Employers' and Patients' Evaluations of the Services of Private versus Government Higher Education and Health Institutions in Addis Ababa

Tenkir Bonger[1], (PhD)

Abstract

As part of the study on Investment Climate and Business Environment (ICBE) in Addis Abeba, Ethiopia, this study reports on interviews with thirty randomly-selected employers of private higher education (PHE) graduates, thirty of their alumni, and thirty patients of private health institutions. Employers were asked to compare the service provision performance of private higher education graduates and private health service provision with that of government. The comparative criteria for each are listed in tables 2 and 3. In both education and health, with respect to each of the criterion, respondents were asked to choose between *About the Same*, *Better* or *Worse*. About 2/3 of the employers of the PHE graduates stated that the work output of PHE graduates and of government trained graduates was *About the Same*. 26% rated them *Better*, and 12% considered them *Worse*. 45% of the patients said that private sector provision was *Better* than that of government, while only 11% stated that private provision is *Worse*. Only 1/3 said that they are *About the Same*. This implies that compared to education, there is a wider perceived gap in health service provision by government and the private sector in favor of the latter. Under the sum total of health service provision, 82% responded that private provision is *Better*. From this finding, it can be asserted that private sector higher education and health institutions are making noticeable progress at least in the eyes of employers of graduates and patients receiving the services of private health institutions. The policy reforms appear to be bearing fruit, as expressed in the expansion figures for PHE and private health service provisions reported in the main study. However, there are several areas that require fine tuning of policy and institutional reforms. Rather than absorbing the "leftover" from the government sector, as is the case now, genuine and effective partnerships between government institutions, private institutions, and employers need to be remodeled with a certain level of autonomy for each. Government needs autonomy to ensure that its social goals are not subsumed by the profit motive of private firms. The latter requires autonomy to tailor its services in order to meet the specific demands of the market. As the ultimate beneficiaries of the process, employers, students and patients can enrich the institutional package.

[1] Tenkir Bonger PhD(London)
Professor of Development Economics &Dean of the School os Business Studies Mulunguhi University, Kabwe ZAMBIA
e-mail:kelemu70agere@yahoo.com

The Study Context[2]

In the aftermath of the Cold War and the globally discredited command economy, the Ethiopian People's Revolutionary Democratic Front (EPRDF) overthrew the state socialist military regime of Colonel Mengistu Haile Mariam and seized power in 1991. The hitherto overtly hard line Marxist guerilla organization declared a market-led economy, elected governance, and an ethnic-based federal system as the linchpins of its policy framework.

In the past five years or so, the Ethiopian economy has been growing at an unprecedented rate of 10% per annum. Concurrently, both government and private sector growth, especially in education and to a lesser extent in health services, have been remarkable. While factors accounting for the growth rates are numerous and their interactions complex, the superior governance of the Investment Climate and the Business Environment (ICBE), and with it the mushrooming of the private sector in education and health, must have had some contributory impact, both quantitatively and in driving the institutional momentum for growth and development.

This paper, which focuses on private sector institutional development in the vital services of higher education and health care, is extracted from a wider study on Investment Climate and the Business Environment [ICBE] in Addis Abeba, Ethiopia in the post 1991 period. ICBE encompasses aspects of institutions as they relate specifically to the start-up, growth, development, and performance of businesses, and their capacity to drive the pace of economic and social progress. Among a myriad of economic, social and cultural institutions, the business environment is enveloped by the formation, character and capability of the state to lead and/or promote the development process in conjunction with the private sector[3].

This is partly because the state has the authority and capacity to create and modify institutions in order to define property rights and enforce contracts. The negotiated and/or contested social space between the private and public spheres represented by the state at a given time bring to the fore the opportunities and constraints in the

[2] The full report, which amplifies some of the conclusions in this paper, is found in the Trust Africa funded ICBE – Ethiopia Draft Research Report. Tenkir Bonger. 2009. "Investment Climate and the Business Environment in Private Higher Education [PHE] and Private Health Sectors in Addis Abeba [Ethiopia] in the Post 1991 Period".

[3] It is for this reason that we have the following commentary on the state and society in the development process. A recent discourse in this realm is the concept of the "developmental state" [See chapter 2.7 in the main research report].

formulation of the ICBE. Constructing a working institutional and policy framework between the private and the public sectors in the context of developing countries is a critical pre-requisite for successful transition towards growth and development. In this arena of discourse, the relative role of the private sector and the state as drivers of the development process has been a contentious issue.

The optimum synergy of the nexus between state, private and indigenous institutions is of paramount significance. This is because state institutions can be dull, didactic and repetitive actors entangled in a web of rent-seeking behavior without the self-propelling, dynamic and creative energies to drive growth and development. The private sector, under the aegis of markets is certainly better endowed in accomplishing the latter. Moreover, the private sector's near-instantaneous restructuring in response to hard and soft technology on the supply side, and its profit motive with its built-in goal to meet the needs of changing demand in the market, make it a potential engine for self-sustaining growth if not development.

In order to achieve the latter goal, private sector growth needs to be guided by avowed policies and able public institutions to channel growth towards social goals such as a representative governance, equitable distribution of assets, relevant education, opportunities for decent jobs, intra- and inter-generational distribution of incomes, and social and environmental security. If these are not embedded in the development processes, growth generated by the private sector alone may not be developmental, posing considerable risk for the attainment of sustainable human development.

Given the ecological and social diversity between and within countries, national and regional policy and institutional frameworks need to be interfaced with realities at the local community level. On the other hand, left to themselves, traditional institutions at the local level may lack mechanisms of resource transactions and transfer, as well as sufficient incentives to drive individuals towards self-enrichment and investment in the future. Their permeation by acquisitive values and long-term national visions need to be built into the indigenous institutional frameworks for development.

As the more recent experience of East Asian countries has brought to the fore, *the construction of an interface and a negotiating space between the modern state, the private sector and traditional institutions is a prerequisite for any sustainable growth and developmen*t. To work out the optimum in creating and nurturing a policy space between local, state and private partners, one needs to examine the specificity of each and interface them in a manner which meets the sustainable growth and development objectives of society. Whereas ICBE requires institutional reforms to hasten the pace of growth, based on these, further institutional social engineering is required to

distribute and sustain the fruits of growth in vital sectors such as education and health.

Reporting on evaluation of the outputs of PHEs and private health institutions by employers of PHE graduates and patients in Addis Abeba in the post-1991 period, this paper aims to *bring to the fore some building blocks to restructure institutions and policies for sustainable human development*[4]. Socially comprehensible, functional, durable, and predictable but also adaptable institutions derived from such interfacing are the *sine qua non* requirements of the development process.

Towards this end, to shed light on the on-going ICBE process, the data Collection Team interviewed 424 respondents including the managers and staff of PHE institutions and health service providers[5], the direct beneficiaries of the private social services (students, graduates, and patients), the indirect beneficiaries (parents and employers) and the regulatory authorities (education and health bureaus of the City Government of Addis Abeba). The data collected address the social characteristics of respondents, inputs and outputs of their services, infrastructure, degree of competition, current capacity utilization and future plans/expectations, land, business-government relations, crime and conflict resolution, and overall investment climate constraints and evaluations. The survey commenced on the 2nd week of October and was completed on the 2nd week of December 2008.

Prior to assessing and embarking on fine-tuning of policies and institutions for the optimum synergy and partnership between the private and public sectors, the benefit of the services and the institutional set-ups delivering them, in this case private education and health, need to be evaluated by the ultimate consumers. To that end, employers and patients were interviewed to compare the performance of PHE graduates and the service provision to patients by private health institutions with that of government. From the interface of the output of PHE in the form of the performance of their graduates and that of the provision to patients of services by private health providers, the study aims to bring to the fore areas requiring further fine-tuning of policy in ICBE.

Within this framework, the next section provides a brief background on the development of education in Ethiopia, followed by a statement on the demand for

[4] Towards this end, although the last section offers recommendations along this line, not all are derived from discussion in this paper. They are rather garnered from the conclusions in the Research Report cited under footnote # 1.

[5] The list of private education and health providers from which data were collected is found in Appendix 1.

health and education services and the reasons for choosing private service provision in the two sectors. The main result of the report, found in section four, compares the performance of graduates of PHE institutions with those of government and patients' response of comparisons of private and government provision of health services. The final section concludes the paper.

Background to Educational Development in Ethiopia[6]

The long history of education in Ethiopia is highly associated with the introduction of Christianity around 330 A.D and Islam around the 7th century. The existence of the Ethiopian alphabet dates back to 4th century A.D. (Mammo 2005). It remained the main institution of education until the 19th century (Ayalew 2000:6). In traditional Ethiopia, the indigenous educational systems of both Orthodox Christianity and Islam served as the main sources for the recruitment of civil servants such as judges, governors, treasurers and general administrators.

The establishment of a central state authority and permanent urban seat of power, the arrival of foreign embassies, the development of modern economic sectors and other emergent social conditions called for modern education in Ethiopia. At the beginning of the twentieth century, the indigenous and religious educational systems fell short of meeting the needs of people involved in statecraft, diplomacy and commerce, which led to the introduction of government-sponsored secular education system (Library of Congress 1991).

Around the end of the 19th century, the practice of sending young Ethiopians abroad for higher education intensified due to the influence of missionaries and of Menelik II's[7] government (CICE:3). In effect, secular education officially commenced in 1908 with the opening of Menelik II School in Addis Ababa (Ayalew, 2000:8-14). By the time of the death of Emperor Menelik II in 1913, only three more schools were established in the provincial centers, one each in Harar, Dessie and Ankober.

In 1974, when the Ethiopian Revolution[8] erupted, only 15.3% of the relevant age cohort was attending primary schools. In the same period, Kenya and Tanzania had

[6] Although the evaluation attempted to measure both education and health service outputs, in the light of the fact that study was engaged in educational institutions including those trained for health services, the following short section is confined to education in general. This section is extracted from literature review chapter by Demmelash Habte in the main Research Report.

[7] Menelik II was the Emperor of Ethiopia from 1872 to 1913. He underscored a major victory aginst the Italian colonialists at the famous Battle of Adowa in 1896.

[8] The Ethiopian Revolution of 1974 led by the military *Derg* (1974-91) swept away imperial rule.

almost reached universal primary education. In Somalia, Sudan, Zimbabwe and Zambia, 50%, 51%, 72% and 95% of their primary school aged children, respectively, enrolled at schools (CICE:6). By 1985/86, enrollment in Ethiopia's primary, junior secondary, and senior secondary schools totaled 3.1 million students, up from the nearly 785,000 enrolled a decade earlier.

Currently, Ethiopian higher education is undergoing transformation both in public and private domains. In the pre-1991 period, Ethiopia had only three public universities; now there are twenty-two. As a result of post-1991 liberalization, private higher education institutions have also started to flourish. At present, the enrollment capacities of higher education institutions, both public and private, has reached around 200,000 students (combining day, evening and distance learning).[9] The Ministry of education statistics (MoE 2007) shows that private college enrollment has reached about a quarter of total higher education enrollment. Most private institutions are based in the capital, Addis Ababa, with a few campuses located in major regional towns. The most common programs in the private sector include business and economics, computer studies, legal studies, information technology (IT), health care and teachers training.

In 2006, primary school enrollment reached 12,657,342 (MoE 2007), up from 2,466,464 in 1991 (World Bank 2007). The primary gross enrollment ratio at the national level reached 85.8%, with 78.5% female enrollment and 92.9% male enrollment *(ibid.)*. When alternative basic education is included, the gross enrollment rate for primary education reaches 91.3% (98.6% for boys and 83.9% for girls). From 2001/02 to 2005/06, at the national level, the average annual growth rate was 11.7%.

In the same period, according to World Bank (2007) secondary school total enrollment reached 5,061,872 (34.7%), up from a mere 720,825 (12.9%) in 1992. The female gross enrollment rate rose from 11.11% in 1991 to 28% in 2006. By 2006, the total combined enrolling capacities of the government's Technical and Vocational Education Training (TVET) program and of non-government institutions was 123,557, including both regular and evening programs (MoE 2007). The percentage share of vocational and technical enrollment from total secondary enrollment increased from 0.2% in 1999 to 2.4% in 2006 (World Bank 2007). Total enrollment in higher education institutions showed remarkable growth, from 34,076 in 1991 to

[9] The private sector is allowed to take students when they do not qualify for bursary; usually the leftovers come to private higher education institutions.

191,165 in 2005 (*Ibid.*). Non-governmental higher education institutions enrollment in 2005/06 was 39,691, which was about 22% of the total (MoE 2007)[10].

Clients' Demand for and Reasons for Choosing the Private Higher Education [PHE] and Health Services

At the personal and household level, the demand for education and skills training depends on the financial and social benefits it confers on recipients. The purchase of health services reduces discomfort and pushes the frontiers of well-being. In effect happiness and engagement in remunerative activities are enhanced. These are largely realized through the acquisition of gainful employment in firms and/or self-employment following qualification certification to deliver services. Tailoring training and education to the changing demands of employers and that of health services according to the needs of patients are among the major functions of the suppliers of education and health services.

In order to assess the quality of service provision, the ICBE study sent out questionnaires soliciting the opinions of employers, alumni and patients in the private sector. Given the theoretical and methodological problems posed in the quantification and valuation of the outcomes of these social services, the study picked out some subjective proxies to be responded to by the users of the services (employers and patients) and the direct beneficiaries (alumni of private colleges) to throw light on the quality of provisions by the private sector and compare them with those of government services.[11]

The following section briefly reports on the reasons for choosing private sector provision by consumers of health and education services as a prelude to the discussion on quality of provision presented in section three.

When those alumni who came from government to private institutions were asked why they chose the private sector, the reasons given were *Better Social Environment* (33%) and *Better Job Prospect* (33%), followed by *Better Education* (25%), the

[10] The growth of the economy and the expansion of health services in the last decade have also been phenomenal. I order not to exceed the maximum size requirement for this paper; the section on health is omitted.

[11] A complete economic assessment would also have required estimations of direct and indirect costs and the setting of scientifically measureable quantified benefits of the social services, which were beyond the scope of the study and the study grant proffered. Resource constraint compelled the study to focus on the private sector in Addis Abeba only.

Company of Better Behaved Students (11%) and *More Clever Students* (15%), *Better Library* (11%), *Better Lab* (15%), and *Better Extra-curricular Activities* (11%). When the alumni were asked why they came to the last private institution they attended from another private one, the main reasons given were *Seeking Better Social Environment* (48%) and *Education* (48%). This was followed by *Better Job Prospect* (33%), *Joining Well-behaved Students* (24%) and *More Clever Students* (5%), *Better Library* (15%), *Better Laboratory* (4%), and *More Extra-curricular Activity* (12%).

From the point of view of many of the alumni, *Social Environment/Relaxed Learning Atmosphere* and the *Prospect of Obtaining Jobs* were the major driving forces for joining the private higher institutions of learning from which they graduated. However, very few (13.3%) encountered *Innovative Methods of Learning and Subject Delivery*. They also perceived their alumni colleges as *Profit-making Institutions* (31%), *Venues for the Improvement of the Quality of Educational Standards* (24%), *Serving the Community* (20%), *Meeting National Goals* (16%), and *Expanding Own Business* (10%).

Among patients receiving health services by the private sector, the most important reason for coming to the private sector was the *Proximity of Services* and the *Expectation of Obtaining Better Services.*[12] The most important reason why patients came to the private health institution was the expectation of *Better Treatment/Examination* (51%), followed by the *Expectation of Better Medication* (32%), *Better Prospects of Regaining Health* (22%), *Better Social Environment* (20%), and *More Courteous Staff and Relaxed Atmosphere* (22%). Only 5% said that they came to the private sector from government in order to *Pay Less*, which indicates the existence of higher fees in private health institutions. However, *Reduced Payment* was a major reason why patients moved from a previous private health institution to the current private one where they were interviewed (40%). Another major reason for such a move was *Better Prospect of Regaining Health*. The other main reasons given were *Expectation of Better Treatment* (46%), *Better Medicine* (29%), *More Courteous Staff* (23%) and *Better Social Environment*.

4.0 Employers Comparison[13] of the Performance of Graduates of PHE with those of Government and that of Health Services by Patients

[12] 58% of the respondents were, however, first timers to the private health centers at which they were interviewed. Only 27% and 15% had been to government and other private health centers, respectively.

[13] Rather than comparison, which is only relative, absolute measurement would have required a fixed standard value against which the proximity of both the private and public services could have been estimated. Being an ICBE study, this was again beyond the scope of the research.

In both education and health, the ultimate users of the services (employers, alumni and patients) were asked to assess the outputs of the service providers with respect to selected measures of quality. For education, the criteria by which employers assessed private college graduates were *Academic Qualification/Professionalism*, *Depth of Knowledge in their Respective Areas*, *Aptitude*, *Willingness to Take Responsibility*, *Willingness to Take on More Work Load*, *Consciousness about Rights*, *Consciousness about Obligations*, *Punctuality at Work*, *Counseling/Helping Others*, *Friendliness*, *Flexibility at Work*, *Cooperativeness*, and *Actions towards Self-Improvement*. The latter is a proxy for entrepreneurial inclination. Employers were asked to rate the performance of PHE graduates as **WORSE**, **BETTER** and **ABOUT THE SAME** compared to public sector graduates. The responses came from 30 employers of graduates of PHE institutions who also had employees who graduated from government higher institutions (see table 1, below)[14].

[14] The full list of the employer institutions having both public and private college graduates is found in Appendix 2.

Table 1: Size by No of Employees of the Employer Organizations

No of employees	Frequency	%
10-20	3	10
24-101	13	43
150-800	10	33
1,183-12,000	4	14
Total	30	100

Source: ***Survey Result of the ICBE Study in Addis Ababa,* 2009.**

The evaluation criteria in the provision of health services were *Quality of Services*, *Qualification of Staff*, *Punctuality*, *Patient/Staff Ratio*, *Examination and Treatment*, *Counseling*, *Friendliness*, *Flexibility*, *Physical Environment*, *Social Environment*, *Service Charges* and *Location*. The three ratings were the same as for the PHE institutions.

Education

Table 2 Performance Assessment of PHE Institutions Graduates by Employers and the Alumni Themselves

Proxy Measures of performance	*Assessment by Employers*				*Assessments by Alumni*			
	1	2	3	4(2-1)	1	2	3	4(2-1)
	Worse	Better	AS	Difference	Worse	Better	AS	Difference
1. Academic Qualification	29	14	57	-15	6	42	53	36
2. Knowledge depth	20	27	53	7	8	40	52	42
3. Aptitude	13	20	67	7	12	32	56	20
4. WTTMR	7	33	60	26	8	27	65	19
5. WTTMWL	17	20	63	3	14	27	59	13
6. CA Rights	….	14	86	14	3	27	70	24
7. CA Obligations	…	12	88	12	7	18	75	11
8. Punctuality	3	28	69	25	2	50	48	48
9. Counseling Others	7	21	72	14	7	35	58	28
10. Friendliness	…	38	32	38	….	39	56	39
11. Flexibility	3	33	60	30	5	47	48	42
12. Cooperativeness	…	39	61	39	4	42	54	38
13. Actions for SI	7	40	53	33	5	43	52	38
Mean Freq %age	8	26	66	18	7	36	57	29

AS = About the Same. WTMR = Willingness to take more responsibility. WTTMWL = Willingness to take more work load CA = Consciousness About SI = Self Improvement

Overall, 2/3 of the employers consider that their employees sourced from both the private and the government educational institutions have **ABOUT THE SAME** standard with respect to the 13 enumerated attributes in the table above. In light of the recent arrival of private institutions, that their products are considered of similar standard by employers is an indicator of a salutary performance. Further, those who rated them **BETTER** (26% on average) exceed those who considered them **WORSE** (8%). From this finding, it can be safely asserted that private sector higher education institutions are making noticeable progress in terms of acceptability of their graduates

by employers[15]. While the alumni who say that their institutions were **WORSE** are about the same as those of employers, a significantly higher percentage of respondents (57%) said that they were **BETTER** at the expense of those who reported them to be ABOUT **THE SAME** (36%).

None of the employers rated PHE graduates as **WORSE** than those of government in terms of the very important attributes of *Consciousness about Rights*, *Obligations*, *Friendliness* and *Cooperativeness*. 39% and 38% of the employers rated PHE graduates as **BETTER** than public sector graduates with respect to *Cooperativeness* and *Friendliness* respectively. When the proportion of those respondents rated the graduates from PHE institutions as **WORSE** (in all less than 10%) are deducted from those who rated them as **BETTER**, the net gain is 33%, 30%, 26% and 25% with respect to *Self Improvement*, *Flexibility, Willingness to Take More Responsibility*, and *Punctuality*, respectively.

Hypothesizing that the alumni may overrate themselves with respect to the selected attributes, the responses of alumni and employers were subjected to a statistical difference test of significance. Except for *Punctuality*, where only 28% of the employers said that they were **BETTER** against 50% by the alumni themselves, there was no statistically significant difference between the responses of the two groups of respondents[16].

A significant result emerging from the data is that as ascertained by their employers, private sector alumni are more aware of both their *Rights* and *Obligations.* In this respect, none of the employers considered the private sector alumni to be **WORSE** than the government graduates. It appears that given that PHE students pay fees, they are more inclined to seek accountability from service providers in terms of both the *Provision of the Educational Services* and the *Creation of a Better Social Environment* to attract more students. Simultaneously, the alumni had to meet the academic standards on their part resulting in the recognition and implementation of conditions of *Right* and *Responsibility*, which may have been taken to the world of work.

[15] It should however be borne in mind that this is only a *relative* measure which does not say anything about the *absolute* quality of education provided.

[16] A Chi Square Test was applied to the frequency distributions. Only under punctuality, employers considered the private sector graduates worse at a statistically significant level compared to the self-evaluation of the same by the alumni.

The reason for their better performance at work could also be attributed to the fact that about 2/3 of their parents had obtained at least a Diploma (28%), first degree (24%) and Masters degree (8%). This is quite high given the low level of education in the country as a whole. Thus, since most students in PHE come from educated families, they benefit from academic and social tuitions including on the dinner table, boding well for their performance, sustainability and development. That most of them originate from the urban social milieu would have added to their better social interaction and mobility in the modern sector of the economy, prompting their employers to rate them **BETTER** than those who graduated from government institutions.

Another interesting point emerging from the study is that, albeit at varying degrees, the employers response about the performance of PHE institutions under the category **BETTER** is greater than **WORSE** in all cases except in *Professional Qualification*, where contrary to all the other attributes, **WORSE** scored greater than **BETTER** by as much as 15%. Whereas in the outcomes from the qualification, i.e. the service output attributes, PHE employees earn a net positive score between **BETTER** and **WORSE** in favor of the former. The reversed case for *Professional Qualification*, which may otherwise could have been hypothesized to be among the 'causes' for *Better Performance* is somewhat intriguing. This may be the result of embedded bias by the employers who most probably are government institution educated and hence are protecting their own mode of training and education.

The assessment of the alumni of PHE as **BETTER** was higher than **WORSE** in all cases with the overall positive difference being as high as 29% as compared to that of employers which is 18%. Such important positive attributes for the alumni of private educated employees as compared to those of government could have partly been the result of inculcation from the academic and social environment of the private education sector. Currently the alumni are engaged in self improvement programmes in the areas of *Academic Endeavor* (58%), *Professional Development* (43%), *Improving Physical Environment* (40%), *Sport (*35%), *Culture* (28%), *and Expanding the Horizon of Social Interaction* (35%).

In the end, 57% of the employers were indifferent as to whether to choose future employees from private or government institutions. However despite the marked difference in the assessment of their performance in favor of PHE graduates (30%), the demand for government educated ones was higher than the preference from the private (13%). Again, this may be a reflection of the embedded preference of the employers for the type of institution they came from: the government.

Health

Overall, 45% of the patients said that the private sector provision is **BETTER** while only 11% (a good part of accounted by payment of higher fees) of the interviewed patients stated that private provision is **WORSE** than that of government. Only 1/3 (against 2/3 for education) said that they are **ABOUT THE SAME IN HEALTH**. This implies that there is a wider perceived gap in health service provision between the public and private sectors. Under the sum total of health service provision, as many as 82% respondents said that quality of service is **BETTER** in the private sector. The private sector showed **BETTER** results (68%) in *Patient Examination and Treatment*.

According to the interviewed patients, private sector provision was preferred because of *Lower Patient/Staff Ratio* (74%), *Punctuality* (67%), *Less Work Load of Staff* (67%) and *Suitability of Location* (61%). More than half of the patients also considered that private sector health provision was **BETTER** in terms of a *Healthy Life Prospect* (57%), *Counseling* (53%), *Friendliness* (54%) and *Physical Environment* (51%). However, more respondents said that *Fees* were worse in the private than in the public facilities.

Patients who attended other private sector health service providers said that the current one on the day of the interview was preferred because of *Better Location* (63%), *Quality of Service* (59%), *Lower Patient/Staff Ratio* (49%), *Physical Environment* (48%), *Counseling* (45%), *Punctuality* (47%), *Friendliness* (47%) and *Less Work Load* (46%). At an average of 48%, the difference between BETTER and WORSE is marginally higher in the private sector provision to that of government (45%). In addition, 30% of patients rated their health institution in which they were treated as **EXCELLENT**, 47% VERY **GOOD,** and 23% GOOD (see table 3 below for details).

Table 3: Performance Assessment of Private Health Institutions by Patients and the Alumni Themselves

Proxy Measures of performance	*Compared to Government*				*Compared to Other Private*			
	1	2	3	4(2-1)	1	2	3	4(2-1)
	Worse	Better	AS	Difference	Worse	Better	AS	Difference
1. Quality of Service	2	18	16	80	…	50	40	59
2. Staff Qualification	9	41	50	32	2	42	53	40
3. Examination &Treatment	4	68	28	64	8	27	65	19
4. Healthy Life	10	57	33	47	…	40	60	40
5. Counseling	7	53	40	46	7	45	48	38
6. Patient/staff ratio	4	74	22	70	7	49	44	42
7. Work load	2	67	31	65	10	46	44	36
8. Punctuality	2	67	31	65	5	47	48	42
9. Friendliness	4	54	42	50	3	47	49	44
10. Flexibility	4	45	51	41	2	43	55	41
11.Physical environment	25	52	23	27	10	48	41	38
12 Social environment	13	43	44	30	7	38	55	31
13. Fees	57	26	17	-31	11	35	54	24
14. Location	8	61	31	53	9	63	27	54
Mean Freq %age	11	56	33	45	6	46	49	40

AS = About the Same

The respondents recommended the following for more improvement of services: *More and Better Equipment* (34%), *More Space* (16%), *Less Charges* (3%), *Improved Social Environment and Combinations* (45%).

Summary and Conclusion[17]

Driven by the restructuring world economy with massive incremental output and demand in Asia by China and India in particular, the Ethiopian economy had been experiencing a remarkable growth, at a rate of over 10% on the average in the last consecutive six years. The growth rate in the post 1991 period as a whole has been significantly higher than the previous decades. This is more interesting because it is posited on small holder based agriculture. Concurrently, the government of Ethiopia has been taking several institutional and policy reforms which have created a positive climate for economic growth.

With respect to PHE and private health, the policy reforms appear to be bearing fruit as expressed in the expansion figures and the responses of service provider firms on different measures of aspects of ICBE. From the study, it emerges that private sector higher education and service provider health institutions are making a notable progress[18].

Notwithstanding the trends in positive achievements, there are several areas which require fine tuning of policy and institutional reforms. Privately educated employees are more conscious of both their *Rights* and *Obligation*. Since clients have to pay fees and have the right to choose and demand for better services, PHE colleges have to respond to this situation by preparing their students to the world of work.

Given the low level of the economy, tremendous growth in private health and education may have proceeded at the expense of quality. The main study from which this paper has been produced suggested that checks on quality and standard are weak. There is thus the need to use *absolute dimensional criteria using a benchmark* to

[17] It is worth repeating that some of the conclusions here are derived from the wider Research Report of the main study.

[18] Despite their better performance however, employers do not value the qualification of PHE institutions as much as that of Government ones. Most senior managers having been graduates of government institutions, this perhaps reflects their own bias against qualifications from private higher educational institutions.

compare and monitor quality. Following this, there might be the need to *classify and ascertain minimum standards*, not just for levels such as **LOWER**,**MEDIUM** and **HIGHER CLINICS**, **HOSPITALS**, **PRIMARY, SECONDARY SCHOOLS** etc. but also the use of *grades within* so that clients can get information to help them buy services with the resources at their disposal.

The growing size and scope of the private health sector, both for profit and not-for-profit, offers an opportunity to enhance the health service coverage through such measures as *subsidy* and as well *enabling government to give more focus to rural areas*. Improving the quality of education at all levels and strengthening the public – private partnership in health and education are the main areas of challenge that all stakeholders must consider and accordingly deal with in the future.

Rather than absorbing the left over from the Government sector, genuine and effective partnership between government and the private sector have to be remodeled with a certain level of autonomy for each. Government needs autonomy to ensure that its social goals are not subsumed by the profit objectives of PHE firms. The latter requires autonomy to tailor its services in order to meet the specific demand of the market. The ultimate beneficiaries of the process, employers and students can enrich the institutional packaging through bringing in their up to date need in the state of the art and the content area of education**.**

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Employers' and Patients' Evaluations of the Services of Private versus Government Higher Education and Health Institutions in Addis Ababa

Annex 1 Private Health and PHE Firms Interviewed

No.	Name of Health Firms Interviewed		Name of PHE Firms Interviewed
1	Abinet Clinic	1	Addis Ababa Polytechnique College
2	American Ghibi Clinic	2	Admas University College
3	Arat Kilo Clinic	3	Africa Health College
4	Arsho Laboratory	4	Atronus College
5	Asegedech Mother and Children Hospital	5	Ayer Tena Health Science College
6	Awash Dental Clinic	6	City University College
7	Aynalem Clinic	7	CPU College
8	Blue Nile Clinic	8	Dynamic International College
9	CMC Michael Clinic	9	Ethiopis Distance Education College
10	Connel Clinic	10	Hayat Medical College
11	Dashen Clinic	11	Hilcoe Computer Science College
12	Dr. Akalewold Special Dental Clinic	12	Infonet College
13	Dr. Yeshihareg Dental Clinic	13	Keamed Medical College
14	Eldina Clinic	14	Kunuz College
15	Empire Clinic	15	Micro link IT College
16	Entoto Godana Clinic	16	Miracle Health College
17	Genet General Hospital	17	National College
18	Kidist Mariam Clinic	18	New Abyssinia University College
19	Luck Clinic	19	New Generation University College
20	Master Dental Clinic	20	Nolicom College
21	Megenagna Clinic	21	Orbit Information Technology College
22	Raey Clinic	22	Roha College
23	Selam Teklehaimanot Clinic	23	Royal University College
24	Sengater Clinic	24	St. Marry University College
25	Seyoum Special Eye Clinic	25	Tropical College of Medicine
26	St. Michael Clinic	26	Unity University
27	Tensae Clinic	27	Universal Medical College
28	Tesfa Kokeb Clinic	28	Yanet Health Science College
29	Tezena General Hospital	29	Yardstick Distance Education College

30	Toneam Dental Clinic	30	Yenegew Sew University College

Annex 2 Interviewed Employer Organizations

1	AB Plast PLC
2	Abyssinia Bank S.C
3	ACOMEX PLC
4	Addis M.F
5	ADS Pharma
6	Africa Insurance S.C
7	Africa Printing Press
8	Alliance Flowers PLC
9	Ambassador Textile and Garment PLC
10	ASA PLC
11	Awash International Bank
12	Chamber Printing Press
13	Comet Trading PLC
14	Commercial Bank of Ethiopia
15	Dream Flowers PLC
16	Ethiopian Insurance Corporation
17	Ethiopian Telecommunication Corporation
18	Finfine Furniture Factory
19	Global Insurance S.C
20	Jupiter Trading
21	Lion International Bank
22	Meweda Academy
23	Myungsung Christian Medical Center
24	NAS Foods PLC
25	Nib International Bank S.C
26	Nile Insurance S.C
27	Raselase Diversity School
28	SNAP Computers
29	United Bank S.C
30	Wogagen Bank S.C