Health worker remuneration in WHO Member States

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Objective To present the available data on the money spent by Member States of the World Health Organization (WHO) on remunerating health workers in the public and private sectors.

Methods Data on government and total expenditure on health worker remuneration were obtained through a review of official documents in WHO's Global Health Expenditure Database and directly from country officials and country official web sites. Such data are presented in this paper, by World Bank country income groups, in millions of national currency units per calendar year for salaried and non-salaried health workers. They are presented as a share of gross domestic product (GDP), total health expenditure and general government health expenditure. The average yearly change in remuneration (i.e. compound annual growth rate) between 2000 and 2012 as a function of these parameters was also assessed.

Findings On average, payments to health workers of all types accounted for more than one third of total health expenditure across countries. Such payments have grown faster than countries' GDPs but less rapidly than total health expenditure and general government health expenditure. Remuneration of health workers, on the other hand, has grown faster than that of other types of workers.

Conclusion As they seek to attain universal health coverage (UHC), countries will need to devote an increasing proportion of their GDPs to health and health worker remuneration. However, the fraction of total health expenditure devoted to paying health workers seems to be declining, partly because the pursuit of UHC calls for strengthening the health system as a whole.

Abstracts in عربي, 中文, Français, Русский and Español at the end of each article.

Introduction

A sufficient number of motivated health workers of different types is a precondition for achieving universal health coverage (UHC).[1] *The world health report 2006* refocused the world's attention on the acute shortage of health workers in many countries – a persistent problem – but it also made clear that governments need information on the costs of training, hiring, deploying and remunerating health workers when developing plans to improve the availability, distribution, capacity and performance of their health workforces.[1–7] Unfortunately, data of this sort are only available for selected countries.[8,9] According to a report from 48 African countries developed in the mid-1990s, the proportion of total health expenditure spent on health workers ranged from 17% to 74% and was 46% on average.[10] The World Health Organization (WHO) subsequently estimated the share of government expenditure devoted to paying health workers in 64 countries as ranging from 10 to 90% and being 42% on average.[7] This variability reflects differences across countries in accounting procedures, wages and the price of other health inputs, such as medicines.[11]

Despite the shortage of data, the information that exists has been used to estimate resource gaps and implement policies affecting the health workforce. For example, in the 64 countries identified as having the greatest health worker shortages, the yearly cost of training and employing an additional 3.5 million doctors, nurses and midwives and 2.8 million other workers was estimated at 17 800 million United States dollars (US$) in 2006.[3,4] If salaries were increased to try to retain the newly trained health workers, the costs would be substantially higher.

The data supporting the estimates just described pertain to a limited number of countries and only to medical and paramedical workers, since remuneration data for other types of health workers are not available.[12] Even for these categories, comparisons across studies and countries are made difficult by variations in payment modalities, statistical practices and in the definition of the different types of workers and their respective roles.[13] To obtain a complete picture, it makes sense to first identify and assess the data available from as many countries as possible using standardized definitions and accounting practices to facilitate comparisons.[14] This paper, based on the data available for 2000 and 2010, reports on the first attempt to do so for all 194 WHO Member States.

Methods

We searched for data on payments made to different types of health workers by conducting a documentary review and directly contacting officials from all WHO Member States. These officials included WHO focal points in charge of health accounts – appointed by health ministries – and staff in statistics offices responsible for national accounts reports. The data reported here follow the international standards developed for the entire health workforce,[14] which is defined as "all people engaged in actions whose primary intent is to enhance health".[7] This definition embraces anyone working towards promoting, restoring or maintaining health, including people in management and support jobs that are essential for health systems to function (e.g. health insurance personnel). We also report on the remuneration of government health workers.

General government health expenditure comprises all current and capital spending earmarked for the maintenance,

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restoration or enhancement of the health status of the population. Total health expenditure comprises all expenditure earmarked for the maintenance, restoration or enhancement of the health status of the population, regardless of the outcome of the goods and services consumed, and including public and private spending.[15] We used general government expenditure on health and total health expenditure as the denominators for our calculations.

Health worker remuneration is frequently reported as the following two variables or indicators, though not by all countries:

i) Total remuneration of all salaried workers in the health system, which refers to wages and salaries (including benefits and allowances) and to social contributions paid on behalf of workers involved in providing health services. A subcomponent is the remuneration paid by government to its employees.
ii) Remuneration of independent practitioners (e.g. self-employed health workers such as physicians and physiotherapists), which comprises their business income net of operating costs, taxes and capital consumption. In national accounts this is called "mixed income".[16]

We break down these broad categories into:

i) total remuneration of salaried health workers, as a share of total health expenditure and gross domestic product (GDP);
ii) remuneration of salaried health workers paid by the government, as a share of general government health expenditure, total health expenditure and GDP;
iii) total remuneration of independent health practitioners, as a share of total health expenditure and GDP.

Data were collated in millions of national currency units per calendar year and are reported by World Bank country income groups for 2013.[17]

We also assessed changes in remuneration over time and compared data for health workers with data for workers in the whole economy. Only 62 countries had data available for 2000 and 2010 for both health workers and workers in the total economy, so we supplemented this with data from 43 countries having one data point close to 2000 (up to 2003) and another close to 2010 (2008–2011). To allow for differences in the number of years between data points, we report the average yearly change for the case of health workers (i.e. the compound annual growth rate) and we report the number of countries covered in the analysis in each table.

Data sources

General government health expenditure and total health expenditure are published annually by WHO in its Global Health Expenditure Database (GHED) for all its Member States after country data searches and consultations. This was our main source of data for denominators and remunerations.[18] We obtained the remuneration given to salaried health workers in each sector (in total and by governments) and to all salaried workers in the economy, including all industries combined (in total and by governments), from reports on government finance, budget records and national accounts, labour and general government accounts and health accounts. These data are published by ministries of finance and health, statistical offices, central banks, health insurance entities and international organizations such as the International Monetary Fund (government finance statistics and country reports), the United Nations, the Organisation for Economic Co-operation and Development, the Statistical Office of the European Union and the World Bank (public expenditure reviews). Statistical yearbooks, institutional annual reports and national web sites were supplementary sources of information. The specific data on health worker remuneration and the source from which we obtained each data point are available on the GHED, as are the figures for each country separately.

Data caveats

Most of the data on the remuneration of salaried health workers pertains to direct health care provision. Payments to other types of health workers – e.g. to people who dispense medicines and lenses in pharmacies and other retail units or who work in the administration of health insurance – are not routinely reported. In addition, outsourced services are reported as service purchases without any breakdown of how much is paid to health workers.

Government health workers can also be paid through external funds or through special budgetary arrangements that are not systematically accessed, such as through the armed forces. Some public hospitals are reported as corporations and aggregated with private entities, which reduces the amount reported as having been paid by the government. The available metadata are not always clear about what they comprise but, if anything, our numbers probably underestimate the payments made to health workers.

Results

Remuneration of salaried health workers

The remuneration of all salaried health workers – in the public and private sectors combined – is available for only 136 countries and averages 33.6% of total health expenditure (Table 1). The average remuneration increases the higher the country income group: it is 38.1% and 28.7% of total health expenditure in the highest and lowest country income groups, respectively.

Data for independent practitioner remuneration are even more scarce ($n = 89$). The average remuneration is 9% of total health expenditure. It varies enormously across countries – from negligible to around 50% of total health expenditure – and this is one reason that the differences observed by country income group are not statistically significant.

More countries report the remuneration paid by government to salaried health workers ($n = 179$). Such remuneration accounts for almost 20% of total health expenditure and for 33.2% of total government health expenditure, on average (Table 2). The shares in low-income countries are significantly lower than in the higher-income countries combined.

Remuneration of all health workers

Total remuneration of all health workers is the sum of the remuneration of salaried and independent health workers. The 33.6% of total health expenditure comprised by remuneration of salaried health workers cannot strictly be added to the 8.9% pertaining to independent practitioners (Table 1) because the data are not available for the same countries. If we include only those countries for which data for the two components are available ($n = 75$), the total remuneration

Table 1. **Remuneration of salaried health workers as a share of total health expenditure (THE) in 194 Member States of the World Health Organization, 2010 (or closest available year)**

Country income group[a]	Total no. of countries	Average[b] remuneration as share of THE					
		Of salaried health workers		No. of countries with data	Of independent health practitioners		No. of countries with data
		%	SD		%	SD	
High	50	38.1	13.8	44	9.6	12.0	40
Upper middle	56	33.2	11.2	43	7.5	7.9	31
Lower middle	52	30.5	12.0	33	10.7	15.4	13
Low	36	28.7	14.7	16	7.6	7.5	5
All	194	33.6	13.0	136	8.9	11.0	89

SD, standard deviation.
[a] According to the 2013 World Bank classification, based on per capita income.
[b] The figures are arithmetic averages of the shares in each country group. This unweighted average represents the typical proportion of countries in a particular income group rather than the population-weighted average of all countries in the group.
Note: The data for the different variables in the table are not necessarily for the same countries.
Source: WHO Global Health Expenditure Database.[18]

Table 2. **Remuneration of salaried health workers by governments as share of total health expenditure (THE) and general government health expenditure (GGHE) in Member States of the World Health Organization, 2010 (or closest available year)**

Country income group[a]	Average[b] government remuneration of salaried health workers				No. of countries with data
	Share of THE		Share of GGHE		
	%	SD	%	SD	
High	18.0	17.4	31.2	20.2	48
Upper middle	23.4	10.8	38.2	15.8	51
Lower middle	18.7	10.9	34.7	15.8	48
Low	9.9	6.5	26.2	14.3	32
All	18.1	15.3	33.2	17.2	179

SD, standard deviation.
[a] According to the 2013 World Bank classification, based on per capita income.
[b] The figures are arithmetic averages of the shares in each country group. This unweighted average represents the typical proportion of countries in a particular income group rather than the population-weighted average of all countries in the group.
Note: The data for the different variables in the table are not necessarily for the same countries.
Source: WHO Global Health Expenditure Database.[18]

Table 3. **Average[a] yearly change in the remuneration of salaried health workers and independent health practitioners, compared with that of total salaried workers and independent workers in the total economy, in 75 selected Member States of the World Health Organization, 2000–2010**

Country income group[b]	No. of countries with data	Average yearly change in remuneration as share (%) of GDP			
		Salaried health workers	All salaried workers	Independent health practitioners	All independent workers
High	39	1.34	−0.12	3.16	−1.06
Upper middle	25	0.12	−0.43	−3.14	−0.71
Lower middle	8	3.90	1.04	−1.18	−1.68
Low	3	1.34	−2.98	10.84	−0.24
All	75	1.24	−0.20	0.90	−0.98

GDP, gross domestic product.
[a] The figures are arithmetic averages of the shares in each country group. This unweighted average represents the typical proportion of countries in a particular income group rather than the population-weighted average of all countries in the group.
[b] According to the 2013 World Bank classification, based on per capita income.
Note: The data for the different variables in the table are not necessarily for the same countries.
Source: WHO Global Health Expenditure Database.[18]

Table 4. **Average[a] yearly change in the remuneration of all salaried workers and of salaried health workers in 106 Member States of the World Health Organization, 2000–2010**

Country income group[b]	No. of countries with data	Average yearly change			
		In remuneration of salaried health workers, as share (%) of THE	In expenditure on health, as share (%) of GDP	In remuneration of salaried health workers, as share (%) of GDP	In remuneration of salaried workers, as share (%) of GDP
High	44	−0.56	1.90	1.05	−0.08
Upper middle	36	−0.64	1.14	0.32	0.25
Lower middle	20	−0.27	1.34	1.62	0.30
Low	6	−0.09	1.45	1.44	−1.41
All	106	−0.51	1.51	0.93	0.03

GDP, gross domestic product; THE, total health expenditure.
[a] The figures are arithmetic averages of the shares in each country group. This unweighted average represents the typical proportion of countries in a particular income group rather than the population-weighted average of all countries in the group.
[b] According to the 2013 World Bank classification, based on per capita income.
Note: The data for the different variables in the table are not necessarily for the same countries.
Source: WHO Global Health Expenditure Database.[18]

Table 5. **Average[a] yearly change in government remuneration of health workers, including salaried health workers, in 106 Member States of the World Health Organization, 2000–2010**

Country income group[b]	No. of countries with data	Average yearly change			
		In government remuneration of health workers, as share (%) of GGHE	In government expenditure on health, as share (%) of GDP	In government remuneration of salaried health workers, as share (%) of GDP	In government remuneration of all types of workers, as share (%) of GDP
High	44	−1.19	1.98	0.69	0.00
Upper middle	36	−2.13	1.96	−0.57	0.84
Lower middle	20	−0.07	1.90	0.47	0.54
Low	6	−1.66	2.92	0.63	2.35
All	106	−1.33	2.01	0.22	0.52

GDP, gross domestic product; GGHE, general government health expenditure.
[a] The figures are arithmetic averages of the shares in each country group. This unweighted average represents the typical proportion of countries in a particular income group rather than the population-weighted average of all countries in the group.
[b] According to the 2013 World Bank classification, based on per capita income.
Note: The data for the different variables in the table are not necessarily for the same countries.
Source: WHO Global Health Expenditure Database.[18]

of all health workers accounts for 34.5% of total health expenditure, on average (Table 3).

Changes over time

We first focused on the 106 countries for which data on payments to salaried health workers were available for the period (Table 4). From 2000 to 2010, total health expenditure grew faster than the GDP; it increased as a share of GDP at an annual rate of 1.5%. Total payments to salaried health workers also grew but at a slower rate than total health expenditure, so the share of total health expenditure paid to these health workers decreased in country income groups (at an average rate of 0.5% annually). However, because total health expenditure was increasing as a share of GDP, expenditure on salaried health workers also increased as a share of GDP at an average annual rate of almost 1%, despite a more modest increase in upper-middle-income countries.

Salaried worker remuneration

The period analysed includes the first years of the recent financial crisis. The health wage bill for salaried workers continued growing more rapidly than the total economy (Table 4). On the other hand, the remuneration of all types of salaried workers did not change substantially over the period as a share of GDP (the average annual growth rate was 0.03%, i.e. not significantly different from zero).

Government expenditure on health workers

Government health expenditures grew more rapidly than both GDP and total health expenditure over the period, at an average annual rate of 2% (Table 5). Government expenditure on salaried health workers also increased as a share of GDP, but less rapidly than total expenditure on salaried workers, as shown in Table 4. In fact, payments to salaried health workers fell as a share of government health expenditure by over 1.3% annually and did so more rapidly in upper-middle-income countries.

Government payments to all types of salaried workers, however, increased at a faster rate than payments to health workers in all but the high-income countries.

Table 6. **Average[a] annual remuneration of salaried health workers in 92 Member States of the World Health Organization, 2010 (or closest available year)**

Country income group[b]	No. of countries with data	Average remuneration per worker	
		In US$, 2010	In PPP, 2010
High	39	28 298	28 063
Upper middle	32	8037	14 667
Lower middle	16	3079	5927
Low	5	473	1347
All	92	15 352	18 102

PPP, purchasing power parity; US$, United States dollars.

[a] The figures are arithmetic averages of the shares in each country group. This unweighted ratio represents the typical proportion of countries in a particular income group rather than the population-weighted average of all countries in the group.

[b] According to the 2013 World Bank classification, based on per capita income.

Note: The data for the different variables in the table are not necessarily for the same countries.

Source: WHO Global Health Expenditure Database.[18]

Payments to independent practitioners versus salaried workers

Data on payments to both salaried and independent workers, both in the health sector and in the entire economy, were available for only 75 countries for 2000 and 2010. Payments to both types of health workers increased as a share of GDP: for salaried health workers at over 1.2% annually and for independent health workers at just below 1% (Table 3). The growth rate of payments to independent health workers showed more variability across country income groups, but the small number of countries in some of the groups resulted in differences that are not statistically significant. Total remuneration to independent health workers increased faster than remuneration to other types of non-salaried workers. In fact, the share of GDP comprised by the remuneration of independent workers in all sectors fell between 2000 and 2010.

Average level of remuneration

Total expenditure on health worker remuneration is a function of the number of workers and how much each worker gets paid. To get an idea of the average payment made to each worker, we divided total expenditure on remunerations by the reported number of salaried workers for the 92 countries with available data. The global average in 2010 is US$ 15 352 (18 102 in purchasing power parities) per employee. We recognize the limitations of this estimate. For example, the incomes of different types of health workers vary considerably, so the differences across country groups in Table 6 also reflect differences in the mix of health workers. However, the variations across country income groups are as expected – health worker payments increase with country income group – and this gives face validity to the data presented earlier.

Discussion

Appropriate health financing schemes are needed for progress towards UHC. Also essential are systems capable of delivering high-quality health services covering health promotion, disease prevention and treatment, and rehabilitation and palliation. These services need to be accessible and affordable,[19] but this is not possible without sufficient health workers possessing the right skills and located close to the people who need them.

Health workers need to be paid and questions of how much remuneration will motivate them to provide good services, stay in rural areas and not emigrate, for example, have long exercised the attention of policy-makers.[2] At a higher level, the critical questions are how much money has been raised to pay the health workforce and at what rate this amount has changed over time. These are the main questions addressed in this paper, which provides critical information not previously available but crucially important for planning the changes needed to attain UHC.

The data herein presented, which resulted from a laborious effort to obtain all the information available from WHO Member States on health worker remuneration, point to several important findings. First, payments to health workers comprise an important component of total health expenditure and GDP. Payments to salaried and self-employed health workers combined accounted, on average, for over 34% of total health expenditure and around 2.5% of GDP in the 75 countries for which both sources of data were available in 2010. In the 136 countries with information on salaried health workers, their remuneration alone accounted for 33.6% of total health expenditure. This suggests that for all health workers combined, including those who are self-employed, the share of total health expenditure surpasses 34%. Only pharmaceuticals account for a higher share of total health expenditure.[20] On the other hand, our estimates are lower than those from earlier studies based on smaller samples of countries. For instance, Peters reported a share of 46% of total health expenditure, but those estimates were made more than 15 years ago, when health systems were less complex than now.[10]

Second, these expenditures can be expected to increase over time and as a share of GDP. This has occurred over the past 10 years, largely because the overall number of health workers has increased everywhere. Interestingly, payments to health workers have increased more slowly than other types of health expenditure, which suggests that the health sector is becoming more reliant on technology or more capital-intensive everywhere.

Our findings have major implications with regard to the type of strategies that would accelerate progress towards UHC. In most low-income countries, funding for health is simply not enough to allow all people to access even a minimum set of needed health services.[21] Considerably more will need to be spent on the health workforce for this to change, but the path to UHC also requires investment in other components of the health system, including medicines, infrastructure and information systems. The dilemma for governments is how much of the funding, which is currently insufficient, should be devoted to its health workforce.

Third, payments to salaried health workers have increased more rapidly than payments to other salaried workers. Although the data do not allow us to determine if this is the result of changes in the number of workers or in their average remuneration, expenditure on the health workforce seems to have been protected despite the recent financial crisis.

These findings are important, but complete and accurate data are not yet available for all countries. Although expenditure on the total health workforce is frequently found as a line item in government budgets and national accounts reports, coverage is incomplete and more effort is required to build low-income countries' capacity to track and report the remuneration of various types of health workers.

In addition, identifying the flows linked to financial incentives, delivered sometimes as cash payments and sometimes in kind, is fraught with difficulty. This means that the data reported here might be underestimating true expenditures. Other possible causes of underestimation include the inability to identify the component of outsourced services paid to health workers from existing accounts, and the exclusion of retail sellers of medical supplies and health insurance administrators from health expenditure records.[4,22]

The remuneration of independent health practitioners, especially in countries with large private sectors, warrants particular attention. How much is paid to independently employed workers relative to salaried workers reflects the way labour markets are organized in different settings. In many countries independent practitioners are self-employed but receive the bulk of their income from social health insurance or government payments, in much the same way that salaried workers do. Fortunately, the new system of health accounts, published in 2011, includes a component for monitoring factors of provision, and this could be expanded to ensure uniform reporting of expenditure on various types of health workers over time and across countries.[15]

In summary, this study confirms, on the basis of data from many more countries than previously available, that payments to health workers account for a substantial share of total health expenditure. However, this share has been decreasing over time. It also shows that payments to salaried health workers have increased as a share of GDP, while those to other types of workers have remained stable or fallen. ■

Competing interests: None declared.

ملخص

مرتبات العاملين الصحيين في الدول الأعضاء في منظمة الصحة العالمية

الغرض عرض البيانات المتوفرة حول الأموال التي تنفقها الدول الأعضاء في منظمة الصحة العالمية (WHO) على مرتبات العاملين الصحيين في القطاعين العام والخاص.

الطريقة تم الحصول على بيانات حول الإنفاق الحكومي والإجمالي على مرتبات العاملين الصحيين من خلال مراجعة المستندات الرسمية في قاعدة بيانات الإنفاق الصحي العالمي الخاصة بمنظمة الصحة العالمية، وتم الحصول عليها مباشرة من مسئولي البلدان والمواقع الإلكترونية الرسمية للبلدان. ويتم عرض هذه البيانات في هذا البحث، حسب مجموعات دخل البلدان وفق البنك الدولي، بالمليون من وحدات العملة الوطنية لكل سنة ميلادية للعاملين الصحيين الذين يحصلون على راتب والذين لا يحصلون على راتب. ويتم عرضها كحصة من إجمالي الناتج المحلي (GDP)، وإجمالي الإنفاق الصحي والإنفاق الصحي الحكومي العام. وتم كذلك تقييم متوسط التغير السنوي في المرتبات (أي معدل النمو السنوي المركب) بين عامي 2000 و2012 كدالة لهذه المعاملات.

النتائج في المتوسط، مثلت المدفوعات إلى العاملين الصحيين من جميع الأنواع أكثر من ثلث إجمالي الإنفاق الصحي عبر البلدان. وزادت هذه الدفعات أسرع من إجمالي الناتج المحلي للبلدان ولكن بسرعة أقل من إجمالي الإنفاق الصحي والإنفاق الصحي الحكومي العام. وفي الجانب الآخر، زادت أجور العاملين الصحيين أسرع من الأنواع الأخرى من العاملين.

الاستنتاج سوف تحتاج البلدان في سعيها للحصول على تغطية صحية شاملة (UHC) إلى تخصيص نسبة متزايدة من إجمالي ناتجها المحلي للصحة ومرتبات العاملين الصحيين. ومع ذلك، يبدو جزء إجمالي الإنفاق الصحي المخصص للدفع للعاملين الصحيين في تناقص، ويرجع ذلك جزئياً إلى أن السعي نحو التغطية الصحية الشاملة يتطلب تدعيم النظام الصحي بكامله.

摘要

世卫组织成员国卫生工作者报酬

目的 介绍有关世界卫生组织（WHO）成员国公共和私营部门卫生工作者开支的可用数据。

方法 通过审阅世界卫生组织全球卫生支出数据库的官方文档以及直接从国家官方和国家官方网站获取有关卫生工作者报酬的政府和合计开支的数据。本文按照世界银行国家收入群组介绍带薪和非带薪卫生工作者的这些数据，并以每日历年各国百万货币为单位。这些数据按占国内生产总值（GDP）、卫生总开支和一般政府卫生支出的份额进行表示。本文也评估了 2000 年至 2012 年间报酬年平均变化（即复合年增长率）与这些参数的函数关系。

结果 平均而言，各类卫生工作者的报酬占据各国卫生总开支三分之一以上。这些开支增长比各国的 GDP 增长速度快，但是比卫生总开支和一般政府卫生支出增长速度慢。另一方面，卫生工作者的报酬增长比其他类型工作者的报酬增长快。

结论 各国都在努力实现全民医疗保障制度（UHC），因此需要增加卫生和卫生工作者报酬的 GDP 比例。但是，专用于支付卫生工作者报酬的卫生总开支的比例似乎有所下降，部分原因是 UHC 的实现需要从整体上强化卫生系统。

Résumé

La rémunération des travailleurs de la santé dans les États membres de l'OMS

Objectif Présenter les données disponibles sur les sommes dépensées par les États membres de l'Organisation mondiale de la Santé (OMS), liées à la rémunération des travailleurs de la santé dans les secteurs public et privé.

Méthodes Les données sur les dépenses gouvernementales et totales liées à la rémunération des travailleurs de la santé ont été obtenues en examinant les documents officiels de la base de données des dépenses mondiales liées à la santé de l'OMS et directement à partir des représentants et des sites Web officiels des pays. Ces données sont présentées dans ce document, par groupes de revenu de pays de la Banque mondiale, en millions d'unités monétaires nationales par année civile pour les travailleurs de la santé salariés et non salariés. Elles sont présentées comme part du produit intérieur brut (PIB), du total des dépenses de santé et des dépenses générales de santé du gouvernement. La moyenne annuelle du changement de la rémunération (c'est-à-dire le taux de croissance annuel composé) a également été évaluée entre 2000 et 2012 en fonction de ces paramètres.

Résultats En moyenne, le coût des rémunérations pour tous les types de travailleurs de la santé représentait plus du tiers du total des dépenses de santé dans les différents pays. Ce coût a augmenté plus rapidement que le PIB des pays, mais moins rapidement que le total des dépenses de santé et des dépenses générales de santé du gouvernement. La rémunération des travailleurs de santé a d'autre part augmenté plus rapidement que celle des autres types de travailleurs.

Conclusion Alors qu'ils cherchent à atteindre une couverture maladie universelle (CMU), les pays devront consacrer une proportion croissante de leur PIB à la santé et à la rémunération des travailleurs. Toutefois, la portion du total des dépenses de santé consacrée à payer les travailleurs de santé semble diminuer, en partie parce que la mise en place de la CMU exige un renforcement de l'ensemble du système de santé.

Резюме

Оплата труда работников здравоохранения в государствах-членах ВОЗ

Цель Представить имеющиеся данные о средствах, потраченных государствами-членами Всемирной организации здравоохранения (ВОЗ) на оплату труда работников здравоохранения в государственном и частном секторах.

Методы Данные о государственных расходах и общей сумме расходов на оплату труда работников здравоохранения были получены на основе анализа официальных документов из Глобальной базы данных ВОЗ по расходам в области здравоохранения, а также непосредственно от должностных лиц и с официальных веб-сайтов стран. Эти данные, упорядоченные по группам стран, выделяемым Всемирным банком в зависимости от их дохода, были указаны в настоящей статье в миллионах национальных денежных единиц, выплачиваемых за календарный год штатным и внештатным работникам здравоохранения. Они представлены в виде доли от валового внутреннего продукта (ВВП), общей суммы расходов на здравоохранение и общей суммы государственных расходов на здравоохранение. В качестве функциональной зависимости этих параметров также были проанализированы среднегодовые изменения в оплате труда (т.е. совокупные темпы годового прироста) в 2000-2012 гг.

Результаты В среднем на выплаты работникам здравоохранения всех категорий приходится более трети всех расходов на здравоохранение в разных странах. Суммы таких выплат росли быстрее, чем ВВП стран, но менее быстрыми темпами, чем общие суммы расходов на здравоохранение и общие суммы государственных расходов на здравоохранение. С другой стороны, уровень оплаты труда работников здравоохранения растет быстрее, чем уровень оплаты труда других категорий работников.

Вывод Поскольку страны стремятся достичь всеобщего охвата населения медико-санитарными услугами, им придется направить большую долю своего ВВП на здравоохранение и оплату труда работников здравоохранения. Однако, похоже, доля оплаты труда работников здравоохранения в общих расходах на здравоохранение сокращается. Это происходит отчасти потому, что стремление выполнить рекомендации по всеобщему охвату населения медико-санитарными услугами требует укрепления системы здравоохранения в целом.

Resumen

El salario del personal sanitario en los Estados miembros de la OMS

Objetivo Mostrar los datos disponibles sobre el capital que los Estados miembros de la Organización Mundial de la Salud (OMS) destinaron a remunerar al personal sanitario en los sectores público y privado.

Métodos Se extrajeron datos sobre el gobierno y el coste salarial total del personal sanitario mediante una revisión de los documentos oficiales de la base de datos Global Health Expenditure Database de la OMS, y directamente de los funcionarios del país y los sitios web oficiales de los países. Este informe presenta los datos en millones de unidades monetarias nacionales por año natural destinados al personal sanitario, asalariado y no asalariado, a través de la clasificación de países por los grupos salariales que emplea el Banco Mundial. Se presentan como un porcentaje del producto interior bruto (PIB), el coste sanitario total y el coste sanitario general de los gobiernos. También se evaluó el cambio salarial anual promedio (es decir, la tasa del crecimiento anual compuesto) entre los años 2000 y 2012 como una función de estos parámetros.

Resultados En general, los pagos al personal sanitario de cualquier tipo representaron más de un tercio del coste total en salud entre los países. Estos pagos han aumentado a mayor velocidad que los PIB de los países, pero a menor velocidad que el coste sanitario total y el coste sanitario general de los gobiernos. El salario del personal sanitario, por su parte, ha aumentado a mayor velocidad que el de los trabajadores de otros sectores.

Conclusión En su esfuerzo por alcanzar la cobertura sanitaria universal (UHC), los países tendrán que destinar una mayor proporción de su PIB a la sanidad y al salario de los trabajadores sanitarios. Sin embargo, la fracción del coste sanitario total derivado del pago del personal sanitario parece reducirse, en parte porque para alcanzar la cobertura sanitaria universal es necesario fortalecer el sistema sanitario en su conjunto.

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