



Advocacy brief Uganda

# Uganda's human resources for health: paradoxes and dilemmas



This document is part of Wemos and ACHEST's contribution to the Health Systems Advocacy Partnership

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Wemos and the African Center for Global Health and Social Transformation (ACHEST), as part of the Health Systems Advocacy Partnership and supported by IDA Charity Foundation, conducted an extensive literature review and interviewed representatives of the government of Uganda, the donor community and civil-society organisations. Our findings were presented and validated by the Human Resources for Health Technical Working Group of the Ugandan Ministry of Health in May 2019. The full report can be found here: [www.wemosresources.org/uganda-report/](http://www.wemosresources.org/uganda-report/)



1

Health systems must have a sufficient in number, well-trained, gender-balanced, equitably distributed and adequately remunerated health workforce.

2

There are not enough health workers for the size of the Ugandan population.

Uganda

Kampala

3

Uganda has a large pool of trained, licensed, but unemployed health professionals.

4

Inadequate funding and poor management impede improvements in recruitment and retention of health workers.

5

International recommendations include minimum public spending of around USD 90 per capita. Uganda currently spends USD 51, out of which only USD 8 come from the government.

# Uganda's human resources for health: paradoxes and dilemmas

For any health system to operate well and serve its purpose of improving the population's health and leaving no one behind, it must have a workforce that is sufficient in number, well-trained, gender-balanced, equitably distributed and adequately remunerated.

Uganda has had a huge shortage of human resources for health (HRH) for many years now. This shortage has had a dire impact on a number of critical health indicators, which are lagging behind national and international targets. This applies especially to maternal mortality. At the same time, the shortage of HRH is a global health issue that goes beyond both national borders and the health sector. It is a global responsibility and a matter of global social justice, as it is an essential requirement for exercising the right to health for people all over the world.

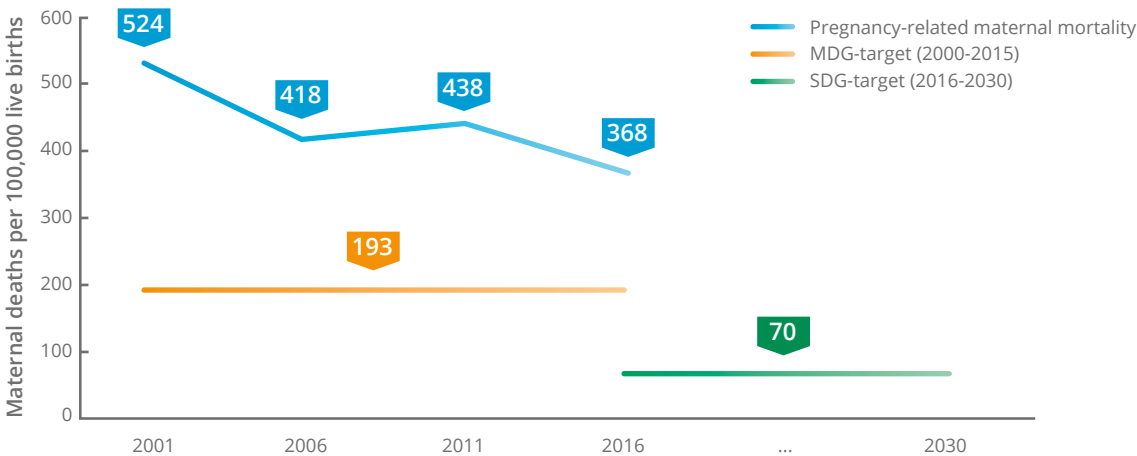
Most maternal deaths are preventable nowadays, as the healthcare solutions for preventing or managing complications are well-known. However, health workers are needed to provide these solutions. Two important strategies for improving survival rates and the health of women and new-borns are to ensure that

deliveries are conducted by skilled birth attendants<sup>1</sup> and also to ensure that women receive proper antenatal care.<sup>2</sup>

Despite the efforts made by the Ugandan government and its development partners, the shortage of health workers still persists. HRH plans for the period before 2010 did not pay sufficient attention to the lack of resources, and instead tended to focus more on effectiveness and efficiency. This focus has changed in more recent plans, such as the Health Sector Development Plan, which are now beginning to deliver results.

Inadequate funding and poor management have been identified as factors impeding improvements in the recruitment and retention of health workers. The level of domestic resources currently allocated to the health sector, representing around 1% of GDP,

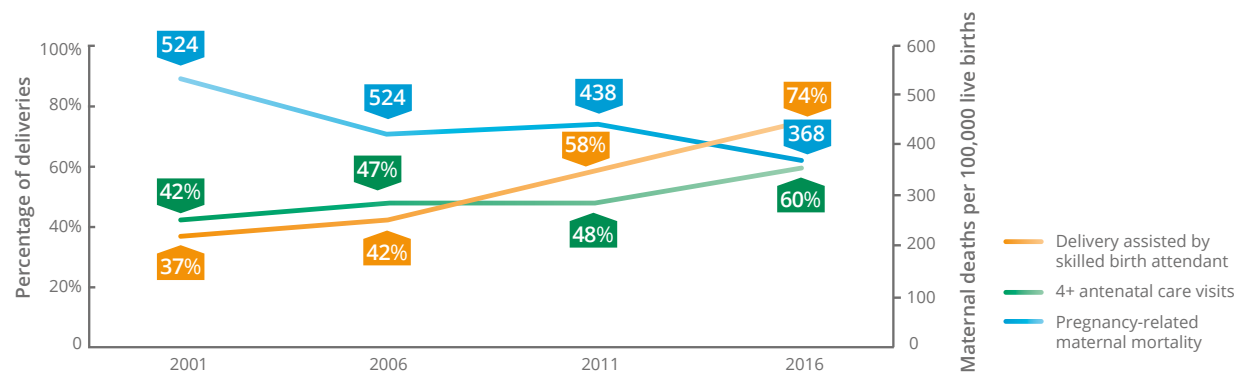
Maternal mortality in Uganda, 2001-2016 *Source: DHS Uganda*



<sup>1</sup> The term 'skilled birth attendants' includes doctors, nurses, midwives and medical assistants or clinical officers.

<sup>2</sup> Benova et al., 2018.

## Health services compared with maternal mortality ratio in Uganda (2001-2016) *Source: DHS Uganda*



is not enough to fund a health system that can offer the Ugandan population a minimum healthcare package. A large share of the health budget in Uganda (40%) is funded by donors, and in many cases these funds cannot be used to pay health workers' salaries. Uganda lacks a robust national tax-funded health system and a national health insurance scheme. These factors keep household out-of-pocket spending on health at an unacceptably high level, i.e. around 40% of the total health expenditure.

### There are not enough health workers for the size of the population

The World Health Organization (WHO) has calculated that, in order to achieve universal health coverage (UHC) and the UN Sustainable Development Goals (SDGs), a country needs to have at least 4.45 skilled health workers for every 1,000 inhabitants.<sup>3</sup> If we apply this formula to Uganda, the total number of skilled health workers required by the country would be 167,765. At the moment, however, the number (i.e. of doctors, midwives and nurses employed) stands at just 27,761. This is around one-sixth of the requirement.

However, in assessing the current situation in Uganda, it would be logical also to take account of what are known as 'allied health professional cadres'. These include clinical officers<sup>4</sup>, laboratory staff, theatre staff, orthopaedic officers, dental officers, pharmacy staff, radiographers, dispensers and anaesthetists. If these are indeed included in the equation, the number of health workers employed in Uganda comes to approximately 39,000.<sup>5</sup> Although a higher figure than the number mentioned above, it still means that **Uganda has only one employed professional health worker for every 1,000 inhabitants.**<sup>6</sup>

This relatively small number of health workers have to shoulder heavy workloads every day and contend with a lack of essential medicines, equipment and basic infrastructure, especially in hard-to-reach rural areas. **Many of them regard the poor working conditions as even more discouraging than their low salaries.**

While staffing levels in the healthcare sector have risen in absolute terms during the past decade, rapid population growth in Uganda means that the ratio of

<sup>3</sup> The WHO takes the figure for doctors, midwives and nurses only as a proxy for the total number of health workers required.

<sup>4</sup> Clinical officers have a separate training programme to medical doctors, but their roles include many medical and surgical tasks usually carried out by doctors, such as anaesthesia, diagnosis, treating medical conditions and prescribing medicines.

<sup>5</sup> Government of Uganda, 2017.

<sup>6</sup> Including those employed in the public sector (2019 data supplied by IntraHealth), plus the four private not-for-profit medical bureaus (2017 data, last published and available).

health workers to inhabitants has not risen accordingly. Indeed, there has even been a decline in the staffing ratio for midwives and nurses. The relevant standards for staffing levels were set back in 1999, when the population was just over 21 million. Today, in 2019, the population of Uganda has almost doubled to 40 million. Moreover, the country's epidemiological profile has also changed in the meantime, with an increase in the burden of non-communicable diseases, leading to concomitant changes in its healthcare needs. **The Ministry of Health needs to revise standard staffing levels to reflect the population's increase, as well as the needs of different areas and population groups.**

Apart from the absolute numbers, the distribution of health workers around the country is also an important consideration. Uganda's population is predominantly rural but we see that rural areas and areas that are hard to reach are severely underserved. For example, while 90% of the health worker posts were filled in Kampala, only 53% of them were filled in rural Moroto district.

The irony is that there is a large supply of qualified and licenced, but unemployed health professionals. Their number rose from 90,412 in 2017 to 101,350 in 2018.<sup>7</sup> This makes HRH in Uganda a case of a **shortage in the midst of plenty**. If the existing supply were to be absorbed into the workforce, the ratio of doctors, nurses and midwives per 1,000 inhabitants would rise correspondingly from 0.60 to 2.9. Although this is clearly a much higher figure, it is still below the WHO target of 4.45.



Qualified health professionals, both employed and unemployed, are leaving the country or the public health sector for other jobs. This **brain drain** widens the health workforce gap and also produces a much heavier workload for those left behind.<sup>8</sup> The net loss of doctors due to migration is at least equivalent to 10% of the annual number joining the healthcare market.<sup>9</sup>

#### The health workforce is gender-imbalanced

Of the Ugandan health workforce, 54% consists of women and 46% of men. These figures are for all positions and all levels. Although there would at first sight appear to be a gender balance, the picture is very different if we zoom in more closely. 80% of senior medical officers are men, whereas 94% of nurses are women. Uganda is no exception in the trend for global health to be *'delivered by women but led by men'*.<sup>10</sup> This occupational gender segregation widens the gender pay gap and places women at an economic disadvantage. Moreover, the health sector is weakened by the loss of female talent, knowledge and ideas that women in decision-making position could bring.

Professions (public sector)	2010 (total)	2017 (total)	2019 (total)	2010 (per 1000 pop.)	2017 (per 1000 pop.)	2019 (per 1000 pop.)
Doctors	791	1298	1210	0,03	0,03	0,03
Clinical officers	2014	2756	3399	0,06	0,07	0,08
Midwives	3574	5353	5157	0,12	0,14	0,13
Nursing staff	12404	17258	17995	0,40	0,46	0,45

Population growth from 31.1 million in 2010 to 37.8 million in 2017 and further to 40.3 million in 2019. (Government of Uganda, 2017; Uganda Bureau of Statistics, 2019)

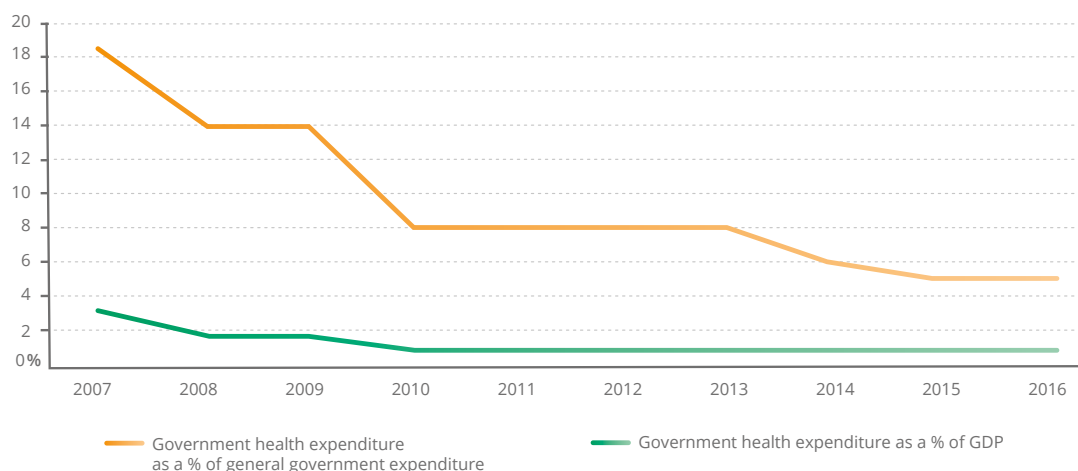
<sup>7</sup> Ministry of Health, 2018.

<sup>8</sup> International Organization for Migration, 2015.

<sup>9</sup> Omaswa et al., 2017.

<sup>10</sup> World Health Organization, Global Health Workforce Network, Women in Global Health, 2019.

## Trends in budget allocation to health 2007-2016 Source: WHO Global Health Expenditure Database (GHED)



### The irony of dwindling investment amid economic growth

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 fact, total health expenditure per capita has fallen, after peaking at USD 63 per capita in 2010, to USD 51 per capita in 2016. **Of the latter figure, only USD 8 came from the government's domestic budget.**<sup>11</sup> The bulk of health expenditure comes from external and private domestic sources, rather than from public domestic sources.

Compared with its neighbours, Uganda allocates the lowest share of GDP and government expenditure to the health sector. It is below the targets for health spending, i.e. 5% of GDP and USD 86 per capita on health and UHC, set out in McIntyre et al.<sup>12</sup> and the WHO<sup>13</sup>. An absolute target, of course, needs to be adjusted over the years. Currently, the World Bank estimates that 90 USD per capita per year is needed for UHC while a costing exercise by the WHO came up with a number of USD 112.<sup>14</sup>

Moreover, although Uganda's GDP has been growing, the government captures only 14% of it through taxation. This is due to the massive size of the informal economy, plus tax avoidance and tax evasion by individuals and national and multinational corporations. It is estimated that Uganda loses more than USD 547 million annually as a result of illicit financial flows. This represents almost USD 14 per capita.<sup>15</sup>

### Budget allocation: who gets the lion's share?

The health sector in Uganda urgently requires more funding. Between FY 2018-19 and FY 2019-20, there was a 1.5% decrease in the funds allocated to health, while there was a 2% rise in the transport funding at the same time.<sup>16</sup> Although the prioritisation of transport and infrastructure is helping to foster the development of the oil sector, investments in the health sector are a proven driver of economic growth. In its 2017 Article IV Consultation, the IMF recognised that Uganda's health spending was relatively low, at 1% of GDP, but advised the government to consider raising social spending only once the economy had recovered.<sup>17</sup> Two years later, however, in the 2019 consultation, the IMF concluded that the trend towards lower spending on health and education should be reversed in order to create more inclusive growth.<sup>18</sup>

<sup>11</sup> Ministry of Health, 2016.

<sup>12</sup> McIntyre et al., 2017.

<sup>13</sup> Jowett et al., 2016.

<sup>14</sup> Stenberg et al., 2017.

<sup>15</sup> SEATINI and Oxfam, 2018.

<sup>16</sup> Ministry of Finance, Planning and Economic Development, 2018.

<sup>17</sup> International Monetary Fund, 2017.

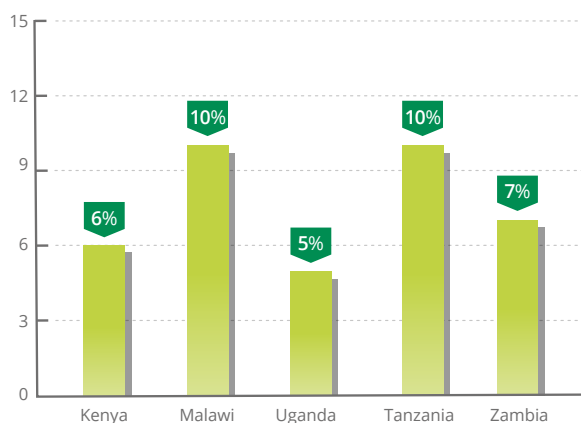
<sup>18</sup> International Monetary Fund, 2019.

<sup>19</sup> Ministry of Finance Planning and Economic Development, 2019.

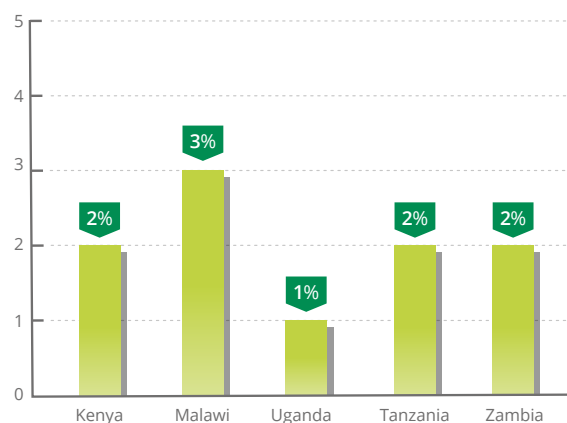
*This is the most recent available data. It is different from the WHO GHED figures, which were used for intercountry comparability.*



Government health expenditure as % of general government expenditure (2016) Source: WHO GHED



Government health expenditure as % of GDP (2016) Source: WHO GHED



## Our recommendations

- ▶ The Ministry of Health should **adjust the staffing level standards for the health workforce to the size, distribution and needs of the population**. The last staffing level standards were set back in 1999, when Uganda's population was half of today's.
- ▶ The Ministry of Health should **absorb trained but currently unemployed health workers** into the public sector as soon as possible through mobilisation of resources.
- ▶ Align the training of new health workers with those professions where there are the greatest staff shortages. **Uganda can adopt the WHO Country Coordination and Facilitation multisectoral mechanism** that brings together the Ministries of Education, Health, Local Governments and Public Service and training institutions to forecast and plan the training of health professionals according to the needs.
- ▶ **Meet the Health Sector Development Plan target and the Abuja Declaration commitment of allocating 15% of the government budget to health**. The government currently invests only 6.4% of its budget in health.<sup>19</sup>
- ▶ **Set a target of spending 5% of GDP and at least USD 90 per capita on health**, in accordance with the international recommendations on the route to UHC.
- ▶ **Expedite the ratification the National Health Insurance Scheme Bill**. This could help to reduce household out-of-pocket payments from 40% of total health expenditure closer to the 30% target that the government has set for 2020.
- ▶ The Government of Uganda should strengthen staff capacity and improve administrative efficiency so that they can **detect and investigate tax dodging and capital flight** by multinational corporations and close loopholes that corporations and individuals can take advantage of. They should expand the tax base by tapping into hard-to-reach economic activities.
- ▶ **The IMF should help the government to raise public spending on health by easing the strict targets on monetary and fiscal policy**. The IMF should highlight the importance of investing in public health in its policy advice to the Ugandan government.
- ▶ **Development partners and donors should raise their support for health worker recruitment and salaries by offering more flexible and dependable funding**. They should increase the proportion of funds channelled through the government and return to a sector-wide approach.
- ▶ Civil-society organisations (CSOs) can hold governments, donors and international financial institutions to account for their roles in the critical situation currently facing the public health sector in general and the health workforce in particular. **CSOs need to continue advocating the right to health**.



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# Colophon

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