Financing the health workforce in Uganda

A team from ACHEST and Wemos share their work on health workforce financing in Uganda

Health workers play a critical role in the provision of health care and represent the single largest cost element in providing health services in low-income countries; from health promotion to prevention, treatment, rehabilitation and palliative care. Many of the poorest countries in the world lack the resources, both human and financial, to meet the pressing health needs of their populations. Millions of people die prematurely, or suffer from illness or disability unnecessarily, because appropriate Human Resources for Health (HRH) to provide care are not available or accessible to them.[1]

Staffing unmatched by population growth

Like most sub-Saharan countries, the shortage of health workers in Uganda persists despite efforts by government and development partners to ameliorate the situation. At the time of the last revision of staffing norms in 1999 the population of Uganda stood at just over 21 million, nearly doubling in 20 years to 40 million in 2019.[2] Although the absolute numbers of filled positions between 2010 and 2019 increased, the health worker to population ratio remained static over the same period. The WHO has recommended that in order to realise Universal Health Coverage (UHC) as part of the Sustainable Development Goals (SDGs), a country needs at least 4.45 professional health workers for every 1,000 inhabitants.[1]

A 2019 report on conducted by ACHEST and the Dutch medical foundation WEMOS showcased the situation of the health workforce in Uganda, particularly focusing on financing the public health workforce and how shortages contribute to the unacceptably high maternal mortality rates and poor health outcomes in general. The study revealed at the time a ratio of approximately one employed professional health worker per 1,000 inhabitants.[3] The total number of skilled health workers required for the Ugandan population in 2019 was 167,765, however, the available number (i.e. of doctors, midwives and nurses) in post stood at just 27,761 revealing a catastrophic staffing gap. Insufficient funding and poor management of the funds are impeding factors for improvement in the recruitment and retention of health workers.

The report advances policy recommendations for the Government of Uganda, development partners and international financial institutions to work towards:

- adjusting the health workforce needs to the current population, taking into account population size, health needs and life expectancy;
- stepping up levels of and effective management of domestic and;
- better mobilisation and utilisation of development assistance for health.

The report underscores the need to invest in health workers in Uganda to achieve UHC and the SDGs.

The investment case for HRH

Investing in the Health workforce not only promotes but also protects and sustains the population's health. A health workforce adds economic value because economic growth and development depend on a healthy population. About one-quarter of economic growth in low- and middle- income countries (LMICs) between 2000 and 2011 resulted from improvements in health.[4] There is an enormous payoff from investing in health. Improved health contributes importantly to income growth in LMICs, as measured using traditional national income accounting (based on gross domestic product). But while GDP captures the benefits that result from improved economic productivity (the so-called instrumental value of better health), it fails to capture the intrinsic value of better health – the value of health in and of itself. Global Health 2035[5] reports a more comprehensive understanding of the returns to investing in health by estimating this intrinsic value using "full income" approaches. Full income approaches suggest that the intrinsic value of better health is likely to be a multiple of its instrumental value. These results provide planning ministries in LMICs, as well as donor agencies, with a strong new rationale for increasing health spending.

Pro-poor pathways to UHC, such as publicly financed insurance, would provide financial protection and essential health-care interventions to everyone – ensuring high-quality, low-cost services at the point of care. And the returns on investing in health, based on methods that include both the benefits of improved economic productivity and the intrinsic value of health, would far exceed the costs.

Better health can stimulate economic development through different pathways; first of all, it improves labour productivity, because healthy children attend school and receive improved education. Healthy citizens are more likely to invest in the economy and healthier populations can attract foreign investment. The workers-to-dependents ratio increases and the demographic dividend can be harnessed. Moreover, investing

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in decent jobs in the health sector contributes to social protection and social cohesion. The health sector is an important source of jobs for women, youth, and in rural areas, where other sectors do not invest. Investing in health employment can tackle the twin crisis of youth unemployment and the global shortage of health workers, and contribute to gender equality.[6]

Health sector funding

Despite the growth in Uganda's GDP between 2007 and 2016, the public health sector has not been able to attract an adequate share of resources. The government's health budget has been on the decline as a proportion both of GDP and of general government expenditure. In monetary terms and according to the WHO, total health expenditure per capita has fallen, after peaking at US$63 per capita in 2010, to $38 per capita in 2016. Of the latter figure, only $6 came from the government's domestic budget.[7]

The National Health Accounts 2015/16 report itself paints a different picture of the health expenditure in Uganda. According to this report, the total health expenditure per capita in 2016 stood at $51 per capita, out of which only $8 came from the government's domestic budget.[8]

Nevertheless, even if these figures are higher than the ones provided by the WHO, they are still below international recommendations and it is still notable that health expenditure derives more from external and domestic private resources than from the domestic government budget. Between the financial years 2017/2018 and 2018/2019, the government domestic budget for the health sector decreased from $492 million to $334 million. The health budget for the FY 2019/2020 was even lower at $323 million, which equals $8 per capita. In the National Budget Framework 2019/20-2023/24, the budget allocation to the health sector was 8.9% of the general government expenditure which saw a decline in 2020/21 to 5.9% of the national budget which despite the outbreak of the Corona pandemic.

Domestic prioritisation of health is important, but not sufficient. If Uganda allocated 5% of its GDP to health, that would amount to $1,169 million, which would mean only $29 per capita in 2019. This last fact also explains the importance of a combination of an absolute and relative target for health spending, as proposed by McIntyre et al[9] and the need for both domestic and international resources to contribute to the health sector.

As a comparison, the transport sector, which is considered to be central to Uganda's economic development was allocated USD 1,237 million in 2017/2018, representing 20.8% of the total government budget, for 2019/20, this budget rose to $1,435 million.[10] Notably, between 2018/19 and 2019/20, the health sector saw a decrease of 1.5% in its budget, whereas the transport sector saw an increase of 2%.

The health sector wage bill

The wage bill of the health sector has seen an increase, from $108 million in 2017/2018 to $160 million in 2018/2019, in part as a result of industrial action by the health workers. However, these extra funds were spent on higher salaries, not on filling more staff positions. The wage bill for the sector remained largely unchanged for the Financial Year 2019/2020.[11]

Out-of-pocket expenditure

'OOP' spending on health in Uganda has been around 40% of total health expenditure during the last decade, even if the absolute OOP per capita has decreased. But lower absolute OOP spending does not necessarily mean lower financial barriers, as it can also be explained by no access to healthcare exactly due to inability to pay. One of the targets of the Health Sector Development Plan 2015/16-2019/20 was to bring this percentage down to 30% by the end of 2020.

According to the National Health Accounts 2015/16, household OOP represented the 95.6% of the overall private health expenditure, while employer-based insurance, (compulsory and voluntary) and community-based insurance together stayed under 5%.[12] Uganda currently has 5% of the population covered under health insurance and only 11% of persons aged over 15 years are even aware of health insurance.[13]

Health insurance

There is no operational national health insurance scheme (NHIS) in Uganda. This is one of the end term targets for the completion of the HSDP. The NHIS Bill has been presented to Cabinet and the Parliament for approval. The scheme is expected to reduce OOP and ensure affordability of health services for individuals under both formal and informal employment.

In early March 2021, the Minister of Health withdrew the NHIS Bill from the floor of parliament for further review following objections from some stakeholders reversing gains arising from a protracted campaign championed by civil society for the enacting into law an instrument providing for affordable health insurance.

If the NHIS bill is eventually ratified, Uganda will join Kenya and Rwanda as countries in the East African region that have implemented such a scheme. Notably, the NHIS Bill has been waiting for approval since 2007, when it was initially drafted, whereas the plans to launch a compulsory public social health insurance scheme started back in 2002.

Conclusion

HRH demand and supply in Uganda is based on staffing norms that should be revised on a regular basis to respond to population and disease burden dynamics. The MoH is preparing a WISN report, which will configure the national need. The current ratio of approximately one employed professional health worker per 1,000 inhabitants is clearly too low. At the present time, the health workforce is not keeping up with the population growth, nor the epidemiologic changes and demographic trends, including increased life expectancy. Paradoxically, this is a case of a shortage in the middle of plenty, as there is a large pool of qualified and licensed health professionals, who remain unabsorbed and out of the labour market. Notably though, even if all the unemployed health professionals were absorbed, Uganda would be still far from the international requirements for UHC. In addition, brain drain – qualified health workers migrating abroad – is enlarging the existing gap. The remaining health workers have to deal daily with a heavy workload and lack of essential medicine, equipment and basic infrastructure, especially in hard-to-reach rural areas. According to the leadership of the Ugandan Medical Association, health workers regard the inadequate working conditions as more crucial than low salaries.

The problems and gaps of the Ugandan health workforce are persisting due to insufficient financial allocation and poor management of HRH and existing funds. Weak technical leadership for HRH at the MoH, mismatching of training to health needs, and decentralised recruitment and management are major contributing factors. There is an irony in the high donor investment and declining government investment in health amid Uganda's economic growth. Total health expenditure has been decreasing in the last decade; as a percentage of the total government expenditure, as a percentage of the GDP, and per capita. Since 2007, increases in external financing have been accompanied by decreases in domestic government financing.

Why is the public health sector not able to attract a greater share of resources, or at least retain their share of government funding? The complex political economy of the budget allocation process explains why the public sector has consistently not been prioritised. The prioritisation instead of the transport and infrastructure sector, which contributes to the development of the nascent oil sector of the country, is a political decision of the Government of Uganda. The question is whether this is in the best interest of the population and their health.

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