POSSIBLE IMPACTS OF STRUCTURAL ADJUSTMENT PROGRAMME ON THE HEALTH CARE SERVICE SYSTEM

Abdulhamid Bedri Kello

1. INTRODUCTION

Modern health care delivery system in Ethiopia is dominated by the government health care structures. The government provides both curative and most of the preventive services. The policy of 'free' medical care (for those who could not afford to pay for the services) on the one hand, and other economic factors (population growth, stagnant or dropping per capita income with the dropping level of food production and undernourishment, domestic and imported inflation, increasing share of salaries out of total recurrent health budget, and discouraging of private, particularly traditional medical services) on the other hand have resulted in a very wide gap between the supply and demand for health services. Since the health care institutions are the point of delivery of government subsidy to the poor, thinning out of available resources in an attempt to distribute the service, to as many people as possible has created a deep crisis in the health sector. The health service system presently is nearly paralyzed as a result. The major reason for such a crisis is the increasing demand for health services, which is determined by population growth; hereditary factors, nutritional status and general living conditions of the people; and, accessibility of the health service system including price of the services.

To make matters worse, foreign exchange problems have contributed to the decrease in the supply of health care services by making it nearly impossible for the government health system to access imported items. As a result, there are little or no drugs; equipment are not functioning properly; sanitation in the health service units is very bad; supervision is inadequate; and there is a general sense of decay, particularly in the hospitals. The preventive health service system is in no better shape, despite the aid received from international organizations such as the UNICEF and the WHO.

The aim of this paper is to investigate the possible impacts of reforms associated with stabilization and structural adjustment in Ethiopia. It has the following objectives:

1) to investigate the condition of health service financing in Ethiopia;

2) to present government policies of health service financing and provision;
3) to investigate possible impact of a structural adjustment programme (SAP) on the health care services; and

4) to investigate possible reforms of the health care financing system that could be taken to mitigate possible negative impacts of SAP.

Secondary data from the Ministries of Health, Planning and Economic Development, and Finance, and the Central Statistical Authority is used in addition to published materials.

The paper is organized as follows. Section 2 deals with the health environment in the country. This section is followed by a description of the health service financing policies and the financial situation of the system. Section 4 covers the possible changes that could be introduced by SAP and affect the health services. Finally concluding remarks are made.

2. THE HEALTH ENVIRONMENT

2.1. Introduction

This section deals with the health environment. The introductory part covers the macro-economic conditions in the country and major factors that affect health care services. This part is followed by parts that discuss the health status of the people and the health service system.

Ethiopia is among the poorest countries in the world. It has 52 million people (1991 estimate), whose number is growing at around 3% per annum with a per capita income of US$120 (World Bank, 1991). The Ethiopian population is increasing at an alarmingly fast rate. If this rate is kept up, the present population size will double in a short time with the consequent increase in the need for health services dramatically (Table 1 in the Annex indicates the rate and size of population growth). Around 80% of the population is in the agricultural sector, which contributes about 40% of the GDP and 85% of exports. Most of the rural people are in or near absolute poverty.

There has been a decline in economic performance over the last two decades and GDP declined by 2.6%. The major cause for this was the decline in the growth rate of the agricultural sector (0.8% average growth rate 1985-1989) (Mekonnen, 1992). The likely explanations for the fall in the performance of the agricultural sector include the low investment level, war, the highly constraining inappropriate government policies, population pressure on land, and drought. The economic crisis has affected all sectors of the economy; it reduced industrial output, increased unemployment, increased external debt and deepened the balance of payments deficit, increased government budget deficit financing, accelerated inflation and resulted in deterioration of social indicators.

2.2 The Macro-economic Environment

There has been a decline in the country's economic performance over the last two decades. The major causes are civil war, drought and inappropriate economic policies. The
GDP growth rate has declined in the period from 1975-1990. Agriculture grew at an average of 0.8% during this period (Mekonnen, 1992) (Table 2 gives GDP contributions from agriculture, industry and services at current market price rates for selected years). Reduced industrial output, increasing unemployment, increasing debt service ratios (see Table 3), declining foreign exchange reserves (Table 4), increasing government budget deficit financing (Table 5), inflation and other deteriorating social indicators marked the period.

2.3 Health Status of the Population

Life expectancy at birth is estimated to be around 42 and infant mortality rate (IMR), estimated for the country in the period 1985-1990 was 149 per live births (World Resource Institute, 1991).

The leading causes of hospital deaths were malaria (17.8%), tuberculosis of the respiratory system (9.9 %), bronchopneumonia (6.5%), meningitis (3.7%), gastro-enteritis and colitis (3.1%) (MOH, 1991). The leading causes of outpatient morbidity in children under five were acute upper respiratory infections (10.3%), gastro-enteritis and colitis (7.3%), infections of the skin and subcutaneous tissue (7.0%), helminths (5.2%), ascariasis (5.2%) and bronchopneumonia (4.7%) (MOH, 1991).

The leading causes of adult morbidity were acute upper respiratory infections (9.7%), malaria (4.3%), helminths (4.1%), gastritis and duodenitis (4.0%), infections of skin and subcutaneous tissue (3.7%), pyrexia of unknown origin (3.2%) and ascariasis (3.0%) (MOH, 1991).

It can be observed that most of the childhood diseases are due to preventable causes. The prevalence of intestinal parasites and other intestinal infections reflects poor sanitary facilities and lack of education. It could also be a reflection of the fact that only 10 per cent of the population had access to safe water and even a lesser proportion (5 per cent) had access to safe disposal of human waste.

The nutritional status of the population is very low. Out of a sample of 1,250 children 0-5 years of age, 18.5% were stunted, 7% were wasted and from 40 to 60% had first and second degree malnutrition (World Bank, 1988). The Ethiopian Nutrition Institute indicated that the weight for height of an average Ethiopian adult is about 80% of the standard of the reference population, while 12 per cent of the people fall below 70% level. The average calorie intake is deficient by 400 Kcal per person per day (Gebre Egziabher and Beyene, 1986). Protein-energy malnutrition affects from 50 to 60 per cent of the children below 5 years of age. It is overt in about 8 to 10 per cent of the children under 5. In some areas, the average food intake of children from 6 to 36 months amounts to only 40% of calorie and 60% of protein requirements (Gebre Egziabher and Beyene, 1986). Micronutrient deficiencies are widespread. Iodine deficiency (mean prevalence of around 30%), Vitamin A deficiency (around 20% of children), and Vitamin C deficiency (around 10% of children). In areas where malaria and hookworm are highly prevalent and where teff is not grown, iron deficiency anaemia is also considered to be a serious problem. Nutrient deficiency problems such as rickets, Vitamin A deficiency, iron deficiency anaemia, goiter and riboflavin
deficiency are prevalent with seasonal and spatial variations in the country (World Bank, 1988 and Gebre-Egziabher, 1986).

The RRC estimates that 8 million people are either starving or are under threat of famine. This aggravates the nutritional status of the population and may have a lasting and serious effect, especially on children and mothers.

2.5 Status of Health Care Services

The health care services are to be organized and provided in the country through a network of community health services, health stations, health centres, rural hospitals, regional hospitals and central referral hospitals. At the bottom of the health service tier are the community health service. Each community health post is expected to serve 1000 people staffed by a community health worker and a traditional birth attendant (TBA). The community health services have not functioned as expected and most of the community health agents (CHA) opted to provide private curative services instead of their planned role in promoting preventive services. The major reason for the failure of the community health service system in Ethiopia is mainly the inappropriate method of renumeration of the community health workers.

Health stations were expected to be provided service for 10,000 people and run by health assistants who provide preventive mother and child health (MCH) care and basic curative services. They were to give support to CHAs and TBAs.

The Ten Year Perspective Plan (1983-93) expected that ten health stations (HS) will be supervised by a health centre. These health centres (HC) were expected to provide referral services to the Health Stations. Health Centres also provide both preventive and curative care.

At the top of the tier there are the regional and central referral hospitals. The referral system never functioned in full, since patients can enter into the health service system at any point, including at the teaching hospitals such as the Black Lion Hospital.

There are 89 hospitals, with 12,106 beds, 160 health centres and 2,292 health stations in the country. Of these, 345 health stations, 35 health centres and 11 hospitals are partially or fully damaged by the war. Other facilities are not operating at full capacity because of shortage of drugs, reagents and equipment, and ill-maintenance of the facilities.

The Ministry of Health owns and runs 77.8% of the health facilities, while the rest of the facilities are owned and run by other government agencies, non-governmental organizations and religious missions.

There are 1,658 medical doctors (one physician for every 31,360 people), 3924 nurses (one nurse for every 13,250 people), and 10,839 health assistants (one health assistant for every 4,797 people), 14,553 community health agents and 12, 219 traditional birth attendants. The health worker/population ratios given above are among the lowest in the
world. The attrition rate of particularly lower level health workers is very high. For instance, according to a World Bank study, out of 4,000 nurse posts nearly 2,000 remained unfilled (World Bank, 1988) not because of shortage of trained nurses, but because the nurses either left the health service system altogether or have moved into other activities. The major reason for such attrition is the unattractive salary paid by the government sector for nurses. The same applies to the other health manpower categories. The dropout rate of the volunteer CHAs and TBAs was as high as 60 per cent in many regions.

Four urban centres in three regions (Addis Ababa, Asmara, Harar and Dire Dawa) constituting 4.6% of the total population, had 44% of the total hospital beds, 39% of all doctors and 28% of all nurses.

In addition to the governmental health services, there are other service giving agencies, such as, religious missions, NGO services, traditional practitioners, community clinics, private modern practice (private outpatient clinics, pharmacies, and drug vendors). The expansion of private outpatient clinics in the major urban areas of the country is noticeable and it appears that private practice in modern medicine is on the increase.

These non-governmental institutions probably will expand since the emphasis of the government on government-sponsored health service system has relaxed. However, care needs to be taken to protect the consumers against malpractice and ‘excessive’ charges (WHO, 1991b).

3. GOVERNMENT HEALTH CARE SERVICE FINANCING

3.1. Introduction

Government health service financing policies and the level and structure of financing of health services is analyzed in this section. The policies are reviewed because they have a direct impact on the amount of funds required to provide adequate health services for the demand generated by the policies. Following this review a detailed description of the health budget is given.

3.2. Government Health Care Service Financing Policies

In the 1950s, the government started the designing of development plans. the First Five Year Development Plan did not include a health service plan and this became a point of criticism that resulted in the Second Five Year Health Development Plan (Schaller, 1964). The plan argued that the options for health care financing were limited to the expansion of budgetary allocation to the services and encouraging voluntary contributions by the public. The Third Five Year Development Plan too considered the same means of raising funds for the expansion of health services.

The 1974 revolutionary situation brought about the adoption of the policy of extending access to health services to all people irrespective of the ability to pay. This was in line with
the socialist orientation of the government in the period (MOH, 1978). During the Dergue period, the government tried to finance health care services through its revenue, collected from general tax and other government incomes; user charges were levied in health facilities, poor households were exempted from the charge and heavy government subsidies were paid; and, private practice was actively discouraged.

3.3. Government Health Care Service Financing

The Ethiopian government spent Birr 2.9 per head in 1990. This is a very low level of spending compared with the spending in developing countries who spent an estimated US$ 9, and much lower compared to the level in the middle income countries who spent US$ 31 (World Bank, 1987).

The current levels of spending on the health sector is not sufficient to finance the intended provision of health care services. Table 5.8 shows treasury expenditure on the health care services had an average share of only 4.2 and 2.9% in government revenue and expenditure respectively between 1984/85-1989/90. The same table also shows that government health expenditure had on the average accounted for only 1.5% of GDP and that recurrent expenditures in the health budget had been increasing during the period under review. In addition to the government budgetary allocation, health care services had been supported by external resources. Donor inputs had tended to manifest a declining share in total expenditure on health between 1985-90 except for 1989 (Table 5.5), presumably because of the inability to create a conducive policy environment.

The available data indicate that the health sector faces deep problems, largely because of the inability of the government to make the required allocations on account of financial constraints. This is reflected in the low per capita expenditure on health services and the resultant deterioration of the critical indicators of health conditions. There is, therefore, a need to design appropriate health financing mechanisms with the view of expanding better health activities to meet the great needs of the rapidly growing population. Since a strong financial base is a prerequisite for an effective health care system, such mechanisms would considerably improve the health status of the population.

4. SAP AND THE HEALTH SERVICE SYSTEM IN ETHIOPIA

The major transitional adverse social consequences of structural adjustment programmes are: declining per capita income and real wages; rising unemployment and underemployment; deterioration in the level of social services as a result of cuts on social public expenditures; falling in educational and training standards; rising malnutrition and health problems; and rising poverty levels and income inequalities. (UNECA, n.d.).

4.1. Introduction

The transitional adverse social consequences of SAPs are the result of devaluation, liberalization and retrenching of public employees. The World Bank recently has introduced a 'safety-net' provision to combat these negative effects of SAPs. These issues are discussed
Figure 1 Demand and Supply of Health Services

in relation to their effect on the health sector. In order to set the context of the discussion a framework for the discussion, is given at the outset by introducing functions defining the demand and supply for health care services in Ethiopia (Figure 1 gives a summary of the major issues involved in these equations). The discussion will be based on two scenarios, one of which is based on a set of assumptions as given below (Scenario 1) and the other on the actual components of Economic Restructuring Programme as have been indicated by the government announcement of October 1, 1992 (Scenario 2).

Regarding Scenario 1, to simplify matters and facilitate a clear presentation, the discussion assumes the following:

1) The SAP involves retrenching and liberalization with devaluation.

2) A devaluation of the Birr will be through floating it in the market and that the rate would be Birr 7 to the U.S dollar.²

3) Everything remains the same except the variable under consideration.

The third assumption applies to the discussion of the effects of the already adopted programme. These assumptions are modified when Scenario 2 is discussed.
The discussion is divided into demand and supply functions analyses. Only the most important functions are defined explicitly as the purpose is not to analyze demand and supply for health services as such. Most of the important factors that are to be affected by a SAP are variables that affect the demand for health care services as to be shown below. (The variables that are marked $\bullet$ in both the demand and the supply functions are analyzed in detail to look at the effect of SAP on the health care service system).

4.2. Demand

It is possible to define a simplified demand function for health care services by:

$$D = f (X_1, X_2, X_3, X_4, X_5) \quad (1)$$

where $D =$ demand for health services

$X_1 =$ disease prevalence and incidence
$X_2 =$ price of health care services
$X_3 =$ income levels of the population
$X_4 =$ availability of services
$X_5 =$ population numbers

$$\left(\frac{\partial D}{\partial X_1}, \frac{\partial D}{\partial X_3}, \frac{\partial D}{\partial X_2} > 0; \frac{\partial D}{\partial X_4} < 0; \frac{\partial D}{\partial X_5} \geq 0\right)$$

$$X_1 = f (C_1, C_2, C_3, C_4, C_5) \quad (2)$$

where $C_1 =$ climate and other natural factors
$\bullet C_2 =$ nutritional status of the population
$C_3 =$ hereditary factors
$\bullet C_4 =$ educational status of the population
$\bullet C_5 =$ level of environmental and personal hygiene

$$\frac{\partial X_1}{\partial C_4}, \frac{\partial X_1}{\partial C_5} < 0; \frac{\partial X_2}{\partial C_2} > 0$$

$$X_2 = f (\mu_1, \mu_2) \quad (3)$$

where $\bullet \mu_1 =$ cost of production of services
$\bullet \mu_2 =$ production efficiency
$\mu_2 = f(m_1, m_2, m_3)$

where $m_i =$ managerial inputs
Abdulhamid Bedri: Possible Impacts of SAP on the Health Care Service System

- $m_2 =$ morale of workers

\[
\frac{\partial X_2}{\partial \mu_1} > 0, \quad \frac{\partial X_2}{\partial \mu_2} < 0
\]

\[X_3 = f(\omega_1, \omega_2, \omega_3) \quad (4)\]

where $\omega_1 =$ Gross national product
$\omega_2 =$ income distribution
$\omega_3 =$ employment rates

\[
\frac{\partial X_3}{\partial \omega_1}, \frac{\partial X_3}{\partial \omega_3} > 0
\]

\[X_4 = f(\epsilon_1, \epsilon_2, \epsilon_3) \quad (5)\]

where $\epsilon_1 =$ government decisions and policies
$\epsilon_2 =$ profitability
$\epsilon_3 =$ other factors such as establishing of health facilities by religious missions and receiving grants

\[
\frac{\partial X_4}{\partial \epsilon_2} > 0 \quad \text{(for private health care facilities and other organizations that operate on a profit and loss basis).}
\]

4.3. Supply of health services

The supply function for health services in Ethiopia could be defined as:

\[S = S_g + S_p + S_{ngo} \quad (6)\]

where $S_g =$ government health care services
$S_p =$ private health care services
$S_{ngo} =$ health services provided by NGOs and religious missions.

\[S_g = f(Y_1, Y_2, \ldots, Y_7, 1, x) \quad (7)\]
where $Y_1$ = government budget allocated  
$Y_2$ = price of inputs  
$Y_3$ = availability of foreign exchange  
$Y_4$ = foreign aid  
$Y_5$ = physical existence of facilities  
$\epsilon_1$ = government policy  
$Y_6$ = physicians lobby and other political forces  
$Y_7$ = occurrence of epidemics

\[
\left( \frac{\partial S_g}{\partial Y_1}, \frac{\partial S_g}{\partial Y_2}, \frac{\partial S_g}{\partial Y_3}, \frac{\partial S_g}{\partial Y_4}, \frac{\partial S_g}{\partial Y_5}, \frac{\partial S_g}{\partial \mu_2}, \frac{\partial S_g}{\partial Y_7} \right) > 0; \quad \frac{\partial S_g}{\partial Y_2} < 0.
\]

\[
S_p = f(\epsilon_2, \epsilon_1)
\]

\[
S_{ego} = f(I, \epsilon_1)
\]

where $I$ = the interest of the NGO.

4.4. Variables Affected by SAP

- Nutritional status of the population

Scenario 1

A SAP could possibly depress the nutritional status of the urban low income groups as a result of: (a) increased unemployment (retrenching) and consequent fall in the income of the people involved; (b) increased food prices, that could follow devaluation mainly through increased transport costs (without subsidy on such costs) such increase could be substantial; (c) removal of subsidies on food items and discontinuation of provision of cheap food items to the urban areas through government procurement agencies, for instance cereals; (d) possible marketing of urban land and houses could push rents up and hence the low-income people could be pushed out to the peripheries of urban areas, a factor that could increase the distance between job areas and their homes; and, (e) loss of income through collection of rent income by particularly women from low income families through acquisition of subsidized consumer goods from government stores and kebele shops that are ultimately sold at higher prices in the open market. Presently, some of the measures that are involved in a SAP have already been taken and some of the above consequences have already occurred. For instance, the price differential between government owned enterprises and the open market are nearly gone that it has become unattractive to buy good from these shops to sell in the open market.
Abdulhamid Bedri: Possible Impacts of SAP on the Health Care Service System

Scenario 2

The above discussion may not hold in the context of the actual policy adopted. (a) The announcement has not indicated whether there would be retrenching or not. However, it is possible to deduce from developments in the manufacturing sector and the policy change in the employment of tertiary level educational establishments graduates this year that there will be retrenching in the government bureaucracies. Thus, it is possible the above condition in Scenario 1 could hold. (b) Transportation cost cannot go up at this rate, therefore the increase will be much lower; the exchange rate of Birr 5 to the dollar will reduce the cost of maintenance and the subsidized price of petrol has led to only a slight increase in transportation cost. Taking the same example as the one given in the footnote number 2, it is possible to see that the increase in transportation cost could be very low. If the example holds, the increase per quintal will be at most around 50 cents. In relative terms this is less than a 1% increase. (c) It seems that subsidies will not be discontinued after all. Government officials have been indicating that the government will intervene to regulate and stabilize basic goods prices in the open market despite the discontinuation of rations. Rationed goods could possibly continue on to be provided to the urban poor. Therefore, reduction in welfare due the introduction of free market operations are to be moderated. (d) the government has only indicated that there is a need for a revision of the land and housing policies. Most probably, Scenario 1 situation could ultimately come. (e) Most of the rent collected by the low-income population have already gone or are to go. Thus, the effect of the SAP on the nutritional status of the people is less marked in Scenario 2 than it is in Scenario 1.

● Educational status of the people

Scenario 1

Liberalization could bring about the introduction of fees for education, which could result in withdrawal of some children from the school system. In the long-run, such a negative trend could result in a fall in the educational status of the people. However, a possibility exists whereby the economy recovers and starts to grow, thus combating this fall in educational status.

Scenario 2

The cautious manner in which the government has adopted the SAP is indicative of the possibility of leaving the educational sector existing intact for sometime to come. However, indications are there that private school systems could develop in the medium term. This will only increase access to the school system since the students to be enrolled will reduce the pressure on the government school system.
The Ethiopian Economy: Problems of Adjustment

• Hygiene

Scenario 1

The short-run effects of SAP could depress hygienic standards due to the possible fall in income levels of the people. Personal hygiene, housing conditions and even neighbourhood sanitation levels could go down. In lots of areas of Addis Ababa, houses do not have useable latrines, mostly a result of low income levels, consequently lots of people use fields and roadsides to dispose human excreta. Therefore, further depression of income levels could increase the number of households without useable latrines.

Scenario 2

As long as the income levels are depressed, the discussion under Scenario 1 holds. But, the level of the fall in hygienic standards is much reduced as a result of the several steps that were adopted in the SAP package in Ethiopia. If alternative employment is offered to the people to be made redundant, the fall could further be reduced.

• Cost of production of services

Scenario 1

Devaluation of the Birr would result in increase in the cost of imported items such as drugs and fuel. Fuel price increase will result in increased cost of transportation as argued above. This will affect production costs. For instance, supervision and preventive services provided by the Ministry of Health heavily rely on transportation facilities. Such increase has to involve either increased subsidies or increased price for the services for which charges could be levied; otherwise, services have to be cut back. The nature of preventive services makes it difficult, if not impossible, to collect fees and at the same time maximize the effect of the preventive programme. Thus, increased costs would decrease access of low income people to the services.

Scenario 2

Transportation costs have not been markedly increased as shown above, therefore, the cost increase resulting from this cost category will not be high. The cost increase associated with increased price of imported items will be the major area that leads to increases in cost of production of health services. Therefore, the need for subsidy on imported drugs and medical equipment is not to be ruled out. It is also to be noted that a substantial portion of these items is imported through grants of international organizations such as UNICEF and the WHO.
Abdulhamid Bedri: Possible Impacts of SAP on the Health Care Service System

- Efficiency of services

  Scenario 1

  If liberalization extends to the health sector and the private sector is encouraged to invest in health care services, then efficiency of the private services could be higher than the present government-run institutions, since the private investors would make sure cost of production of services are kept as low as possible in order to maximize profits. However, the expansion of the private sector would be at the expense of the public sector as far as skilled manpower is concerned. Such a loss incurred by the government health sector could possibly depress efficiency in the sector, which is already very low.

  SAP could result in increased cost of living accompanied by a constant nominal income, that translates itself in a fall of the standard of living of salaried people. Pay levels are already low. A further reduction in the purchasing power of the health workers could result in further erosion of their morale. This low level of health worker morale has already been indicated as a major factor affecting efficiency of the manpower (Abdulhamid et al. 1992). For instance, the salary of physicians (General Practitioners) has remained Birr 835 for more than 20 years. Assuming a conservative inflation rate of 8% per year, their salary today has dropped to Birr 179 in 1972 money terms. Thus a further erosion in the purchasing power of their salary could have a negative effect on the efficiency of their contribution.

  Scenario 2

  It seems that the government has taken the possible negative effects of decreasing income levels following the introduction of SAP into considerations when it introduced a salary increment and a reduction in income tax levels. Therefore, the degree to which the morale of works could have been affected had been reduced at least in the short-run.

- Employment status

  Scenario 1 and 2

  The short-term effect of a SAP would result in higher unemployment rates than what is existing presently. Even the ‘safety-net’ provision, perhaps, may not be able to accommodate all of the workers who will be unemployed, since the jobs that are to be created as ‘safety net’ are to be mostly manual labour and not all of the unemployed would be able to undertake physical work.
The Ethiopian Economy: Problems of Adjustment

- Government health care policy and other related decisions

Scenario 1

Various policy measures could affect the supply and demand for health services. It is possible to envisage a situation where the government partially removes the 'free medical care' provision by introducing various methods of health service financing options to the people, except in disaster areas (Abdulhamid et al. 1992). Furthermore, it is possible that subsidies paid to the fee-paying users of health services could be removed. Such moves could decrease the demand for health services with possible consequent fall in the health status of the people who do not get the services.

Government decisions regarding the provision of health care services including health care policies, influence the availability of the services. For instance, whether the government allows private practice and the participation of NGOs affects the availability of services in areas of interest of these agencies. Presently the policy of the government seems to be one of indifference to the expansion of private medical care. The NGOs are only superficially supervised by the Ministry of Health. Liberalization could possibly involve actively supporting the private sector and changing the health care services financing policies.

Scenario 2

The cautious move the government took in introducing the SAP is indicative that it would not go as far as demanding payment for all health services provided by the government institutions. It does not also seem that the government would privatize the health service units including hospitals or make them autonomous enterprises. Most probably the government would continue to keep the status quo in the operation of the health service units it owns while allowing private investors to participate. But, the possible impact of such a move has to be seen.

- Profitability

Scenario 1 and 2

It is possible to envisage that the higher the profitability in investing in health care services to the private sector, the more would capital investment be attracted. However, this will be associated with income levels of the people who demand the service. Therefore, the investment would be concentrated in the high income urban areas.
5. CONCLUDING REMARKS

The initial aim of stabilization and SAPs is increasing the capacity of a nation to pay for what it consumes, in terms of government budget and the current account balance. Measures involved in both will have implications for the health care system in Ethiopia. First, because it is the government health care system that dominates the sector; and second, many of the materials that have to go in the production of the services are imported.

The possible impacts of SAP to the health service system can be classified as direct and indirect effects. The direct effects are the effects on the health service system, such as affecting the efficiency of the health care service units, cost of production of health care services and flow of funds to the health service system whereas the indirect effects are, such as affecting the nutritional status of the people, hygiene levels, employment status, and the educational status of the people that affect the health status of the population.

Since the budget allocated to the Ministry of Health is already inadequate, any additional cut could further reduce the potential to provide the services, unless there are possibilities of generating funds from alternative sources. If the SAP changes the exchange rate, as it would most likely do, and the value of the Birr drops, the cost of production of health care services would increase. Services could improve, provided that there are enough funds to cover the costs and if the health service system gets access to foreign exchange.

Steps that could result in increased flow of funds to the health service system (if one assumes a constant or dropping budgetary allocation) have to be: increased non-budgetary funds in the government health sector and encouraging private practice in curative services. The government has several options to increase funds including: increase in user charges, introduction of income generating activities, introduction of social insurance scheme, developing other insurance institutions, trying to get more grants and other donations from domestic and international sources to the health service system, introducing a community based system of loans to access curative services. In addition to these, other measures that help in cutting costs through improved efficiency could be introduced. Both these measures could be fruitful only if the number of patients treated in these institutions remains manageable and the institutions are given financial autonomy. This would require dropping the practice of making the health service institutions provide ‘free’ medical care, which makes them points of delivery of subsidy.

Encouraging private medical services has its own problems, apart the competition for the fee-paying patients who could subsidize the poor who might get treatment in the government-run medical services.

The solution to the direct negative effects on the health care service system are less intractable than the ones to the indirect effects. Thus, improving the supply of health services is more manageable than trying to address the indirect effects that determine the demand for health services.
The Ethiopian Economy: Problems of Adjustment

It is appropriate, however, to pose the question of what could be the conditions without a SAP. If things continue on as they are now, it is possible to envisage that the health service system could collapse altogether and there is probably no alternative to accepting the need for structural change in the economy and the health service system in particular. In fact, one should argue that the health service system should not be insulated from the programme of adjustment in the interest of promoting the interest of the low-income earners, because it would only postpone the pain of going through structural change to a later date. It could be argued that the introduction of a structural change is compulsory, thus any delay only costs the society more.

NOTES

1. Table 1 and the rest of tables in this paper are placed in the Annex.

2. This rate is nearly the present black market rate of Birr 7.40 for the US dollar. Given the extremely high debt service ratio, this rate is probably to be the rate at which the birr is to be exchanged. However if the debt ratio decreases as result of increased exports, more capital inflow or cancelling or rescheduling debt by the developed countries, it is possible to see a reduction in the amount of birr paid to the dollar.

3. It is possible to get a rough estimate of costs assuming the following:

   a) that a quintal of cereals is transported at a rate of Birr 50 a distance of 500km, which is a rate that is a currently charged by the private sector,
   b) that the vehicle is consuming petrol, and
   c) that vehicle depreciation charge including maintenance is equal to fuel expenses; then it is possible to see that the cost will increase to around Birr 60 (translated into percentage it could possibly around 5%) for cereals with a SAP. That is: the fuel need is 500km/5km per litre = 100 litres, which gives a litre a quintal on a 100 quintal vehicle. Therefore, at a $1 per litre rate, the increase will be Birr7. Birr 1.60 = Birr 5.40. Thus a total cost will go up by Birr 10.80. In relative terms, for example for teff, the price goes up by 10.80/200 = 5 per cent.

REFERENCES


CSA (Central Statistical Authority) Statistical Abstract (various issues).


Abdulhamid Bedri: Possible Impacts of SAP on the Health Care Service System


National Bank of Ethiopia, Annual Reports (various issues).


