacy of policy in Africa is the way the bureaucracy is structured. Not only does it lack transparency but it also fails to incorporate responsibility, accountability, and incentive compatibility. The most common characteristic of bureaucracies in African countries is the confusion between providing service and assuming authority. At the risk of simplicity, a typical bureaucrat in Africa assumes a post not to provide service but to exert authority. And the checks and balances attached to such authority are minimal at best and not effective at worst. A clear sense of accountability, and appropriate consequences for once action are not in place, to safe guard against inefficiency and abuse.

Further, by in large the incentive structure is such that rewards

(say, promotion) and punishment (say, demotion) are not related to work performance but to other criteria. Hence, such a work environment cannot encourage hard work since it is not incentive compatible. Instead this encourages abuse and/ or shirking on the job. All these hinder economic efficiency by increasing, to use the polite term, "transaction costs" to the economy. As of necessity therefore any policy followed in such a work environment cannot be effective regardless of the policy chosen.

As a summary, this brief essay argued that the main growth paradigms that have been followed in Africa delivered less than satisfactory. Admittedly policies were ill-designed. However, African countries failed to achieve even modest economic growth not necessarily because they followed wrong economic policies but mostly because they failed to implement policies effectively. And they failed to implement policies because they failed to put the right institutions in place, they failed to produce both qualitatively and quantitatively capable work force, and they miserably failed to set up a bureaucratic structure that is accountable, responsible, and incentive compatible. This is not to suggest that appropriateness of policy has no role to play, but to stress that the history of economic performance of other countries and the attendant evidence in the African region suggest that the culprit for the dismal performance of African countries is more related to the implementation issue rather than the policy choice per se. It is true that the literature is kin in attributing the past failures to ill-defined domestic policies and external shocks (domestic policy makers, experts of the international institutions, and academic writers, for instance argue so). But that is only half of the story, and a lesser half at that. Until African policy makers recognise this, they will keep missing the most important ingredient of the growth recipe and keep complaining about the taste of the dish. ■

BLONDIE

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SHOULD INTEREST INCOME IN ETHIOPIA BE TAXED?

Abu Girma Moges*

1. INTRODUCTION

Saving is a critical link by which economic agents determine their inter-temporal allocation of resources. It is commonly a reflection of what a community and its members perceive as their future prospects of acquiring and augmenting their assets. In this process of individual saving decision making, a number of factors would be taken into account some of which are not amenable to precision. It is therefore unavoidable to gauge the future prospects of an economic agent rewards for current decision on a mixture of several decision variables. The core of the decision variable and the main motivating factor behind any saving endeavour of economic agents is their inherent desire to improve their future well-being. This process could be materialised, however, only if the saved resources are efficiently and effectively allocated to finance productive investment activities whose returns could serve as the reward for economic agents to postpone their current consumption to a higher real level of consumption in the future. The main economic criteria for economic agents to engage themselves in the process of saving relative to their level of income, apparently is the combination of their real level of income and the attractiveness of the discounted rewards from the saving process. This leads us to the fundamental question of why saving rates are so different across economic agents and across countries. And more pertinent to our analysis, why should saving endeavours be penalised (instead of being encouraged) by the fiscal system? The answer to this question is quasi-economic and lies deep into the realities of political power and processes in the system.

I would like to start my argument with statements of some proposition of a political-economy nature. First, governments whether in developed or underdeveloped countries do not have their own earned income and hence they depend on their population, especially the income earning economic agents, to generate their revenue. This is facilitated by the legal monopoly right that sovereign governments enjoy levying and collecting taxes from their citizens. Second, despite the problem of ensuring its allocation, these governments have the responsibility to judiciously allocate these collected economic resources to maximise social benefits. Third, despite the flexibility to transfer benefits and obligations across time horizon, it is absolutely necessary for governments to run sustainable fiscal balances. This implicitly considers that the expenditure component of the fiscal account should also be subject to adjustment. Fourth, governments by definition have no property of their own. Instead they administer the property of the population that they represent in the political process. This requires accountable and responsible institution of public resource allocation. Fifth, the collection of government revenue should to a certain degree take into account a comprehensive measure of ability to pay of the economic agents. Governments should subject themselves to hard budget constraint both in the short term and in the long-term context. External borrowing could not be used indefinitely to breach current fiscal discipline even if it allows a certain degree of flexibility in the fiscal policy making. Six, it is important for governments to pursue, as a matter of policy, a small and yet efficient government in the national economy. The efficiency component must be emphasised in the process since increasing the size of the government in the national economy has been mostly the cause instead of solution to economic problems in developing countries. These are the underlying stylised facts even if numerous cases could be given otherwise.

The motivation behind this short article is the recent undertaking of the Ethiopian Federal Government to amend its income tax

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proclamation and introduce a 5 per cent interest income tax. Whereas interest income constitutes a form of revenue for economic agents, the very nature of the saving process, especially in a country where the national saving is precariously low, imposing tax gives rise to further disincentives to any saving efforts. This feature, of course, could be elaborated from different perspectives and this article develops an argument against the measure and forwards an alternative proposal. The tone of this paper is normative, as is evident from the title, and involves issues of who should do what and why. This short article argues in a non-technical terms that premature policies that are geared towards increasing fiscal revenue by imposing taxes on efforts to saving and investment would have adverse repercussions both on the performance of the national economy and hence on the revenue collection objectives of the public sector.

2. WHY DO ECONOMIC AGENTS SAVE?

Economic agents engage in the process of saving to increase their flow of real income from the additional returns that their saved resources would generate. There are several objectives why economic agents would like to put part of their wealth in the form of financial assets. Financial assets could be put either in interest or non-interest bearing forms of assets[1].

Despite the stylised facts of increasing marginal propensity to save when the current income of economic agents increases over time, the empirical observation across economic agents and countries strongly suggests that economic agents with more or less equivalent real level of income exhibit quite different rate of financial saving. Even taking groups of economic agents with comparable income level and living in countries with different level of economic, social and political development indicators tend to have quite remarkable difference in terms of both aggregate saving behaviour and financial saving. It should be noted that even in economically developed countries, there are households living from pay-check to pay-check whereas in countries where the majority of the population is living in abject poverty, there is real saving that is far from being trivial relative to their average level of income. The dispute about the marginal propensity to save of households, income groups, regions, countries and other economic agents is ultimately an empirical issue and cannot be resolved with theoretical argument. The simultaneous interaction of substitution, income and wealth effects would make responsiveness to incentives quite ambiguous. At a macroeconomic level, interest rate liberalisation and increase in real interest rate on deposits has resulted in shifts in the composition of saving in favour of financial assets. The empirical results, nonetheless, exhibit that the relation between the rise in real interest rate and rate of financial saving is not robust. However, my conjecture is that economic agents respond to real incentive factors and would always aspire to improve and stabilise the future of their economic well being. In this process, saving serves as a golden chain across time.

Perhaps the most remarkable feature of national saving rate is its tendency to increase persistently when the economy is growing fast and steadily. This seems to reflect to a certain degree that a growing economy can afford to increase both what it saves and consumes over time. This is an inherent feature in the process of economic growth. Economic growth emanates from the contributions of the various sectors of the economy and these sectors might not necessarily be growing at the same rate. The sector which grows faster than the rest would register growth rate faster than the overall growth rate of the national output. The sector, which is growing faster than the rest of the economy, creates both additional capacity of and demand for goods and factors. This induces the sector to generate an increasing share of its earnings for investment particularly from its retained earnings. This suggests that the dynamism of the national economy depends on the relative share of the leading sector and its growth rate. In this context, even if there is a certain degree of inter-sectoral linkages and hence spill over effects, it is not possible to assume an equal distribution of growth momentum throughout all the sectors of the national economy. The increase in the rate of national saving then depends on the average propensity to save of the leading sector compared to the overall average propensity to save in the country. Having outlined these general features, I now turn to the subject matter of this analysis: taxation of interest income in Ethiopia.

3. THE TAX AMENDMENT PROPOSAL AND ITS POSSIBLE IMPLICATIONS

This piece is motivated by a recent proposal to introduce interest income tax on bank deposits. The driving force behind the proposal is the objective of increasing public revenue and widening the tax base in the fiscal network. It is clear from the overall argument that raising government revenue is needed to accommodate the rising public expenditure requirements. In this context, the introduction of tax levy on income generated from interest bearing financial saving would be an easy source of government revenue.

The proposal contends that there would be a 5 percent tax levied and collected by financial institutions from depositors[2]. This could be further explored from portfolio and rate of saving perspectives. First, the introduction of interest income tax introduces

into the decision behaviour of the potential savers about their reaction on the rate of returns on interest bearing financial deposits in the banking system. Potential savers would tend to change their portfolio and forms of financial saving. Second, taxing interest income reduces the after-tax returns to saving decision and hence would adversely affect the incentive to save in the country.

This might raise the issue of marginal responsiveness of economic agents towards tax disincentives. Economic agents indeed respond to any form of disincentive. Apparently, those who are involved in financial saving tend to be better informed about risks and opportunities in the economy and it would be quite surprising if they do not respond to disincentive measures. It is important to note that, unless it is misallocated and abused, all financial saving could potentially be converted into investment that could be used in the production of goods and services and generation of employment opportunities. Therefore, any measure to tax the effort of capital accumulation would cost the society in an intertemporal context. What is lost due to the disincentive created by the taxation network penalises not only the savers but also those who could have been gainfully employed as a result of capital accumulation. This argument remains valid even if the government were to use those collected interest income tax for almost the same purpose as the private agents would have used. This assumption would not hold in our context mainly because the government reserves the discretionary power to allocate the funds collected in such a manner to whatever purpose, productive or unproductive, it pleases. This is a general problem with broader features in the process of taxing economic agents and allocation practice of such funds.

It is possible to argue about the necessity of levying interest income tax from the perspective of additional revenue from taxing income. Taxes could be levied on income, consumption or wealth. But the choice of the taxation base has implications on how fiscal policy administration and implementation and subsequently on the degree to which the policy affects the real sectors of the economy. Since interest income constitutes one form of income of economic agents, irrespective of the source and nature of this income, it should be taxed. If the taxation network is going to address the issue of sources of income and there is an intention of discriminating across economic activities, then it would be logical to impose taxes on income that is generated from interest on interest bearing deposits. In this context, when it is necessary to levy tax on interest income, it should be considered in a more comprehensive manner in which the computation would take interest income as part of the personal income of economic agents. It is even possible to give the choice to the taxpayers to report their income by source and their tax obligations be calculated accordingly.

In this sense, a comprehensive approach to income taxation should be introduced. It is not only interest income that escapes the fiscal network. One can observe several loopholes through which some privileged groups systematically evade their tax obligations[3]. This should be facilitated by the fact that tax identification number is going to be introduced and practised. The implication of this argument is that the currently proposed interest income tax is regressive in nature that takes no consideration of the ability of the taxpayers in a broader perspective. Apparently, there are a number of other sources of income that effectively escape the taxation network mainly because of the failure of the fiscal system to trace the different sources of income of the tax payers.

There are indeed certain economic activities whose nature and linkage with the rest of the national economy is such that the fiscal system should deliberately avoid imposing tax obligation. These are broadly activities that tend to expand the tax base and the overall growth trajectory of the national economy. This policy position is sensitive to the level of economic development and the relative importance of growth and redistribution objectives. In the context of underdeveloped countries whose capital base, both physical and human components, is quite small, it becomes absolutely necessary to put in place policies that would encourage the accumulation of capital. The very nature of human capital accumulation is not easy to be subjected to the fiscal network. This provides a partial shield against the disincentive impacts of taxation. Instead, the fiscal system benefits at a later stage via higher income taxes from those economic agents with higher human capital and hence higher taxable income. This argument could also be extended to the accumulation of physical capital. The difference, however, is that it is possible to subject the accumulation efforts of physical capital to current tax obligations. Unless this is deliberately avoided, a systematic tendency would be introduced that would discourage accumulation and growth initiatives.

4. CONCLUDING REMARKS AND ALTERNATIVE PROPOSALS

It is in the nature of normative arguments that disagreement tends to sway in academic and policy dialogues. Its underlying logic is how economic agents should be persuaded in one way or another to what the society values as crucial to the overall economic status of the country. It turns out to be difficult when the government should be persuaded to refrain from taxing saving endeavours in the interest of long-

term capital accumulation and economic growth. This is partly because of the interaction among economic and political forces to influence the policy stance. Saving is essentially a voluntary decision even if there are rooms to execute forced measures when the intention is transparently and credibly announced in advance and credibly implemented.

The driving force behind the proposal is increasing government revenue collection and accommodating the insatiable appetite of the government to raise its revenue collection. This would further discourage financial saving.[1] This policy move would not be to the long term economic growth objectives of the country. Imposing interest income tax obligation in this country where our average saving rate, both private and public, is incredibly low would be counter productive. The saving rate is extremely low so much so that it could not even finance the depreciation of the capital stock in the country. This process cannot continue indefinitely by borrowing from the rest of the world. It is possible to buy time and flexibility through this mechanism. However, providing incentives for all domestic economic agents to increase their real saving and investment endeavours remains very crucial.

Accordingly, I would venture to propose quasi-fiscal and monetary measures that would provide positive and incentive preserving real interest rate and rewards for time deposits and long term treasury bills. Moreover, measures to improve the divisibility of investment outlets should be encouraged so as to improve investment activities in various sectors of the national economy. It is also time to seriously consider the introduction of income tax deductible saving initiatives by economic agents. Perhaps, it would be possible to allow economic agents to put aside a certain optimal share of their income in the form of saving in financial assets. This is a subject that requires further research to which we should direct our attention in the future. These alternative proposals in effect carry the message that given the depressingly low saving rate in the country, it would not be a prudent policy to introduce taxes on income from saving at a flat rate. The measure would be premature in the Ethiopian context and would cost the country both in lost employment and income opportunities.

[1] Ironically, this freedom of choice of financial savers has been violated by no one but the Commercial Bank of Ethiopia–the very institution that should have encouraged economic agents to increase their financial saving so that it would have resources to lend to potential borrowers for the purpose of investment. The very fact that CBE resorted to implicit or explicit pressure on financial savers to put their assets in non-interest bearing denominations is a clear gauge of the deeper problems in the financial system and the broader national economy.

[2] It should be noted that financial savers in Ethiopia are penalised for their decision to put their resources in the form of financial saving. Note that even interest bearing financial deposits yield about 6 per cent rate of interest. The average inflation rate in the country currently runs between 5 to 7 per cent. This would leave depositors in real terms with nearly nil rewards. However small 5 percent tax on interest income might sound, it is denting further down what savers receive from their deposit in the banks. Apparently, depositors are penalised for failure of financial institutions to properly and efficiently allocate financial resources in various sectors of the national economy. The latter in turn reflects the overall problems that prevail in the system that must be addressed to allow economic resources get employed in activities where they can be most productive.

[3] The imputation of income generated from fringe benefits and subsidised services to non-low income households and enterprises should be replaced by a comprehensive approach to income assessment so as to improve the prudence of the fiscal system and reduce the distortion that would be created by leaving a large segment of the taxation base not be subjected to its fair obligations. ■

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ከቡራን አንባቢያን፣ በቅጽ 3 ቁጥር 5 ልሣነ-ኢኮኖሚክስ "የወጪ-ንግድ፣ ጠቀሜታውና ልፋቱ" በሚል ርዕስ በቀረበ ዕሑፍ ላይ የተለያዩ ማድፈቶችና ጉድለቶች ስለሚታዩ ማስተካከያዎችና ማረሚያዎች ከዚህ በታች ቀርበዋል።

ውጭ-ንግድ ተብሎ የተጻፈ በሙሉ የወጪ-ንግድ ተብሎ ይነበብ። እንዲሁም በገፅ 27 የመጀመሪያው ረድፍ 23ኛ መሥመር "በኤኮኖሚ ከዳበሩ አገሮች..." ምትክ "...በኢኮኖሚ የዳበሩ አገሮች፣ በገፅ 29 መጀመሪያ ረድፍ ሰባተኛ መሥመር "ከአሳሳቢ ደረጃ ያለፈና..." ምትክ "... ከአሳሳቢ ደረጃ ያለፈውና..."፣ እንደዚሁም በዚሁ ረድፍ 13ኛው መሥመር "...ለመወዳደር አቋማቸው ..." ምትክ "... ለመወዳደር አትማቸው ስለማይፈቅድ..."፣ ከዚያም በገፅ 31 መጀመሪያ ረድፍ ሁለተኛው ረድፍ 8ኛ መሥመር "...ቅመማ ቅመሞችን በ ተሻለ ሁኔታ..." ምትክ "... ቅመማ ቅመሞችን በተቻለ ሁኔታ..." ተብለው ይነበቡ።

በገፅ 26 ሁለተኛ ረድፍ ሶስተኛ መሥመር "ለምርት ተግባር ከውጭ..." ከሚለው ቀጥሎ "አገር ለተገዙ ጥሬ ዕቃዎች የተከፈለ የጉምሩክ ቀረጥና ሌሎች ክፍያዎች ዕቃዎች ለውጭ ገበያ ሲላኩ ...." የሚለውና በዚህ ገፅ ሁለተኛ ረድፍ ከመጨረሻው መሥመር "ስለሚያሻ ት" ከሚለው ቀጥሎ "ለመግባት ከፍተኛ የውጭ ምንዛሪ ያስፈልጋል። በአንፃሩ ኢትዮጵያ ለውጭ ገበያ የምታቀርባቸው በአብዛኛው የግብርና ውጤቶች ሆነው በቅድሚያ የሚጠቀሱት ቡና፣ ቆዳና ሌጦ፣ የቅባት እህሎች፣ ጥራ ጥሬዎች ..." የሚለው እንዲሁም በገፅ 29 የመጀመሪያው ረድፍ 25ኛ መሥመር "በ1987" ከሚለው ቀጥሎ "የበጀት ዓመት በወጪና በገቢ ንግድ የግሉ ዘርፍ ድርሻ 47%የነበረው በ1990 ወደ 74% አድጓል" የሚለውና በገፅ 31 ሁለተኛው ረድፍ ምን ይሻላል ከሚለው በታች 4ኛው መሥመር "የአፍሪካ መሪዎች ጉባኤ " ከሚለው ቀጥሎ "...ሊቀመንበር እ.ኤ.አ. ባለፈው የካቲት ወር 2000 ባንግኮክ በተካሄደው የተባበሩት መንግሥታት የንግድና የልማት ጉባኤ..." ስለተዘለለ ተስተካክሎ ይነበብ። ለተፈጠረው ስህተት ትልቅ ይቅርታ እንጠይቃለን።

ERRATUM

We would like to inform our readers that in the article written by Desta Mebratu, *Economic Focus*, V. 3, No. 5, page 4, sub-heading of the last paragraph Megawatt approach should read as Negawatt approach. We apologise for the error.

PRIVATE EXPENDITURE TRENDS IN ETHIOPIA AND IMPLICATIONS FOR HEALTH SYSTEMS FINANCING

Jan Valdelin, Netsanet Walelign and Alan Fairbank*

Summary: The paper deals with health expenditures in Ethiopia, one of the poorest countries in the world. The health system is constrained by serious under funding. Informed decision-making requires improved data on out-of-pocket expenditures, while public expenditure is well documented by the Public Expenditure Reviews. The authors try to provide an estimate of the public-private shares of total expenditure based on demand side secondary data. These data are compared to a supply side estimate of private sector health facility costs in 2000, based on a recent study. The findings seem to be consistent with a relative share for private health expenditure of about two thirds of the total. Out of this private share about two thirds are used for drug purchases. The role of drugs in the current period and in the growth of the private sector is emphasised. By dividing the total health expenditure by public and private providers, it is shown that private providers supply about three fourths of the services and pharmaceuticals paid for by patients. The authors conclude that out-of-pocket spending is a greater share of total recurrent spending than previously thought, that the private spending is a relatively stable source of funding, justifying and attracting both public and private investment. The government has an opportunity to design a deliberately sequenced strategy for improving quality and increasing fees so that the twin benefits of higher revenue and increased utilisation are realised.

Key words: Ethiopia, out-of-pocket health expenditure, drug expenditure, private providers, public-private health sector mix.

INTRODUCTION

Ethiopia is one of the poorest countries of the world in terms of current GNP per capita, estimated at 83 USD in 1997/98 by the country's authorities[1]. The latest available UNDP Human Development Index report ranks Ethiopia in position 172, out of 174 countries.[2] During the 1990s population growth has averaged 2.9 % annually[3], while economic growth has been at the level of 4.4%[4], resulting in an average annual growth rate of real GDP per capita of 1.3%. In the preceding 10 years (1981-1991), the economic growth rate was 1.9%[5], leading to a net decline in per capita income of about 1.2%.

Following the decentralisation reforms in 1993, the provision of health services has been delegated to Ethiopia's nine regions and two city administrative councils (Addis Abeba and Dire Dawa). The regions and councils are dependent on federal subsidies/grants for their health sector budget. The health sector share of the total government capital and recurrent expenditures has risen to 8.1% and 6.7%, respectively, in 1998/99[6]. Since 1993, the Federal Democratic Republic of Ethiopia (FDRE) has a new health policy, as reflected in the first Health Sector Development Program (HSDP) 1997-2001. The new policy includes the promotion of the participation of the private sector in health care provision. Since the new policy was introduced, the private sector supply has quickly expanded (cf. below), starting from a small base at the time of the fall of the regime of the planned economy in 1991 and the introduction of a new economic policy in 1993.

PURPOSE OF PAPER

Donors and government alike have agreed that the health sector in Ethiopia is grossly under-financed in relation to intended levels of provision of health care. "The lack of sufficient funds is the single most important limiting feature of the health care system", according to the World Bank Social Sector Report[7]. The Health Care Financing Strategy is an effort to address this issue[8]. "Correct estimates of the true costs and financial requirements of the health sector will allow for more accurate and long-range planning for the sector"[9]. But detailed data on sector finance are still to be established for informed decision making. One example will suffice to demonstrate the need for improved data. The Ethiopian official population estimate of the year of the National Health Accounts (NHA), 1995/96, exercise was 54.6 million. The total health expenditure according to the NHA

estimate was 1.466 billion ETB, leading to a total expenditure per capita of 26.85 ETB, equivalent to 4.24 USD[10]. The Policy and Human Resource Development (PHRD) project provided an estimate of private expenditure per capita of 8 ETB in the same year of NHA, i.e. about 1.3 USD at the annual average official rate. This current assumption, as officially reported by the World Bank Social Sector Report, would lead to a total expenditure of 16.6 Birr per capita, when added to the public expenditure of 8.6 per capita[11]. This is at odds with the NHA estimate, where total expenditure is more than 1.6 times larger. The purpose of this paper is to produce an estimate of the private health expenditure trends from 1995 to 2000 based on demand side official surveys and a supply side estimate commissioned by the Essential Services for Health in Ethiopia (ESHE) project. The public health expenditure is established from official statistics. The result is used to analyse future options for health systems financing in Ethiopia.

AVAILABLE STUDIES AND DATA

The most recent effort to give a full picture of the health sector is the Social Sector report of the World Bank, based on a large number of PHRD studies in health (nine separate studies), population and education. These studies used existing secondary data and generated primary data through institutional, community and household surveys.[12]. The Central Statistical Authority (CSA)[13] regularly produces Household Income, Consumption and Expenditure Surveys (HICES), the most recent one being the one from 1995/96. The CSA has also produced the regular Welfare Monitoring Survey (WMS) of 1996, 1997 and 1998. The NHA for 1995/96 used secondary data, but has also produced primary data from surveys of regional public expenditure, parastatal expenditure and health insurance claims. Finally, the ESHE Project has sponsored a study of private health facility costs.[14]. All these studies together contain data on private health expenditure in Ethiopia from 1995 to 2000. They are used as the sources for this paper.

METHODOLOGY

Thanks to the generous support of the CSA, the authors have had access to the raw data of the HICES 1995/96 as well as the Welfare Monitoring Surveys of 1997 and 1998. For the year 2000, we have used the ESHE project study on private facility expenditures to estimate by proxy out-of-pocket health expenditures. From the 1995/96 HICES, we have established a projection of expenditures with the help of official statistical data on population, economic growth etc. Independently from that projection, we have used the available raw data to establish demand side survey founded private expenditure levels of 1997 and 1998. These years are then followed by an estimate from a different data source, i.e. the private facility expenditures from which an estimate of out-of-pocket expenditures for the year 2000 has been derived.

ESTIMATED TRENDS OF PUBLIC HEALTH EXPENDITURE, 1995-2000

The best available trends of public expenditure on health are the results of the Public Expenditure Reviews, conducted in collaboration between the FDRE and the World Bank, the latest from 1999[15]. The public expenditure estimates are presented in table 1.

Table 1: Public Expenditure in Health 1995/96- 1998/99 (million ETB)

Item/Year	1995/96 actual	1996/97 pre-actual	1997/98 pre-actual	1998/99 per projection	1999/00 budget rev. (80%, 92%)
Capital Expenditure	154	266	342	349	491
Recurrent Expenditure	328	332	400	469	374
Total Expenditure	482	598	742	818	866
Population (million)	55.8	57.2	58.6	60.1	62.6
Total Expenditure per Capita (ETB)	8.64	10.45	12.66	13.61	13.83
GDP Deflator	100	103.18	113.17	113.63	113.63
Constant Prices Total Expenditure	482.00	579.57	655.65	719.88	761.86
Constant Prices Exp./capita (ETB)	8.64	10.13	11.19	11.98	12.17
Change Over Previous Year %		17	10	7	2

The table contains a few items to be noted. First, as can be seen, only the 1995/96 figures are definite expenditures, while the remaining years are "pre-actual" estimates, PER expenditure projection and the final year is our budget projection using Ministry of Finance data.[16]

Second, for 1999/00, we have used the budget figure. This figure will not be the final expenditure, as budget utilisation has been below 100% over the last few years. Assuming that budget utilisation will be 80% of capital budget and 92% of the recurrent budget (actual utilisation in 1997/98), and using the same deflator as for 1998/99, the constant prices expenditure per capita in 1999/2000 would be about 12.2 ETB, less than 2% higher than the year before. Although the total absolute expenditure has been increasing, from 1995/96 to 99/00, the growth rate of public expenditure per capita has been rapidly declining. Partly, this is a reflection of the country's increased allocations to defence after the beginning of the external armed conflict in 1998 and the tight squeeze on the country's economy. From 1998, there have been delays or actual cancellations of donor commitments to funding of the health sector.

It deserves to be mentioned that the public expenditures from the mid-90s to the end of the century do not demonstrate the rapid increase of the health budget that took place from 1992 to 1996. The 1996 to 2000 period is a period starting from a much higher level of expenditure than the country had witnessed during the previous ten years. As the table demonstrates, we expect the absolute amount of total

expenditure to continue to increase during all the period, including in constant prices.

ESTIMATED TRENDS OF PRIVATE HEALTH EXPENDITURE 1995-2000

Until now, there has been no published data series on comparable demand side based estimates of private health expenditures. Although there are studies of smaller sample size conducted by the Addis Abeba University, these results have not been possible to use for national estimates. The 1995/96 HICES of CSA has been officially published, including figures on income and expenditure. The figure on private expenditure on health is the most recent official figure based on demand side surveys. The corresponding figures from the 1997 WMS and the 1998 WMS[17] have not been published. Income and expenditures were not included in the published reports. By using the raw data from the 1997 and 1998 HICES, we have established the following new estimates of private health expenditure (table 2). The figures should be comparable to the 1995/96 figures, as the data generating methods have been the same[18]. The total expenditure includes transport costs to the health care providing facility, constituting about 14% and 12% in 1997 and 1998, respectively. The 1995/96 published data also includes transport costs.

Table 2: Private Expenditure on Health 1995/96-1998 (million ETB)

Item/Year	1995/96 HICES	1997 WMS	1998 WMS
Total Expenditure (million)	765.92	885.55	1044.38
Rural Expenditure	585.85	578.24	751.39
Urban Expenditure	180.07	307.32	292.98
Population (million)	52.69	52.06	53.75
Rural Population (million)	45.07	44.69	46.38
Urban Population (million)	7.62	7.37	7.37
Total Expenditure per Capita (ETB)	14.54	17.01	19.43
Rural Expenditure/capita (ETB)	13.00	12.94	16.20
Urban Expenditure/capita (ETB)	23.63	41.70	39.75
GDP Deflator	100	103.18	113.17
Constant Prices Total Expenditure	765.92	858.26	922.84
Constant Prices Exp./Capita (ETB)	14.54	16.49	17.17
Change Over Previous Year %		13	4

Private expenditure according to the demand side surveys and the rural/urban division has not been steadily increasing in absolute monetary terms from 1995/96 to 1998. Rural expenditure in 1997 was lower than the year before and urban expenditures were lower in 1998 than in the preceding year. The total private expenditure, disregarding the rural/urban division, has, however, steadily increased by about 16% and 18%, respectively. Considering constant prices and population growth, the per capita expenditure growth rate has decreased considerably from 1997 to 1998.

PUBLIC AND PRIVATE EXPENDITURES: COMPARISON WITH THE NATIONAL HEALTH ACCOUNTS

The two estimates of public and private expenditure on health are combined in the following table to get the overall spending per capita from 1995/96 to 2000. Total private expenditure has been assumed to increase by 17% from 1998 to 1999 and from 1999 to 2000.[19]

Table 3. Total Expenditure on Health 1995/96-2000 (million ETB)

Item/Year	1995/96	1997	1998	1999	2000
Total Public Expenditure	482	598	742	818	866
Total Private Expenditure	766	886	1,044	1,221	1,429
Total Expenditure	1,248	1,484	1,786	2,039	2,295
Public Share Of Total %	39	40	42	40	38
Private Share Of Total %	61	60	58	60	62
Population (Million)	56	57	59	60	63
Total Expenditure Per Capita (ETB)	22	26	30	34	37
GDP Deflator	100	103	113	114	114
Constant Prices Total Expenditure	1,248	1,438	1,578	1,794	2,019
Constant Prices Exp /Capita (ETB)	22	25	27	30	32
Change Over Previous Year %		12	7	11	8

The Ethiopian National Health Accounts (NHA) team presented a first estimate in September 2000. The methodology of this study was different from the HICES. It used both primary and secondary data, the latter being first of all the 1995/96 HICES as well as government expenditure data (audited data for 1995/96). But in addition the NHA team questioned the Regional Health Bureaus (RHB) of the country, parastatals (all regional capitals and a sample of Addis Abeba) and the Ethiopian Insurance Corporation (sample of expenditure) as well as NGO's (official reports to central agency). The Team's assessment of the methods used and the data obtained is that "the total health care spending estimated for the country in this study is understated".[20] The main sources of understatement would, according to the Team, be the NGO expenditures and other bilateral and multilateral assistance expenditures. The reason for the latter is that "funds that were not channelled through either the federal or regional government have not been accounted for".[21] It should be noted that the public expenditure data for the past year suffer the same weakness, i.e. donor funds which are not directed to channel one, will not be recorded as public expenditure. This affects only the capital expenditure estimates as donor funds are accounted for as capital expenditure.

In spite of its assessment regarding underestimating the total health expenditure, the NHA team presented a total health expenditure estimate for 1995/96 of 1466 million Birr, i.e. about 218 million more than the figure in table 3 above. This is quite possible as the private expenditure figure previously cited, may exclude parastatals (about 62 million ETB in 1995/96 according to the NHA team.) as well as insurance payments. Using the same population estimate as in table 3, the annual per capita health expenditure of Ethiopia in 1995/96 would be 26.2 ETB, or 4.14 USD, leaving us with a big gap to the average estimate of

Sub-Saharan African countries of 14 USD.[22]

On the other hand, the NHA estimates of out-of-pocket expenditures do not distinguish between public and private providers of services. Some of the expenditures on pharmacies could be to public so-called Special Pharmacies, charging the clients for drugs with a mark-up of usually 20% on purchase price. Likewise, as the Team points out, a certain share of unclassified out-of-pocket expenditures could also be paid to public providers, i.e. creating some risks of double counting. Still the NHA has chosen to report the out-of-pocket expenditures as private expenditure as a whole. The share of private expenditure was reported as 58%, which can be compared to the 61% based on the survey data in table 3. Over the years, the private share of the survey data, including projections, in table 3 is between 58% and 62%. The out-of-pocket expenditures in 1995/96 were about 766 million ETB, out of which in turn 476 million were to pharmacies, i.e. about 62% of the out-of-pocket spending was on drugs.[23]

The role of drugs in the development of a health sector in transition from a planned economy to a market economy with a public/private mix in the provision of services is crucial. Not only do pharmaceuticals count for a large share – a third in 1995/96 – but also, the availability of drugs is a major parameter in the quality of services and in the perceived quality of services. The magic attraction of drugs in the transition plays a great role in people's decisions to allocate funds for health service, i.e. their health seeking behaviour.[24] The success of the Special Pharmacies bear witness to the future potential of quality improvements through improved drug availability.[25]

ESTIMATE OF THE SUPPLY SIDE

The 1993 new health policy and the 1994 new licensing regulations brought about an increase in the private service provider facilities. The study on private facility expenditures[26] by Tadesse Biru generated for the first time cost data on these newly established providers. By using these data, a complementary comparison with the demand side data may be done.

As a general note, it should be mentioned that previous efforts to estimate unit cost studies of health services in Ethiopia have demonstrated great difficulties in this respect. The two main outcomes of the most recent study[27], as we see it, is, on the one hand, that the concept of a standard unit has not been convincingly established, and on the other hand, that the greatly varying relative shares of fixed and variable costs makes it impossible to establish a unit cost that is useful for policy purposes. The recent private facility expenditure study conclusively demonstrates the same difficulty, for example by identifying total initial investments costs for special clinics that vary by a factor of 1 to 3 for different areas of the country.[28] For future studies in this area, there is a need for detailed scrutiny of the private investors accounting procedures in their estimates of fixed costs. It may be assumed that the lack of established industry accounting principles has influenced previous study results.

Nevertheless, we try to make an estimate of the total private health expenditure in the country for the year 2000, based on the private facility expenditures. This implies a shift of emphasis of analysis: from the overall distinction between public expenditure and private expenditure, to the more detailed distinction of for which providers (public or private in this case) the out-of-pocket expenditures are used.

The first step is to isolate the expenditures on drugs. Drug expenditures from private sources may be for public special pharmacies or for private pharmacies. Patients of public providers may have to buy their drugs from private pharmacies, if, for example, the pharmaceutical in question is not available in the public pharmacy. Patients of private providers may also have to go to public special pharmacies, when the private drug market is out of stock or too expensive. The distribution of drug purchases is not a main concern, however. Our concern here is to take out the drug costs from the out-of-pocket expenditures in order to analyse the role of the public and private health care providers in a period when the private sector is expanding. In the 1995/96 HICES, the "medical care & health expenses" are split into different items, one of them being "pharmaceutical products, herbicides".[29] Out of the total annual expenditure of 67.11 ETB, the drugs account for 40.36 ETB, i.e. 60%. This is close to the same share as the NHA result for the same year. We use this figure as the estimated drug cost for the following years as well, moving from 60% in 1996 and 1997, 61% in 1998 and 1999 and 62% in 2000.

The second step is to estimate the share of the private expenditure for other costs than drugs, i.e. for medical care provided by facilities. By the use of the raw data from the 1995/96 HICES, 1997 WMS and 1998 WMS, we establish the following shares of visits for government facilities: 1996 48.5%, 1997 56.4% and 1998 50.7 %. The remaining categories are all considered as private providers, including the traditional healers, except for the 'not stated' category.

The result is the following table, where the out-of-pocket expenditures are divided by drugs and public and private facilities. Like in table 3 above, the private expenditure for 1999 and 2000 are projections, just in order to get an idea of the order of magnitude to be expected for year 2000 in terms of demand for private provider services.

Table 4. Distribution of Health Institutions Visited (million ETB)

Item/Year	1995/96	1997	1998	1999	2000
Total Private Expenditure	766	886	1,044	1,221	1,429
Estimated Drug Costs	460	531	637	745	886
Medical Care Expenditure	306	354	407	476	543
To Public Providers	149	200	207	241	275
% Change Over Previous Year		34	3	17	14
To Private Providers	157	151	200	233	266
% Change Over Previous Year		-4	32	17	14

Given that the assumptions made (total expenditure growth 17%, share of drugs 61 and 62% and private share remaining the same as in 1998) in the table above hold, one would expect out-of-pocket expenditures of 266 million ETB to private service providers (excluding drugs) in the year 2000.

This simple projection can be compared to an estimate of the total cost for the private service providers in the year 2000 provided in the report by Tadesse Biru. The total number of private facilities in the country is around 1225, including pharmacies, but excluding rural drug vendors. The study has demonstrated that most of the existing private providers were established after 1994[30]. The increasing number of private facilities since then could imply an increasing share of out-of-pocket expenditures since the latest WMS in 1998.

To arrive at an estimate of how much patients paid to private facilities in the year 2000, we estimate the total costs of the private facilities in 2000. Based on the 2000 survey of private facilities, the mean recurrent expenditures for five categories (hospitals, special clinics, higher clinics, medium clinics and lower clinics) of facilities (for our purposes we are excluding the pharmacies; cf. drug costs above) were calculated. By using the means of recurrent expenditures and the total number of facilities in the country we arrive at an estimated total recurrent costs of private facilities annually at 95.2 million ETB[31].

The total capital investment of these same facilities is harder to estimate from a sample, due to the variations of standards between facilities, even of the same category (cf. unit cost above). The initial capital costs vary strongly within facility categories. In order to establish a rough estimate of the order of magnitude of the total private investment we have established the average investment cost by facility type (hospital, special clinic, etc.) by using the means of the regional sample means. By accepting this as a rough proxy of the investment cost by category and by applying the total number of private facilities in the country by category, we arrive at an estimate of the initial investment cost. The estimate of the total private investment cost, most of it incurred after 1994, is 265 million ETB.

The depreciation to be covered for break-even in the private facilities has been estimated by assuming that the hospitals use a depreciation period of ten years, special clinics three years and clinics, which is more than two-thirds of the total investment, two years. The total depreciation per year is then 99.7, say 100 million ETB.

The cost of capital for the investors may be measured by the average bank rate of interest, currently at 6% per year. Investors would at least like to see that return on their capital.[32] Assuming that an investor would like to see at least the double bank rate as return for a risky investment, we calculate the annual cost of capital at 12%[33], i.e. 31.8 million.

The result of this break-even analysis, with many assumptions that may not hold, is that the minimum revenues required for the private sector to break even in the year of 2000 is in the magnitude of 227 million ETB. The profit margin in the different facilities is anybody's guess at this stage.[34] Assuming a mark-up of 20%, the total additional costs to the patients would be in the order of 45.4 million ETB. Adding all cost items leads to a total expected invoice to clients at more than 272 million ETB.

Our projected expenditures on private health facilities (table 4 above) were 266 million ETB in the year 2000. The supply side estimate of costs arrives at a total in the same order of magnitude, i.e. 272 million ETB in the year of the survey.

IMPLICATIONS FOR HEALTH SYSTEMS FINANCING IN ETHIOPIA

The year 2000 estimates of the size of the public and private sub-sectors in terms of private expenditure shares have a number of implications. Although the estimated expenditures (table 4) are of the same magnitude, i.e. 275 million ETB for public providers and 266-272 million for private ones, the number of facilities in the two sub-sectors differs. The total number of private hospitals, special clinics, higher clinics, medium clinics and lower clinics were around 990 in 2000[35]. The public hospitals, health centres and health stations, numbered around 2,672 in 1998.[36] A simple calculation of the average private expenditure per facility illustrates that the average private facility would receive 268,000 ETB per year, while the average public one would receive about 103,000 ETB, i.e. less than 40% of the private average.

In our effort to separate the expenditures by provider category we excluded the drug expenditures. As indicated above the pharmaceuticals play a very special role in the transition of the system from a planned economy public system, to a mixed public/private system in a market economy. Our claim that we cannot tell where people buy their drugs is a bit exaggerated: in fact, the public pharmacies have until recently been distributing prescribed drugs without cost to the patient. Over the last five years, public facilities have started to have Special

Pharmacies parallel to the "budget pharmacy" (the facility based pharmacy financed by the health budget). The sales of the Special Pharmacies may have a great local importance[37] but their share of the total drug consumption of the country would still be marginal. The public budget pharmacies have low availability of drugs and are often out of stock of essential drugs. Even patients, who have a waiver for fees at the public facility, may therefore have to buy prescribed drugs at a cost from private pharmacies. It may be concluded that the lion's share of drug expenditures are incurred at private facilities. The growth of the private sector is highest among drug distributors. The number of rural drug vendors has more than doubled in three years' time, for example. Returning to table 4 data, but now including the drug costs and by assuming that more than 90% of drug sales are private we get the following distribution (table 5) of out-of-pocket expenditures between the public and private providers.

Table 5. Public-private Provider Shares with Drugs Included (million ETB)

Item/Year	1995/96	1997	1998	1999	2000
Total Private Expenditure	766	886	1,044	1,221	1,429
Medical Care Expenditure	306	354	407	476	543
To Public Providers	195	225	261	305	352
% Change Over Previous Year		16	16	17	15
To Private Providers	570	659	781	914	1,075
% Change Over Previous Year		-4	19	17	18

The total distribution of out-of-pocket expenditure between public and private provider sub-sectors of the health sector, drugs included, can therefore be expected to be a situation where the public providers make up 25% of the sector, while private providers take a share of 75%. We conclude that the division of the sector's expenditures by the public or private origin of the providers illustrates an even greater role for the private sector, than the mere division by source of finance.

CONCLUSIONS AND POLICY RECOMMENDATIONS

The overall division of the country's total expenditure on health into public and private expenditure demonstrates that the out-of-pocket expenditures make up almost two thirds of the total expenditure. This relative share of private expenditure has often been questioned by policy makers in Africa, as has been demonstrated by the NHA exercises[38]. In some cases, ambitious governments could at first not accept these surprisingly high relative shares of private expenditure. In Ethiopia, policy makers have been aware of the relative role of the private sector and have emphasised the importance of private participation in its future development. The division of the sector by origin of providers, points to an even more important role of the private sector, and particularly to the role of pharmaceuticals, both as a consumer of funds as well as a parameter of perceived and real quality of services.

Health care financing in Ethiopia suffers many of the same problems encountered in other extremely low-income countries with limited infrastructure and constrained public budgets: very low rates of recurrent spending per capita on the private side (not much more than one percent of total consumer expenditure, on the average) and low shares of public budgets spent on health (5-7% of the total recurrent budget devoted to health). With urban hospitals absorbing a substantial share of the public budget, and staffing of peripheral facilities taking up most of the rest, very little in the way of public funding is available for drugs, ancillary services such as lab tests, or routine maintenance of facilities and equipment. As much as two-thirds of all recurrent spending is spent, it seems, by individuals out-of-pocket—more than has been traditionally thought. Paradoxically, the government dominates on the investment side—spending about three-quarters of all capital investment in the health sector.

But there is a question about whether this high level of government investment has maintained its initial value and delivered the level of services intended. Despite the rather extensive investment in a government health services infrastructure during the 1990s, there has not been increased use of, nor increased (relative) spending on, government health facilities. In fact, it appears that chronic under funding of the costs of operating that infrastructure has led to considerable inefficiency as staffing and costs have risen, but utilisation has not kept pace.

Moreover, often the intended beneficiaries of the investments are left no better off after the construction of facilities if operating costs are not—as is often the case—fully funded. Patients then are forced to pay the high prices in the private sector for drugs that should have been provided at lower prices in the public facilities (but were unavailable due to insufficient budgets). This impact tends to have adverse distributional consequences: those with the least ability to pay often are the farthest from reasonable access to government facilities in urban areas which generally have better funding and more regular drug supplies.

While it might seem that encouraging more private investment in the health sector would primarily serve higher-income persons, perhaps at the expense of the poor, there are benefits, which accrue to society as a whole. The increased flow of spending to private suppliers encourages increased flow of private investment in facilities and in staff that is available to all—even though the price may be relatively high. To the extent private parties invest in the health sector, the government can be more discriminating about how it invests its funds in the sector.

The very existence of private providers, where before there were none, provides more choice for patients (more treatment options become available) and has the built-in advantage that the owners of private clinics and hospitals have a vested interest in preserving and improving the productivity and efficiency of their investment. In contrast, even when government-employed practitioners have an interest in enhanced productivity and efficiency, seldom do they have the tools and resources needed to implement any sustained level of quality of care.

Having established that there is more of a willingness to pay out-of-pocket for medical care than previously thought, policymakers should view this as an opportunity to attract a portion of such spending to their own facilities. To do so, they would need to simultaneously improve quality, by providing regular supplies of drugs and other supplies, and raise user fees. In so doing, they could increase the benefits to be realised from the substantial past investment in facilities and could raise some of the funds needed to operate them (and to sustain their level of quality).

In summary, the implications of our findings are:

1. Private spending (out-of-pocket) is a greater share of total recurrent spending in the health sector than previously thought— almost two-thirds of the total, with almost two-thirds of that spent on drugs;
2. While private spending on health is a low proportion of all consumer expenditures, it evident that it is, over time, a relatively stable source of funding which both attracts and justifies increased investment—public and private—in the sector;
3. Within this context, there is an opportunity for the government to design a deliberately sequenced strategy for improving quality, say, by increasing the number of Special Pharmacies, and increasing fees—so that the twin benefits of higher revenue and increased use of government facilities are realised simultaneously.

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APPENDICES

1. Acronyms

CSA	Central Statistical Authority
ESHE	Essential Services for Health in Ethiopia
ETB	Ethiopian Birr
FDRE	Federal Democratic Republic of Ethiopia
GDP	Gross Domestic Product
GNP	Gross National Product
HICES	Household Income, Consumption and Expenditure Survey
HSDP	Health Sector Development Program
NHA	National Health Accounts
RHB	Regional Health Bureau
PER	Public Expenditure Review
PHRD	Policy and Human Resource Development Project
UNDP	United Nations Development Program

USD	US Dollars
WMS	Welfare Monitoring Survey

2. Tables

Table 1: Public expenditure in health 1995/96- 1998/99 (million ETB)
Table 2: Private expenditure on health 1995/96-1998 (million ETB)
Table 3: Total expenditure on health 1995/96- 2000 (million ETB)
Table 4. Distribution of health institutions visited (million ETB)
Table 5. Public-private provider shares with drugs included (million ETB)

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* The authors as individual researchers present this paper. Ethiopian authorities do not necessarily share conclusions and views expressed in this article.

[1] The World Bank's estimate for real per capita GNP in dollar terms was 100. Ethiopian Economic Association, 2000, p. 1.

[2] UNDP, Human Development Report, 1999, table 8:171, as quoted in Ethiopian Economic Association, 2000.

[3] The Central Statistical Authority estimates as quoted in Ethiopian Economic Association, 2000, p. 56. World Bank and UN estimates are higher, up to 3.3%.

[4] Average growth rate of real GDP 1991/92-1997/98, Ethiopian Economic Association, 2000, p. 18.

[5] Ibid, p. 16.

[6] World Bank, 1999, Annex, tables 4 and 5. Figures quoted are projected expenditures.

[7] World Bank, 1998, p. 41.

[8] *Health Care and Financing Strategy*, Ministry of Health, 1998, adopted by the Council of Ministers the same year.

[9] World Bank, op. cit.

[10] Using the annual average official exchange rate of the time, 6.32 ETB to a US dollar. The ETB was devaluated in 1991 and was in September 2000 exchanged at 8.25 ETB for a dollar.

[11] World Bank, 1999, p. 93.

[12] PHRD, *Health Sector Review, Synthesis and Summary*, Addis Ababa, November 1996.

[13] The authors acknowledge the precious support from the Central Statistical Authority, Federal Democratic Republic of Ethiopia, who made available to us the raw data of the 1995/96 Household Income Consumption and Expenditure Survey, the 1997 Welfare Monitoring Survey and the 1998 Welfare Monitoring Survey.

[14] Report by Tadesse Biru, 2000.

[15] World Bank, 1999, op.cit.

[16] A major reason for the delay in estimating final expenditures is the recent decentralization and the delays in establishing the final regional level expenditures.

[17] The Welfare Monitoring Studies use the same raw data as the HICES.

[18] The data cleaning process may differ slightly, as we have not been able to fully check the procedures from 1995/96. In our data processing we have excluded cases of annual health expenditures above 10000 ETB and transport costs above 2000 ETB. Note that the population figures used in the HICES refer to settled population only, about 4% less than the total population in 1997/98.

[19] This is the average rate of increase from the two previous years. The population figures represent total population as used by the Public Expenditure Review team plus estimates of the CSA for the last two years.

[20] NHA Team, Proceedings, September, 2000.

[21] Op. cit.

[22] World Bank, 1994, as quoted in World Bank, 1998.

[23] The NHA Team chose to leave about 20% of the out-of-pocket expenditures unallocated as to providers, which leaves us with some uncertainty as to the share of drugs. The share of drugs could be even greater. Accepting the lower figure for drugs, they still would make up almost a third of the total expenditure on health.

[24] The ESHE project plans to carry out a study of drug use in Ethiopia during next year.

[25] Cr. ESHE project, *Ethiopia's Health Care Financing Experience*, Draft, October 2000.

[26] Tadesse Biru, 2000, op. cit.

[27] Development Studies Associates, 1998.

[28] Tadesse, op. cit. table 5.

[29] CSA, Statistical Bulletin 204, p. 96.

[30] More than two thirds of the sample.

[31] Calculated from Tadesse, op. cit., Table 11.

[32] We have no way of estimating the opportunity cost of capital for these investors.

[33] A common credit interest rate in the banking system is currently 11%.

[34] 82% of the facilities in the sample claimed they were breaking even or making profit during the year of the survey.

[35] Tadesse Biru, Table 11. This figure excludes of course the private traditional healers.

[36] Ministry of Health, 2000, p. 2.

[37] ESHE project, 2000.

[38] Cf. the Third Regional NHA workshop in Cape Town, 2000, sponsored by SIDA, USAID and the World Bank. ■

HIV-AIDS AND THE ETHIOPIAN BUSINESS COMMUNITY*

Berhanu Nega**

I. INTRODUCTION

The HIV/AIDS pandemic, which was considered to be the most serious health hazard facing humanity this past century, is by now widely acknowledged to be the most serious threat to the development efforts of developing countries. An epidemic that supposedly started in the developed countries has quickly become the "disease of the poor" aggravated by the limited financial capability and institutional weaknesses of poor countries.

By the end of 1998, 33.4 million people were estimated to live with HIV/AIDS throughout the world and 5.8 million adults and children have been newly infected by the virus during the year of which 43% are women. Of this global figure, only 6.7% or about 2.3 million are in the developed countries of Europe, North America, East Asia & Pacific and Australia and New Zealand. The rest of the infection is in the developing countries of Africa, Latin America and South-East Asia. Because of this high prevalence in developing countries, some of the benefits of development that accrued to these countries over the past half a century or so are quickly eroded because of this scourge.

The most affected, of course, are countries in Sub-Saharan Africa. There are an estimated 22.5 million people infected with the virus in Sub-Saharan Africa amounting to two thirds of the world's total and nine million African people have died of AIDS since the epidemic started in the early 80s, 2.2 million in 1999 alone. In sixteen African countries more than one in ten adults under 50 are infected. There are already 12 million African children that have lost their mother or both parents. What is even more alarming is the rapid pace of its spread. In 1999 alone there were four million new infections in Africa.[1] HIV/AIDS will have reduced life expectancy in Africa by 2005 from 60 to 45 years wiping out the progress achieved in the past three to four decades.

Ethiopia is one of the highly affected countries in Africa. At 10.63% adult HIV/AIDS prevalence rate, there are some three million people infected by the virus at the end of 1999 claiming the lives of 280,000 people in 1999 alone[2]. That is an average of 767 people per day! In the number of infected people and death rate, Ethiopia is second in Africa following South Africa.

The crisis has affected all sectors of society. According to the International Labour Organisation, "AIDS threatens every man, woman and child in Africa today. The pandemic is the most serious social, labour and humanitarian challenge of our time."[3] It has killed teachers, business managers, workers, farmers, political leaders, and all kinds of professionals. Still, the amount of effort put to fight this scourge is far from what is necessary to mitigate its disastrous effects. While AIDS activists and some Non Governmental Organisations have tried to increase awareness about the disease and even taken positive measures at curbing its spread and caring for the afflicted, the epidemic is not getting the full attention of stakeholders in society that it certainly deserves. Only recently and largely prodded by international pressure, African governments have started to make a concerted effort in fighting its spread. The business community, save for some exceptions, has largely ignored the problem as if it has no effect in its core activities. African businesses, as a recent survey of the business community in the continent suggests, seem to be in denial.[4] On the other hand, it is becoming increasingly obvious that fighting and eventually winning the epidemic requires the combined efforts of governments, the business community, civil society institutions, NGOs and the community at large.

The economic, social, and psychological effect of this epidemic is currently being felt in all sectors of the society, and, without an immediate and concerted action by every one, it could have a truly disastrous effect on our society in the future. Despite such a high prevalence rate, however, the response of the various sectors of the society is far from what is necessary to avoid the looming disaster. This is particularly true to the Ethiopian business community who, if initiated, has the wherewithal to contribute significantly towards the struggle against this plague.

This short paper is designed to present the case for business involvement in the fight against HIV/AIDS in Ethiopia. It tries to argue that businesses in Ethiopia have the moral, social and economic responsibility to get involved in the fight against

HIV/AIDS in the country. It in particular tries to argue that the long-term self-interest of business requires its involvement. It also tries to identify specific activities that businesses could undertake to effectively contribute towards this struggle.

II. THE SOCIAL AND ECONOMIC EFFECTS OF HIV/AIDS IN ETHIOPIA

The social and economic impact of HIV/AIDS cannot be understated. If unchecked, it is an epidemic that can destroy a whole generation. It destroys the human capital of a society that is desperately required for development. It weakens our social and economic institutions. It could obliterate the family as an important institution as more and more children become orphans. It has serious negative effect on economic performance both by affecting the overall output of a country and by making the cost of business prohibitively high.

Social and Demographic effects:

If we look at the global picture, there were some 33.4 million people estimated to be infected by the virus at the end of 1998. Of this total number, 22.5 million (67.4%) are in Sub-Saharan Africa, 6.7 million (20.1%) are in South and South East Asia, and 1.4 million (4.2%) in Latin America. The rest of the world combined accounts for only 2.8 million infected or about 8.4% of the total.[5] If we look at the trend in new infections, SSA's picture looks very grim in deed. Of the 5.8 million people newly infected through out the world in 1998, 4 million (69%) are in Africa. (See table 1 below)

As intimated earlier, Africa is the most affected continent in the world. Within Africa, South Africa with 4.2 million affected leads the pack followed by Ethiopia with 3 million (of which 2.9 million are adults) and Nigeria is third with 2.7 million people infected. (See table below). The number of children orphaned at age 14 or less is highest for Uganda where the virus struck earlier with 1.7 million orphans followed by Nigeria with 1.4 million and Ethiopia is third with 1.2 million orphans.

However, partly owing to the low level of income and the weakness of our health infrastructure, the number of people dying from the disease is the highest in Ethiopia compared with other African countries. In South Africa, where there are the highest number of people infected, the death to infection ratio is about 6% (with an estimated 250,000 people dead in 1999). In comparison, the ratio for Ethiopia is 9.33%, (which is more than one and half times that of South Africa.[6] The cumulative number of AIDS deaths in Ethiopia since the epidemic struck in the early 80s is conservatively estimated at 1.2 million and expected to increase to 1.7 million by the year 2002.[7] This is about 6.4% of the total AIDS deaths in the world for a population a little less than 1% of the world population. If present trends continue (i.e. using the low prevalence estimate of the government) Between 2002 and 2014, an additional 3.35 million Ethiopians are expected to die from the disease raising the cumulative number of people that will die of AIDS to 5.25 million people by 2014.

One obvious implication of this is a significant decline in the life expectancy of the average Ethiopian. The life expectancy at birth is currently estimated by the Central Statistical Authority to be about 50 years without taking into account the effect of HIV/AIDS. "However, due to the large number of infant, children and young adult deaths due to AIDS, it may only be about 42 years." By the year 2014, the life expectancy that would have been 56.4 years without AIDS is expected to reduce to only 46.5 years owing to the HIV/AIDS pandemic. AIDS is also claiming the lives of children at an alarming rate. The infant mortality rate, expected to decline from the current 97 per 1000 live birth to 79 by the year 2014 without AIDS will increase to 85 because of it while child mortality rate will be 147 because of the disease from the expected 127 without the disease. According to the Ethiopian Ministry of Health, "AIDS could soon become the major cause of death for children under the age of five, worse than other major causes such as diarrhoea and respiratory diseases."[8] The total population of the country that could have been 92 million by 2014 will only be 85 million because of the disease.[9]

The epidemic is having a strong and negative impact on the health sector of the country particularly given the government's weak financial capacity. According to a study by Kello, the cost of hospital care for an AIDS patient ranges from birr 425 to 3140 for an average of birr 1800. The total cost of caring for AIDS patients, according to government estimates is about 87 million birr in 2000 expected to rise to 185 million by the year 2014.[10] According to UNAIDS, if Ethiopia is to adequately care for all the AIDS patients the required health expenditure will rise by 74 to 121 million USD. This is an additional 3 to 5 dollars in per capita income that the country does not have and need to get from foreign sources. Currently, as much as 42% of all the country's hospital beds are occupied by AIDS patients and this is expected to rise to 54% by the year 2004 leaving only 46 % of the beds for all other afflictions in the country. Given the widespread occurrence of other epidemics such as malaria in the country and the miserable condition of the country's health sector, it is not difficult to imagine the potential increase in mortality caused by other diseases because of the suffocation of the health care system by the HIV/AIDS epidemic.

The epidemic also affects the education sector. It does so by, among other things, the increase in the number of teachers that dies of the disease and/or by the rate of absenteeism of infected teachers. A rough estimate of the size of this is given by the percentage of pri

Table 1. Comparative HIV/AIDS Prevalence and Socio-economic Effect in Selected Countries

DESCRIPTION		BOTSWANA	KENYA	NIGERIA	SOUTH AFRICA	UGANDA	ETHIOPIA	WORLD*	SSA*
People Living with the Virus	TOTAL	290,000	2,100,000	2,700,000	4,200,000	820,000	3,000,000	33,400,000	22,500,000
	ADULTS(15-49)	280,000	2,000,000	2,600,000	4,100,000	770,000	2,900,000	32,200,000	21,500,000
	CHILDREN <15 YEARS	10,000	78,000	120,000	95,000	53,000	150,000	1,200,000	1,000,000
	WOMEN	150,000	1,100,000	1,400,000	2,300,000	420,000	1,600,000	13,880,000	10,750,000
Adult Prevalence Rate (%)		35.80	13.95	5.06	19.94	8.30	10.63	1.10	8.00
Orphaned at Age<14 (Cumulative)		66,000	730,000	1,400,000	420,000	1,700,000	1,200,000		
Estimated Deaths in 1999 (Cumulative)		24,000	180,000	250,000	250,000	110,000	280,000	13,900,000	11,500,000
Bed Occupancy (%)		50-60	30	1to2	26-70 (2010)	50	28(2005)		
Loss of GDP Per Capita Growth(%)		1.1	1.3	0.95	1.0	0.8	0.6		
Required Health Expenditure Rise USD in Million		11to16	78-125	229to329	112to180	74to121	112-156		
Resource Gap for Response Per Capita		9.8	2.6-4	2 to3	2to4	3to5	2to2.5		
Resource Gap for Response in Millions of USD		15.62	124.33		177.83	121.1	165.63		
Loss of HH Income(%)		8 to 13	49-78						
Business Impact AIDS Related Costs		4.9 % wage bill	20% of profits		7-9% of wage bill		50% of illnesses		
%Primary Students who Lost a Teacher to HIV		3.91	1.68	0.57	1.24	1.6	1.17		
Orphans Cumulative		66,000				1.7 million	1.2 million		
Loss of Work Force(%)		17to30				15to16	8to10		

* 1998 Data, Source: UNAIDS: 2000

mary students that have lost a teacher because of AIDS. As can be seen from table 1, the highest rate (3.9%) is in Botswana mainly because of the high adult prevalence rate (35.8%) followed by Kenya and Uganda at about (1.6%) where the epidemic started earlier than Ethiopia. The rate for Ethiopia is a significant 1.17-%. That is 51,000 primary school pupils out of 4.3 million that have lost teachers for AIDS in 1999.[11] For a country that has a serious shortage of trained and experienced teachers, it will neither be easy nor cheap to replace these teachers.

The Economic Impact of HIV/AIDS

As suggested earlier, HIV/AIDS is no more just a health and humanitarian crisis. It has become a monumental development problem through its negative effects on a country's economy. There are various ways through which it affects the economic performance of a country. At the macroeconomic level, it reduces total output and is potentially inflationary. It negatively affects government budget by increasing its expenditure for healthcare and reducing revenues owing to the reduction in output. The foreign exchange position of the country is also affected because of the high foreign exchange demand to purchase medicine and related products. The increased AIDS related expenditure also reduces national savings and thus investment. At the firm level, the epidemic could affect business by increasing the cost of doing business through increased labour costs, loss of trained human manpower, reduced productivity and absenteeism. It also affect business on the demand side by reducing the demand for goods and services that they produce owing to the overall decline in output and expenditure shifting as household expenditure for health care and funerals increase at the expense of other spending.

UNAIDS projections show that the per capita income growth of Ethiopia will be reduced by 0.6% by the year 2010, which is the lowest by comparison with the selected African countries reported in table 1 and much lower than the average SSA country in general. Still, this is a significant loss for Ethiopia.[12] According to our simple projection, (see tables 2-1 & 2-2 in the appendix) this amounts to a loss of 60 birr in per capita income by the year 2010 amounting to over 4.8 billion birr in total income. It is expected that Ethiopia will lose 8.3% of its potential workforce in 2005 and 10.5% in 2020. The loss of workforce could reach 2.45 million if we take the government's conservative projections or could rise as high as 2.7 million if we use UNAIDS' prevalence rate as a base. With a mean expenditure for treatment of birr 1930 and funeral expenses of birr 327, (several times more than the average income of most households) it is not difficult to imagine the reduced national savings owing to AIDS. This would certainly lead to a reduced investment thus reducing economic growth. In terms of foreign exchange allocation, if the country spends the required amount of money to import

drugs to treat all AIDS patients; it could spend from 7 to 37 weeks worth of all its foreign exchange quota in 1994.[13] This is a foreign exchange that the country could ill afford.

Although there is no detailed data for Ethiopia, the disease affects areas critical to our economy and its potential for development. According to recent surveys of some African countries, thirty per cent of Malawi and Zambian teachers are infected for example and in many African countries the disease hit professionals hard. A 1997 study in Rwanda showed that "the likelihood of HIV infection for a pregnant woman to be 38 per cent if her husband worked for government, 32 per cent if he was a white-collar worker, 22 per cent if he was in the army and 9 per cent if he was a farmer."[14] As in other African countries, AIDS affects the various sectors of the Ethiopian economy differently. According to a 1994 survey, the mean number of hours spent per week in agriculture per household was found to be 33.6 hours in non-AIDS afflicted households, as compared with between 11.6 and 16.4 hours in those that were afflicted.[15] The urban economy is the most affected currently owing to the high prevalence rate in urban areas (13.4% for urban areas in general and 16.8% for Addis Ababa) compared with rural areas (with 5% adult prevalence rate). Within the urban economy, following the transportation sector (because of mobility) and the insurance sector, the industrial and services sector will be highly affected.

The effect on Business

Tibebe Markos was a young, healthy looking and energetic BA degree holder in finance and accounting in his early 30s when he started work on December 27, 1999 as the chief of finance for an upstart holding company implementing a number of industrial projects in Addis Ababa. He got this nationally advertised position winning a highly competitive and costly recruitment process that includes many highly experienced people in the field. His primary task in his new position was to institute a sophisticated computerized finance and accounting system for the parent company and its subsidiaries. About a month after he started his new job, he fell ill from a "chronic case of ulcer" and failed to report to work for about a week. For the next three months, he was able to work only for 28 working days because of his recurring illness. The company found out in April that his illness was AIDS and that he was going to die from it, which he did in May of that year. It took two rounds of national advertising and over seven months of intensive recruitment to replace Tibebe. The new finance manager calculated the opportunity cost to the company of Tibebe's illness as:

Cost of advertisement	2688
Salary paid during illness	4600
Work undone until replacement (productivity loss)	20,086.74
Recruitment cost (including board members' time)	2000
Total cost to the firm	29374.74

This is one real life example of the cost incurred by a firm because of HIV/AIDS. The cost will be even higher if we include the time lost for funeral and health insurance costs (in this case it was not applicable). It is not difficult to imagine what the cost will be to a firm with many workers falling to this epidemic.

Clearly, in today's very tight competitive environment, businesses need to do whatever they can to reduce cost to stay competitive. They certainly have to avoid any thing that could potentially raise their cost and reduce their productivity. As the above example shows and from the experience of many African countries, it has been evident that the epidemic can seriously raise the cost of businesses directly and indirectly. One such direct effect is the loss of skilled and experienced workers including senior staff, which both reduces productivity and increase the cost of training new recruits. Productivity of enterprises is also affected by absenteeism owing to illness or attending funerals of relatives or fellow workers. In a 1994 survey of 15 firms in Ethiopia, AIDS accounts for 53% of all incidences of illness over a five-year period.[16] According to the Ethiopian Ministry of Health, "the number of workdays lost to illness for a person with HIV/AIDS can range from as little as 30 to as many as 240 days in a year."[17] UNAIDS estimates that HIV will result in a fall of productivity to reach as high as 50% in the next five to ten years. Another direct cost to business is the cost of health care. In Zimbabwe, for instance, insurance premiums generally doubled between 1996 and 1998 while a flower company in Kenya reported that its health care costs rose ten times between 1985 and 1995. The costs of HIV to 5 firms in Botswana is estimated to rise 7 times between 1996 and 2004 to equal 5% of the total wage bill. An average Zimbabwean worker spends ten per cent of his working time for funeral.[18] All this adds significantly to the cost of the business firm negatively affecting its competitiveness.

Business bottom line is affected not only on the cost side. Its profits also suffer for lack of demand for their products. Demand is affected both by reduced income of households and because of expenditure switching. The reduced income of households can be captured at the macro level by the decline in GDP owing to the epidemic. As stated earlier, the total income loss assuming a 0.6% per-capita GDP growth reduction, could be close to 5 billion birr per year in 2010. In terms of expenditure shifting, the loss of demand for Ethiopian businesses (other than those related to healthcare and funerals) is estimated at about 4.1 billion birr for medical care and 688.5 million birr for funerals over the next ten years. This comes to an annual average cost of health care and funerals of over 475 million birr.[19] According to one study, the expenditure on normal goods and services of households

in which someone is suffering from AIDS is often halved.[20] As a Thai businessman succinctly put it "dead customers don't buy."[21]

All these combined could reduce the profitability of business significantly. Although there is no such calculation for Ethiopia, if we take the experience of other African countries, the loss in profitability could range from as little as 0.5% in the less affected industries such as textiles to as high as 15% in the highest affected transportation sector. (See graph in appendix).

Business Response to HIV/AIDS

Albeit scanty, the above evidence clearly indicate that businesses in Ethiopia, like all businesses in most affected countries in Africa, have a clear *business* interest to be engaged in the fight against HIV/AIDS. Although many businesses do not see the direct effect of the disease now, if current trends continue or get worse for lack of a concerted action, their bottom line is sure to seriously suffer in due time. As the competition gets stiff and the global economy gets more and more knowledge intensive, no country or business can afford to lose its professionals, teachers, managers or other skilled personnel at such a high rate and hope to survive let alone emerge victorious. Therefore, for the Ethiopian business community self-interest alone demands, even requires its constructive engagement.

However, the self-interest of business in general is not measured only by the short-term cost benefit calculus of the individual firm. The overall socio-economic environment on which business activity is conducted has a crucial bearing on its profitability or even survival. One such environment that is seriously threatened by the HIV/AIDS pandemic is social stability. The tremendous burden put to bear on the country's health care system, the massive number of AIDS orphans that are sure to be added to the army of street children in our cities, the decline in our education partly owing to the loss of many experienced teachers, the erosion of our value system as a result of the obliteration of families, the weakening of our defence forces because of the high prevalence of the disease in the military, added to the overall economic decline expected to come as the disease takes its toll all add up to erode the social fabric that has woven us together as a community. This atmosphere could seriously threaten our social and political stability that is so necessary for business to flourish.

But, that is not the only reason why businesses have to be involved. There is compelling moral and citizenship reasons that justify business involvement. After all, business owners and managers are human beings endowed with feelings and concerns for their fellow humans. Any natural disaster that strikes human beings anywhere must surely engender their sympathy and provoke action. That is why, although the size and modality of the responses differ, all of us (irrespective of our religious or nationality differences) feel the pain of a natural calamity that befalls humans anywhere. It is the inherent moral obligation of our existence that triggers such sympathy. It is also to this universal moral obligation that we appeal when we ask the support of other well-endowed countries during natural disasters in our own country or the indignation we feel when such support is denied for political or other reasons.

This moral obligation is even more compounded when the calamity occurs in ones own country. Here the universal moral requirement becomes even more forceful because of the sense of community one shares as a citizen of a country. Being a citizen of a country bestows on the individual certain privileges and responsibilities that non-citizens do not have. The right to freely trade in ones country comes with the responsibility to pay taxes and to play by the established rules of the game. The right to choose our leaders or aspire to any public office within our country comes with the obligation to use our votes properly as voters or commit our selves to genuine public service if elected. The strong case for a free market system is made on the basis of the wider benefits it accrues to the larger community. It is therefore legitimate to expect businesses to give back to the community in times of hardship some of the excess resources they are privileged to accumulate in good times.

If the above argument is somewhat valid, the question to address then is why the business community fails to get actively involved in the fight against AIDS. There are two plausible, albeit not justifiable, reasons for that. The first reason is directly related to the epidemic itself. Most business leaders do not seem to have realised the magnitude of the problem and its potential consequences. This is true not only to Ethiopian business but also businesses in other parts of Africa. According to a survey compiled for the Africa Competitiveness Report 2000, in a "comparison between perception of business and the best scientific estimates of infection rates and AIDS deaths, business leaders tend to perceive HIV infection levels to be lower than those recorded by UNAIDS...The average ACR figure (calculated as a population weighted average for the 29 countries where UNAIDS data are available) is 4.26 per cent against a UNAIDS average of 6.16 per cent."[22] This is a sizeable difference especially when considering the fact that the survey was done in 1999 while UNAIDS estimate was for 1997. This gap between scientific estimates and business perception is even wider for Ethiopia. As can be seen from table 4 in the appendix, UNAIDS adult prevalence rate estimates of 9.31% and 10.63% for 1997 and 2000, is more than three times the 3.02% business leaders estimate to prevail in the work force. One reason for this divergence could be a difference in the prevalence rate of adults in the general population

and that of the work force. However, according to the ACR analysis, "there is also evidence to support the view that these ACR figures reflect a degree of denial" among the business community. This is partly an indication that "the full fury of the epidemic has yet to be felt and that business leaders are unaware of this."[23] If the latter has some truth, one of the important tasks of those already involved in the fight against HIV/AIDS is to double their efforts to raise the awareness of the business community on the current status and future implications of the epidemic.

In the Ethiopian case, there is also a more general problem that afflicts the business community when it comes to active participation in the affairs of the larger community namely apathy. Save for issues that narrowly concerns their own businesses directly or in exceptional cases where the country's sovereignty is threatened by outside forces, the Ethiopian business community is very shy in making its presence felt in the broader concerns of the society. This is true both in areas it considers political (peace and stability, democratisation...etc.) and activities that it presumes are relegated to the state (cleaning streets or neighbourhoods for example). This is a trend that damages the credibility and respectability of business in the society. On the other hand, this is a trend that hurts society by robbing it of the skill and resources that the business community posses and that the community can use for the overall advancement of society.

Areas for effective business participation

If the case for the involvement of the business community is plausible, the next step is to identify the modality of its participation. Clearly, the responsibility to contribute towards the struggle against this epidemic should be equally shared by all members of the society. Effective struggle requires identifying the comparative advantage of each sector of the community for optimal use of the available resources. In general, it is fair to say that businesses are well placed to join the fight against AIDS either by themselves or in co-operation with the public sector and/or with non-governmental agencies active in the fight against AIDS. Obviously, each business has to choose the activities that suit its own environment in consultation with organisations that have wide experience in the field.

One such possible activity that businesses can consider is workplace preventive activities which have proven effective in many African countries both in terms of their ability to reach targeted groups and even more directly in reducing cost by cutting in the rate of absenteeism. In Ethiopia, a good example of a workplace activity that effectively reduce business cost and also provide a larger social good is Kombolcha Textile's family planning program. This program operated by the company's clinic in collaboration with the local branch of the Family Guidance Association of Ethiopia provides modern family planning methods for the company's female employees and other local residents. The result was impressive. In the four years since the program was introduced, there was a significant decrease in unwanted pregnancies. Abortion rate decreased from 2-3 per week to about one in three months. The number of workman days lost due to maternity leaves and leave before delivery decreased from 15,330 days in 1997 to 7,470 days by the year 2000.[24] If we assume temporary workers at a daily wage of birr 15 would replace these lost days, it would amount to a saving of close to birr 120,000 for the firm.

Similar co-operative activities could be taken by businesses for the prevention and care of HIV/AIDS. As suggested earlier, businesses can choose the kinds of activities they wish to involve in. For the purpose of this paper, and on the basis of the successes registered in other countries,[25] at least four areas can be identified for business participation in the prevention of the spread of the epidemic and in contributing to the care of the already afflicted. These are:

1. Since heterosexual intercourse is known to be the main transmission mechanism of the HIV virus in Ethiopia and condoms are known to be at the heart of an effective prevention strategy, businesses can use their experience in promoting their products by introducing innovative marketing tools for the promotion and marketing of condoms and other mechanisms of safe sex.

2. Business marketing skills can also be used in identifying tools for targeting highly affected groups in the community such as the youth.

3. Businesses can take a number of work place actions to safeguard their own employees from the disease and contribute to the care of affected workers. This could be done through work place preventive educational programs and instituting strong measures against stigmatisation of affected workers.

4. Businesses can also use their tremendous financial resources and extensive contacts in government to lobby for an effective AIDS policy in the country and participate in mobilising the larger community for preventive action, contributing towards the care of orphans and the loving care of those afflicted by the disease.

CONCLUSION

Without a doubt, HIV/AIDS is one of the most serious humanitarian and developmental challenges facing the country today. By the total number of infected persons, Ethiopia is only second to South Africa in the African continent, which is by far the worst affected region in the world. There is no person in the country that is not affected by the scourge in one form or another. The disease has

killed many times more compatriots than all the wars this country has fought against foreign aggression in this century combined. The struggle against this epidemic requires the combined efforts of the government, non-governmental organisations, professional associations, the donor community, and all citizens of this country. Businesses in particular have both the self-interest and moral duty to contribute to the struggle against this epidemic. They also have the skills and the means to make an effective and durable contribution. HIV/AIDS is not a mysterious punishment that is handed down by some super natural force. Its causes are known and, although the cure is not yet available, there is sufficient and widespread knowledge about the actions that need to be taken to prevent its transmission. Neither is it a problem that goes away if ignored. It needs concerted action to mitigate its disastrous effects. It is high time that the Ethiopian business community wakes up from its slumber and proves that it is a good citizen of this community by making its human and material resources available to fight this scourge of the century.

APPENDIX: BASIC FIGURES ON HIV/AIDS

Table 1: Regional HIV/AIDS Statistics and Features, December 1998

Region	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate[1]	Percent of HIV-positive adults who are women	Main mode(s) of transmission[2] for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s -early '80s	22.5 million	4.0 million	8.0%	50%	Hetero
North Africa & Middle East	late '80s	210 000	19 000	0.13%	20%	IDU, Hetero
South & South-East Asia	late '80s	6.7 million	1.2 million	0.69%	25%	Hetero
East Asia & Pacific	late '80s	560 000	200 000	0.068%	15%	IDU, Hetero, MSM
Latin America	late '70s -early '80s	1.4 million	160 000	0.57%	20%	MSM, IDU, Hetero
Caribbean	late '70s -early '80s	330 000	45 000	1.96%	35%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	270 000	80 000	0.14%	20%	IDU, MSM
Western Europe	late '70s -early '80s	500 000	30 000	0.25%	20%	MSM, IDU
North America	late '70s -early '80s	890 000	44 000	0.56%	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s -early '80s	12 000	600	0.1%	5%	MSM, IDU
TOTAL		33.4 million	5.8 million	1.1%	43%	

Source: UNAIDS, AIDS Epidemic Update – December 1998, p.5.

Table 2-1: Projections Based on Ethiopian Government Prevalence Rate and that of UNAIDS

	%	Year 2000	Year 2010
Total population	100.00	61.095	79.90
Adults (15-49)	44.52	27.201	35.57
AIDS Prevalence (based on Gov. Estimate of 7.7% prev.)	9.56	2.600	3.40
AIDS Prevalence (based on UNAIDS estimate of 10.63% prev.)	10.66	2.900	3.79
		2000	2010*
GDP (in million)		51776.1	84337.8
GDP per capita		847.469	1055.54
GDP per capita with AIDS**		847.469	995.196
GDP with AIDS		51776.1	79516.2
Loss GDP with AIDS			4821.65
Work force AIDS prevalence		2000	2010
Total work force million (15-49)	23.60	24.28	31.76
Gov. projection		2.32	3.04
UNAIDS		2.59	3.39
Active work force millions (15-49)	19.02	19.57	25.60
Loss of WF Gov. projection		1.87	2.45
Loss of WF UNAIDS		2.09	2.73

*Assuming a 5% annual GDP growth.
** Based on the UNAIDS projection of decline in per capita GDP of 0.6% in year 2010 and a population growth of 2.9% per annum.

1 The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1998, using 1997 population numbers.
2 MSM (sexual transmission among men who have sex with men), IDU (transmission through injecting drug use), Hetero (heterosexual transmission).

Table 2-2. Annual Projections Based on Government Current Prevalence Estimate and that of UNAIDS

	2000	2001	2002	2003	2004	2005	2007	2008	2009	2010
Adults (15-49)(CSA:1999)	27.20	27.94	28.70	29.48	30.28	31.11	32.82	33.71	34.63	35.57
People infected(Gov. Est.)	2.60	2.67	2.74	2.82	2.89	2.97	3.14	3.22	3.31	3.40
People infected(UNAIDS)	2.90	2.98	3.06	3.14	3.23	3.32	3.50	3.59	3.69	3.79
New AIDS cases	0.22	0.23	0.23	0.24	0.24	0.25	0.27	0.27	0.28	0.29

Source: Author's calculation. All projections are calculated using the following linear growth formula: $V_{2010} = V_{2000}*(1+r)^t$; where t=time, r = the growth rate.

Table 3. Results of a Survey of 65 Business Leaders on HIV/AIDS and Its Effects on Business

ITEM	Acc. ACR 1999
Average estimate of % of work force that is infected	3.02%
Average Estimate of % of work force that has died of AIDS	5 years ago = 0.34%, in 1999 = 0.69%, by the year 2002 = 1.38%
Average estimate of % of infected employees that are managers	2%
Workers	43.33%
University graduates	2%
Lacking a formal education	36%
Percentage of firms that rank the AIDS epidemic as having a moderate or major impact on healthcare costs	19.05
On time lost to AIDS related sickness	19.05
Time lost due to attending funerals	14.29
Reduction in skill level of work force	23.81
Increase in training cost	14.28
As a response to death and disability from HIV infection, % of firms that hire more than one employee in management	0.00
Labourer or clerical position	2.33
As a response to HIV/AIDS, % of firms that provide routine HIV screening to their employees	0.0
Free condoms	15.79
HIV counselling or education	16.67

Source: Africa Competitiveness Report 2000/2001.

* Preliminary draft.

** Director, Ethiopian Economic Policy Research Institute. The author highly appreciates the research help from Daniel Assefa and Getachew Asgedom of the Institute.

[1] Joint United Nations Program on HIV/AIDS (UNAIDS), September 2000.

[2] AIDS in Africa: Country by Country. Africa Development Forum 2000.

[3] Platform of action on HIV/AIDS in the context of the world of work in Africa, ILO, 2000.

[4] The African Competitiveness Report 2000/2001. World Economic Forum, Geneva, Switzerland 2000.

[5] UNAIDS, AIDS Epidemic update, December 1998, p.5.

[6] It should be noted that the official Ethiopian government estimates are a bit lower than the estimates by UNAIDS. According to the most recent government estimates, the number of people infected is 2.6 million and the adult prevalence rate is 7.3%. The number of AIDS deaths, which UNAIDS estimates at 280,000 for 1999 is lower in the government's estimate to 193,130. Since we are doing inter-country comparisons here, we are using UNAIDS figures. See, AIDS in Ethiopia, Third Edition. Disease Prevention and Control Department, Ministry of Health. Addis Ababa: November 2000.

[7] AIDS in Ethiopia, op.cit., p.26.

[8] AIDS in Ethiopia, p.30.

[9] AIDS in Ethiopia, p. 27-28.

[10] Ibid, p.29.

[11] UNICEF and UNAIDS, 2000.

[12] For economic growth impact of HIV for 80 developing countries, See R. Bonnel (2000) Economic Analysis of HIV/AIDS, ADF 2000 Background Paper, World Bank. See also the graph in the appendix.

[13] Kello, A. B. Impact of AIDS and its impact on the economy and Health care service system in Ethiopia. Cited in "AIDS in Ethiopia" op.cit., p.32.

[14] African Competitiveness Report 2000, p.28.

[15] Baryoh, 2000.

[16] Bersufekad Assefa. "A Study on the Socio-Economic Impact of HIV/AIDS on the Industrial Labour Force in Ethiopia." 1994, Unpublished.

[17] AIDS in Ethiopia, p.34.

[18] UNAIDS, 2000.

[19] This is calculated based on the following rather conservative assumptions. Current HIV carriers 2.6 million; new additions in ten years 415,365; death within the next ten years out of the currently infected 2.6 million while, of the newly infected 270,680 for a total estimated deaths in ten years of 2.81 million. It is also assumed that 75% of patients will seek medical care resulting in expected patient visits of health facilities at 2.1 million and an average cost of care equaling birr 1930 and funeral 327.

[20] A. M. Kimball and M. Thant, "Viewpoint," The Lancet, 347 (1996): 70-72.

[21] Quoted in Africa Competitiveness report, 2000, p.28.

[22] ACR 2000/2001, p.28.

[23] ACR 2000/2001, p.31.

[24] Reproductive health through business enterprises: The experience of Kombolcha Textile Enterprises, pp. 3-4.

[25] Ibid. p.35. ■

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