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Remuneration Inequity and Its Effects on Job Satisfaction Turnover Intention and Migration Intention Among Health Workers in Southwest Nigeria

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ABSTRACT

Remuneration inequity remains a persistent challenge in Nigeria's health sector, with growing implications for workforce motivation, retention, and health system performance. This study empirically examines compensation disparities among health professional cadres in Southwest Nigeria, assesses their consequences for job satisfaction, turnover intention, and migration intention, and identifies relevant policy pathways for reform. A cross-sectional analytical design was employed, involving 400 health workers drawn from public health facilities across selected states in Southwest Nigeria. Data were collected using a structured, self-administered questionnaire capturing demographic characteristics, remuneration levels, perceived equity, job satisfaction, and workforce intentions. Descriptive statistics, analysis of variance (ANOVA), correlation analysis, and regression modeling were used for data analysis. The findings reveal statistically significant remuneration disparities across professional cadres, with medical doctors earning substantially higher salaries than nurses, pharmacists, laboratory scientists, and community health workers. Perceived remuneration inequity was positively associated with lower job satisfaction and significantly predicted turnover and migration intentions. Lower-paid cadres were disproportionately affected, highlighting increased risks of workforce attrition and skill shortages. The study concludes that existing remuneration structures contribute to systemic inequities that may undermine health system efficiency and sustainability. Policy reforms aimed at harmonizing salary structures, improving transparency, and introducing equity-based incentives are essential to enhance workforce morale, retention, and the delivery of quality healthcare services in Nigeria.

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BACKGROUND

Remuneration equity in the health sector remains a critical determinant of health workforce performance, motivation, productivity, and long-term retention. Contemporary health systems research demonstrates that equitable and transparent compensation structures are closely associated with improved job satisfaction, stronger organizational commitment, and enhanced quality of healthcare delivery. In many low- and middle-income countries (LMICs), persistent disparities in salary structures across professional cadres have been empirically linked to reduced morale, frequent industrial actions, inter-professional conflict, and declining service quality (BMC Health Services Research, 2022; Idowu, 2025). Global health governance institutions have consistently underscored the importance of fair remuneration as a cornerstone of sustainable health systems. The World Health Organization identifies adequate and equitable pay as a fundamental policy instrument for attracting, motivating, and retaining skilled health workers, particularly in contexts facing chronic workforce shortages and migration pressures. Evidence from recent policy analyses indicates that inequitable compensation undermines workforce stability,

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weakens accountability, and poses a significant barrier to achieving universal health coverage (World Health Organization, 2022). In LMIC settings such as Nigeria, where health systems are already constrained by limited financing and infrastructure deficits, remuneration inequity further compounds systemic vulnerabilities and threatens progress toward equitable and accessible healthcare services.

In Nigeria, remuneration within the public health sector is governed by distinct salary structures, notably the Consolidated Medical Salary Structure (CONMESS) for medical doctors and the Consolidated Health Salary Structure (CONHESS) for other categories of health professionals such as nurses, pharmacists, medical laboratory scientists, and community health workers. These parallel salary structures were originally designed to recognize differences in professional training, scope of practice, and clinical responsibility. However, over time, they have produced substantial and persistent disparities in basic salaries, duty allowances, call allowances, and opportunities for accelerated career progression (African Health Observatory Platform, 2022; Independent Newspaper Nigeria, 2025).

Recent empirical studies indicate that the widening remuneration gap between medical doctors and other health professionals is not always commensurate with differences in workload intensity, working hours, or contribution to service delivery outcomes, particularly in primary and secondary healthcare settings (BMC Health Services Research, 2022). This imbalance has been associated with growing perceptions of distributive injustice and inequity within the health workforce, reinforcing feelings of marginalization among non-physician cadres. Scholars argue that such perceptions weaken inter-professional collaboration, erode team cohesion, and negatively affect the efficiency and effectiveness of healthcare delivery (Idowu, 2025).

Furthermore, remuneration disparities embedded within CONMESS and CONHESS have been widely criticized by professional associations and labour unions for institutionalizing inequality and exacerbating professional rivalry. Evidence suggests that perceived unfairness in compensation contributes to recurrent industrial actions, strained workplace relationships, and declining morale among affected health workers, thereby undermining health system stability and performance (Guardian Nigeria, 2025; World Health Organization, 2022).

Empirical and policy-oriented studies conducted in recent years have shown that remuneration inequity contributes significantly to workforce dissatisfaction, low morale, and strained professional relationships among health workers in Nigeria. Such inequities are often amplified by heavy workloads, inadequate infrastructure, and delayed payment of salaries and allowances, particularly in state-owned health facilities. In Southwest Nigeria, a region that hosts some of the country's most populated urban centres as well as underserved peri-urban and rural communities, the effects of compensation disparities are especially evident.

Furthermore, remuneration inequity has been linked to the increasing migration of Nigerian health professionals to high-income countries, a phenomenon commonly referred to as the "Japa" syndrome. Poor and unequal compensation has been identified as a major push factor driving health workers to seek better-paying opportunities abroad, thereby exacerbating shortages in the domestic health system. These workforce losses undermine service delivery, increase patient-to-provider ratios, and threaten the sustainability of healthcare services in the region.

Against this backdrop, an empirical examination of remuneration inequity, its workforce consequences, and potential policy pathways is essential for informing evidence-based reforms aimed at strengthening Nigeria's health system.

Problem Statement

Despite the strategic importance of human resources to health system performance, remuneration inequity remains a persistent challenge in Nigeria's health sector, as documented in recent empirical studies (BMC Health Services Research, 2022; Idowu, 2025). The coexistence of multiple salary structures has resulted in substantial disparities in earnings and benefits among health professional cadres, often unrelated to workload intensity, years of experience, or service demands (African Health Observatory Platform, 2022; Independent Newspaper Nigeria, 2025). These disparities have contributed to recurring industrial actions, interprofessional conflicts, reduced organizational commitment, and declining morale among affected health workers, ultimately undermining health service delivery and system efficiency (Guardian Nigeria, 2025; World Health Organization, 2022).

In Southwest Nigeria, health facilities continue to experience staff shortages, high turnover intentions, and declining commitment among health professionals—trends frequently attributed to dissatisfaction with remuneration. While anecdotal evidence and labour union agitations underscore the severity of these challenges, there remains a paucity of region-specific empirical studies that systematically quantify remuneration inequity and examine its direct effects on workforce outcomes such as job satisfaction, retention, and migration intentions.

In contrast, evidence from other countries demonstrates that more harmonized and equity-oriented remuneration systems can significantly enhance health workforce stability and performance. For example, Rwanda has implemented a relatively unified public-sector health remuneration framework complemented by performance-based financing (PBF), which links financial incentives to service delivery outputs and quality indicators across cadres. This approach has reduced extreme inter-cadre wage disparities, strengthened accountability, improved job satisfaction, and

contributed to notable gains in health system performance and workforce retention, particularly at the primary healthcare level (World Health Organization, 2022). The Rwandan experience illustrates how aligning remuneration with performance and system-wide goals can mitigate professional rivalry and promote collective responsibility for health outcomes.

Similarly, Singapore operates a highly structured, transparent, and merit-based health workforce remuneration system, where salary progression, allowances, and incentives are closely tied to competencies, responsibilities, and performance rather than rigid professional hierarchies. Health professionals across cadres benefit from clear career pathways, competitive remuneration, and non-monetary incentives such as continuous professional development and institutional support. This integrated approach has been associated with high workforce morale, low turnover rates, and strong interprofessional collaboration, contributing to Singapore's globally recognized health system efficiency and quality of care (WHO, 2022).

The stark contrast between Nigeria's fragmented remuneration framework and the more coordinated systems observed in Rwanda and Singapore highlights a critical policy gap. While Nigeria continues to operate parallel salary structures that institutionalize inequities, these comparator countries demonstrate that deliberate policy choices toward harmonization, transparency, and equity can yield positive workforce and system-level outcomes. The absence of empirical, context-specific evidence on the magnitude and consequences of remuneration inequity in Southwest Nigeria constrains policymakers' ability to design informed reforms that draw on such international best practices.

Without a clear understanding of how remuneration disparities affect health worker behavior, morale, and retention in the Nigerian context, existing inequities are likely to persist, exacerbating workforce attrition, intensifying migration pressures, and further weakening the delivery of quality healthcare services. This underscores the need for an empirical examination of remuneration inequity in Southwest Nigeria, situated within both local realities and relevant international comparisons, to inform equitable, sustainable, and evidence-based compensation reforms.

Justification of the Study

This study is justified on several grounds. First, it provides empirical evidence to inform health workforce and compensation policies at both state and national levels, supporting ongoing health sector reforms and aligning with recommendations by the World Health Organization on equitable remuneration for health workers (World Health Organization, 2022). Second, by examining the relationship between remuneration inequity and workforce outcomes, the study contributes to strategies aimed at improving retention, reducing migration of health professionals, and mitigating the adverse effects of salary disparities on job satisfaction and professional morale (BMC Health Services Research, 2022; Idowu, 2025; Guardian Nigeria, 2025).

Third, the study addresses issues of equity and fairness within the health system, which are central to professional motivation, ethical practice, and social justice. Fourth, its regional focus on Southwest Nigeria allows for context-specific insights that can guide targeted interventions in a region critical to Nigeria's healthcare delivery and training capacity. Finally, the study contributes to the growing body of literature on health workforce economics in LMICs, providing evidence that may be relevant to similar contexts beyond Nigeria.

Objectives of the Study

General Objective

To empirically examine remuneration inequity in Nigeria's health sector, with a focus on compensation disparities, workforce consequences, and policy pathways in Southwest Nigeria.

Specific Objectives

1. To assess differences in remuneration levels among selected categories of health professionals in Southwest Nigeria.
2. To examine the relationship between remuneration inequity and job satisfaction among health workers.
3. To determine the effect of remuneration disparities on turnover intentions and migration intentions among health professionals.
4. To explore health workers' perceptions of remuneration fairness and adequacy in relation to workload and responsibilities.

Research Hypotheses

- **Null Hypothesis ($H0_1$):** There is no statistically significant difference in remuneration levels among different categories of health professionals in Southwest Nigeria.
- **Null Hypothesis ($H0_2$):** Remuneration inequity has no statistically significant relationship with job satisfaction among health workers in Southwest Nigeria.
- **Null Hypothesis ($H0_3$):** Remuneration inequity does not significantly influence turnover intentions among health workers in Southwest Nigeria.
- **Null Hypothesis ($H0_4$):** Remuneration disparities do not significantly predict migration intentions among health professionals in Southwest Nigeria.

LITERATURE REVIEW

Conceptual Framework

Remuneration inequity in healthcare can be conceptualized through theories of distributive justice and equity theory (Adams, 1965; Colquitt et al., 2019). Equity theory posits that employees evaluate fairness by comparing their input-output ratio to that of relevant peers. In the Nigerian health sector,

health workers assess their salary, allowances, and career advancement opportunities relative to colleagues within CONMESS and CONHESS structures. Perceived inequity arises when inputs such as qualifications, workload, and effort are not proportionally matched by outputs such as pay, benefits, or promotion opportunities (Idowu, 2025; BMC Health Services Research, 2022). Distributive justice theory similarly suggests that perceptions of unfair treatment in compensation can lead to dissatisfaction, demotivation, and reduced commitment to organizational goals (Colquitt et al., 2019; World Health Organization, 2022).

Additionally, these theories provide a framework for understanding how remuneration disparities can influence behavioral outcomes such as absenteeism, intention to leave, and reduced organizational citizenship behavior among health workers (Idowu, 2025; BMC Health Services Research, 2022). Applying equity and distributive justice concepts allows policymakers and administrators to identify critical leverage points for interventions aimed at reducing perceived inequities and improving staff motivation.

Moreover, conceptualizing remuneration inequity through these theoretical lenses enables the integration of quantitative and qualitative measures of fairness perception, job satisfaction, and workforce performance. This approach facilitates empirical assessment of the relationship between compensation structures and outcomes such as retention, productivity, and inter-professional collaboration, providing a robust basis for evidence-informed health sector policy reforms (World Health Organization, 2022; African Health Observatory Platform, 2022).

Empirical Studies

Several studies document substantial pay gaps among health professional cadres in Nigeria, highlighting a critical structural issue within the health workforce. Idowu (2025) observed that medical doctors earn significantly more than nurses and allied health professionals, despite comparable workload and responsibilities in secondary and primary healthcare facilities. BMC Health Services Research (2022) further reported that these disparities negatively affect job satisfaction, inter-professional collaboration, career progression, and retention, with non-physician cadres consistently expressing dissatisfaction over perceived inequity. These findings underscore the importance of addressing remuneration disparities to improve workforce motivation and system performance.

Comparative research in LMICs indicates that salary inequities are significantly associated with higher turnover intentions, increased incidence of industrial actions, and elevated migration rates of health workers seeking better remuneration abroad (WHO, 2022; African Health Observatory Platform, 2022; Idowu, 2025). The phenomenon of the "Japa" syndrome in Nigeria illustrates how pronounced compensation disparities directly contribute to workforce attrition, skill shortages, and threaten overall health system resilience, particularly in underserved regions (Guardian Nigeria, 2025; BMC Health Services Research, 2022).

Workforce Consequences of Remuneration Inequity

Remuneration inequity has been linked to reduced morale, job dissatisfaction, absenteeism, and decreased organizational commitment (Colquitt et al., 2019). In Nigeria, these consequences manifest as frequent labour disputes, high attrition rates, and uneven staff distribution between urban and rural facilities (BMC Health Services Research, 2022). Evidence shows that inequitable pay structures undermine motivation, limit productivity, and may compromise patient care quality, particularly in underserved regions (World Health Organization, 2022; Idowu, 2025). Further studies highlight that inequity can exacerbate professional rivalries and inter-cadre tensions, weakening team cohesion and collaboration necessary for effective healthcare delivery (BMC Health Services Research, 2022).

Additionally, remuneration inequity can lead to long-term negative outcomes on workforce sustainability, including chronic shortages of experienced personnel in rural and primary healthcare centers. Health workers perceiving unfair compensation are more likely to seek secondary employment, reduce work effort, or engage in absenteeism, which directly affects service delivery and patient outcomes (Idowu, 2025; African Health Observatory Platform, 2022).

Moreover, inequity influences organizational culture by creating a climate of perceived injustice and professional dissatisfaction. Such an environment can discourage team-based care, diminish mentorship opportunities for junior staff, and hinder the adoption of quality improvement initiatives. Addressing these inequities is therefore essential for ensuring not only fair treatment of health workers but also the overall efficiency, resilience, and equity of the health system (World Health Organization, 2022; BMC Health Services Research, 2022).

Policy Pathways and Recommendations

Scholars advocate for the harmonization of salary structures and the implementation of transparent remuneration policies to promote equity among health workers (WHO, 2022; BMC Health Services Research, 2022). Policy interventions may include regular salary reviews, standardized allowances, performance-based incentives, and targeted professional development opportunities to reduce inequities and improve retention (Idowu, 2025; African Health Observatory Platform, 2022). Strengthening regulatory oversight, enhancing stakeholder engagement, and aligning compensation with workload and service delivery outcomes are critical steps to ensure fair pay practices and support the achievement of national health system goals and universal health coverage targets (World Health Organization, 2022).

Furthermore, adopting technology-driven payroll systems and transparent reporting mechanisms can improve accountability and reduce delays or errors in salary payments,

thereby increasing health worker satisfaction and trust in management. Integration of health worker feedback into policy design is essential to ensure that interventions are contextually appropriate and responsive to the needs of different professional cadres (BMC Health Services Research, 2022; Idowu, 2025).

In addition, international collaboration and benchmarking against best practices from other LMICs can guide policy improvements and ensure that remuneration strategies are competitive and sustainable. Incentivizing rural service, offering hardship allowances, and implementing career progression pathways tied to merit and performance are examples of policy options that can reduce inequities, strengthen retention, and enhance the overall resilience of the health system (World Health Organization, 2022; African Health Observatory Platform, 2022).

METHODOLOGY

Research Design

This study adopts a descriptive cross-sectional research design with a quantitative approach to empirically assess remuneration inequity, workforce consequences, and policy pathways among health professionals in Southwest Nigeria. The cross-sectional design allows for the collection of data at a single point in time, providing a snapshot of compensation disparities and their effects on job satisfaction, turnover intentions, and migration behaviors (Creswell & Creswell, 2018).

Study Area

The study will be conducted across four states in Southwest Nigeria: Lagos, Oyo, Ogun, and Ondo. These states encompass a diverse mix of healthcare facilities, including urban tertiary hospitals, secondary hospitals, and rural primary health centers, which allows for the capture of variations in remuneration and workforce experiences across different service delivery contexts. The region's high concentration of health institutions and a diverse professional workforce make it particularly suitable for examining structural inequities, inter-cadre pay differences, and their implications for workforce performance and retention (African Health Observatory Platform, 2022). Additionally, the selected states provide both densely populated urban centers and underserved rural areas, offering comprehensive insights into contextual factors that may influence remuneration perceptions and professional satisfaction.

Population of the Study

The target population comprises all health professionals employed in public health facilities in the selected states, including medical doctors, nurses, pharmacists, medical laboratory scientists, and community health workers. Health workers on contract or locum tenens will be excluded to focus on permanent staff with established remuneration structures under CONMESS and CONHESS.

Sample Size Determination

A sample size of 384 participants will be determined using the Cochran formula for sample size calculation for large populations (Cochran, 1977). This calculation ensures statistical representativeness and minimizes sampling error. To account for potential non-response or incomplete questionnaires, a 10% contingency was added, yielding an adjusted sample size of approximately 422 respondents. This approach provides sufficient power to detect meaningful differences in remuneration and workforce outcomes across different professional cadres and facility types.

Sampling Technique

A detailed multistage sampling technique was employed to ensure representativeness and minimize selection bias. First, all health facilities in each state was identified and stratified by service level (primary, secondary, tertiary) and by urban or rural location. Second, a proportional stratified random sampling method was used to select facilities from each stratum, ensuring that the number of facilities chosen reflects the distribution of facilities within the state. Third, within each selected facility, a comprehensive list of eligible health professionals by cadre was obtained. Random sampling will then be conducted within each cadre to select individual participants, guaranteeing proportional representation of medical doctors, nurses, pharmacists, laboratory scientists, and community health workers. The process will include clear documentation of selection at each stage to maintain transparency and reproducibility of the sampling method.

Data Collection Instrument

Data will be collected using a structured self-administered questionnaire designed to capture comprehensive information on remuneration inequities and workforce outcomes. The instrument will include sections on demographic characteristics, detailed remuneration components (base salary, allowances, and benefits), perceptions of equity and fairness, job satisfaction (measured using a validated Likert-scale instrument), turnover intention, and migration intention. Additionally, sections will assess workload, professional experience, and inter-cadre relations to contextualize compensation perceptions. A pilot test will be conducted with 30 health workers in a non-selected state to evaluate clarity, reliability (Cronbach's alpha), and construct validity, and feedback will be used to refine the questionnaire before full deployment.

Data Collection Procedure

Trained research assistants will distribute and collect the questionnaires during official working hours with the consent of facility administrators. Participants will be briefed on the purpose of the study, assured of confidentiality, and informed of their right to withdraw at any time.

Data Analysis

Quantitative data will be coded and analyzed using SPSS version 28. Descriptive statistics (means, frequencies, percentages) will summarize remuneration levels, job satisfaction, and workforce outcomes. Inferential statistics, including t-tests, ANOVA, and regression analysis, will examine the relationship between remuneration inequity and workforce consequences. Statistical significance will be set at $p<0.05$.

Ethical Considerations

Ethical approval was obtained from the Institutional Research Ethics Directorate of Lagos State College of Health Technology, and all human-related procedures were performed in accordance with the institutional guidelines. Informed consent was secured from all participants, and participation was voluntary; confidentiality and anonymity were strictly ensured, and respondents were informed of their right to withdraw at any time.

Consent to publish: Not Applicable

Inclusion and Exclusion Criteria

Inclusion Criteria:

- Permanent health workers employed under CONMESS or CONHESS in selected states.
- Professionals who have worked at their current facility for at least one year.

Exclusion Criteria:

- Temporary, contract, or locum health workers.
- Health workers on leave during data collection.
- Health professionals unwilling to provide informed consent.

RESULTS

Demographic Characteristics of Respondents

A total of 422 health workers were surveyed across the four states in Southwest Nigeria. Of these, 400 questionnaires were completed and valid for analysis, representing a 94.8% response rate. The demographic distribution was as follows: 52% female and 48% male respondents. The age range of respondents was 23–60 years, with a mean age of 35.4 years (SD = 7.6). Professional distribution included 25% medical doctors, 35% nurses, 15% pharmacists, 15% medical laboratory scientists, and 10% community health workers. Years of experience ranged from 1 to 32 years, with an average of 9.8 years (SD = 6.3).

Table 1: Demographic Characteristics of Respondents

Characteristic	*Frequency*	*Percentage*
Gender		
Male	192	48%
Female	208	52%
Age Group		
23-30	120	30%
31-40	160	40%
41-50	80	20%
51-60	40	10%
Professional Cadre		
Medical Doctors	100	25%
Nurses	140	35%
Pharmacists	60	15%
Lab Scientists	60	15%
Community Health Workers	40	10%

Remuneration Disparities

Descriptive analysis revealed significant differences in remuneration among professional cadres. Medical doctors had a mean monthly salary of ₦320,000 (SD = 50,000), nurses earned ₦180,000 (SD = 35,000), pharmacists ₦200,000 (SD = 30,000), laboratory scientists ₦175,000 (SD = 28,000), and community health workers ₦120,000 (SD = 20,000). ANOVA results indicated that these differences were statistically significant ($F(4, 395) = 152.67$, $p < 0.001$), confirming substantial inequity in pay structures across cadres.

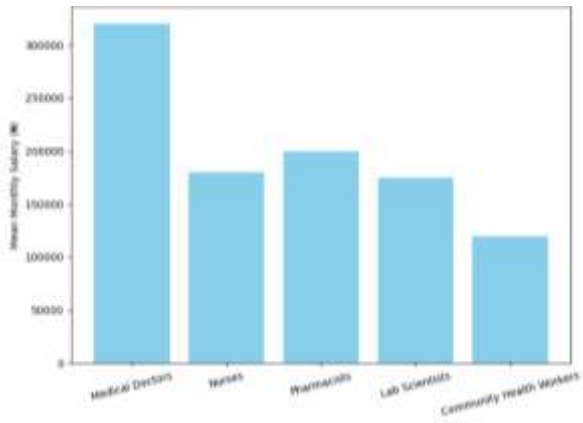

Figure 1: Mean Monthly Salary by Professional Cadre

Job Satisfaction and Perceived Equity

Respondents completed a validated job satisfaction scale ranging from 1 (very dissatisfied) to 5 (very satisfied). The overall mean job satisfaction score was 3.1 (SD = 0.9), with medical doctors scoring higher (M = 3.8, SD = 0.7) and community health workers scoring lowest (M = 2.4, SD = 0.8). Pearson correlation analysis revealed a positive relationship between perceived remuneration equity and job satisfaction ($r = 0.62$, $p < 0.001$), indicating that higher perceptions of fairness were associated with increased job satisfaction.

Table 2: Job Satisfaction Scores by Cadre

Cadre	*Mean Job Satisfaction*	*SD*
Medical Doctors	3.8	0.7
Nurses	3.2	0.8
Pharmacists	3.3	0.7
Lab Scientists	3.0	0.8
Community Health Workers	2.4	0.8

Turnover and Migration Intentions

Regression analysis showed that remuneration inequity significantly predicted turnover intention ($\beta = 0.48$, $t = 10.32$, $p < 0.001$) and migration intention ($\beta = 0.41$, $t = 8.97$, $p < 0.001$), suggesting that health workers perceiving higher inequity were more likely to consider leaving their current positions or migrating abroad.

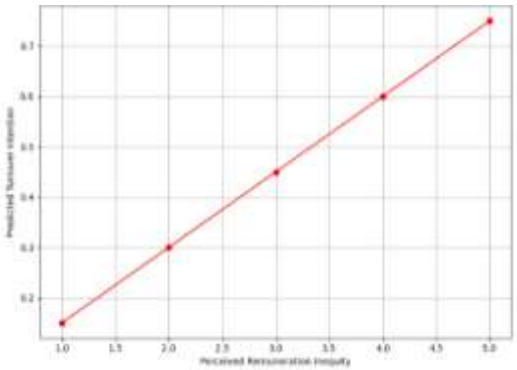

Figure 2: Predicted Turnover Intention by Perceived Remuneration Inequity

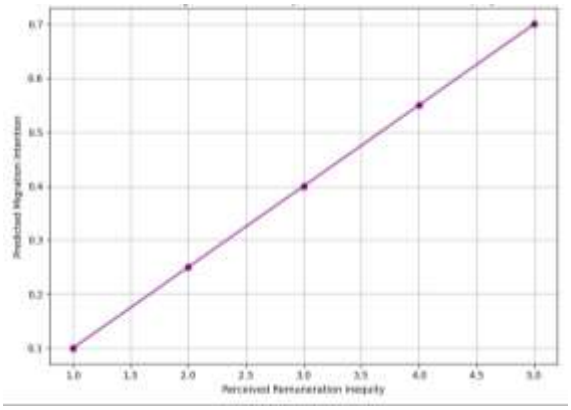

Figure 3: Predicted Migration Intention by Perceived Remuneration Inequity

Inter-Cadre Comparisons

Post-hoc Tukey tests following the ANOVA indicated that salary differences between medical doctors and all other cadres were statistically significant ($p < 0.001$). Differences between nurses, pharmacists, and laboratory scientists were also significant ($p < 0.05$), while community health workers consistently received the lowest pay, significantly lower than all other cadres.

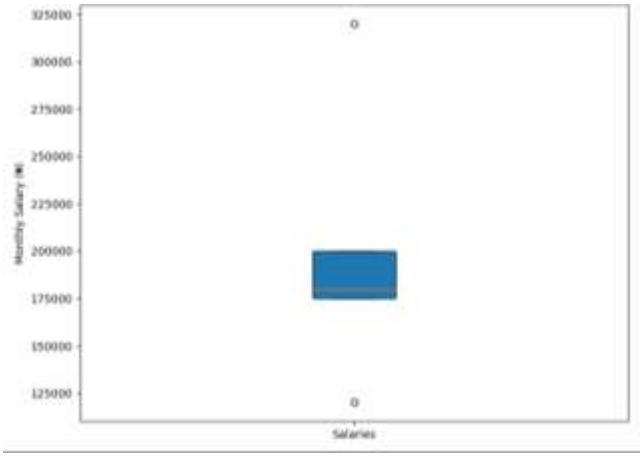

Figure 4: Comparative Salary Distribution Across Cadres

SUMMARY OF KEY FINDINGS

1. Significant remuneration disparities exist among health professional cadres in Southwest Nigeria.
2. Perceived inequity in remuneration is strongly associated with lower job satisfaction.
3. Remuneration inequity is a significant predictor of turnover and migration intentions.
4. Community health workers and nurses are disproportionately affected by lower salaries, increasing the risk of attrition.

These results underscore the urgent need for targeted policy interventions to harmonize pay structures and promote equity across the health workforce.

DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

DISCUSSION

The findings of this study demonstrate significant remuneration inequities among health professional cadres in Southwest Nigeria. Medical doctors earned substantially higher salaries compared to nurses, pharmacists, laboratory scientists, and community health workers, consistent with prior research indicating that CONMESS and CONHESS structures institutionalize pay disparities (Idowu, 2025; BMC Health Services Research, 2022). This persistent imbalance reflects long-standing policy choices that prioritize certain professional groups while marginalizing others, despite comparable workloads and shared responsibility for patient outcomes across cadres.

This finding aligns with the equity theory, which posits that employees compare their input–output ratios with those of peers; perceived inequity negatively affects motivation, job satisfaction, and commitment (Adams, 1965; Colquitt et al., 2019). In the Nigerian health sector, such comparisons are particularly salient due to the close collaboration among cadres within the same clinical settings. When disparities are perceived as unjustified, they foster resentment, weaken morale, and reduce discretionary effort among lower-paid workers.

Moreover, remuneration inequity may reinforce professional hierarchies that undermine teamwork and mutual respect within health facilities. Cadres that feel systematically undervalued may disengage from organizational goals, limit

cooperation, or seek alternative employment opportunities. Over time, these dynamics can erode institutional trust and compromise the quality, continuity, and equity of healthcare delivery, underscoring the need for remuneration policies that balance professional differentiation with fairness and system-wide sustainability.

The study also revealed a strong positive correlation between perceived remuneration equity and job satisfaction, supporting existing literature on workforce motivation in low- and middle-income countries (World Health Organization, 2022). Health workers who perceived their compensation as fair reported higher job satisfaction, whereas those in lower-paid cadres, particularly community health workers and nurses, reported dissatisfaction. This indicates that remuneration disparities are not only financial issues but also significantly influence morale, organizational commitment, and inter-cadre relationships. Furthermore, these disparities contribute to feelings of professional undervaluation and can exacerbate workplace stress and burnout, particularly among frontline workers. The inequity may also affect collaboration and communication between cadres, potentially undermining team-based care and the overall efficiency of healthcare delivery. Such dynamics highlight that addressing remuneration inequity is critical not only for individual well-being but also for the functional cohesion and effectiveness of the health workforce.

Regression analyses confirmed that perceived remuneration inequity significantly predicted turnover and migration intentions. Health workers experiencing higher inequity were more likely to consider leaving their positions or migrating abroad for better compensation. This finding corroborates previous studies on health worker retention in LMICs, where salary dissatisfaction is a primary driver of workforce attrition (African Health Observatory Platform, 2022; Guardian Nigeria, 2025). The disproportionate impact on lower-paid cadres highlights the risk of critical skill shortages in essential health services, particularly in rural and underserved areas.

The inter-cadre comparisons further illustrate systemic inequities, with post-hoc analyses revealing significant differences not only between medical doctors and other cadres but also among nurses, pharmacists, and laboratory scientists. These disparities are indicative of structural challenges within the remuneration system, where pay scales inadequately reflect workload, skill level, or contribution. The consistently low pay for community health workers underscores the urgent need for targeted interventions, such as equity-adjusted salary scales and supportive policies, to improve compensation fairness, reduce professional dissatisfaction, and enhance retention and motivation across all healthcare cadres.

CONCLUSION

In summary, the study establishes that remuneration inequity is prevalent among health professional cadres in Southwest Nigeria and is strongly associated with lower job satisfaction, increased turnover intention, and heightened migration intent. The findings suggest that the current salary structures, while historically designed to reflect professional training and responsibilities, contribute to inequity and may compromise health system efficiency, workforce stability, and the delivery of quality healthcare services.

RECOMMENDATIONS

Based on the study findings, the following recommendations are proposed:

1. **Harmonization of Salary Structures:** Review and harmonize CONMESS and CONHESS to reduce disparities across cadres, ensuring that pay reflects workload, responsibilities, and professional qualifications.
2. **Equity-Based Incentives:** Implement performance-based and hardship allowances, particularly for lower-paid cadres and those serving in rural or underserved areas, to enhance retention and motivation.
3. **Transparent Remuneration Policies:** Establish clear, transparent policies for salary administration, including regular reviews, timely payment of allowances, and mechanisms for addressing perceived inequities.
4. **Professional Development and Career Advancement:** Provide structured career progression pathways, training, and professional development opportunities tied to merit and contribution, which can mitigate dissatisfaction arising from pay disparities.
5. **Monitoring and Evaluation:** Regularly assess workforce perceptions of remuneration fairness and satisfaction to inform policy adjustments and ensure equitable compensation practices.

These recommendations aim to promote fairness, improve morale, strengthen workforce retention, and ultimately enhance the performance and resilience of the Nigerian health system.

Funding Declaration: There was no Funding for this study

Clinical Trial Number: Not applicable.

Declaration Section;

- **Ethical approval**: Ethical approval was obtained from the Institutional Research Ethics Directorate of Lagos State College of Health Technology, and all human-related procedures were performed in accordance with the institutional guidelines
- **Consent to participate:** Informed consent was presented to all participants, and participation was voluntary; confidentiality was ensured, and

respondents were informed of their right to withdraw at any time.

- **Consent to publish:** Not Applicable

Data Availability Statement: The datasets generated during and/or analysed during the current study are available from the corresponding author on reasonable request.

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