



Original Article

Theoretical Review of Pay Restructuring in Uganda's Public Service Health Sector

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This article examines the impact of wage reforms on service delivery, financial stability, managerial efficiency and donor influence and focuses on the public health sector in Uganda. Like other reforming countries, Uganda also implemented salary structure reform for various reasons, but the most important ones were to pay civil servants a living wage, make remuneration transparent, align the salary structure with the single-spine structure and consequently increase the number of employees motivation and efficiency in service delivery. The study analysed research articles, policy documents, reports, and media coverage on pay changes for public health workers. Key findings show that the original goal of wage reforms, such as the single-spine structure, has not been achieved; several pay scale structures were reintroduced. Different service models are used to calculate wage. Similar cadres of civil servants receive different salary grades; and wage allocation receives more funding than other areas, such as development and supplies. The results suggest that salary increases affect allocations in other important areas but do not always result in public health workers' commitment to service. Compromise and negotiation have played an important role in public sector wage restructuring. A review of wage reforms implemented across Uganda's public sector will be based on the recommendations and issues addressed in this study. The study provides crucial benchmarks with regard to wage reform strategies that promote diversity in the public sector and the distribution of authorities. This study is unique because it focuses on wage restructuring in the public sector to align practices with policies. Although based on a review of relevant documents, it was conducted for the first time in Uganda.

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INTRODUCTION

Restructuring of public services has been a global trend since the 1980s, particularly in developing countries (Clayton & Pontusson, 1998; Haque, 2001; Bangura, 2000). The main aim of the reforms was to increase the effectiveness, efficiency, motivation, and accountability of service delivery (Haque, 1999; Clayton & Pontusson, 1998; Therkildsen, 2001; Ayeni, 2002; Olum, 2003). One of the major reforms that these countries implemented was wage restructuring (Clayton & Pontusson, 1998; Bangura, 2000). The primary objectives of wage restructuring were to reduce the current wage bill, which was no longer fiscally feasible, to increase wages for skilled and professional public servants, and to ensure fairness and equity in wage distribution (Clayton and Pontusson, 1998; Ayeni, 2002; Bangura, 2000; Therkildsen, 2001). The effects of wage reforms included demotivation of public sector workers, difficulties in attracting and retaining skilled workers, increased unclear benefits, and bribery (Clayton & Pontusson, 1998; Lienert & Modi, 1997).

Like other reforming nations, Uganda implemented salary structure reform for various reasons, but primarily as an incentive for civil servants (Olowu, 1999; Olum, 2003; Sendyona, 2010; Robinson, 2007). The civil servants' salaries were far from enough to cover their living expenses (Olowu, 1999; Sendyona, 2010; Therkildsen, 2001). The objectives of the 1995 Civil Service Remuneration Policy were to pay a living wage, streamline payroll, make remuneration transparent and align the salary structure with the single-spine structure (Sendyona, 2010; Emuron, 2020) and, by implications, improve employees' motivations and efficiency in service delivery.

A country's transformation depends heavily on the performance of its health sector (World Health Organization., 2000; Walt, 1994). Although sub-Saharan Africa accounts for 13% of the world's population, it spends less than 1% of global health expenditure, and the continent has a disease burden of 24% (Anyangwe & Mtonga, 2007; Azevedo, 2017; Deaton & Tortora, 2015). The Ministry of Health in Uganda is responsible for ensuring that the people of Uganda receive health services effectively and efficiently (Ministry of Health, 2020). At the national and district levels, the health service delivery system is divided into centralised and decentralised health systems (Bashaasha, et al., 2013; Nannyonjo & Okot, 2013; Ministry of Health, 2020). Among the main beneficiaries of the wage reform are public health workers (Ssenkooba et al., 2007; Sendyona, 2010). However, healthcare workers are still pushing for wage increases despite the wage reform (Munabi-Babigumira et al., 2019; Kingma, 2018; Willis-Shattuck, 2008). Despite significant progress in wage reforms, Uganda still faces problems such as poor work morale, absenteeism, a lack of adequately qualified health workers, inadequate training, high layoff rates and overworked medical professionals and staff (Maniple, 2015; Azevedo, 2017; Kingma, 2018) which have, in addition to other factors contributed to waning health care system.

In Uganda, salary reforms have been implemented in the public sector to improve the living standards of civil servants, including health workers (Emuron, 2020; Olum, 2003; Sendyona, 2010; Ssenkooba et al, 2006). However, the actual impact of these wage reforms on health workers and the health service has not been examined. Studies show that only 9 to 16% of government employees, including healthcare workers, are satisfied with their salaries as the government

does not provide a minimum wage (Akena et al, 2020; Mo Ibrahim Foundation, 2018). This analysis aims to shed light on the challenges and impacts of wage restructuring in the Ugandan Ministry of Health. It addresses the keywords of financial stability, central planning, management efficiency, donor pressures and service models, which are crucial factors in understanding the complexity of this process.

Significance

This study is important as it provides an understanding of the challenges associated with wage reform in the public sector. Hopefully, this will expand the knowledge already available on public sector reform in Uganda. It will influence policy on civil servant salary revision by shedding light on the impact of pay reforms on healthcare workers.

General objective of the Study

The study's overall objective was to examine and analyse the problems and impacts of wage reforms in the public sector. We focused on the impact of wage reform on managerial efficiency, financial stability, donor implications, and wage reform models.

Research Questions

The study was guided by the following questions:

- What wage reforms have been implemented in Uganda?
- What types of services have these reforms impacted?
- What are the impacts of wage reforms on financial stability, managerial efficiency, and donor influence?

The article consists of five sections. The first section provides an introduction. The second part discusses the gaps identified from the review of relevant documents. In the third section, the study methodology is presented. The main results were examined and presented in part four. And the fifth section provides the conclusion.

LITERATURE REVIEW

In this section, we reviewed relevant literature related to public health wage reform and identified the gaps that this study aimed to address.

A study conducted by Murindwa (2006) found that local governments at the decentralised level received unconditional block grants from central governments from which they were expected to, among other things, pay the salaries of civil servants, including health workers. During the same period (2001/02), payroll was re-centralised to improve payroll efficiency. However, the incentives were insufficient to attract and retain health workers in remote areas. This feeds into Ssengooba et al (2007) postulated that in Uganda, the workforce responded to the system of decentralisation as if it were a resource constraint affecting the recruitment of health workers, but health workers play a key role in all reforms.

Further, an analysis of Uganda's critical health infrastructure, including human resources for health, revealed that only about 52% and 56 % of required human resources for healthcare positions were filled due to inadequate funding (Odokonyero et al. (2017). This exacerbates the challenge of low retention and motivation of healthcare workers, particularly in rural areas.

Issues And Challenges in Implementing Wage Reforms in the Health Sector

Fiscal Stability

Using empirical data analysis, McCoy et al. (2008) examined historical trends in the pay of civil servants in Africa over the past 40 years and found that health workers often use other sources of income to supplement their formal salaries. Additionally, ACHEST and Wemos (2019) found that health expenditure had declined as a proportion of Uganda's budget. The problems and gaps in the Ugandan health workforce persist due to inadequate financial allocation.

McPake's (2013) study in five countries (Ghana, Nepal, Sierra Leone, Zambia and Zimbabwe) reviewing financing and human resources for health policy found that the lack of human

resources for health care is not universal, but this is the case due to the maldistribution within the countries and in most countries the health workers were well paid. Bulthuis et al. (2020) argued that the most critical factors are inadequate financial, human, and other resources. That inadequate supply chains hinder effective interventions.

Management Efficiency

To understand the cause of the decline in bribery and corruption in the Ugandan health system, Caryn Peiffer et al. (2021) determined that the Health Monitoring Unit (HMU) was the influencing factor through a literature review and in-depth interviews with users and experts. To ensure the sustainability of healthcare efforts, the wages of healthcare workers should be increased to reduce the temptation to demand bribes.

ACHEST (2019), in their report, believe that health workforce problems persist due to poor management and weak technical leadership in the Ministry of Health. Therefore, they postulated that efficient management practices such as strengthening accountability and promoting transparency are essential to optimise the impact of wage restructuring.

In a recent study on the causes of absenteeism in Uganda, Bruckner (2019) found that the country has one of the highest healthcare absenteeism rates in Africa, with the prevalence estimated at 37% to 48%. The economic cost of absenteeism goes far beyond the public wage bill wasted on services not provided. Capital investments in buildings and medical equipment are partially wasted because facilities are often closed and, therefore, not fully utilised. Absenteeism was also sometimes linked to poor maintenance of the clinic. These findings feed into our study aimed at establishing whether the wage reform has reduced the problem of absenteeism among health workers.

Tweheyo et al (2017) found low salaries and poor staffing ratios in a study based on interviews and focused group discussions with selected rural health workers on various factors leading to absenteeism in the country. That the challenges

they faced included inadequate funding of health care facilities, stressful work environments and conditions, lack in career advancement, and weak supervision. Lack of organisational commitment was presented by Crook (2010) as the reason for the failure of public service reform programs in sub-Saharan Africa. The study recommended that the best way forward was to identify and work with competent managers and promote and disseminate more effective incentives for the success of reforms.

Vian et al (2013), in the study examining the perception of per diem among government and non-governmental organisation (NGO) officials in Malawi and Uganda, found that per diem facilitated training and increased employee motivation. The study also found that despite these benefits, many respondents expressed dissatisfaction that they caused conflict and promoted a negative organisational culture that led to negative changes in working time arrangements. They gave unfair financial advantages to already better employees. Further, in a study to identify barriers to the sustainability of digital health interventions in low- and middle-income countries, Kaboré et al. (2022) found that the major barriers included infrastructure and electricity. The moderators included employee motivation and competence.

Donor Influence

The review of existing literature revealed that a large portion of the health sector budget in Uganda is donor-funded. For example, Ssengooba et al (2006), in their article on resource allocation in the Ugandan health sector, noted that in the 1990s, 45% of the budget was funded by donors. Elsewhere, Witter (2017), in a study to understand the patterns and drivers of post-conflict policy reorientation of health systems in Uganda, Sierra Leone, Cambodia, and Zimbabwe, found that the role of the Ministry of Health was weaker than expected, while the transition from donor dependence was not linear.

Donor pressure can significantly impact wage reforms in the health sector, particularly in sub-Saharan Africa. Azevedo (2017) found that

supportive oversight for districts by the Ministry of Health and district health teams for primary health facilities was also inadequate due to poor funding, except partners such as PEPFAR, USAID and CDC to whom donor funds are channelled to the national health system to improve data quality.

Zakumumpa et al (2021), in attempting to understand the process of handing over the President's Emergency Plan for AIDS Relief (PEPFAR) to the government and facilitation, noted that key stakeholders, particularly with political ministries, in the planning process were critical. The study provided insights into effective donor transitions... pragmatic strategies to increase public spending on health workforce expansion in poor countries.

Service Pay Models

The various models governments have been adopted to allocate pay to various level of civil service include the salary salary structures, the collective bargaining model and institutional pay model.

The Salary Scale Grades

According to the job classification system and salary grade occupations, the salary grade model is a method for determining the wage distribution (Risher & Schay, 1994; Dreher, 1981). The majority of sub-Saharan African countries that have implemented public service reforms established commissions to address pay inequalities and biases for public sector workers (Asare & Mperere, 2017). All public employees, regardless of their specialization or type of public organization, are paid according to the same salary structure under the Single Spine salary structure (Asare & Mperere, 2017). The single spine model, unlike the multiple spine model, eliminates multiple salary structures and assigns all public sector employees to the same spine (Asare & Mperere, 2017). According to Asare & Mperere (2017), there are still inequities that need to be addressed, which is why the single spine salary structure was created. This has led to strikes and unrest by various unions.

It was also noted that the fiscal challenges are complicated by the single-spine policy. According to a 2009 study by Cavalcanti on the fiscal costs of implementing the single wage reform in Ghana, the proposed wage reform would result in a significant increase in government spending on workers' wages, increasing the country's base wage bill by almost 50% compared to previous estimates. In their article on narrowing the pay gap between the public and private sectors in Ghana, Ampofo & Doko Tchatoka (2019) found that while the policy was effective in closing the gender pay gap in the health and education sectors, it widened the gap in the Administrative sector, where male employees benefited more. They also showed how the policy reduced labor productivity in terms of overall income. The main reason for this is a decline in the engagement of male and female public employees in administration, health and education, respectively.

The Collective bargaining pay model

According to Wynn (1970), in the collective bargaining model, conflict is viewed as necessary to gain influence and influence over the other party. This belief is also an integral part of employees' wage negotiations (Eberts & Stone, 1986; Bales, 1997). Lee's (1978) research on unions and wage rates used a simultaneous equation model to examine the relationship between unions and wages for semi-skilled workers in various industries. The study found that unionism, which includes collective bargaining, has a positive impact on wage increases. However, in his article on the discrepancy between collective bargaining and individual labor rights, Bales (1997) argues that the focus has shifted to individual labor rights established by law and courts, replacing the idea of collective bargaining by workers. Peters (2018) points out that political systems with unionization may face challenges in maintaining control over budgets and personnel policies.

Institutional Model

The institutional service model focuses on an organization's dedication to serving under its specific mandate (Holland, 1997). Given their unique organizational traits, institutions design appropriate, customized programs and incorporate service into their basic principles and activities (Ruef & Scott, 1998; Holland, 1997). In the 1990s, according to Brignall and Modell (2000), the public sector in nations such as the United Kingdom as well as Scandinavia had to improve in order to be more productive and efficient while maintaining the same standard of public services. They began utilizing private sector management strategies and frequently needed to negotiate with other businesses to complete tasks.

According to Peters (2018), governments today employ a wide range of autonomous and quasi-autonomous organizations to provide public services. That the primary defense is that, because these agencies are less directly supervised and have the ability to base decisions more on performance and economic standards than on political considerations. Peter (2018) points out that these organizations, however, bring with them fresh accountability issues. In 2008, Davis and Gabris published an article titled "Strategic compensation: Utilizing efficiency wages in the public sector to achieve desirable organizational outcomes." They pointed out that since public sector organizations will always be under pressure to maintain low costs while providing higher levels of service, it is important to take into account an organization's relative position in the local labor market. They found that wage rates are a significant predictor of increased reputational service quality, which in turn leads to organizational performance.

The Impact of Public Sector Pay Reform on the Quality and Accessibility of Health Services

The soft aspects of human resource management, such as employee satisfaction and morale, are the most important drivers of performance. And while employee wages are important, non-monetary incentives are also essential (Currstine et al., 2007).

Hagopian et al. (2009) also found that overall satisfaction among Ugandan health workers is not high. Satisfaction with salary was particularly low, and physicians were the least satisfied group. The working and living conditions were also very poor, and the workload was considered unmanageable. That about one in four healthcare providers would soon quit their job if they could, and more than half of doctors said they would happily quit their job. Although pay and job security are clearly important determinants of morale, many organisations in developing countries are able to significantly improve their performance by cultivating a participatory, open and performance-oriented culture (Fritzen, 2007).

In a study by Krogstad et al. (2006) in Norway, it was found that professional development is most important for doctors. However, for registered nurses, experiencing support and feedback from their closest supervisor was the most important explanatory variable for job satisfaction. Although different renditions can be applied herein, reflections of cultural values, loyalties and motivation are interpreted as driving factors.

The literature reviewed highlights the importance of reforming healthcare staff salaries, inadequate funding, inefficiency, and low standards. However, this study finds that wage reforms implemented to date have not changed the narrative, and competing factors in healthcare remain.

RESEARCH METHODOLOGY

This study adopted a qualitative research approach and used a combination of document analysis and case studies. We present examples of various documents related to budget allocation for wages and salaries in the public sector in general, including the health sector. Since wages, salaries and monetary benefits are centrally determined by the annual policy correspondence with the public service, including the health sector, we have analysed them in terms of the key issues relevant to wage reforms in the public health sector. We reviewed the reports/documents representing the first major attempt at pay reform. We have deliberately selected five ranks of healthcare

professionals, showing their previous salary scales and the new salary scales under the new models. The aim was to highlight the wage reform attempts of the last few decades. We also examined selected legal acts related to collective bargaining as a model for wage bargaining. We also analysed the standing instructions circulars on various wage reforms for the general health sector and selected autonomous public health authorities to highlight the wage reforms in the selected health sectors resulting from the institutional restructuring. We reviewed newspaper articles about wage reforms or salary increases for health workers in the public health sector and donor support to the health sector.

We compared the first wage reform of 2003 and the second wage reform of 2018/2019 for health workers by reviewing the salary structures for selected health worker ranks for the periods. For this purpose, we have deliberately selected a few ranks of healthcare workers to show the percentage change in their respective salary levels. We also analysed the fiscal impact of the salary reform on the budget over this period. We also looked at the recent salary reform (2023/2024) and called it the third reform by analysing the salary structure for this period. We analysed it in comparison to selected cadres of health workers to show the percentage changes in salary levels. We also deliberately selected the structure of the Uganda Cancer Institute as an example of an institutional compensation model and compared their compensation with the regular compensation of public health workers. Based on reports and analyses from selected agencies, we also reviewed budget spending and the impact on the health sector for the period in question,

particularly under the second and third wage reforms.

We analysed the results using a thematic approach. An approach that capture critical and important data that provides meaning and corresponds with the research question (Vaismoradi et al., 2013).

RESULTS & DISCUSSIONS:

The Service Models

The Salary Scale Grade Model: In 2003, the Ugandan government introduced the uniform pay scale as a model for allocating different salary levels to civil servants (Emuron, 2020; Ministry of Public Service, 2003). This was the result of the job evaluation report, which converted the existing multi-tiered scales into single-tiered scales. Ten salary levels with the nomenclature "U" were planned. Grades ranged from U8, the lowest grade, to U1 (special grade), the highest grade (Ministry of Public Service, 2003). The structure was streamlined and integrated traditional/teaching staff, lawyers, medical and allied health staff, police and prison staff and support staff.

A single-spine salary scale was created by combining multiple salary levels from different salary scales in the 2003 wage reform. The chosen cadres of doctors, dentists, and occupational health specialists were paid according to salary scale 5a-3 before the job evaluation in 2003. They transitioned from the "single salary" pay scale to the U4 "single spine" pay scale. Information on the various pay scale types, from multiple to new scales with a single spine, is provided in the table below.

Table 1: Sampled revised salary grade scale reforms of 2003

Designation	Scale before job evaluation	Adopted Single Spine
Dental Surgeon	U5a-3	U4
Medical Officer	U5a-3	U4
Epidemiologist	U5a-3	U4
Medical Biochemist	U5a-3	U4
Pharmacist	U5a-3	U4

Source: Ministry of Public Service Salary Structure of FY2003/2004

The Collective Bargaining Model

Public Service Bargaining, Consultation and Dispute Settlement Mechanisms Act was passed by the government in 2008 (Ministry of Public Service, 2019). According to the Ministry of Public Service (2019), the law calls for creating a negotiation, consultation, and dispute resolution mechanism for public service and other related matters. In order to enhance their pay, the Uganda Nurses and Midwives Union and the Ugandan government signed a collective agreement (Parliament of Uganda, 2022). Nurses and midwives comprise 70% of Uganda's health workforce, yet they still face marginalisation. Labor unions have a strong influence on wage allocation (Lee, 1978). In June 2018, a strike threat by the Nurses and Midwives Union led to the conclusion of the collective agreement.

Institutional Service Model

The Ministry of Public Service (2023) reports that the Ugandan government established Uganda

Cancer Institutes and Heart Institutes as specialised health facilities with separate salaries and fees from the standard health service. According to the Uganda Cancer Institute's strategic plan, equitable access to comprehensive, high-quality cancer services will be improved, and cancer risks will be decreased by enhancing health promotion and cancer prevention. Provide both domestic and foreign trainees with specialised cancer training. After gaining independence, the institute left its departmental home at Mulago National Referral Hospital. Its newfound status as a stand-alone entity, complete with a wage and salary structure, allowed it to set itself apart from the traditional healthcare system and enable it to hire and pay professionals. Indeed, the cancer institute still attracts and retains highly qualified and specialised staff which sets it apart as a unique entity in the provision of quality cancer care to patients from the country and the East Africa region.

Table 2: The sampled Salary Scale and Salaries of the Uganda Cancer Institute

S/N	Medical Rank	Salary Scale	Monthly pay (US\$)
1	Senior Consultant	UCI-M2	\$4,987
2	Consultant	UCI-M3	\$4,732
3	Principal Medical Officer	UCI-M4	\$4,245
4	Medical Officer	UCI-M10	\$2,956
5	Nursing Officer	UCI-M10	\$2,956

Source: Cancer Institute Establishment Structure for Year 2023; **Note:** The conversion from Uganda shillings to US\$ was done using 1US\$ to UGX:3570 as an exchange rate at the time of developing this article.

The 2018/2019 Pay Reform

UGX 4,242.15 billion was allotted to the government's payroll in the 2018/2019 fiscal year, along with higher pay for specific civil servant categories, such as healthcare professionals (Ministry of Public Service, 2018). An additional 525,190,918 UGX was allotted for the phase one improvement. Justice, professionalism, affordability, sustainability, appropriateness, performance orientation, consolidation of the salary approach, ability to innovate, and spiral effect were the guiding principles for improvement. A multi-scale salary classification

was reintroduced, with the Med Scale serving as the new nomenclature for the medical carder.

The salary change for different categories of health workers from 2003 to the 2018/2019 fiscal year was analysed. The highest percentage increases were observed for medical officers with a first degree and enrolled nurses with a certificate, both at 80%. The next highest increases were for nursing assistants with a diploma at 78%, followed by specialists at 75%, consultants at 73%, theatre assistants at 69%, and senior consultants at 63%.

Table 3: The 2003 Pay Reform and the 2018/2019 Pay Reform compared

Designation	2003 Pay Scale		2018/19 New Pay Scale	
	Scale	Pay (Monthly)	New Scale	New pay (Monthly)
Senior Consultant	US1E	\$470	U1SE	\$1,261
Consultant	US1E	\$317	U1E	\$ 1,177
Specialist	U2	\$259	U2 (Med-1)	\$ 1,050
Medical Officer	U4	\$164	U4(Med-1)	\$ 840
Assistant Nursing Officer	U5	\$74	U5(Science)	\$ 336
Enrolled Nurse	U7	\$34	U7(Med)	\$ 172
Theatre Attendant	U8	\$27	U8(Med)	\$ 88

Source: Ministry of Public Service Salary Structures for FY: 2003/2004 & FY2018/2019: Note: The pay figures were converted into dollars using the current rate of 1US\$ to UGX:3570

Fiscal Implications for the 2018/2019 Salary Reform

The improvement had financial ramifications because it did not allocate funds for hiring, except for 1,100 post-primary humanities teachers and post-primary science teachers/tutors. For the 2017–18 fiscal year, the hardship allowance—which is payable to qualified employees—was kept at thirty per cent of the increased salaries for workers under the first phase (Ministry of Public Service, 2018). For health workers, lunch and combined sick pay were kept at the levels of the 2017–2018 fiscal year.

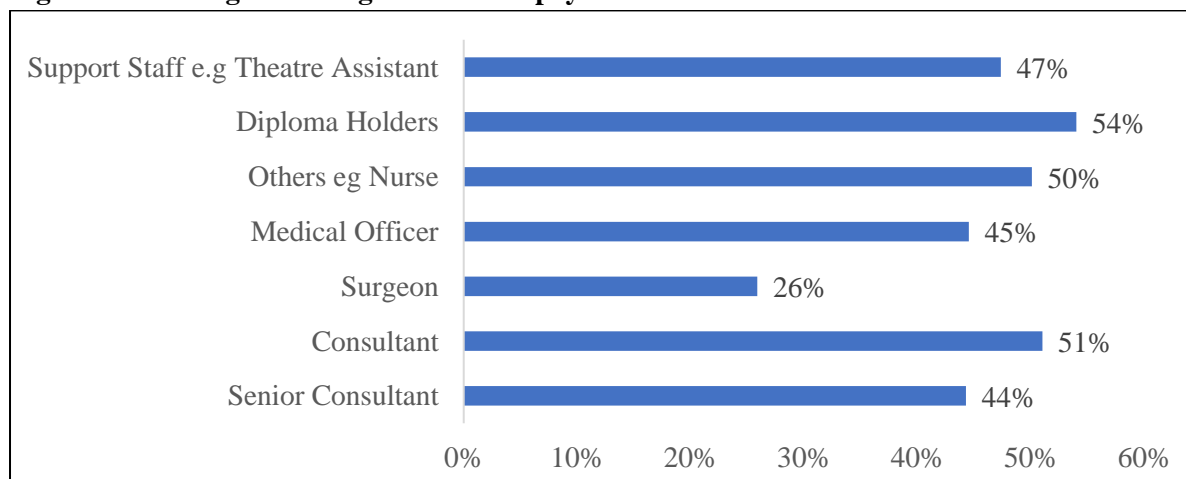
The Third Reform for the 2022/2023 Financial Year

Health professionals—including health teachers—topped the list of civil servant categories whose pay increases occurred in the

fiscal year 2022–2023. The enhancement resulted in eliminating retention benefits for medical officers and consolidating health benefits like the lunch allowance (Ministry of Public Service, 2022). In addition to their pay, public servants receive routine non-wage benefits as a source of motivation (Gindling et al., 2019). The Ministry of Public Service (2022) states that non-health professionals who hold positions in establishing health facilities, district health departments, city health departments, and municipal health departments continue to receive the allowance.

With regard to percentage increase, health professionals with diplomas received the highest increase—54 per cent—followed by consultants (51%), other health workers (50%), support staff (47%), medical officers (45%), senior consultants (44%) and surgeons with the lowest accrual ratio (26).

Figure 1: Showing Percentage increase of pay in the FY2022/2023 for selected health workers

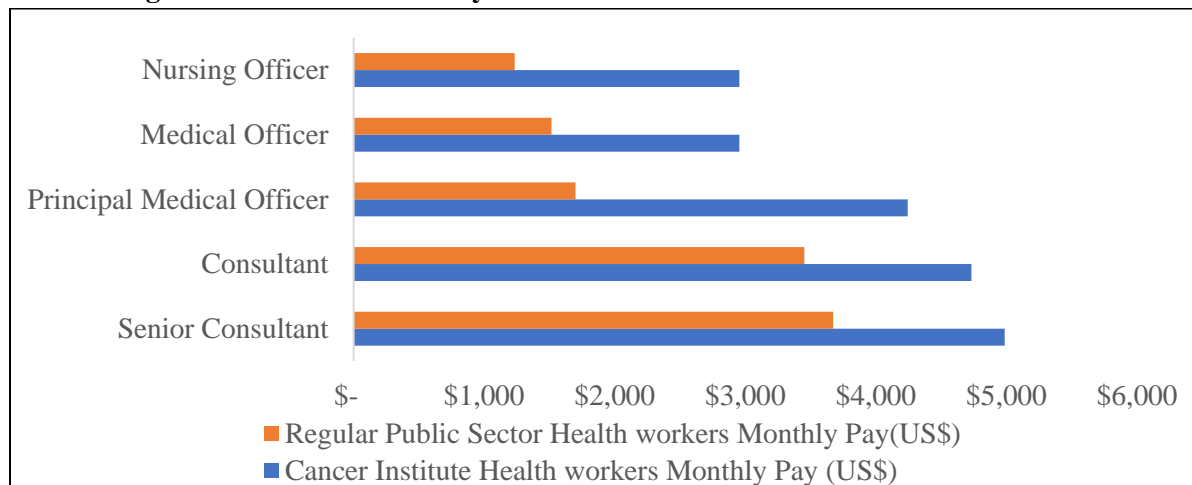


Analysis of the percentage increment for some selected health cadres for phase 3 pay reform in FY2022/2023

Commenting on the salary increase for health workers in an interview with New Vision, the President of the Uganda Medical Association said the salary increase was intended to help them "be

in the same market as other people, but that is not commensurate with the services we provide" (Oledo, 2022).

Figure 2: Comparison between the pay for Health workers under the Institutional Service Model and the Regular Public Service Salary Structure Model



Analysis of pay figures from Cancer Establishment Structure (2023) & Ministry of Public Service Salary Structure (2022/2023)

There is a glaring difference between the two models: health workers in the public sector who follow the institutional service model receive higher pay than those who follow the regular salary scale model. According to the analysis, a consultant at the Cancer Institute makes \$1,281 more than a consultant at the regular public health worker pay scale, and a senior consultant at the organisation makes \$1,314 more than a consultant at the regular civil service salary structure. The salary of a Cancer Institute medical officer is \$1,441 higher than that of a worker in the regular public health worker pay scale, and the salary of a principal medical officer at the institute is \$2,544. At the Cancer Institute, a nursing officer's pay is \$1,235 higher than that of a public health worker on the standard pay scale. The institutional service and compensation models for regular healthcare workers differ significantly in salary levels.

Analysis of the Fiscal Implication of the Health Workers' Pay Reforms

According to Amnesty International (2023), an analysis of Uganda's budget allocation data for the 2022–2023 fiscal year revealed a 47 per cent increase, with the health budget rising by 0.7 per

cent. Even with the increase, it is still less than the target (7.7% of total expenditure) as opposed to the Abuja Declaration's recommended 15% (Amnesty International, 2023; UNICEF, 2023). In 2018/19 and 2020/21, the health sector budget decreased from 42% of total health expenditures to 35% (UNICEF, 2023). Dr Otile (2022), an advocate for improved health and health systems, also brought up this point that "the government is still performing poorly in achieving the 15 per cent of the national budget as per the Abuja declaration".

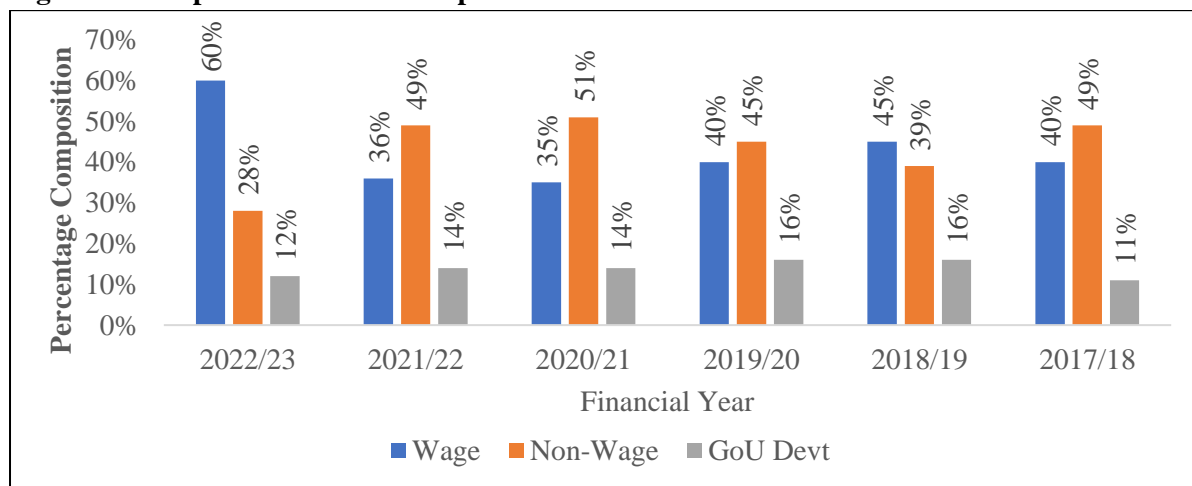
Large disparities in overall health coverage remain across Uganda's sub-regions (UNICEF, 2023). On average, universal health coverage in Uganda is 59%, while recommended universal health coverage is 90%. The state budget mainly covers recurring wages and salaries, with wages increasing by 23% from 21% due to salary increases for scientists, which include health workers. Meanwhile, the allocation for development stood at 15%, compared to 10% in the 2021/202 financial year (UNICEF, 2023). Peter Waiswa, associate professor of health policy, planning and management at Makerere School of Public Health, quoted the New Vision

newspaper as saying that "salary alone is not a good motivator" for health workers. He stressed that "the government must also invest in health infrastructure and equipment and increase the number of medical professionals in its facilities to reduce the burden on the shoulders of those already in service" (Waiswa, 2022).

In the 2022/2023 financial year, health budgets remained predominantly recurring. While the

salary distribution had decreased from 45% in the 2018/2019 financial year to 36% in the 2021/2022 financial year, the salary increases for scientists and health workers in the 2022/2023 financial year resulted in an increase in the health budget to 60% (UNICEF, 2023). The increase will impact other healthcare costs that are not payroll-related - they fell from around 50% to 28% in 2020/21. This negatively impacts other performance areas (UNICEF, 2023).

Figure 3: Composition of Health Expenditure



The ration of wage allocation to other spending: adopted and modified from (UNICEF, 2023) (Source: Government Budget 2018/2019-2022/2023)

The majority of general health spending in the fiscal year 2022–2023 went toward wages (60 per cent), non-wage costs (28 per cent), and development (12 per cent). Meagre allocations had an impact on equipment procurement, training, and monitoring. The 45 per cent pay increase remained a top priority in 2018–2019; non-wage costs and development came in at 39 and 16 per cent, respectively. The portion allotted for development has consistently been the lowest over all the years. This implies that the government spent less money on development initiatives like buying equipment. Pay is not a motivator (Marcus & Forsyth 2008; Gerhart and Rynes, 2003); rather, the availability of tools and medical equipment to support health workers in their work is, as previous research in this area has demonstrated (Marcus & Forsyth, 2008; World Health Organization, 2006).

Donor Support

About 40% of the recurrent budget is funded by donors (Daily Monitor, 2021). Donor contributions to the health sector totalled UGX:3966.1 billion in the 2018–19 fiscal year. Roughly 76% of all resources in the health sector came from donations (UNICEF, 2018). The donor funds are largely used to tackle the financial difficulties associated with coordinating endeavours within this sector (World Health Organization, 2017). However, although not the focus of this article, we note that the recently passed Anti Homosexuality Act, 2023, by Uganda's parliament and subsequent assent to it by the President will likely affect donor funding to this critical sector. Certainly, donor agencies often have their gaze anchored on certain principles (see Akena, 2014 for more), and deviation by recipient countries from those principle can be consequential.

DISCUSSION

The issues and impacts identified in the study highlight the complexity of wage restructuring in the public health sector. The restructuring of salaries of health workers in the public sector had a fiscal impact on the overall budget allocation for the health sector. In 2022/2023, 60% of the health sector budget went to wage protection and only 12% to development. This means that the government spent less funds on development initiatives such as purchasing equipment. Pay alone is not a motivator (Marcus & Forsyth, 2008; Gerhart & Rynes, 2003); Rather, there is the availability of tools and medical equipment to support health workers in their work, as previous research in this area has shown (Marcus & Forsyth, 2008; World Health Organization, 2006; Twineamatsiko et al., 2023). It is common for health workers to have to improvise means to provide services to patients or clients, including referral of cases that could be treated due to lack of equipment in their facilities (Moyimane et al., 2017; Perry & Malkin 2011; Ojwang et al., 2021). This lack of medical supplies and equipment demotivates health workers and is a reason for some to leave the country (Willis-Shattuck et al., 2008; Vlaev et al., 2017; Muthuri et al., 2020, June).

The tax impact of wage restructuring was accompanied by a hiring freeze (Alesina & Perotti, 1997; Forni & Novta, 2014; Lienert, 1997). Funds that should have been allocated to review and expand staffing standards or to hire more health workers ended up being allocated as salary increases for the few existing health workers. As a result, the proportion of health workers in the population remains low (Ministry of Health, 2019; Hagopian et al., 2009; Kinfu et al., 2009; Anyangwe & Mtonga, 2007).

The wage reform reintroduced the multi-tiered salary structure that the government had attempted to integrate into a unified salary system (Asare & Mpere, 2017). With the introduction of the uniform salary system, wage discrimination was intended to be abolished. Ensure a fair and equitable compensation structure. However, these

goals were not achieved. New salary scales for health workers have been introduced; A qualified health professional earns more than a senior medical officer due to the government's conscious decision to specifically increase the salary of health professionals (Therkildsen, 2001). Furthermore, various categories of workers, including health workers, protested against the low wages resulting from individual work (Therkildsen, 2001; Cavalcanti, 2009; Asare & Mpere, 2017). This forced the government to use the tool of collective bargaining to meet the demands of striking nurses and midwives (Eberts & Stone 1986; Bales, 1997; Wynn, 1970). This collective bargaining approach made it impossible for the government to stick to its policy of cutting wages for all civil servants, resulting in wage discrimination (Peters, 2018). The nurses and midwives union, which includes 70% of health workers, and the Ugandan government signed a collective agreement following the 2018 strike. Unions have a strong influence on wage distribution (Lee, 1978).

In addition to collective bargaining, the public health sector promoted the adoption of an institutional compensation model by establishing institutions such as the Uganda Cancer Institution as a semi-autonomous agency with its own salary scales that were twice that of regular public sector health workers (Peters, 2018).). At the Cancer Institute, a nursing officer's salary is \$1,235 higher than that of a public health worker on the standard pay scale. The institutional service model and compensation models for regular health workers differ significantly. Therkildsen (2001) found that salary reform could lead to a salary increase for certain categories of staff.

The enhancement resulted in the elimination of retention benefits for medical officers save for the categories of health workers who did not benefit from the enhancement. In as much as Therkildsen, (2001) opines that pay reform leads to consolidation of non-wage benefits. These benefits are actually meant to act as additional incentives to employees (Gindling et al., 2019). The objective of the allowance was attract the

health workers to rural health facilities where over 74% of the population resides (Twineamatsiko et al, 2023). “Consider a snapshot of health and wellbeing outcomes among rural Ugandans compared to their urban counterparts: women have more unmet family planning needs; women are less likely to have a skilled health care provider present when they give birth; children ages 12-23 months have lower rates of vaccinations; and residents have less access to safe drinking water and sanitation services.”¹

A salary increase should support an equitable distribution of health workers, particularly between urban and rural areas (Anyangwe & Mtonga, 2007; Roodenbeke & World Health Organization, 2011; World Health Organization, 2006). Many healthcare professionals prefer to work in urban areas with better infrastructure, amenities and opportunities (Okoroafor et al., 2021). This concentration of health workers in urban areas has made it difficult to implement wage reforms aimed at smoothing the distribution and attracting health workers to work in rural areas (Hagopian et al., 2009; Azevedo, 2017).

About 40% of the recurring budget is funded by donors (Daily Monitor, 2021). About 76% of all resources in the health sector came from donations (UNICEF, 2018). Donor funds are largely used to address the financial difficulties associated with coordinating efforts in this sector (World Health Organization, 2017). Although not the focus of this article, we note, however, that the Anti-Homosexuality Act 2023 recently passed by the Ugandan Parliament in Uganda and the President's subsequent assent thereto are likely to have an impact on donor funding for this critical sector. Certainly, donor organizations often focus on certain principles (see Akena, 2014 for more), and a deviation by recipient countries from these principles can have consequences. In 2020, the

Ministry of Health conducted routine monitoring of support and found that the performance of health units was inadequate due to inadequate funding. However, these units received additional support from partners such as PEPFAR, USAID and the CDC.

Management Effectiveness

Without strengthening managerial effectiveness, salary reforms do not improve health outcomes (Petersen et al. 2006; Cassels, 1995). The fact that in the 2022/2023 financial year 28% of budget allocations for the health sector went to wage costs and 60% to wage costs meant that certain activities such as support supervision, training and capacity building were affected. For example, unnecessary and high referrals, especially of IV patients in health centers, are reported to be burdening hospitals due to the lack of a performance monitoring system for doctors in health centers (Ministry of Health, 2021). This is despite the fact that doctors received the highest share (80%) of the 2018/2019 salary increase. The capacity of health teams to support oversight and community health departments in regional referral hospitals to coordinate local governments' oversight activities is limited (Ministry of Health, 2021; Hagopian et al., 2009). Increasing salary levels neither changed their work ethic nor improved service seekers' perceptions (Berry et al., 1990; Eichler, 2006; Mosadeghrad, 2014).

CONCLUSION AND RECOMMENDATIONS

The article aimed to provide a comprehensive overview of the hurdles faced by the Ministry of Health in Uganda in relation to wage reforms and the implications of the same on service delivery. The study utilized qualitative research techniques to explore these hurdles and difficulties, primarily focusing on reviewing literature and policy

¹ <https://www.ahealthierworld.jhu.edu/uganda-rural-health-equity> “Advancing health in rural Uganda through strong community health programs.”

documents. The key result demonstrated that different service models are used to determine salaries for health workers. These include centrally determined job classifications and salary levels, Collective bargaining, and institutional politics. As much as public health workers in Uganda benefited from pay restructuring, the reforms also had an adverse impact on fiscal policy and resulted in a freeze in some sectors or activities within sectors, such as a hiring freeze and under-provision of medical care and other facilities. Staffing levels in healthcare facilities were impacted, resulting in ineffective service delivery. Customer dissatisfaction and management inefficiencies are still reported. The management inefficiencies were due to insufficient budget allocations for leadership capacity building due to salary increases. The lack of medical supplies and facilities is partly a factor causing professionals to leave government medical services and opt for private practice or leave the country despite the salary increase. Unequal distribution of urban and rural health workers continues to be reported despite pay enhancement. Therefore, the salary restructuring in the public health sector presents overwhelming burdens on service delivery that need to be addressed by policymakers.

The key recommendation is that government, while considering pay restructuring, should use empirical data to inform well define policies other than relying on political influence and maneuvering by various interest groups clambering for pay enhancement.

Disclaimer

This study was admittedly based on an analysis of existing documents, literature, and case studies. Therefore, we cannot justifiably suggest the extent to which our statements, grounded in the reviewed literature can easily be transferable to other contexts. Therefore, we suggest that further studies be conducted with human participants to examine how restructuring in the public sector would align practices to existing policies/legislation to improve service delivery.

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