Dying for economic growth? Evidence of a flawed economic policy in Uganda

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Uganda is now regarded as a success for having achieved remarkable economic progress. Nevertheless, no substantial improvement in social welfare is apparent. The World Bank, the International Monetary Fund, and latter-day free-market converts, including welfare-state donor countries and Uganda's own finance ministry, love to describe the country as an economic star, but shy away from explaining in a convincing way why, for such a brilliant economic performance, the country has a miserable social-welfare situation, as epitomised by persistently high maternal and infant mortality.

The reason for this paradox is that the economic policy has succeeded specifically at the expense of social welfare. This policy extols export-oriented private-sector investment, which is expected to lead to economic growth and increased household incomes. Better incomes are said to be the only way to ensure social welfare. But to create the necessary macroeconomic environment for investment and the private sector, public expenditure, particularly for social services, must be highly restricted,[1] and any social-welfare targets, such as the Millennium Development Goals, that cannot be achieved within these constrained social spending limits must be abandoned.[2] According to the government's policy, welfare should therefore be postponed until economic growth has reached some arbitrary optimum.

Under this approach, inflation is presently 5·7%,[3] and has been controlled at below 10% per year since 1990. Government expenditure is 23% of gross domestic product (GDP), and half this expenditure is external aid. There has been tremendous investment, especially of foreign origin, in trade, manufacturing, and infrastructure. The economy has grown at a rate of 6·5% GDP per head from US$190 in 1989 to $250 in 2003.[3] Income poverty is said to have fallen greatly from 56% in 1992 to 35% in 2000, but it increased to 38% in 2002.

However, these statistics hide sad economic and welfare realities. First, the definition of income poverty for Uganda is based largely on lack of food, but this term has become synonymous with poverty as whole. Those who praise Uganda's so-called economic miracle say without a second thought that the country's entire poverty has reduced from 56% to 35%. Yet this notion of poverty excludes or grossly understates the scarcity of social services such as health services, and child and family protection and support, which have got worse.[4] Further, the simplification of poverty into lack of income has excluded non-monetary aspects of poverty such as powerlessness, exclusion, and hopelessness, which cannot be expressed in statistics but have also worsened.[5]

Second, mean income inequality increased from a Gini co-efficient (a measure of inequality where 0=total equality and 1=total inequality) of 0·35 in 1992 to 0·43 in 2003, with huge regional disparity against northern and eastern Uganda, which has been under rebellion since the advent of the National Resistance Movement government in 1986.[3] Government economists blame the civil war for the regional economic disparity. Since the war has been of constant intensity throughout these years, it cannot fully explain the widening economic gap, which also exists in peaceful areas of the country.[5] Poor people across the country have, through a participatory approach to poverty definition, said many times that they are finding it increasingly difficult to access social services, and that whatever services are available are becoming less complete and of poorer quality.[5] These problems can only be explained for the most part by a flawed economic policy that arbitrarily reduces social services.

Third, Uganda's economy is heavily dependent on external aid. Uganda has hit an all-time high debt burden of US$4·3 billion,[6] which has become unsustainable since the country's entire GDP is just over US$6 billion. Some analysts say that aid is the reason for Uganda's economic growth, and that internal revenue generation is relatively insignificant in its so-called economic success.[6] But, they argue, this aid has made Uganda poorer, not better off.

Nevertheless, progress has been made in other aspects of development. Social stability has been established in a large part of Uganda, after a turbulent past before 1986.[7] Some progress has been made in establishing democratic governance, after a series of dictatorships and military governments since independence in 1962. Universal primary education introduced in 1997 has attained 90% enrolment of children in 2004 with near equal participation by boys and girls. The frequency of HIV has fallen greatly from about 30% in the early 1990s to about 4·1% in 2004.[8] Progressive policies and laws have been introduced to target vulnerable and often marginalised groups such as women, children, and the disabled; however, most of these policies have remained largely unimplemented because of lack of funding.[7]

But overall, Uganda's social conditions have not improved, and some have got worse. Uganda's infant mortality rate increased between 1995 and 2000,[9] and child mortality in those younger than 5 years increased during the same period (table 1). These figures were obtained from surveys that did not cover the remote, unstable, and largely neglected districts. In fact, a recent study in Uganda[7] concluded that infant and child mortality has not improved since 1970, when the infant

mortality rate was 120 per 1000. This rate was 122 per 1000 according to the 1991 national census,[12] and the next reliable survey was the 2002 national census, whose results are still being analysed.

Maternal and childhood mortality are intricately linked. Therefore, Uganda's persistently high maternal mortality ratio of more than 500 per 100 000 livebirths for the past two decades (according to demographic and health surveys) is not surprising. WHO asserts that these surveys, which are done routinely around the world, have generally underestimated maternal mortality.[13] It estimates that Uganda's real rate could be about 1200 per 100 000 livebirths. Therefore, despite its spectacular economic performance, Uganda has been cited as one of eight countries that account for most of the world's maternal deaths.[14] The importance of persistently high mortality is profound; it defies and questions the basis of any social or economic progress a country may claim to have made.

2·5 million orphans and other helpless children—a tenth of the entire population—have no social support.[15] Community and family social safety nets are overstretched or have broken down as a result of population mobility and the adoption of the western lifestyle of nuclear families. Yet there is no publicly funded nationwide programme to support such children. Access to basic needs such as food and nutrition, safe water and sanitation, and health care has remained low and is very unfairly distributed. Humanitarian and multilateral organisations, to which the government has increasingly relegated social services, provide scattered and fragmented welfare, which has had no substantial positive effect nationwide. Table 1 provides a snapshot of the stagnation in Uganda's health and social welfare status.

Four possible reasons for the declining social welfare are HIV/AIDS, conflict, poverty, and contraction of the economy that happened more than 20 years ago. The HIV/AIDS pandemic has contributed to Uganda's high mortality rates, but it cannot account for their persistence at such a high level, or for their rising trend; HIV frequency fell from 1990 to 2004.[8] Moreover, studies[16] have shown that the effect of a moderate and low rate of this infection, such as Uganda has had for 10 years, is that it does not halt or reverse falling or stable child mortality. Instead, as Uganda's HIV frequency rapidly declined, its child mortality increased. The 18-year-old war in the north of the country cannot also fully account for the persistence of high mortality rates, which are present in peaceful areas as well. Furthermore, for countries in which universal social welfare policies have been pursued, overall mortality rates can be controlled where there is conflict (eg, Sri Lanka).[17]

Poverty, as measured by GDP per person, cannot explain Uganda's deteriorating social welfare, because several countries that have been or are at the same economic level had or have much better social services. Some have argued that one possible reason for the welfare decline might be because Uganda had negative economic growth in the 1980s and is just catching up. Having achieved consistent economic growth for two decades, and having even surpassed the GDP per person of countries that are more stable socially and politically, the contraction of the economy over more 20 twenty years ago cannot convincingly explain why Uganda's welfare is decreasing. Therefore, the most plausible explanation for this welfare stagnation or decline can only be economic policy, which has created an arbitrary limitation on social spending.

Uganda is pursuing an aggressive free-market policy whose target is that by 2025 a certain level of economic transformation will be attained, which will not be reversible.[18] It is envisaged that, based on the country's natural resources and labour, manufactured goods and services will be produced for the domestic market and for export. These changes are expected to raise incomes through increasing self and wage employment. Over time, with the expansion of the economy, wage employment is expected to become the most important source of household income.[1]

For this policy to be followed through, the economy should be restructured. Inflation and this public expenditure, should be kept to a minimum. The principle of minimum public spending plus the overwhelming need to support and protect the private sector mean that donor funds meant for social welfare can be rejected.[2] Too high a fiscal deficit (spending beyond internally generated revenue), even when funded by donor aid, could well generate inflation and penalise the local private sector by making local currency artificially strong.

However, according to Sachs,[19] the risks of currency overvaluation from donor-financed health spending are overstated. He argues that there are no precedents in the world where such risks have occurred. He concludes that there are no justifiable reasons to prevent donors from providing grants to obtain the necessary inputs for

	1990–95	2000–04	Change
Nutritional status (wasting in children)	6·2%	7–8%	Deterioration
Access to safe water	39·4%	53·8%	Improvement
Access to proper sanitation	34%	51%	Improvement
Infant mortality rate (per 1000)	81 (97)*	88 (101)*	Deterioration
Neonatal morality (per 1000)	27	33.2	Deterioration
Malaria morbidity proportion	25%	37%	Deterioration
Rate of diarrhoea	17·7%	17·8%	Deterioration
Income Gini coefficient†	0·35	0·43	Deterioration
Maternal mortality (per 100 000)	506	505	No change
Child mortality (per 1000)	147	151	Deterioration
Life expectancy (years)	50	47	Deterioration
Delivery in health facilities	38%	38%	No change
Fertility rate (number of children)	7·4	6·9	Little change

Sources: Uganda Demographic Health Surveys 1995[10] and 2000–01.[11] Data are percentage of total population unless otherwise indicated. *By indirect method. †Source of income Gini coefficient is Government of Uganda.[3]

Table 1: **Health and welfare status from 1990 to 2004**

provision of health care in a poor country in which most people have no reliable access to basic health care or other forms of social protection.

Uganda and other developing countries have embraced a mythical free-market policy. The policy entails, among other things that: (a) a government should have a low budget deficit or even run a surplus; (b) the government should take a minimum role in business or economic production, which should be run by the private sector; (c) social-welfare institutions and services should be privatised, except perhaps for very basic services for the poor; (d) an environment should be created for competition; and (e) there should be deregulation of the economy to remove bureaucratic obstacles for effective private-sector participation.

But donor countries advocating free-market policies do not themselves practice what they preach. The USA is the most ardent free-market advocate but practices something different.[17] For example, the two main political parties in the USA now accept that when a country is in recession, it is not just permissible but desirable to run budget deficits. Yet developing countries are told that central banks should focus exclusively on price stability.

That the role of the government in the economy and social protection is dominant is even more obvious in western Europe, which has welfare states. Donor governments therefore have welfare of their people as their primary focus, and they manipulate economic control variables (inflation rate, interest rate, public debt, balance of payment, and money supply) to ensure they have an optimum balance between social welfare and economic growth. But poor countries are told to concentrate only on macroeconomic stability.

In Uganda, a wide range of reforms is being undertaken to support the creation of a private-sector driven, export-led and industry-based economy. Although such reform policies are often introduced with clear promises of improved social services, social benefits have not been achieved. Similar results are evident in other developing countries, that have embarked on this path.[20,21] Typically, economic reforms are introduced with promises to improve the quality, access, and efficiency of public services. However, the actual results have either been that no improvement has been made in these indicators or they have got worse. Reforms have generally had a negative effect on social welfare.[22]

Although decentralisation, a major institutional reform, has transferred power to communities, this transfer has not been matched with the resources that can make improvements.[23,24] Owing to the different stages of development of the local authorities, inequality in provision of social welfare has increased because of this change.[25] Decentralisation has encouraged sectarianism, by which local authorities prefer people from their ethnic background to work in a local authority, even when they are less qualified.[24] Such authorities, eager to reduce expenditure (and often anxious to save money to meet administrative costs such as paying allowances to council members), have retrenched social-welfare staff. Authorities often prefer less costly, but less qualified staff (eg, nursing aides) to professional staff (eg, nurses).[24]

	Actual	Required/acceptable
Facilities that have some services	42·1%	100%
Facilities offering such care	14·2%	100%
Women delivering in health facility	4·0%	100%
Adequate staff number and training	12–41%	100%
All essential emergency functions	3·9%	100%
Met need for such care	5%	100%
Caesarean sections	5%	15%
Case fatality rates (deaths from obstetric complications as % of all obstetric complications seen)	126–620%	30%

Source: Government of Uganda (2003).[30]

Table 2: **Emergency obstetric care in Uganda**

With a deregulation programme in place, through which as few laws as possible are encouraged to reduce bureaucracy, and to enable investment and the private sector to flourish, decentralisation has created fertile ground for corruption.[24] Various forms of corruption, but mostly dubious contract procedures by which local councils swindle public funds with impunity because they are greatly empowered by law, make it impossible for social benefits to reach target communities.

Civil service reform has had two major effects on social welfare. First, the number of social service staff, which is already insufficient, has been reduced. Second, much of the remaining incentive for work has been removed because staff remain grossly underpaid, are under constant threat of being fired, and lack career prospects.[23] A policy of user-fees imposed as a financing reform by donors, especially the World Bank in the early 1990s,[26] did a great disservice to social welfare. Despite the theoretical benefits of such fees (equality, resource mobilisation,

Panel: **Effect of economic policy on maternal health**

Calculations based on the worst scenario of a possible maternal mortality rate of 1200 per 100 000 for 10 years.

- 150 000 maternal deaths.
- 100 000 infant deaths due to maternal deaths
- 40 000 infant deaths from neonatal tetanus
- 30 000 infant deaths due to iodine deficiency
- 220 000 deaths due to malaria
- 600 000 children vulnerable because of maternal deaths
- 5 million women with disabilities due to lack of health care (disabilities include incontinence, anaemia, emotional stress, and so on)
- US$750 million loss of productivity from maternal death
- US$800 million loss of productivity from child death and disability

Source: Okuonzi (2002).[31,32]

	Envisaged results	Actual results
Prepayment/insurance	Generate own fund Improve use of services	Not feasible in Uganda for now
Greater role of non-governmental organisations	Improve efficiency and equality	No clear advantages
Hospital autonomy	Improve efficiency	No substantial advantages
Restructuring of ministry of health	Restrict ministry of health size and structure to policy and technical guidance	Ministry of health size reduced only slightly, but service delivery programmes maintained
Basic package	Government to fund cost-effective package for everybody	Package defined but costs much higher than can be afforded; has made no difference
Sector-wide approach	Sustainable partnership between donors, government and non-governmental organisations; move away from project to budget funding	Formalisation of existing partnership; budget funding has increased but has made no measurable differences in service delivery

Adapted from Okuonzi and Birungi (2000).[23]

Table 3: **Results of individual health reforms**

quality of care, and efficient use of services), the reality was starkly different. The envisaged fund generation through user-fees was clearly negligible, always less than 5% of total health expenditure. There were no demonstrable benefits of these fees on the quality or efficiency of social services. Under political pressure, and with nothing tangible to show from user-fees, the policy was abolished by the government in 2001.[27] The surge of more than 100% in the use of public services soon after the abolition of the fees shows the extent to which poor people were excluded from social services by an inappropriate policy.[28]

Public-private partnership is the new policy being established. If interpreted and applied for the benefit of social welfare, such partnership could improve delivery of social services through the use of private organisations, on a contract basis, to provide services to complement an overstretched public system of social-services delivery. However, if partnership is used as a strategy to enable the private-sector to maximise profit, then social welfare will still be doomed.

A basic philosophy behind free-market reforms is that as much health care as possible should be provided privately, because it is a tradable commodity.[29] As such, public investment in health infrastructure should not be allowed. Besides, it is argued, such expenditure takes away resources needed to create a stable macroeconomic climate. As a result, Uganda's current health-care infrastructure is physically accessible to (ie, within 1 h of walking or travel) about half the population and economically accessible (or affordable) to much less than this proportion. Table 2 presents the situation of health facilities in terms of emergency obstetric care, which is illustrative of the whole health-care system.

The study from which the data in table 2 were taken[30] concluded that the pathetic situation of facilities for obstetric care in Uganda was a deliberate policy not to expand such services countrywide, because they are thought to be expensive, and by extension, wasteful, since they do not directly lead to export-oriented investment. And yet the economic cost of maternal illness, disability, and death is estimated to have been US$1·55 billion over 10 years (panel).[31,32]

In the 1990s, a fashionable policy (and the epitome of health-sector reform) was not to invest in hospitals; they were regarded as too costly and unnecessary.[23] Funds were judged to be better spent in prevention and primary health care. The results are that basic curative care is hard to get in Uganda today, except for those who can buy it from private facilities at exorbitant prices. Table 3 summarises the results of health-sector reform in Uganda, and table 4 assesses progress in terms of key objectives of health-sector performance.

These worsening social conditions, characterised by increasing mortality rates, are not unique to Uganda. In 14 African countries, present rates of child mortality are higher than they were in 1990. 35% of Africa's children are at higher risk than they were 10 years ago.[18] A study[20]

	Expected outcome	Actual outcome
Access	Increased physical access Increased economic access	Increased physical access through the private sector, but reduced economic access
Equality	Increased equality	Reduced equality
Quality	Increased technical quality Reduced consumer-based quality	Same or reduced overall quality of health services
Efficiency	Increased output/outcome for given input	No evidence of improved efficiency
Sustainability	Increasing proportion of internal financing of public services	Over 50% dependence on donors More dependence on external support expected
Health status	Improved nutrition status Reduced mortality rates	Persistently high mortality and childhood malnutrition

Table 4: **Overall assessment of health sector reforms by performance objectives**

compared 20 years of globalisation (1980–2000) with the previous 20 years (1960–80), and found that for all indicators of social welfare (income per person, life expectancy, mortality rates of children and mothers, literacy, and education), there was a clear fall in progress in the past two decades compared with the previous two. These are the results of neoliberal economic policies in Uganda and these countries. Economic policy is therefore the major cause of the decline of welfare.

What is happening in Uganda and other developing countries has happened before. Humankind has failed to learn lessons from history. Examples of exploitative economic strategies include money lending in 15th century Europe, rationalisation of slavery, and forceful dispossession of people of their land in England, forcing them into destitution. Widespread poverty, despite a general rise in prosperity brought about by the industrial revolution in Europe, led to the Napoleonic wars and other revolts. As a result, publicly funded welfare systems had to be established in western Europe. Some have argued that the kind of economic policy that Uganda is pursuing is not a genuine economic and social development strategy; rather it is a misguided strategy that effectively expands the market for multinationals, which are driven by greed for profit, and the need to service the ever-accumulating capital surplus in industrialised countries.[33]

Since the start of the classic market economy, there have been two world wars and several economic systems, which have taught us hard lessons. First, it is the inescapable responsibility of the state to maintain minimum social and economic security. Second, there are no truly free markets; in developed countries, markets are supported by the state, which acts in the interest of multinationals. Third, by contrast with the optimism created by market economic systems and globalisation, there has not been an appreciable rise in prosperity; instead, poverty has spread around the world as a result of reckless globalisation. Fourth, unacceptable social consequences of a bad economic system can only be handled by government intervention; therefore, a minimalist state policy is untenable.[33] These lessons have been distilled into a clear social-policy framework for all nations: economic growth with fair household incomes; gender equality; healthy lifestyles; nutrition and food security; participatory governance; peaceful coexistence (avoid violent conflict); social justice and equity; stable ecosystem; universal access to safe water and sanitation; universal education; and universal health care.[34]

	Infant mortality rate (per 1000)	Life expectancy (years)	Per capita income (US$)
Costa Rica	21	73	1430
Cuba	20	75	1000
Kerala (India)	20	66	160–270
Sri Lanka	34	69	320
China	13–22	80	310
Uganda	88–101	47	350
Saudi Arabia	28	62	>5000
UK	12	80	16 550

Adapted from Abel-Smith (1994).[35] Saudi Arabia, UK, and Uganda included for comparison.

Table 5: **Reduced mortality rates at low cost**

The UK's 200-year history of mortality decline, guided and facilitated by the government, is instructive.[35] Before 1820, the UK's infant mortality rate was about 300 per 1000. The industrial revolution (1820–81) brought about economic growth and better household incomes. On its own, economic growth had no impact on infant mortality. But between 1850 and 1920, adequate resources had been made available to construct municipal sewers and safe water systems. There were also pioneering advances in public-health measures and legislation. These measures included establishment of local government boards for service provision, compulsory education, the poor law, and health boards.

Using such a combination of public measures, the UK reduced its infant mortality rate from about 150 per 1000 in 1850 to 80 per 1000 in 1920. From 1920 to 1960, further government interventions included better housing, universal health care, health visitors, and regulation of milk supply to control contamination. The discovery of antibiotics and vaccines in the 1940s and 1950s accelerated improvements in health care and further reduced infant mortality to 18 per 1000 in 1970.[35]

Economic growth is therefore not the leading guarantor of a nation's wellbeing. How a country deploys its resources for public use determines mortality outcome. This outcome is not a passive product of economic growth but a deliberate, persistent, and consistent government intervention.

Social welfare can be achieved by poor countries too. It is not true that welfare and reduction in mortality must always be accompanied by economic growth. Although economic growth is a good thing, it should not compromise social welfare. Such welfare should be the best possible from existing wealth, however little this may be. It should not be ignored until some arbitrary level of economic growth has been reached. Several poor countries (Costa Rica, Sri Lanka, Cuba, Kerala State in India, Vietnam) did not use the UK's model for improvement of social welfare facilitated by economic growth. These countries took only 20–30 years to attain the same reduction in mortality that took the UK 200 years. Table 5 shows how income per head is unimportant relative to social policy in determining social welfare.

These countries ensured deliberate and focused government intervention in nutrition, land reform, education, water supply, sanitation, health care, community participation, and overall social welfare. Economic considerations were simply complementary to these goals. The key reasons for poor countries' success are: government commitment to social welfare, evidenced by sustainable, predictable, and reasonably high public expenditure; links between sectors and participatory

process; and universal welfare. Broadly, countries have attained economic growth in two ways: industrialisation and exploitation of natural resources such as oil or timber. Uganda's economic strategy (presently being embraced by many developing countries) is the third way—namely, to reduce public spending and to leave investment in people and social infrastructure to individuals and charities, so as to save money to support the private sector and direct foreign investment. This strategy is flawed and doomed to fail because, as history teaches us, it compromises people's welfare, and inevitably gives rise to rebellion and social instability.

Uganda could compromise its economic growth strategy. It could pursue its dream of economic prosperity, but factor in social welfare in determining its pace of economic growth. However, the country does not have the work culture, tradable economic base, and institutional capacity to undergo rapid economic transformation. It needs to do a lot more to develop its capacity, work ethic, and natural resources to generate wealth. The short-cut option should not be to artificially mobilise money by underfunding social services. If macroeconomic stability cannot be achieved for private-sector and direct foreign investment to flourish without grievously damaging social welfare, then clearly the policy is wrong for Uganda.

The sacrifice of human life for an economic model that largely favours foreign investors and multinational companies, and undermines the welfare of indigenous populations, is flawed and immoral. Such a policy will probably backfire through revolts, and lead to political and social instability. It should be abandoned. The decline of welfare from a reckless and heartless economic strategy must teach countries to observe an absolute obligation: at the very least, no country should sacrifice existing welfare or postpone achievement of a reasonable welfare target to implement an economic strategy. Any such policy should allow the most rapid attainment of the highest possible welfare for a given level of economy.

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