A JOINT LEARNING INITIATIVE:

HUMAN RESOURCES FOR HEALTH AND DEVELOPMENT:

Payment of Lunch Allowance: A Case Study of the Uganda Health Service

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1. TERMS OF REFERENCE FOR THE STUDY

Overall goal:

Undertake a case study of an intervention (the lunch allowance scheme) instituted in Uganda to improve retention and motivation of health workers, and draw lessons form it.

Deliverables

(i) *Describe the evolution of the scheme, how and why it was started, by which government agency, and current state.*

(ii) *List category of health workers included in the scheme*

(iii) *Describe implementation steps i.e. was a law passed by government or was it simply an order from the cabinet or from the Ministry of Health, was Ministry of Establishment (civil service/public administration agency) involved, if not how was it bypassed?*

(iv) *Assess impact on brain drain of health professionals (medical doctors and nurses), and*

(vi) *Identify difficulties encountered and lessons learnt.*

2. POLICY GUIDELINES

Government introduced the policy of paying Public Officers money to cater for lunch, dinner or both in 1989. The money was payable to staff whose nature of work required them to remain in office working during the time for the said meals[1]

Initially, there was no standardized rate for the cost of the meals and this varied from location to location. In 1990, the cost was fixed at Ushs.1,000/= per meal.[2]

In 1993 lunch allowance was introduced. The allowance was paid at the discretion of the Accounting Officers (Permanent Secretaries) and subject to availability of funds and was paid based on the following rates which have been maintained to date:-

Officers in salary scale U1-U8 at rate of Ushs. 3,000/= per day

[1] Circular Standing Instruction No. 7 of 1986
[2] Circular Standing Instruction No. 1 of 1990

Support staff at a rate of Ushs. 2,000/= per day[3]

(Salary scale U1 is the highest and U8 is the lowest).

It should be noted from the circulars stated that only officers whose work required them to remain in office during meal hours like Secretaries to Ministers, Permanent secretaries and some Broadcasting staff were the ones singled out to benefit from these allowances. The Health workers were not included in this category.

2. MEDICAL WORKERS STRIKE 1995

In 1995, the Ugandan health workers led by the newly formed Uganda Medical workers Union declared a nation wide strike. One of the grievances that culminated in the 1995 strike was non payment of lunch allowance and yet by nature of their work medical workers were required to remain in office working during either lunch or dinner time. As a result of the strike, Government agreed to pay lunch allowance to all medical workers thus making it a monthly entitlement with effect from 1st July 1996. This allowance was initially awarded to only medical workers and it excluded persons who do administrative and other work (in Uganda referred to as the Common Cadres). The latter, as expected complained and to avoid further discontent, and de-motivation of non-medical staff, a decision[4] was taken to pay all staff deployed in Health facilities/ units including Ministry of Health and district Headquarter staff.

The allowance to be paid at the following fixed rate:-

Officers in salary scale U1-U8- at a rate of Ushs. 66,600 per month. Support staff at a rate of Ushs. 44,000 per month.

3. IMPLEMENT MODALITIES

Lunch allowance in 1996/1997 and 1997/1998 financial year was paid outside the paroll. The funds were remitted as a conditional grant to the Local governments. Dur to complaints about under payments or non-payment by medical workers a policy decision was taken to pay the allowance through the payroll with effect from 1st July 1998. The funds for lunch allowance were therefore , transferred from non-wage to wage in 1998/1999 financial year.[5] The Number of staff and the funds paid out for lunch allowance since 1998/1999 financial year are indicated in Table 1 below:

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[3] Circular Standing instruction No. 7.of 1994

[4] Letter M/MFPED/5/6 from Permanent Secretary/ Secretary to the Treasury of 20 October 1998.

[5] Budget call circular from the Permanent/Secretary/Secretary to the Treasury, Ministry of Finance, planning and Economic Development dated 18th May 1998.

Table 1: Number of Staff and Funds Paid for Lunch allowance since 1998/1999 financial Year

(Exchange rate at the time: US$ 1 = Ug Shs 1000)

FINANCIAL YEAR	NO. OF STAFF	AMOUNT UG shs.
1998/1999	17,056	8,397,783,303
1999/2000	18,732	11,612,022,503
2001/2001	9,737	5,253,721,000
2001/2002	9,685	4,800,599,200
2002/2003	8,999	4,726,652,000

Source: Ministry of Public service payroll Monitoring Unit.

One of the principles of pay reform is to pay a consolidated salary package to staff. In 2000/201 financial year, the salaries for middle to senior level managers and professionals were enhanced substantially. As a result, lunch allowance for Officers in salary scale U5b and above was consolidated into salary . The allowance for the lower level staff has continued to be paid through the payroll as they have received minimal salary increases since 200/2001 financial year. This explains the reduction in the number of staff paid lunch allowance since then.

Table 2: Summary of Lunch Allowance Payments to Medical Workers Financial Year 1998/1999

Salary Scale	No. Staff	Amount
U1	139	75,328,000
U2	122	78,034,000
U3	374	223,353,676
U4	511	287,892,000
U5	2,974	1,608,763,643
U6	2,135	1,257,151,048
U7	4,137	2,579,351,848
U8	286	136,818,000
Support Staff	6,378	2,151,091,088
TOTAL	**17,056**	**8,397,783,303**

Source: Ministry of Public Service

TABLE 3: SUMMARY OF LUNCH ALLOWANCE PAYMENTS TO MEDICAL WORKERS FINANCIAL YEAR 1999/2000

Salary Scale	**No. of Staff**	**Amount**
U1	152	92,887,000
U2	153	94,380,000
U3	389	274,164,000
U4	492	353,386,000
U5	2,843	1,976,800,000
U6	2,469	1,711,012,000
U7	4,863	3,447,941,000
U8	6,948	247,414,000
Support Staff	6,948	3,414038,503
Total	18,732	11,612,022,503

Source: Ministry of Public Service

TABLE 4: SUMMARY OF LUNCH ALLOWANCE PAYMENTSTO MEDICAL WORKERS FINANCIAL YEAR: 2000/2001

Salary Scale	**No. of staff**	**Amount**
U1	46	20,460,000
U2	23	11,682,000
U3	49	27,522,000
U4	44	25,344,000
U5	468	278,740,000
U6	457	294,734,000
U7	895	568,128,000
U8	293	179,1904,000
Support Staff	7,462	3,847,207,000
TOTAL	9,737	5,253,721,000

Source: Ministry of Public Service

TABLE 5: SUMMARY OF LUNCH ALLOAWANCE PAYMENTS TO MEDICAL WORKERS FINANCIAL YEAR: 2001/2002

Salary Scale	No. of Staff	Amount
U1	30	17.974,000
U2	19	11,440,000
U3	41	26,400,000
U4	45	23,726,000
U5	456	247,192,000
U6	489	284,592,000
U7	933	591,734,000
U8	284	182,732,000
Support Staff	7,388	3,414,809,200
Total	**9,685**	**4,800,599,200**

Source: Ministry of Public Service

TABLE 6: SUMMARY OF LUNCH ALLOWANCE PAYMENTS TO MEDICAL WORKERS FINANCIAL YEAR : 2002/2003

Salary Scale		
U1	**No. of Staff**	**Amount**
U4	**1**	**88,000**
U5	**4**	**660,000**
U6	**140**	**95,612,000**
U7	**315**	**209.792,000**
U8	**650**	**449,702,000**
Support Staff	**376**	**222,816,000**
Totals	**7,513**	**3,747,982,000**
	8,999	**4,726,652,000**

Source: Ministry of Public Service

4. CHALLENGES

i) **Reliable data for budgeting**

Most local Governments were operating manual payrolls in 1998. This implied that the central Government did not have reliable data for budgeting purposes. The Ministry of Finance, planning and Economic Development depended on returns from the Local Governments. In FY 1998/1999, when the payment changed from non-wage to wage, Local Governments were required to have all the Medical Workers accessed to the computerized payroll. This resulted in improved budgeting as the provision of funds was based on the staff-on-the payroll.

ii) **Taxation**

When the lunch allowance is paid through the payroll, the Officers are guaranteed of prompt and regular payments. On the other hand, the total emoluments on the payroll are subject to income tax deduction. This implies that the lunch allowance is taxed in cases where the total emoluments are over the taxable threshold of Ushs. 130,000 per month. This has resulted in complaints by medical workers, that the allowance is no longer received in full due to the taxation.

5. BENEFIT OF THE SCHEME

In the short run, it appeared that the Payment of Lunch Allowance minimized Medical Worker' agitation for salary enhancement and has contributed to industrial peace since 1996..

6. IMPACT OF BRAIN DRAIN OF HEALTH PROFESSIONALS (MEDICAL DOCTORS AND NURSES)

It is very difficult to quantify the degree of brain drain among health professionals. There are not many studies done on this subject but one study showed that out of the 140 doctors graduating annually in the two Ugandan Medical Schools of Makerere (100) and Mbarara (40), 70% of whom find their way out of the country for “greener pastures” in Europe, North America an

Southern Africa[6]. Current records available at the Health Professional Councils indicate that about 30% of all the medical officers and 10% of the Nurses have been leaving service every year in search of "greener pastures"[7]. For nurses, no figures are available for 1995. However, it is now very evident that the brain drain among the nurses is highest because of the heightened demand from Europe, Australia and North America. The figures for doctors seem to show a reduction in brain drain but we believe they are not so comprehensive as to be generalized. It is difficult to attribute the reduction in the brain drain to the payment of lunch allowance alone. In fact during this period there was an embargo in recruitment imposed by the Civil Service Reforms at the same time as the introduction of Lunch Allowance. This left a lot of health professionals on the street and as a result many went where their services were needed. Whereas those in service were somewhat motivated by the lunch allowance introduction, many were kept out service and left en masse! For example, it is interesting to note that although 140 doctors qualify every year for the last 10 years, and over 80 doctors per year for over 30 year prior to that , which would give close to 4000 doctors in service today, there are only about 800 doctors in public employment and yet this output has been ongoing. The disparity is even greater for nurses whose output is about 1000 per year and yet there are only about 5,000 only in service!

There are several factors that influence the movement of health professionals. The following factors affect the retention or otherwise of Human Resources for Health in Uganda.

(1) *Embargo on recruitment in the service:* As part of the Civil service reforms, there was no recruitment since 1996. In 2000, there was selected recruitment with a given ceiling which provided for only 3,000 health workers in the whole country. Since then, this ceiling has never been revised upwards.

(2) Some cadres are very difficult to find because of the low output is their health training institutions. These include most of the diagnostic cadres (eg radiography, laboratory technicians), midwives, anaesthetic staff etc. For example the output of the schools of anaesthesia, radiography, dispensing and orthopaedic officers is only 10-15 graduates per year.

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[6] Nzarubara G.R.; Brain Drain/Brain Push in Uganda. Proceedings of Association of Surgeons of East Africa. Supplement) 9, 38-41.

[7] Omaswa F.G., Human Resources for the millennium development goals – the challenge in Uganda. Paper presented by the Ugandan Director of Health Services at meeting of Interested parties, WHO, Geneva, 4th November, 2003.

(3) Generally there is preference of personnel to be deployed in cities rather than the rural areas and even the few who go upcountry are concentrated in hospitals (which are near small townships) rather than health centers which are in the middle of the villages.

(4) Some hard to reach areas do not attract health workers even if positions exist because of lack of amenities like proper housing, water, telephone, television coverage, electricity and poor social contacts.

(5) Work overload: In 1998, only 33% of the health workforce had professional qualifications. The rest were auxiliaries (largely nursing aides). With the recruitment drive in 2000, this proportion has now reached 52%. The health workers in post therefore have to do double (and previously thrice) the workload because of this understaffing and this is very de-motivating especially in an environment of poor remuneration.

7. WAS POOR REMUNERATION THE ONLY CAUSE OF THE STRIKE?

A task force[8] put in place to examine the causes of the strike discovered the following as contributory factors:

- Poor Human Resources for Health Planning
- Fear of contagious diseases/infections by health workers while at work
- Poor amenities at work especially outside the urban areas
- Lack of systematic staff development programmes
- Shortage of drugs an
- Overwork resulting from understaffing d other expendables at work making the workers frustrated in front of a suffering clientelle.
- Abolition of user charges. These charges had been a big boost to the health workers' income and they were abolished by a political decision ahead of a national election!
- Lack of duty facilitating allowances
- Poor remuneration. This was still a factor in its own right but not the only one.

8. WHAT IS THE CURRENT STATE OF AFFAIRS AMONG UGANDA HEALTH WORKERS?

On 7th July 2003, the Permanent Secretary Ministry of Public Service issued Circular[9] Standing

[8] Committee to address the grievances of health workers; Factors affecting service delivery in government hospitals. August 1996.

Instruction No. 2 of 2003 (CSI 2). CSI 2 introduced several payroll reforms as a result of the Job Evaluation (JE) exercise and JE Report of January 2002.

The Uganda Medical Workers' Union, Uganda Medical Association, Uganda Nurses and midwifery Association, Uganda Dentists' Association the Pharmaceutical Society of Uganda – all collectively referred to as Medical Workers- noted that CSI 2 did not address their long awaited need for a better remuneration package. If anything, it seemed to leave them worse off than before. The following examples illustrate the Medical Workers' resentment of CSI 2.

a. A Single spine Salary Structure (SSSS) was adapted in favour of the existing Multi-Spine Salary Structure (MSSS) which all the medical Workers had recommended in the JE Report.
b. It was not easy to trace lunch allowance in the new salaries.
c. The salaries offered by CSI 2 tended to disregard the differentials between medical workers and their counterparts in service and in some cases the difference became less than the lunch allowance figure of 66,000/=.
d. For some cadres e.g Nursing, Clinical, Orthopedic and Anesthetic officer, Grades I and II were merged. This meant that senior officers were rated equally when their seniority and skills were different.
e. Some posts which had scored highly in the JE were rated lower than those which scored lower. For example the Director General of Health Services who scored highest in the JE was placed below the Permanent Secretaries in the CSI 2.

The Medical workers disputed the CSI 2 and threatened to institute industrial action if their concerns were not attended to.

The Ministry of Health met the Medical Workers and requested them to identify all these concerns and make realistic proposals to government in form a document. A retreat was arranged and sponsored for them by the Ministry of Health and a document[10] resulted.

This document was used at negotiations held between the Medical Workers and officials of the Ministry of Public Service in the presence of the Commissioner for Labour but the talks never

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[9] Ministry of Public Service. Circular Standing Instruction No. 2 of 2003: Implementation of the Single Spine Structure: 2003/2004 Financial Year, 7/7/2003.

[10] Report of the Task force to study issues related to Salaries of medical workers arising from Circular Standing Instruction No.2 of 2003. Kampala, 1-6 September 2003.

yielded any useful results and the Medical workers maintained their call for a strike setting October 7th as the day for the strike.

The Minister of Health met the Workers on October 4th. They told him they would proceed with the strike if their grievances were not responded to. The Medical Workers then requested for audience with and were able to meet the President of the Republic of Uganda on Sunday 5th October 20003. At this meeting, (which this writer attended), the President agreed with the Medical Workers that it was in order for differential treatment to be given to vital cadres like medical workers, teachers and researchers. He said this was especially important because of our meager budget and therefore the need to prioritise. He requested for time to look into the Medical Workers' requests and in turn the medical workers indefinitely put off the strike.
To date, there has not been any announcement about a new policy and the medical workers' unrest seems to have been only postponed and not contained.

9. DOES ABSENCE OF STRIKE MEAN THAT ALL IS WELL WITH MEDICAL WORKERS?

The current situation among medical workers is already a threat to their effectiveness and therefore dilutes quality of care. The symptoms are manifested in the two examples below:

- There is a re-emergence of dual employment largely in form of private practice by health workers in full time public employment. This meant inefficiency at their workplace and often conflict of interest leading to misappropriation of resources and taking off time from the place of employment to attend to the private business.

- Many health workers have chosen to stay in service but stage a *go-slow* strike. This has greatly affected their output and made the Uganda Public health services unattractive to use.

10. CONCLUSION

There is increasing recognition of the vital role Human Resources for health in the delivery of sound health services. There is urgent need for their adequate remuneration but it is now accepted that payment of adequate salary and duty facilitating allowances must be supplemented by conducive working environment and enabling Human Resource Management policies and systems. If this is not done, the developing world will continue losing their HRH who have been trained at a high cost.