THE IMPACT OF INDUSTRIAL DISHARMONY IN THE HEALTH SYSTEM

OUTCOMES: A CASE STUDY OF THE NIGERIAN HEALTH SECTOR

BY

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<th>Abbreviation</th>
<th>Full Meaning</th>
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<tbody>
<tr>
<td>AAAQ</td>
<td>Availability, Accessibility, Acceptability, Quality</td>
</tr>
<tr>
<td>ACI</td>
<td>Agency for Clinical Innovation</td>
</tr>
<tr>
<td>AHPA</td>
<td>Assembly of Healthcare Professional Association</td>
</tr>
<tr>
<td>AI</td>
<td>Artificial intelligence</td>
</tr>
<tr>
<td>ASUU</td>
<td>Academic Staff Union of Universities</td>
</tr>
<tr>
<td>BHSS</td>
<td>Basic Health Service Scheme</td>
</tr>
<tr>
<td>COVID</td>
<td>Coronavirus Disease</td>
</tr>
<tr>
<td>FMOH</td>
<td>Federal Ministry of Health</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GME</td>
<td>Graduate medical education</td>
</tr>
<tr>
<td>HCOs</td>
<td>Healthcare organizations</td>
</tr>
<tr>
<td>HCW</td>
<td>Healthcare Worker</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HRH</td>
<td>Health Human Resources</td>
</tr>
<tr>
<td>IAP</td>
<td>Industrial Arbitration Panel</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communications Technology</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>JOHESU</td>
<td>Joint Health Sector Union</td>
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</table>
LGHD   Local Government Health Department
MDCAN  Medical and Dental Consultants' Association of Nigeria
MHWUN  Medical, and Health Workers Union of Nigeria
NARD   National Association of Resident Doctors
NASU   Non-Academic Staff Union
NDP    National Development Plans
NHIS   National Health Insurance Scheme
NHP    National Health Policy
NHS    Nigeria Health System
NIC    National Industrial Court
NLC    Nigeria Labour Congress
NMA    National Medical Association
PENGASSAN Petroleum and Natural Gas Senior Staff Association of Nigeria
PEST   Political, Economic, Social, and Technological
PMTCT  Prevention of mother-to-child transmission
PRC    Provisional Ruling Council
PROMs  Patient-Reported Outcome Measures
SDG    State Development Goals
SMOH   State Ministry of Health
TUC    Trade Union Congress
ABSTRACT

Industrial disharmony is a worldwide phenomenon which affects all professions and all cadres. In Nigeria several sectors have been affected by industrial disharmony, but it is quite common in the health sector. It is an almost intractable problem in the Nigerian health sector and almost every year there are strikes by one profession or the other within this sector. The strikes usually affect the secondary and tertiary tiers of healthcare. This qualitative study set out to analyze the cause, effect, and the impact of industrial disharmony/crises on the health sector, the government, and the people of Nigeria. A careful scientific search of the literature (both in print and online), newspapers, Government and Labour organization publications on the subject were collated and studied to understand the problem of industrial crises and how to proffer solutions to reduce or eliminate these incessant strikes in the Nigerian health sector. It was demonstrated that the main cause of the disharmony was poor remuneration/delayed or unpaid wages, poor healthcare funding, poor work environment, deficient healthcare infrastructure, inadequate and underfunded training, inter-professional rivalry and non fulfilment of government agreements/commitments. These led to poor job satisfaction, poor healthcare worker attitude, brain drain and loss of public’s confidence in the public health sector. These in turn led to poor health indices which influence the health and strength of the national workforce. Ways to reduce these strikes include improved healthcare funding, better training opportunities, collaboration/dialogue amongst the various professions in the health sector and firm commitment of government to fulfill past agreements and commitments willingly entered. Collective bargaining is a tool to be effectively used to carry workers along and get the best for them.
CHAPTER ONE

INTRODUCTION

1.1. Background of the Study

According to the World Health Organization (WHO), Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Even though the WHO states that enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, this is not the case on ground in Nigeria because of industrial disharmony in the health systems. Nigeria has been faced with several shortcomings in the managements of its health systems over decades resulting in repeated reforms of the sectors (Asuzu, 2005). Unfortunately, these reforms have not significantly impacted the health status of over 200 million residents as industrial disharmony is still rampant in the health sector.

Industrial Disharmony. To understand industrial disharmony, we need to examine the word harmony. Harmony is an agreement or being in one accord. It is a pleasing combination of elements that makes things successful, while a team is a group of people involved in the same activity or work. However, with harmonious agreement, a group of health professionals involved in the management of patients could accomplish a better patient recovery outcome. (Uko 2015). The nature of workplace in any organization both at the microeconomic level and macroeconomic platform is very crucial in determining the level at which productive activities are carried out in an economy. This is because work activities do not take place in a vacuum but within a given work context. Therefore, a sound and harmonious industrial relation in an enterprise is essential not only to employers and workers but also to the society because efficient production of goods and services depends on it. The existence of harmonious
industrial relations will reflect efficiency and quality which depends on the level of workers’ motivation. (Osabuohien & Ogunrinola 2007).

Puttapalli & Vuram (2012), defined industrial harmony as being concerned with the mutual relationship between management team and employees in relation to the terms and conditions of employment at the workplace. Industrial harmony is vital in any system as when there is harmony, organizations function smoothly and efficiently. However, the health sector has been plagued with industrial harmony over the years thereby affecting the performance level of this sector.

Healthcare is central to community well-being as well as a fundamental aspect of life (Usman et al, 2020). In Nigeria, healthcare system is organized into primary, secondary, and tertiary healthcare levels. The Local Government Areas (LGAs) are responsible for primary healthcare, the State Governments are responsible for providing secondary care while the Federal Government is responsible for policy development, regulation, overall stewardship and providing tertiary care (Usman et al, 2020). In recent times the federal government has had to take on more primary and secondary healthcare programs as many states and local governments have not taken up their responsibilities. In the health sector there are several professions that are all supposed to work in harmony to deliver care to the patients. (This is akin to the smooth operations of the human body where all the different organs in a system all work harmoniously and seamlessly to make the totality thrive) These professions can be broadly divided into the core healthcare providers, the allied healthcare staff and the non-health or supporting staff. The core healthcare personnel include doctors, nurses, pharmacists, medical laboratory scientists, radiographers, physiotherapists, etc. while the allied health staff include technicians, ward assistants, cleaners, etc. The administrative staff provide support for the 2 groups and include clerical staff, executive officers, administrative officers, finance and audit and several others.
Very often there are disputes between and within these various groups (Oyewunmi & Oyewunmi 2014).

This research will be carried out in Nigeria among the health sector with a focus on studying the impacts of industrial disharmony in the health systems. The decline in the quality of public healthcare delivery and infrastructure in Nigeria is evident. This assessment is apt given the efforts of various agencies (governmental and non-governmental) which have yielded marginal successes, especially in terms of the relatively low access to basic health services. Public healthcare workers have over the years, engaged in recurring negotiations with government at different levels to bring about necessary and important reforms to the public health sector.

The researcher shall examine at the appropriate chapters of this work how major actors in industrial disputes have discharged their respective duties to reduce the rate of industrial disharmony in the Nigerian health sector.

1.2. Statement of the Research Problem

Over the last 30 years, the Nigerian health sector has witnessed various industrial disharmonies which has had major negative impacts on the system. This industrial disharmony which manifests in strike actions leads to service disruptions through strike actions. These healthcare workers’ strikes result in the partial or complete closure of public healthcare institutions preventing Nigerians’ access to quality health services. The impact of these strikes is worst when they occur at periods of national health emergencies such as the recent Ebola viral disease outbreak, Lassa fever or cholera outbreaks or even man-made emergencies like Boko Haram suicide bombings with mass casualties (Oleribe et al, 2015). Even last year and in this year 2021, with a raging pandemic of COVID-19, a National Association of Resident Doctors strike was initiated due to perceived or alleged poor and corrupt handling of interns’ postings and remuneration/allowances, non-payment of COVID-19 allowances, non-payment of resident
doctors training fees and delay or non-payment of salaries in some states of the nation. As seen over the years, and in many studies, strikes have remained common occurrences in Nigeria as there are local, state, regional and sometimes national industrial action on a regular basis. (Oluyemi 2020).

This industrial disharmony has led to several days/weeks of limited (skeletal) services nationwide in the federal and state health institutions. As health workers’ industrial disharmony continue to exist regardless of several methods employed to combat it, the researcher decided to study the causes and the impacts of industrial disharmony in the health system in Nigeria.

1.3. Objectives of the study

The overall objective of this research is to examine the impacts of industrial disharmony in the health system outcomes. The research has the following sub-objectives:

i. To determine the causes of industrial disharmony in the Nigerian health sector

ii. To examine the consequences of industrial disharmony on the Nigerian health sector.

iii. To evaluate the strategies used by the government and individuals in solving industrial disharmony in the Nigerian health sectors.

iv. To determine ways of ensuring industrial harmony in the future.

1.4. Research Questions

This research work will aid the researcher in answering the following research questions:

i. What are the causes of industrial disharmony in the Nigerian health sector?

ii. What are the impacts and consequences of industrial disharmony in the Nigerian health sector?
iii. What are the strategies used by the Nigerian government in settling industrial disharmonies in the health sector? How effective have the strategies been in settling the disharmony?

iv. What are the practical ways of ensuring industrial harmony in the future?

1.5. Significance and Potential Impact of the Study

This project will advance the understanding of the impacts of industry disharmony in the health system. The result of this project will be valuable to government agencies, researchers, and health workers.

1.6. Scope and Limitations of the Study

The study will be limited to the healthcare systems of Nigeria, particularly the public sector (it will not extend to the private hospitals which seldom have industrial disharmony). It will cover the professionals of the health sector but will exclude the unskilled or menial staff of the sector.

1.7. Research Methodology

The Study will adopt the format of qualitative research design. Secondary analysis of data will be carried out to study the causes of industrial disharmony and its impacts on the Nigerian health sector. Additionally, an extensive literature review will be conducted to understand reasons for this industry disharmony and how it has been resolved in the past and how effective the solutions have been. Analysis of this literature will be structured as a comparative body of research. By providing a comparative study of recent research, this project will be able to reveal the causes and impacts of industrial disharmony in the health sector in Nigeria. Furthermore, references of articles retrieved will also be reviewed for additional information on the strategies employed by Nigeria and how these have been influenced by the health sector in the country.
1.8. Organization of Chapters

Chapter One: Background of the Nigerian health sector including the structure, tiers, their functions, fundings, and the challenges. This problem of industrial disharmony, the types of disharmonies and the impact on health care. The research questions relating to disharmony in the health sector were listed.

Chapter Two: Literature review covered the concept of conflict, some conflict theories, industrial conflict management, the economic impact of strikes and the concept of managing the industrial actions by collective bargaining. Some bargaining theories were also discussed.

Chapter Three: Methodology: the research questions were highlighted and the mode of answering these questions in a qualitative approach described. How these data were used to provide answers to the research questions were discussed in this chapter.

Chapter Four: Results: the collected information was used to identify/describe the different types of strikes, the different types of conflict and conflict resolution that are available and those that were used. Also, the various theories of bargaining and the success or shortcomings of these in the Nigerian health sector analyzed.

Chapter Five: Discussion covered the successes and failures of the government to address the perennial problem of industrial disharmony, the way forward and what more needs to be done to end this problem. The limitations and recommendations were also listed.

References

1.9. Definition of Terms

1. Primary health care: essential healthcare that is based on scientifically sound and socially acceptable methods and technology. This makes universal health care acceptable to all. (WHO 1978)
2. **Secondary health care**: the specialist treatment and support provided by doctors and other health professionals for patients who have been referred to them for specific expert care, most often provided in hospitals. (WHO 1978)

3. **Tertiary health care**: specialized care that offers a service to those referred from secondary care for diagnosis or treatment, and which is not available in primary or secondary care.

4. **Strike (industrial action)**: a refusal to work organized by a body of employees as a form of protest, typically to gain a concession or concessions from their employer (Oxford Languages)

5. **Health Sector**: The healthcare sector consists of businesses that provide medical services, manufacture medical equipment or drugs, provide medical insurance, or otherwise facilitate the provision of healthcare to patients.

6. **Health Systems**: A health system, also sometimes referred to as health care system or as healthcare system, is the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations.

7. **Resident doctors**: A resident doctor is a medical school graduate and doctor in training who is taking part in a graduate medical education (GME) program or residency training program.

8. **Consultants**: A physician or surgeon who does not take full responsibility for a patient, but acts in an advisory capacity, deliberating with and counseling the attending physician or surgeon. (In some climes like Nigeria the buck stops with the consultant meaning he is ultimately responsible for all the clients under his care.)
9. **Industrial Disharmony**: When there is inability among the participating parties in industrial relations to reach peaceful agreement as it affects job rules and conditions of work generally.

10. **Relativity in Wages**: This relates to the relationship in wages in the profession to the minimum wage for that business sector or to national/subnational minimum wage. It could also refer to the differential in wages across professions or cadres.
References


CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1. Literature Review

To understand how to put an end to strikes in the health sector a few theories related to the subject will be reviewed and these will help chart a way forward to put industrial disharmony in the health sector. This chapter will examine the following:

1. The Concept of Conflict and some Conflict Theories
2. The Concept of Management and some of Its Theories
3. The Economics of Strikes and the Union
4. The Concept of Collective bargaining and some Bargaining Theories

2.2. Historical Background

Industrial disharmony is almost as old as mankind and inter professional rivalry and intra-professional rivalry are both documented in the bible. Cain killed his brother Abel (Genesis 4:1-8) as an example of inter professional rivalry, while the herdsmen of Abraham and Lot are a good example of intra professional rivalry (Genesis 13:7). The first medical industrial action was recorded in the time of Rameses 111 on the 14th of November 1152 B.C (Daumas 1969 and Romer 1984), while the first recorded national industrial action in Nigeria was in 1945 when 150,000 clerical and non-clerical workers went on strike for better conditions; these also included the health worker. (Oleribe 2016).

Harmony is an agreement or being in one accord. It is a pleasing combination of elements that makes things successful, while a team is a group of people involved in the same activity or work. However, with harmonious agreement, a group of health professionals involved in the management of patients could accomplish a better patient recovery outcome. (Emmanuel 2015). The nature of workplace in any organization both at the microeconomic level and macroeconomic platform is very crucial in determining the level at which productive activities
are carried out in an economy. This is because work activities do not take place in a vacuum but within a given work context. Therefore, a sound and harmonious industrial relation in an enterprise is essential not only to employers and workers but also to the society because efficient production of goods and services depends on it. The existence of harmonious industrial relations will reflect efficiency and quality which depends on the level of workers’ motivation. (Osabuohien & Ogunrinola 2007).

This work looks at 'The Impact of Industrial Disharmony in The Health System Outcomes: A Case Study of the Nigerian Health Sector’. The research questions will be examined and answered in line the objectives of this work. This work will review other works done on this subject and the various guidelines supporting this work. The Nigerian health system has been plagued with numerous healthcare worker strikes (industrial action) at all levels. In the last decade, no sector has been more affected by disputes and strikes in Nigeria than in the health sector. These have resulted in multiple avoidable mortalities and morbidities in Nigeria, further destroying the already poor health outcomes and infrastructures in the country. (Oleribe et al). The decline in the quality of public healthcare delivery and infrastructure in Nigeria is evident. This assessment is apt given the efforts of various agencies (governmental and non-governmental) which have yielded marginal successes, especially in terms of the relatively low access to basic health services. Public healthcare workers have over the years, engaged in recurring negotiations with government at different levels to bring about necessary and important reforms to the public health sector. As seen over the years and in many studies, strikes have remained common occurrences in Nigeria as there are local, state, regional and sometimes national industrial actions on a regular basis. (Oyewunmi & Oyewunmi, 2014).
2.3. The Concept of Conflict and some Conflict Theories

Conflict is a necessary aspect of organizational life. Its presence at the workplace brings about innovation and creative mindset in people through diversity of constructive opinions and criticisms. There are some theories which supports it while others condemn it.

2.3.1. The Concept of Conflict

Conflict remains an indispensable factor in the organization circle. There is no organisation where one can say that conflict does not occur or exist. What then is conflict? It is perceived as a dispute between two or more organisation members or groups because of the need to work in positions that require functional codependency and that differ in status, purpose, value, or perception. (Dialoke and Ogbu, 2017). Conflict is a process resulting in the perceptions of two parties that they are working in opposition to each other in ways that produce feelings of discomfort and/or animosity. Conflict is a process whereby one party perceives that the other is frustrated or is about to frustrate an important concern. In this case, the Nigerian health system has been plagued with numerous healthcare worker strikes (industrial actions) at all levels.

The reasons for the continuous agitations are poor staff welfare, inadequate or irregular wages and poor leadership structure/management and governmental inability to implement agreements and international best practices. Others include underfunding/mismanagement, poor infrastructures, undue propensity on foreign health tourism among the elite, lack of communication, quackery, corruption, brain drain and associated challenges of shortage of manpower, and supremacy tussle among health care professional unions. The strikes consequences are seen in the disruption to service delivery and training programmes, poor health indices and loss of confidence in the hospitals and the healthcare professionals. (Dialoke and Ogbu, 2017).
2.3.2. Industrial Conflict

A Theoretical Exploration: A theory is a body of reasoned supposition submitted to offer explanations to ideas, issues, or hypothetical propositions. In view of this, it is pertinent to attempt a theoretical exploration as to the incidence of industrial conflict especially within the Nigerian environment. In doing so, this study borrows from the Unitary and Marxian theories of industrial relations. Employers and employees usually encounter disagreement in the workplace because of the varied expectation held by both parties regarding industrial arrangement. Naturally, conflict is believed to be a continuous observable occurrence of every aspect of human existence (Elenwo & Ignatius). Industrial conflict in Nigeria health system has been a reoccurring decimal over the years; although successive governments have tried to provide a lasting solution to this problem in Nigeria health system but little or no success has been achieved. Dialogue/negotiation, coercion and sanctions of varying degree has been used by government at both state and federal levels to address this healthcare challenge with no significant result. Accusation and counteraccusation by Nigeria Medical Association’s leadership and Federal/State Government representatives over unfruitful dialogue/negotiations on the best way of resolving this conflict over time has assumed worrisome dimension. (Nsude et al, 2016).

2.3.3. Conflict Theory

The human society is full of conflicts. Conflicts arise because of disagreement between two antagonizing parties/classes. In this work with reference to the industrial society, industrial conflict is the inability of parties to an employment relation (employers and employees represented by their unions or groups) to reach agreement on any issue connected with the object of employer-employee interactions. Industrial conflicts could also be a breakdown of cordial relationship between Labour and Management. Industrial conflict is thus, the result of
an unpalatable, imbalanced, and antagonistic relationship and interaction between and among parties involved in industrial relations. The import of this is that industrial conflict is an expression of not-so-good and hostile relationship between and among (inter and intra) industrial relations parties. That is, either between Labor and Management or between labor and labor. With regards the health sector in the last decade, factions of the health care workers, in a bid to demonstrate its claim to leadership of the union, organized a damaging strike of its members. This strike paralyzed the delivery of healthcare services leading to loss of lives and adverse effects on the health and economy of major urban cities; yet it had little or nothing to do with labor management relationship. Many discussions on industrial conflicts refer to strikes. Strikes are the most overt form of industrial conflicts. Thus, Fajana (2000) defines strike as a “temporary cessation of work efforts by employees in the pursuance of a grievance or demand”. Strikes have become a significant approach toward expressing workplace grievances. Adeogun remarked that strike is all about “grievances, actual or imagined, arising from industrial life.” Okene however added that “in an unashamedly capitalist society like Nigeria, where there is ostentatious display of wealth by the rich, where majority of the workers eke a living out of their wages while their employers live in absolute affluence with the widest ostentation, it is submitted that workers’ grievances can hardly be described as ‘imagined’”. In a society such as ours, where the rich get richer and the poor get poorer; where the capitalists unimaginably exploit the proletariat, strike becomes an asset. Obviously, strike becomes the only weapon to be employed by workers to compel a recalcitrant employer (especially the government as an employer, as in Nigeria) to recognize and bargain with trade unions, to comply with the terms and conditions of an employment relationship.
2.3.4. Marxian (Conflict) Theory

In view of the inherent weakness of the unitary theory in recognizing that an organisation consists of people who have often conflicting interests, the Marxists theorized that conflict is an inherent characteristic of the society. This view of industrial relations looks at the nature of the capitalist society, where there is a fundamental division of interest between labor and capital and sees workplace relations against this background. The conflict theory is embedded in the works and ideas of Karl Marx (1818-1883). This theory explains that conflict is inevitable and stems from inequalities of power and economic wealth inherent in a capitalist economy or society. In Marxian analysis, conflict is attributable to an enduring power struggle between workers and their employers over the control of various aspects of work. Identifying the causes of workplace conflict, further submits that “inequality in the distribution of the proceeds of industry, job-insecurity of the worker, and poor management control strategies breed grievances which lead to conflict.” Here, conflict is seen as inevitable, and trade unions are a natural response of workers to their exploitation by capitalists since it is rather difficult and dangerous for workers to individually express their grievances to management.

Conflicts theorists posit that there may be periods of acquiescence in this conflicting relationship. However, the institutions of joint regulations are believed to enhance rather than limit management’s position as they presume the continuation of capitalism rather than challenge it. This theory (Marxian conflict) is of much relevance in explaining industrial relations in Nigeria. Observably, industrial relations in Nigeria are largely imbalanced and antagonistic between the parties involved, often in favor of capital. The employer is wielding so much power at the expense and exploitation of the worker. Thus, in response to such exploitative tendencies, conflicts result, conflicts over processes of work relations and control. With regards to wages, while the capitalist endeavors to purchase labor at the lowest price
possible, the wage worker on the other hand, tries to sell his only asset at the highest possible price to ensure his existence. (Wokoma 2011).

2.3.5. Types of Conflict

Conflict can be classified into functional and dysfunctional conflict. It is functional when it serves the interest of the organisation. When it becomes dysfunctional, it does not serve the interest of the organisation. Jones and George submitted that organizational conflict is interpersonal conflict, intragroup conflict, intergroup conflict, and interorganizational conflict.

1. **Interpersonal Conflict:**

This refers to conflict that arises between individual members of an organisation, because of differences in their goals or values. For instance, a manager may want certain policies to be implemented but another manager may differ from such implementation of that policy.

2. **Intragroup Conflict:**

This refers to conflict that arises within a group, team, department, branch, or division of the same organisation.

3. **Intergroup Conflict:**

This refers to conflict that arises between two groups, teams or departments or branches.

4. **Interorganizational Conflict:**

This refers to conflict that arises between one organisation and another organisation.

Sources of conflict

Based on the above, one can deduce that conflict can occur with:

1. An individual – This is known as intra-personal conflict
2. Between two groups- This is known as inter-personal conflict
3. Between or among groups of people, units, or departments, this is known as inter group or unit conflict.

4. Between or among different organizations or nations, this is known as inter organizational or inter-national conflict.

“The modern industrial conflicts seem inevitable since the domination of management is to maximize profit while labor’s concern is to secure and maintain the highest level of wages with the best conditions of their service. In this process conflicts emerged between the social partners in an effort of each partner to obtain maximum benefits of the industry. (Elenwo & Ignatius).

There are several factors that produce conflict in the workplace. Kinicki & Kreitner (2010) and Jones and George highlighted the following fourteen factors as the major sources of functional and dysfunctional conflict in the organisation.

1. Different goals and time horizons
2. Incompatible personalities or value systems
3. Overlapping or unclear job boundaries
4. Competition for limited resources
5. Interdepartmental/ intergroup competition
6. Inadequate communication
7. Interdependent tasks
8. Organizational complexity
9. Status inconsistencies
10. Unreasonable or unclear policies, standards, or rules
11. Collective decision making
12. Decision making by consensus
13. Unmet expectations
14. Unresolved or suppressed conflicts

2.3.7. Conflict Resolution Strategies

There are many alternative ways of handling conflicts at the workplace, but it all depends on the industry and the person in charge of such settlement. This study explores the various
approaches of resolving conflicts as outlined by researchers. Organizational behaviorists elucidated those conflicts can be handled using integrating (problem solving) strategy, obliging(smoothing), or accommodating strategy, dominating(forcing) strategy, competing strategy, collaboration strategy, avoiding strategy and compromising strategy.

![Conceptual Framework of the Relationship between Conflict Management Strategies and Industrial Harmony](image)

**Figure.1: Conceptual Framework of the Relationship between Conflict Management Strategies and Industrial Harmony**

Source: Desk Research, 2019

1. Integrating (problem solving) Strategy:
   This refers to when parties involved in a conflict confront the main root cause of their disagreement and choose the best way out.

2. Obliging (smoothing) or Accommodating Strategy: This is when one party neglects its own interests just to satisfy the other party.

3. Collaborating Strategy: This is when the each of the conflicting parties’ desires to fully satisfy the concerns of all parties and there is cooperation and search for mutually outcome.

4. Dominating or Forcing Strategy: This is when one party places more value to his own interest and lesser value to the other.

5. Avoiding Strategy: This is when one aggrieved party withdraws from resolving the conflict or adds more to the contending issues. This is common with the federal
6. Compromising Strategy: This refers to a situation where the warring parties agreed to settle their differences equally without one side gaining advantage.

2.3.8 The Concept of Workers’ Commitment

Commitment is an organizational construct that has received scholarly attention amongst researchers in virtually multidisciplinary fields of study. However, it gained ascendance into management because of organizational ineffectiveness especially in the areas of manufacturing of goods and quality service delivery. Cohen (2003) perceived commitment to be a force that binds an individual to a course of action of relevance to one or more goals. Dost and Khan (2012) also viewed employee commitment as the level at which an employee attaches himself to the job or organisation and sees its success or failure as his own. In line with the above submissions, Neustrom, and Davies (2002) argued that workers’ commitment is the degree to which a worker identifies with the organisation and wants to continue actively participating in it. In another dimension, Narteh (2012) said employee commitment as a felt state of employees’ attachment to their organizations, including their willingness to internalize the values of the organisation and abide by the rules and regulations therein. Generally, commitment is always associated with organizational activities. O’Reilly (1989) viewed organizational commitment as an individual’s psychological bond to the organisation, including a sense of job involvement, loyalty, and belief in the values of the organisation. (Ogbuede, 2017)
Fig. 2. Conceptual Framework Source: Author's Conceptualization (2017) depicts the relationship that exists between conflict resolution strategies and workers' commitment in the oil and gas companies. (Ogbuede, 2017)

### 2.3.9. Unitary Theory

This theory identifies an organisation as comprising of groups of individuals who have and share same goals, and work as members of one team. The unitary view recognizes an organisation as one big happy family. Unitarists view the enterprise as a unitary system with one source of authority – management, and one focus of loyalty – labor. Unitary framework extols the virtue of teamwork, where everyone strives jointly to a common objective, everyone pulls their weight to the best of their ability, and everyone accepts their place and function gladly. The unitary view sees conflict as a bad thing which should not exist because it serves as a constraint towards the achievement of mutual objectives of both management and labor. However, unitarist has been criticized as being essentially autocratic and authoritarian. It also does not recognize the fact that an organisation is made up of individuals and groups with divergent and often conflicting interests.

### 2.4. The Concept of Management and some of Its Theories

For any organization (in this case, health organization) to succeed, survive or thrive, there must be effective and efficient management on the part of the leadership. Management is an essential
component of any organization because it is the component that directs and coordinates the current activities of the organization and makes provisions on the plans. Management can also be defined as the ability or procedures made to achieve the goals of an organization by the way of bringing people and resources together, and the ability to coordinate them and other facilities in the organization. Henri Fayol’s (1841-1925) principles of management brought the idea of how managers should organize and interact with workers. The fourteen principles are still in use till date as he (Fayol) is still considered as one of the most powerful contributors to the present-day management concept. For management to be effective, it should be able to creatively solve problems, motivate employees/workers and be able to achieve the organizational goals and objectives. It consists of various components and activities which are useful to every manager without regard to their level or status. There are seven functions of management that will be discussed below; each function is inseparable because each one depends on the other.

2.4.1. Functions of Management

- **Planning:** It is a process which involves setting the aims, mission statement and objectives of the organization and how they will be achieved. Nothing can be achieved without proper planning. Planning gives the direction of what tasks to do, when to do it and how to perform the tasks. Planning is based on the short- and long-term successes of the organization.

- **Organizing:** After the successful completion of the planning stage, each task is now assigned to different individuals (job holders) or groups of people in the organization. In organizing, different roles are identified and assigned to the right proportion of employees for the plan to be successfully carried out.
- **Directing:** This is the ability to influence the behavior of people (staff) by motivating them, effective communication, and discipline, all aiming towards achieving the goals of the organization.

- **Controlling:** The process of controlling is comprehensive and ongoing. This process involves setting an organizational standard based on the objectives of the organization, comparing the present performance to the set standards, and taking preventive and/or corrective action. This management function is put in place to make sure that all other management functions of the organization are in order and to see to their successful operation.

- **Staffing:** This involves putting the right people in the right positions in order to achieve the aims and objectives of the organization. It involves planning, recruiting, and selecting, training, and developing workforce, and remuneration packages and performance appraisal.

- **Coordinating:** This function involves bringing different people of different culture together and making them to work together in achieving the goals of the organization.

**2.4.2. Management Theories**

The reformation of industries along with the development and increase of factories and large-scale manufacturing made effective management procedures a necessity. These procedures were necessary for maximized productivity in an organization. As a result, a wide range of theories were developed to enhance managerial practices.

**2.4.2.1. The Administrative Management Theory**

It was developed by Henri Fayol in 1916. He propounded that management is involved in every area of our society and lives. He also believed that all activities necessary to carry out our life’s
activities can be grouped into either of the following functions which are planning, coordinating, staffing, organizing, commanding, and controlling. In his theory, he defined management based on six functions listed above; he also gave 14 principles of management. In his definition of management, he proposed that it takes place within a definite organizational make up with specific duties and it is directed towards the attainment of goals by influencing the effects of others.

2.4.2.2. Strengths of Administrative Management Theory

1. Fayol gave a definition of management based on its six functions.
2. He gave basic items and concepts which would be used for future research outlined in his 14 principles.

2.4.2.3. The six functions of management based on Fayol’s definition of management

![Diagram of the six functions of management](https://studiousguy.com/henri-fayols-functions-of-management)

Fig.3. The Functions of Management by Henri Fayol. Source: Henri Fayol’s Functions of Management https://studiousguy.com/henri-fayols-functions-of-management
2.4.2.4. Criticisms of Administrative Management Theory

1. He elaborated on only the framework of formal settings.

2. Attention was not paid to issues such as personal versus group interests, as suggested by compensation and fairness, Fayol thought that in functioning in the employee’s interest the employers were condescending.

3. Fayol outlined matters pertaining to the sensitivity of a customer’s needs such as initiative, though he saw them as issues pertaining to the logical organizational performance framework and not as issues pertaining to revised structures and re-orienting the attitude of people to attain better relationship between an organization and its customers.

4. Many of Fayol’s principles have been incorporated into present day organizations but they were not oriented to function in conditions of spontaneous change and matters of worker’s participation in the making of decisions in organizations.

2.4.2.5. Maslow’s Hierarchy of Needs

Abraham Maslow(lived 1908 -1970): in 1943, this Psychologist is credited with developing a theory on the needs of people. He propounded a theory on the hierarchy of the needs of human beings emanating from their basic needs at the base of the hierarchy to their greater needs at the top of the hierarchy. He also made assumptions on the fact that individuals must meet each level of need before moving their needs to a higher level and this is based on motivation and individual development

2.4.2.6. Assumptions of the Hierarchy of Needs

- Individuals are never fully satisfied.
- The behavior of individuals is purposeful and is driven by the desire to be satisfied.
• Needs can be grouped following ordered structures of necessity from the least to the highest.

Advantages
Maslow’s hierarchy of needs theory has helped managers to envisage motivation of workers. His theory explains how needs can help motivate individuals.
Managers are now encouraged to put into consideration the needs and desires of their employees.

Disadvantages
Experimental studies over the years do not support this theory. Somoye KG, (2015).
Maslow's hierarchy of needs is a motivational theory in psychology comprising a five-tier model of human needs, often depicted as hierarchical levels within a pyramid. Needs lower down in the hierarchy must be satisfied before individuals can attend to needs higher up. From the bottom of the hierarchy upwards, the needs are physiological, safety, love and belonging, esteem and self-actualization.
Maslow stated that people are motivated to achieve certain needs and that some needs take precedence over others. Our most basic need is for physical survival, and this will be the first thing that motivates our behavior. Once that level is fulfilled the next level up is what motivates us, and so on.

2.4.2.7. The original hierarchy of needs five-stage model
1. **Physiological Needs** - these are biological requirements for human survival, e.g., air, food, drink, shelter, clothing, warmth, sex, sleep. If these needs are not satisfied the
human body cannot function optimally. Maslow considered physiological needs the most important as all the other needs become secondary until these needs are met.

2. **Safety Needs** - Next among the lower-level needs is safety. (Master Class staff, 2020). Safety needs include protection from violence and theft, emotional stability and well-being, health security, and financial security. Protection from elements, security, order, law, stability, freedom from fear.

3. **Love and Belongingness Needs** - after physiological and safety needs have been fulfilled, the third level of human needs is social and involves feelings of belongingness. The need for interpersonal relationships motivates behavior. Examples include friendship, intimacy, trust, and acceptance, receiving and giving affection and love. Affiliating, being part of a group (family, friends, work).

4. **Esteem Needs** - which Maslow classified into two categories:
   a. esteem for oneself (dignity, achievement, mastery, independence) and
   b. the desire for reputation or respect from others (e.g., status, prestige). Maslow indicated that the need for respect or reputation is most important for children and adolescents and precedes real self-esteem or dignity.

5. **Self-Actualization Needs** - realizing personal potential, self-fulfillment, seeking personal growth and peak experiences. A desire “to become everything one is capable of becoming”. (McLeod, 2018)

**2.4.2.8. Deficiency Needs versus Growth Needs on Maslow’s Hierarchy**

Maslow separated his hierarchy into two different overarching types of needs: growth needs, and deficiency needs. The main difference between growth and deficiency needs is the change in motivation as needs are met. Motivation increases are growth needs are met. Conversely, motivation decreases as deficiency needs are met. As mentioned previously, self-actualization
is the pursuit of personal growth, thus making it a growth need. Growth needs originate from a desire to become better and grow as a person. As a person fulfills growth needs, their motivation increases as their desire to become even better increases. Conversely, deficiency needs pertain to the four levels below self-actualization: physiological, safety, love and belonging, and esteem needs. Deficiency needs stem from a person’s desire to get rid of deficiencies or obtain things they are lacking. As a person obtains the things they lack, their motivation to obtain these things decreases. Corporate Finance Institute (2020). https://corporatefinanceinstitute.com/resources/knowledge/other/maslows-hierarchy-of-needs/

![Maslow's Hierarchy of Needs](https://corporatefinanceinstitute.com/resources/knowledge/other/maslows-hierarchy-of-needs/)

Fig. 4. Maslow's Hierarchy of Needs. Source: Dr. Saul McLeod

2.4.2.9. **Douglas McGregor’s Theory X and Theory Y** (McGregor D, 2006)

He postulated theories X and Y based on his belief that there are two types of managers. Theory X is a negative theory, and the theory X manager has a negative view of workers. He assumes that they are not ready to work, not worthy of trust and not able to assume any level of
responsibility, hence the need for supervision and force. In Theory Y, the manager assumes that workers are trustworthy and able to assume responsibility; hence they need space to develop their creativity and imagination. Following theory X, workers would show little interest in the absence of an incentive and will try to avoid responsibility. A major weakness of this theory is that it limits the worker’s potential. McGregor believes that the theory Y manager will be more successful. Somoye KG, (2015).

Advantages

- His theory identifies two distinct kinds of individuals for managers to investigate and shows how they can be motivated.
- Theories X and Y look into different management strategies for motivation of the labor force and are also used to help increase productivity of workers

Disadvantages

- It only shows two extreme conditions of possible behaviors of managers which makes it more difficult to be adopted by modern managers. Somoye KG, (2015).

2.5. The Economics of Strikes and The Union

Unions and strikes may seem to be past their prime in the West. There has been, however, an uptick of strikes in the US recently and, among other countries, France has always had its share of contentious politics that often manifests itself in strikes.

The freedom to form and join a union is core to the U.N. Universal Declaration on Human Rights and is an “enabling” right; a fundamental right that ensures the ability to protect other rights (https://aflcio.org/what-unions-do/empower-workers/collective-bargaining).
The decline of strikes, therefore, might be just a temporary part of a longer cycle. They could well come back, perhaps as part of a revival of union strength and a reduction of inequality. To the extent that strikes lead to the loss of production and income, they might appear to be puzzling from a narrow economic viewpoint. John Hicks (1904-1989) a British economist described the irrational nature of strikes and talked about losses of Labour and Management when a strike occurs. To hurdle Hicks’ paradox, Ashenfelter and Johnson assume profit maximizing behavior of firms, but exogenous rule-based behavior of workers. They also embrace the three-party nature of collective bargaining by including the coordination problem between union members and union leaders. The idea is that members may have higher wage expectations than leaders are able to achieve given the firm’s willingness to pay. Members demand a strike if these wage expectations are not met. Leaders try to lower these expectations prior to the end of their contract, but if unsuccessful, may allow the strike since signing an agreement which is less than the rank and file expects could result in union dissension and a decline in the power of the leadership. A strike, although contrary to the membership’s best interests, is preferred by the leadership since they at least appear as adversaries against management. Ashenfelter and Johnson explain that the strike is a costly equilibrating mechanism: “The outbreak of a strike, however, has the effect of lowering the rank and file’s expectations due to the shock effect of the firm’s resistance and the resultant loss of normal income. After some passage of time the leadership feels that the minimum acceptable wage increase has fallen to a level at which it can safely sign with management, and the strike ends.”

Strikes are a result of rigidity in Trade union behavior; that is assumed rather than endogenously determined; manifested in a type of principal agent problem. Strictly speaking, however, the model dodges Hicks’ paradox by strapping the union to a concession function and only allowing the firm to behave optimally. Prevailing conditions such as unemployment
and profits are what determine the rank-and-file members’ expectations (and concession function) to which the firm best responds. Despite the theoretical sidestepping, Ashenfelter and Johnson’s model creates some useful and testable predictions. That unemployment and real wage growth decrease the expectations/demands of union members and decrease the strike rate. Their empirical analysis confirms these predictions. (Chun et al, 2020).

Among attempts to explain strikes as rational behavior, the dominant approach has been to attribute their cause to some form of private information. Strikes then essentially become a costly means of revealing information. One class of such models, following Kennan (John F Kennan, 1904-2005 and Woodrow Wilson’s (1856-1924) classification, may be termed screening models (developed by, among others). These models feature unions that are uncertain about the profitability (or willingness to pay) of the firms with which they bargain. The firms, of course, have reason to downplay their true profitability to deter high wage demands. So, to combat the pooling problem, unions use the credible threat of strikes to screen firms with low valuations from those with high valuations. That is, they make high initial offers to separate out the high types who stand to lose more in a work stoppage. This strategy can induce a separating equilibrium because a labor dispute is more costly for high types than for low types, making it prohibitively expensive for highs to mimic. One problem with screening models is that they assume offers are made between fixed intervals of time (either with alternating offers between the union and firm or with only the union making offers), for no apparent reason. This assumption lends these models an unappealing feature called the Coase Property (first conjectured by Coase, and elaborated upon by Stokey, and Gul et al), which states that as the length of the interval between offers shrinks, wage offers as well as the duration of strike in equilibrium get arbitrarily small. In other words, unless the union can commit to delays between offers, the firm ends up capturing all the gains of trade, and there are essentially no strikes. The challenge, then, becomes one of explaining how the union can commit to delaying
offers, or alternatively, why offers cannot be made continuously in practice Hart rationalizes delays in terms of transaction costs. (Chun et al, 2020).

A surprising aspect of most extant strike models is that union-firm bargaining is almost always treated as a one-time interaction: the union and the firm’s problem is to settle on the terms of a single upcoming contract (either peacefully or by striking) without regard to how the outcome of the current dispute will affect future disputes over future contracts. This omission lends the standard models a static flavor even when they are formally dynamic. In this section we examine two models that are more dynamic in the sense that they consider the effects of strikes on future bargaining outcomes. The models that allow strikes to enhance one side’s reputation. Then construct a model under an indefinite horizon with the possibility of the union dissolving if they lose a strike. A higher discount factor (a longer shadow of the future) increases the likelihood of a strike in that model. (Chun et al, 2020)

There is no commonly accepted economic theory of strikes. The main obstacle is that if one has a theory which predicts when a strike will occur and what the outcome will be, the parties can agree to this outcome in advance, and so avoid the costs of a strike. If they do this, the theory ceases to hold. This might be called the "Hicks Paradox" since it is implicit in Hicks's theoretical discussion of strikes. To state the point in another way, strikes are apparently not Pareto optimal, since a strike means that the pie shrinks as the employer and the workers argue over how it should be divided. If the parties are rational, it is difficult to see why they would fail to negotiate a Pareto optimal outcome. Hicks suggested two possible explanations for strikes: either the union is trying to maintain a "reputation for toughness", or there is private information on at least one side of the bargaining table: Weapons grow rusty if unused, and a Union which never strikes may lose the ability to organize a formidable strike, so that its threats become less effective, The most able Trade Union leadership will embark on strikes
occasionally, in order to keep their weapon burnished for future use. This phenomenon may be responsible for the perennial nature of strikes as most unions change leadership yearly or every 2 years at the most with each executive of these unions wanting to show their members that they are active. Under a system of collective bargaining, some strikes are inevitable for this reason; but nevertheless, most actual strikes are doubtless the result of faulty negotiation. Any means which enables either side to appreciate better the position of the other will make settlement easier; adequate knowledge will always make a settlement possible. An intriguing feature of the Hicks Paradox is that empirical studies generally agree that strike activity is to some extent predictable. It is generally found that strikes are procyclical: in the expansionary phase of the business cycle, strikes increase, and when the economy contracts, strikes decrease.

It is not apparent how the propensity of either or both of the parties to

(a) miscalculate the intentions of the other or

(b) act irrationally would be systematically related to any of the conceptually observable variables in the system. (Ashenfelter and Layard, 1986)

Bargaining is ubiquitous. Any exchange situation, such as the one just described in which a pair of individuals (or organizations) can engage in mutually beneficial trade but have conflicting interests over the terms of trade is a bargaining situation. Stated in general terms, a bargaining situation is a situation in which two or more players have a common interest to cooperate but have conflicting interests over exactly how to co-operate. There are two main reasons for being interested in bargaining situations. The first, practical reason is that many important and interesting human (economic, social, and political) interactions are bargaining situations. The second, theoretical reason for being interested in bargaining situations is that understanding such situations is fundamental to the development of an understanding of the workings of markets and the appropriateness, or otherwise, of prevailing monetary and fiscal policies. Muthoo, (2001).
2.6. The Concept of Collective bargaining and some Bargaining Theories

This section will explore collective bargaining models and how they relate to industrial harmony. It would also explore the possible example from various studies on the subject matter. As much as it can look at the implications of these theories within the scope of industrial disharmony in the health sector. The central feature of noncooperative bargaining models of labor disputes is the role of private information that creates uncertainty surrounding key issues in the negotiations. Labor disputes act as a credible way to signal this information. Ideally, this should be the focus of empirical tests of private information models. However, almost by definition, this is the most difficult test to carry out in the data. While there is ample anecdotal evidence supporting this view of labor disputes, formal statistical tests are difficult to construct. Cramton & Tracy, (2002).

2.6.1. Collective Bargaining

The idea of collective bargaining is almost as old as the formal employment relationship. There are diverse definitions of the concept in terms of its structure and content. The collective bargaining as a method of settling the terms and conditions of employment; it culminates in a final agreement which has a regulative attribute and limits the employer’s freedom of action to the issues covered by the collective agreement. The concept can also be viewed in terms of negotiation, interpretation and administration of an agreement derived from a bilateral or multilateral engagement. (Oyewunmi & Oyewunmi 2014).

2.6.1.1. A Basic pie-splitting model

Collective bargaining is basically concerned with the division of rents which may be collected jointly by the workers and the firm's owners. A strike reduces the pie which will eventually be divided between the two sides, so a strike is a collective mistake. The strike continues only if
each side believes that there is more to be gained by continuing the strike than by settling at the terms which are currently acceptable to the other side. Since the pie is shrinking, there is a sense in which these beliefs are inconsistent: both sides expect to win, but there can be at most one winner.

2.6.1.2. An Escrow Model

As a point of reference, it is useful to consider examples of bargaining processes which achieve a Pareto optimal outcome, (Pareto Optimality) What is Pareto optimality theory? It is a concept that you will find recurring frequently in the economics literature. Described by Vilfredo Pareto (1848-1923) a civil engineer, sociologist, economist, political scientist, and philosopher who described the observation that 80% of results come from 20% of sources. The main proposition of Pareto Optimality can be summed up as follows. An economy is in a Pareto Optimal state when no further changes in the economy can make one person better off without at the same time making another worse off. This is the socially optimal outcome achieved by a perfectly competitive market. It can be shown that an economy will be Pareto Optimal when the economy is perfectly competitive and in a state of static general equilibrium. (https://www.soas.ac.uk/cedep-demos/000_P570_IEEP_K3736-Demo/unit1/page_26.htm) by
Marceau and Musgrave proposed the idea of a "statutory strike", in which production continues as if an agreement had been reached, but both the workers and the employer are subjected to fines which are roughly equal to the costs that they would bear during a strike. They suggested that the fines could be paid into a trust fund which could either become part of government revenue or be divided between the parties when an agreement is finally reached. In either case, the pie would not shrink as the union and the firm argue as to how to divide it. A practical difficulty with this scheme is that the appropriate fines would be difficult to calculate, and any proposed figures would undoubtedly promote further conflict. Instead of having a third party impose fines, it might be possible to achieve a similar effect through a kind of Vickery auction. Supposing that a union and an employer are attempting to negotiate a new contract.
This is a variation on the observation that if the eventual settlement after a strike had been applied at the outset, everyone would have been better off. The escrow model can be used to keep strike theories honest: if the parties are embroiled in the bargaining mechanism. In practice, escrow accounts are apparently not used, but retroactive agreements are common: the union allows the employer to act as banker. The escrow model draws attention to a commonly held opinion about strikes: that the function of a strike is to impose costs on the employer or on the union and so promote agreement if this is so, the escrow model misses the point, since (absent liquidity constraints) no costs are imposed on either side. A variant of the Marceau-Musgrave scheme, which does impose costs on each side, has been suggested by Blackorby and Donaldson: instead of being paid into an escrow account, the difference between the employer's last offer and the union's last demand is collected by the government. (Ashenfelter and Layard, 1986).

### 2.6.2. Two Bargaining Models

Bargaining theory contains very few interesting propositions that can be tested empirically

#### 2.6.2.1. The Nash Model

The most used solution concept in game theory is that of Nash equilibrium. This was described by John F Nash Jr (1928-2015) an American mathematician who had schizophrenia. This notion captures a steady state of the play of a strategic game in which each player holds the correct expectation about the other players’ behavior and acts rationally. It does not attempt to examine the process by which a steady state is reached. (Osborne and Rubinstein, 1994)

A Nash equilibrium of a strategic game \((N; (A_i); (U_i))\) is a profile \(a = (a_1^*, \ldots, a_N^*)\) \(\sum A\) of actions with the property that for every player \(i \in N\) we have \(U_i(a^*) \geq U_i(a_1^*; \ldots; a_{i-1}; ai; a_{i+1}; \ldots)\) for all \(a_i \sum A_i\).
When a game is played, the rationality assumption will force the game into a Nash equilibrium. Okwudiri et al, (2017).

When two parties can do better by cooperating than by acting independently, a bargaining problem arises, involving the division of the gains from cooperation (the "pie"). Nash proposed an ingenious solution for such problems, which predicts that the parties will act to maximize the product of their utility gains from cooperation. (Baron and Berman). Nash's argument was quite simple and can be presented in the context of the pie-splitting problem where two parties divide a fixed sum of money with the understanding that if they cannot agree on a division each party gets nothing. It is assumed that each party would rather have more money than less, and these preferences are represented by increasing utility.

The diagram below explains two parties ("One" and "Two") divide a fixed sum of money \( 7r \), with the understanding that if they cannot agree on a division each party gets nothing. It is assumed that each party would rather have more money than less, and these preferences are represented by increasing utility functions \( U(x) \) and \( V(y) \), with \( U(0) = V(0) = 0 \). Then the triangle above can be transformed into the utility-possibility set \( F \) shown in below. It is assumed that \( F \) is convex. A special point \( N \) is now singled out by the property that the utility product \( uv \) is greater at \( N \) than at any other point in \( F \). Change units so that both One and Two obtain 1 unit of utility at \( N \) and re-draw the utility-possibility set in these new units, it is assumed that \( F \) is convex. A special point \( N \) is now singled out by the property that the utility product \( uv \) is greater at \( N \) than at any other point in \( F \). Change units so that both One and Two obtain 1 unit of utility at \( N \) and re-draw the utility-possibility set in these new units, as shown below.

The point which maximizes the utility. (Ashenfelter and Layard, 1986)

Players 1 and 2 simultaneously choose bids \( p \) and \( q \) in the interval \([0,1]\). If their bids add up to more than 100%, then we say breakdown occurs, and both get zero. Otherwise, when the bids
are \( p + q \leq 1 \), Player 1 gets share \( p/(p+q) \) as his payoff and Player 2 gets \( q/(p+q) \). If \( p = q = 0 \), assume the shares are each. Laying out two definitions here for future reference:

**Definition 1.** An interval equilibrium is a Nash equilibrium in which Player 1 bids by mixing with density \( f_1(p) > 0 \) over the interval \((a, b)\) and Player 2 bids with density \( f_2(q) > 0 \) over \((c, d)\), possibly with atoms somewhere in the interval or at the end points.

**Definition 2.** The player’s bid supports are balanced if and only if element \( s \) being in Player 1’s support \( A \) implies that 1-‘s is in Player 2’s support \( B \), and vice versa.

An example of a symmetric balanced support for an interval equilibrium is both players mixing over \([.2, .8]\). An example of an asymmetric balanced support is Player 1 mixing over \([.2, .4]\) and Player 2 over \([.6, .8]\). Splitting a Pie has a continuum of pure strategy Nash equilibria: every pair of bids with \( p + q = 1 \). There are also many mixed-strategy equilibria, some with bidding over a finite set of points, some with bidding over a continuum. Before we proceed to interval equilibria and the general case for Splitting a Pie, it will be helpful to first understand

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**Fig. 6. Nash Bargaining Solution. Source:** https://ocw.mit.edu › courses › lecture-notes
two well-known results: the hawk-dove equilibrium for Splitting a Pie, and the interval
equilibrium for the Nash Demand Game.

The Nash Demand Game. Finding equilibria for Splitting a Pie that mix over a continuum is
quite involved, but it is much easier to find such an equilibrium for the “Nash Demand Game”
in which players use the “take what you bid” sharing rule. In this game, the player bid p and q,
and they receive p and q as payoffs if \(p + q \leq 1\) but zero if \(p + q > 1\). In the context of bargaining,
if the players reach agreement but they have both bid low, they agree to abandon the remainder
of the pie. This is not suitable for bargaining, but it provides a good model for other situations,
e. g. two hunters independently choose how aggressively to pursue a deer that neither might
catch if they are too timid or too aggressive.

An example of a mixed-strategy equilibrium for the Nash Demand Game is one in which each
player bids \(a\) with probability \(K\) and then mixes using density \(f = f_1 = f_2\) over the interval \([a, 1
- a]\). Player 2 can guarantee a payoff of \(a\) by bidding \(a\), since \(p + a \leq 1\) for any bid \(p\)
Player 1 might play. Player 2 will have a payoff of \(K(1 - a)\) from bidding \((1 - a)\), since \(p + (1 - a) > 1\)
for any bid \(p\) Player 1 might play except for \(p = a\), which has probability \(K\). Since Player 2 is
only willing to mix between bids if they have equal expected payoffs, this implies \(\pi_2(a) = a = \pi_2(1 - a) = K(1 - a)\) and we can conclude that \(K = \frac{a}{1-a}\).

For bids between \(a\) and \(1 - a\), Player 2’s expected payoff is

\[
\pi_2(q) = Kq + \int_a^{1-a} q f(p) dp,
\]

which we can rewrite using \(F\) as the cumulative distribution and our knowledge that \(K = \frac{a}{1-a}\),
and combine with the requirement that \(\pi_2(q) = \pi(a) = a\) to yield

\[
\pi_2(q) = \left(\frac{a}{1-a}\right) q + qF(1 - q) = a.
\]
Using the change-of-variables $p = 1 - q$, this becomes \( \left( \frac{a}{1-a} \right)(1-p) + F(p)(1-p) = a \), which solves to \( F(p) = \frac{a}{1-p} - \frac{a}{1-a} \), which can be differentiated to yield the equilibrium mixing density, \( f(p) = \frac{a}{(1-p)^2} \).

The Nash Demand Game is easy to solve because each player’s payoff function depends on the other player’s bid only if breakdown occurs. If the bids add up to less than one, a player’s payoff is entirely independent of what the other player does. This is what allows us to move smoothly from equation (4)’s \( \int_{a}^{1} qf(p)\,dp \) to equation (5)’s \( qF(1 - q) \). If Player 2’s share of the pie depended on Player 1’s bid via some function \( v_2(q, p) \) instead of just being his own bid \( q \), equation (4) would have the expression \( \int_{a}^{1} q \, v_2(q, p)f(p)\,dp \) and it would no longer be straightforward to extract \( f(p) \) from the integral. The purpose of the present paper is to discover how to do this, with particular attention to the proportional-sharing case of \( v_2 = \frac{p}{p+q} \). (Connell And Rasmusen, 2019).

### 2.6.2.2. Hawk-Dove Equilibria for Splitting a Pie

The simplest mixed strategy for Splitting a Pie has the two players each mix over the same two bids. This is a hawk-dove equilibrium, mathematically the same as the well-known biological model of birds deciding whether to pursue aggressive or timid strategies. Each player chooses \( a \) with probability \( \theta \) and \( 1 - a \) with probability \( 1 - \theta \) for \( a \leq .5 \). The two bids must add up to 1 because otherwise it would be a profitable deviation for one player to choose a bigger number for his lower bid, increasing his share without any greater likelihood of breakdown. This is immediate example of the importance of “balanced supports”. The mixing probabilities must make each action’s expected payoff the same in equilibrium, so

\[
\pi(a) = \theta(.5) + (1-\theta)a = \pi(1-a) = \theta(1-a) + (1-\theta)(0)
\]
which solves to $\theta = 2a$ and $\pi 0 = 2a (1 - a)$.

There also exist asymmetric hawk-dove equilibria, as Malueg points out. Consider the following example. Player 1 chooses $a$ with probability $\theta$ and $b$ with probability $(1 - \theta)$. Player 2 chooses $1 - b$ with probability $\gamma$ and $1 - a$ with probability $(1 - \gamma)$.

Player 1’s expected payoffs from his two pure strategies must be equal for him to be willing to mix between them, so

$$E\pi_1(a) = \gamma \left( \frac{a}{a+1-b} \right) + (1-\gamma) \left( \frac{a}{a+1-a} \right) = E\pi_1(1-b) = \gamma \left( \frac{b}{b+1-b} \right) + (1-\gamma) \left( \frac{0}{b+1-a} \right) \rightarrow \gamma = \frac{a(a+b)}{a^2-b^2+b}$$

Player 2’s expected payoffs from his two pure strategies must also be equal, so

$$E\pi_2(1-b) = \theta \left( \frac{1-b}{a+1-b} \right) + (1-\theta) \left( \frac{1-b}{b+1-b} \right) = E\pi_2(1-a) = \theta \left( \frac{1-a}{a+1-a} \right) + (1-\theta) \left( \frac{0}{b+1-a} \right) \rightarrow \theta = \frac{b(a+b)}{b^2-a^2+a}$$

The Player 1 choosing $.1$ and $.4$ with probabilities of about $.28$ and $.72$, for a payoff of about $.11$; and Player 2 choosing $.6$ and $.9$ with probabilities of about $.93$ and $.07$, for a payoff of about $.84$. Also considering the equilibria with finite support more generally and show that these can be used to approximate equilibria with any support. The importance of Hawk-Dove
is in illustrating why supports must be balanced and in showing how there nonetheless can exist asymmetric equilibria, something that will also be true of interval equilibria. (Connell And Rasmussen, 2019)

2.6.2.3. The Cross Model

An interesting but ultimately unsuccessful attempt to evade the Hicks Paradox was made by Cross (1932). Cross considered a pie-splitting model in which each side maximizes a discounted sum of utility flows by making a continually changing series of "final" demands. A canonical version of this model will be presented here. Suppose that “Two” initially demands $q_2$, but One believes that this demand will be reduced at the rate of $r_2$ dollars per time-period, so that One could obtain the entire pie by waiting $q_2/r_2$ periods. Then to obtain $q$ dollars One must wait until Two has conceded $q + q_2 - ~r$, so One's problem is

$$\max U(q) \exp \left( - \frac{a}{r_2} (q + q_2 - \pi_2) \right)$$

where $U$ is One's utility function, and $a$ is One's rate of time preference. Since $q_2$ and $~r$ enters the objective function only through a multiplicative constant, it is evident that the optimal demand does not depend on either the size of the pie or the demand made by the other side, but only on the gain from waiting ($r_2$) relative to the cost of waiting ($a$). Similarly, Two's demand will depend only on the rate at which One is expected to concede ($r_1$) relative to Two's rate of time preference ($b$). Thus, for example, if we observe initial demands of $60$ and $70$ when the pie is $100$, we should also observe initial demands of $60$ and $70$ when the pie is $950000.

This remarkable prediction surely dams the Cross model unless the anticipated concession rates $r_1$ and $r_2$ are somehow tied to the size of the pie. At the outset each party expects to stand fast while the other concedes. To reconcile these contradictory expectations a model of learning is introduced in which One revises the estimate $r_2$ of Two's concession rate considering the
actual concessions made by Two over time. Assume that each party learns at the same rate according to an adaptive expectations rule. Then
\[ \dot{r}_2 = \alpha [ -q_2 - r_2 ] \]
and
\[ \dot{r}_1 = \alpha [ -q_2 - r_2 ] \]
where the dot notation denotes a time derivative, and \( \alpha \) is a parameter representing the speed at which the parties learn. Assume that each party is an income-maximizer, and that the rates of time preference are equal. Then it can easily be shown that the optimal demands are
\[ q_1 = \frac{r_2}{\alpha} \]
and
\[ q_2 = \frac{r_1}{\alpha}. \]
Substitute these in the learning equations to obtain a pair of differential equations in \( q_1 \) and \( q_2 \):
\[ aq_1 = \alpha [ -q_2 - aq_1 ] \]
and
\[ aq_2 = \alpha [-q_1 - aq_2]. \]
The model can easily be solved by introducing a variable \( Q = q_1 + q_2 \) to denote the sum of the demands, and a variable \( D = q_1 - q_2 \) to denote the difference in the demands. Then by adding and subtracting equations. (4) and (5) one obtains:
\[ (a + \alpha) Q + a\alpha Q = O \]
These Equations can be solved separately. Equation (6) gives
\[ Q(t) = Q_0 e^{-\lambda t}, \]
where \( \lambda = a\alpha/(a + \alpha) \), and \( Q_0 \) is the sum of the initial demands, reflecting the initial beliefs about concession rates. Thus, the sum of the demands declines exponentially, and agreement is reached at \( t^* \), when \( Q(t^*) = \pi \). The solution of eq. (7) is
\[ D(t) = D_0 e^{-\mu t}, \]
where \( \mu = a\alpha/(a - a) \) and \( D_0 \) is the difference of the initial demands. Cross assumed (arbitrarily) that the time preference rates \( a \) exceeds the learning rate \( \alpha \), which implies that the difference of
the demands also declines exponentially, and less rapidly than the sum. Since D(t) does not change sign, whoever makes the larger initial demand will end up with more than half of the pie. In other words, if One expects Two to concede rapidly, while Two expects One to concede slowly, then One will obtain more than half of the pie.

The Cross model has two fatal flaws. First, in real life settings the bargainers do not behave rationally. At any given moment, each act as if all future concessions will be made by the other, even though this is manifestly unrealistic considering the bargaining history so far. Second, the model has no empirical content unless another model is adjoined which explains how each party forms an initial estimate of the other's concession rate. In applications, therefore, the model degenerates into a series of ad hoc speculations about, say, the effect of variations in the unemployment rate on the firm's beliefs about the rate at which workers will moderate their demands. There is no question that such beliefs are important in practical negotiations. The problem is that the Cross model does not add anything to the "war stories" found in the descriptive literature on bargaining and strikes. For example, it is misleading to claim that the Cross model provides "insight" into the bargaining process, by showing that a union may wish to make some concession but be deterred by the prospect that management will infer weakness and become intransigent. One does not need a model to predict this kind of behavior, and it is foolish to expect that an irrational model can be used to sharpen the prediction in some way. The real value of the Cross model is that it posts a "cul de sac" sign on an otherwise plausible avenue of research. By working through the model one is led to appreciate the futility of attempting to build a two-sided model of rational bargaining and strikes in which each side continually revises its subjective expectations about the behavior of the other. (Ashenfelter and Layard, 1986)
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CHAPTER THREE

3.1. METHODOLOGY

3.1.1 Summary of Research

In total, about 150 publications, articles across the above journals and books were obtained for the study, initially. The criteria for selection were based on the relevant to subject matter, cross-sectional, quantitative, qualitative publications, narrative, and systematic reviews. The materials are also as recent as May 2021, they are also written in English language that discussed about the subject in review, which worked on topics and sub-topics looked at in this work. The articles that were not focused on the aspects of interaction were excluded leaving about 80 articles and books for review.

3.1.2. Database Searched

The information used throughout this study was by an extensive literature search of different works on Industrial Disharmony in the Health Sector in Nigeria, Industrial Conflict in the Health Sector in Nigeria, World Health Organisation and International Labour Organisation Articles and Journals. Searches were done in JSTOR, World Economic Forum, Google Scholar, ResearchGate Journals, Academia Education, BMJ, Modules, Lectures, and Individual articles on online.

3.1.3. Searched Terms

The keywords used for searching were, on Industrial Disharmony in the Health Sector in Nigeria, Industrial Conflict in the Health Sector in Nigeria, Bargaining Theories, JOHESU
Strike, doctors’ strike in Nigeria, Management Theories. Writings relevant from these materials were used. Those from international were adapted to the suitability of the practice in the named country.

3.1.4. Data Collection and Analysis

After a thorough review of materials obtained for the study about 80 articles were selected for the study. The studies which had little or no relevance to the subject were removed, and duplicates were also removed.

This section would continue reviewing related articles and will examine the following

(a) Strikes, forms of strike and lockouts
(b) Origin of Nigeria Health Care System
(c) The health care services operate under 3 tiers
(d) Health Care as an Employment Sector: The Importance and Characteristics of Health Labour Markets
(e) The incidence and consequences (indicators and outcomes) of “strike actions” in the healthcare sector in Nigeria
(f) Human Resources for Health and the factors that may influence the human resources for health in Nigeria

3.2. Strike

Strike indicates negative action displayed towards work and refers to the refusal or stoppage of work by a group of employees acting in agreement with mutual understanding to compel an employer yield to their demands as stated in the terms of employment. There are some key elements to strike action:
(i) it indicates negative action towards work,
(ii) the actions are concentrated towards set objectives.

Organizational performance is greatly influenced by industrial actions embarked upon by employees because of the wastage of productive time on the part of the organization.

3.2.1. Forms of Strikes

There are various forms of strike but most notably as indicated by Poole (1980), include:

1. **Wildcat Strike**: This kind of strike occurs when there is infringement or breach in the terms of condition reached by parties and it is not often formally approved by the parties (including the trade union) since management weren’t informed or notified before such action, took place.

2. **Sit-Down Strike**: A form of strike involves a peaceful, sit and watch action at the workplace agreed upon by employees without necessarily engaging on any form of official assignment. This used to be referred to in Nigeria as “work to rule”.

3. **Constitutional Strike**: This form of strike involves actions taken to comply with the rules to the usual process of the employment agreement. These agreements clearly define the time and procedure involved in before employees will embark on protest management’s failure on employment contracts (cease work).

4. **Unconstitutional Strikes**: This form of strike action involves obstructing firms’ operation or demonstration that is in disobedience to the laws required by mutual agreement or the relevant public guiding principles. This includes “picketing “.

5. **Unofficial Strike**: This form of strike is usually not supported by management. This occurs because of the mistrust union members have against the company’s management which eventually leads to express demand on management without considering if such action is supported by those in control of their agitation or at the helm of affairs.
6. **Official Strike**: This form of strike action is formally endorsed by the management of the industry or company.

7. **Other strikes** described by others include: hunger strike, economic strike, sympathy strike, general strike, slow down strike, etc.

### 3.2.2. Lockouts

Lockouts are directly related to employers, and it is seen as a direct opposite to strike action at the workplace. It is an official agreement reached by management to deliberately shut down operations at the workplace or a deliberate attempt to deny workers productivity to compel employees or support other organization in inducing their employees to accept the terms of employment contract. The consequences of strikes and lockouts are detrimental to the industry and the nation’s economy because they lead to loss of production. Lockout could manifest in form of machine shutdown, premises lockdown and personnel lockdown. (Elenwo & Ignatius). It is apparent that the challenge for the opposing parties is not one of ‘sitting at a round table’ as it were. It is not commonly used tool in the health sector. The central issue seems to be that of ensuring a reasonable measure of flexibility to accommodate current realities and recognizing the importance of identifiable interests working together as co-partners, with a view to devise practical ways to resolve fundamental issues that are negatively impacting on the public health sector. A view to the contrary will be counterproductive since it is in the interest of all stakeholders that the Nigerian public health sector is sustainable in the long term. (Oyewunmi & Oyewunmi, 2014).

### 3.3. Origin of Nigeria Health Care System

Health services in Nigeria were initially modeled against the British colonial medical services, but following independence, global trends had a significant impact. Chief amongst these was
the Alma-Ata declaration in 1978, on which the foundations of the current NHP were based. Those foundations were laid in 1984 with primary healthcare adopted in 1985 as the basis of the country’s health policy. However, post Nigeria’s independence in 1960, there have been several attempts to improve healthcare delivery. Successive Nigerian Governments have adopted different National Development Plans (NDP) to help address development challenges in the country at different periods. Some of the notable landmarks in the NDP for the health sector were the 1975–80 NDP which witnessed the proliferation of healthcare facilities within communities and villages through the Basic Health Service Scheme (BHSS). The 1981–85 NDP further segmented healthcare services to be delivered across three levels of care within the public sector. (Randhawa & Ochieng, 2019).

The organization of health care services in Nigeria is complex and includes numerous providers in both the private (private for-profit providers, not-for-profit and community-based organizations, religious and traditional care providers), and public sectors. In the public sector, Nigeria operates a decentralized health system in the three tiers of government namely: Federal Ministry of Health (FMOH), State Ministry of Health (SMOH), and Local Government Health Department (LGHD). The FMOH is responsible for the co-ordination and implementation of the National Health Policy. It oversees health activities in the 36 States of the Federation, Abuja (Federal Capital Territory) and 774 Local Government Areas (LGAs). FMOH also provides tertiary care through the teaching hospitals and federal medical centers. The SMOHs provide secondary health care through the state hospitals and comprehensive health centers, while the LGAs provide PHC services through the primary health care centers. However, all the three tiers of government and agencies also participate in the management of the PHC; resulting sometimes in duplication and overlap of responsibilities, conflict, and waste. (Anyinka 2014).
These are primary, secondary, and tertiary healthcare system. This structure also reflects the three tiers of government in Nigeria, namely Local, State and Federal governments (see Fig. 8 below). Despite significant progress during these periods, there were notable deficiencies such as lack of clear policy framework, lack of manpower development and resource generation.

Fig. 8. Levels of Healthcare delivery in Nigeria. Source: (Randhawa and Ochieng, 2019).

Current issues within the health sector include incessant strikes among health workers, dilapidated hospital buildings, ill-equipped laboratories, dearth of diagnostic tools, lack of healthcare financing and inadequacies of remuneration for the health workers. (Randhawa & Ochieng, 2019).

3.3.1. Tiers of Health Care Services

There are 3 tiers of healthcare which are primary, secondary, and tertiary.
3.3.1.1. Primary Health Care Services

Primary health care is defined as the method of providing health care to community members through total participation and at a cost that is affordable whose aim is for them to be self-determined, self-sustained and self-reliant. Primary health care service is the first point of contact for the members of the community who need treatments, care, preventive medicine (immunizations, prophylaxis treatments) and counselling. It provides continuity of health care services to patients who need care and allows for easy movement within the healthcare system when more specialized services are needed. There are about 10,000 of them nationwide.

The primary healthcare: provides the following basic services to citizens which are:

(1) Educating people to be able to identify and control prevailing health challenges
(2) Maternal and childcare.
(3) Health promotion
(4) Identification, prevention, and control of locally endemic diseases.
(5) Provision of basic drugs
(6) Promotion of psychological, emotional, and spiritual health.

3.3.1.2. The Secondary Healthcare Services

When there are cases that cannot be treated in the primary health system, they are referred to the secondary healthcare services. These are often called the federal hospitals or the comprehensive health centers or specialist hospitals. It is done by using a referral (referral letter) to see a specialist who is an expert in treatment needed. The specialists are trained to focus on a specific type of disease or part of the body. For example, cardiologists focus on the heart; oncologists work on cancers; the ophthalmologists for the eye; and dentist works on the mouth especially the tooth and gum. Most of the Nigerian hospitals are operated by boards.
of trustees or state health authorities which are established by the state governments. (Somoye, 2015).

3.3.1.3. The Tertiary Healthcare Services
The tertiary health centers include the teaching hospitals like LUTH and UCH, specialist hospitals (National Eye Hospitals, National Orthopedic Hospitals, and Federal Neuropsychiatric hospitals). These are the highest levels of care and hence cases not easy to manage at the secondary level are referred here.

3.3.1.4. The Supplementary Services
The benefits of supplementary services include prescription of drugs outside the hospital, dental care, vision care, this is because the government of Nigeria does not provide free services for its citizens, therefore people pay for the services from their own pockets or through private health insurance scheme plans. Some Nigerians who work for private organizations have health insurance packages which cover them and their families. (Somoye, 2015).

3.3.1.5. Private Health Insurance
In private health insurance a plan is made by private insurance organizations to cover the health costs of citizens for a period, either monthly, quarterly, semi-annually, or annually. This insurance is also done by employers of an organization in form of group policies to all staff, which can extent to the immediate family. It is also done by professional associations for their members. The insurance plan is active throughout the duration for which it was bought. It is a relief to the government and its citizens because with the insurance, it is exempted from taxes of the federal and state governments.
3.3.1.6. Other Financing

There are goodwill volunteers and charitable organizations inclined to provide donations for funding of effective health care services and provide help for patients and their families who need medical care. Several non-governmental organizations like hospital foundations or disease-related foundations/projects usually collect funds from the citizens as donations which they use to purchase medical equipment and to carry out research. These volunteers and other organizations (medical missions included) also give their time to the public by holding seminars, medical outreaches, counselling and giving health enlightenment messages. (Somoye, 2015).

3.4. Health Care as an Employment Sector: The Importance and Characteristics of Health Labour Markets

The health workforce represents a significant share of the labor force in virtually all countries. In countries with higher income, the relative importance tends to be higher than in countries with lower income since it can account for up to 13% of the total workforce. In the United States, for example, the health care sector employs 10.6% of the country’s total labor force, and this participation has been increasing over time. (International Labour Office, 2019). The provision of health services depends on several factors, but the availability and retention of human resources is particularly important. The health care worker (HCW) to population density in Nigeria (20 doctors, nurses, and midwives per 10,000 population) is a little below the WHO recommendations of 23 per 10,000. (Susa, 2020).

Despite being a large and important employment sector, labor economic frameworks have been applied insufficiently to understand the dynamics of health sector labor markets. There are multiple manifestations of labor market failures in health care in which the supply, demand and
need dimensions fail to find an optimal equilibrium. Decisions related to health workforce training, such as scaling up the production of health workers, rarely anticipate the levels of likely outflows from the workforce because of poor working conditions, time spent looking for a job, worker illness, retirement, and migration. Getting a better return on investment in the production of health workers will depend therefore on how many of these labor market issues are managed. Underlying health labor market dynamics is the recognition that health workers respond strategically to policy and institutional changes as well as to external forces. The old assumption that health workers are passive actors, inherently competent and motivated to serve the public, does not hold in most settings. Rather, it is important to recognize their behavior as economic actors, with clear preference and, in many cases, making informed choices over

![Employment by Industry](image)

**Fig.9. Beyond Bankruptcy: How Detroit Has Used Data to Encourage Opportunity, Investment, and a Resurgence of Its Auto Industry – Source: EMSI (economicmodelling.co.uk)**
sectors and geographical location. Further, the interaction of health workers as economic agents with institutional employers and patient consumers is an exciting and growing area of work related to results-based funding and incentive systems for performance. Labour market analysis is also important in understanding both within-country shifts of health workers (urban-rural distribution) as well as international flows of workers between countries. In short, further investment in health labor market analysis is likely to inform policies that address diverse market failures and hence contribute to increasing the availability, accessibility, and quality of health workers. (International Labour Office, 2019).

We use an analytical framework (Fig. 3) specifically adapted from the UHC “cube” – integrating Tanahashi’s health coverage model and the right to health – to characterize the dimensions of effective coverage: availability, accessibility, acceptability, utilization, and quality. Focusing on these four dimensions as they apply specifically to the health workforce: availability (e.g., stock and production); accessibility (e.g., spatial, temporal, and financial dimensions); acceptability (e.g., gender and sociocultural); and quality (e.g., competencies and regulation). The framework shifts the focus beyond the current monitoring of access to and contact with a health worker – i.e., skilled attendance at birth, or density of health professionals per 1000 population – and turns the AAAQ dimensions of the workforce into the key determining factors of the quality of care, represented in Fig. 3 as the “effective coverage gap”.

We apply the four workforce dimensions to guide a process-tracing analysis of HRH policy actions since 1990. Process tracing is an analytical tool for exploring causal mechanisms and contributory steps in the chain of events that collectively support a desired outcome. Globally, countries are faced with health system problems which vary from one to the next. While health service delivery challenges are more often seen in countries with a very high Human Development Index (HDI), human resources challenges attract more attention within those
with a low HDI. Healthcare systems in Africa have, over the years, suffered from man-made issues which cut across institutional, human resources, financial, technical, and political developments.

The World Health Organization (WHO) in 2007 proposed a framework that describes healthcare systems in terms of six core components or “building blocks”:

i) service delivery. 

ii) healthcare workforce. 

iii) healthcare information systems; 

iv) medicines and technologies; 

v) financing; and 

vi) leadership/governance

Fig.10. Universal Health Coverage. Source: (WHO, 2010). Adapted from The world health report (2010), UN Economic and Social Council (2000) and Tanahashi (1978).
Most African countries are unable to meet the basic requirement for good healthcare systems. Poor governance and human resource challenges are linked to ineffective integration of services in resource-limited nations. Dilapidated healthcare systems have facilitated medical tourism, for example, leading to over 5000 people leaving Nigeria every month for various forms of treatment abroad and about 1.2 billion US dollars lost from the Nigerian economy to medical tourism yearly. (Oleribe and Uzochukwu et al, 2019). There is a toxic mix of problems including inaccessibility of quality health care, poor hygiene, corruption, malnutrition, lack of access to safe drinking water, poor health infrastructure, fake drugs, insufficient financial investment, and lack of sufficient health personnel. Government’s performance in the health sector has been abysmal. Investment in infrastructure has been poor, and meager remuneration for health workers has created a massive brain drain to the US and Europe. The annual budget of the government for the health sector is 4.17% of the total national budget, which is equivalent to only $5 per person per year! Hardly a year passes without a major national strike by nurses, doctors, or other health care workers. The major reasons for these strikes are often attributed to poor wages and lack of government investment in the health sector. (Tumba, 2019). Other causes of industrial crisis in the Nigerian health sector include policy inconsistencies and wrong placement of health in organizational priorities on the part of the management. When employers place higher premium on capital input far above the workers welfare without appreciating that the latter makes the former productive, industrial rancor easily sets in. Low level of workers’ motivations with respect to remuneration (both promptness and total package) has been a bone of contention between the workers and employers. (Osabuohien & Ogunrinola).

Another underlying problem leading to disharmony is unhealthy rivalry among health professionals and this has contributed to the dysfunction of the health system. Yet, effective
teamwork among health professionals is recognized as an essential tool for patient-centered health service delivery, and the process of providing health care is interdisciplinary requiring health professionals to work in teams. A lack of teamwork leads to poor coordination of patient care, poor utilization of care, patient dissatisfaction, medical errors, and patient mortality. The key drivers of disharmony and unhealthy rivalry among health professionals in Nigeria include among others, the struggle for the most important profession in health care, with some health professionals claiming superiority over others; the struggle for leadership positions; and the disparity in remuneration of health workers. The problem has been allowed to fester for decades without adequate intervention by policy makers and the government.

Over the years, medical doctors have laid claim to the leadership of Federal and State Ministries of Health, as well as other health institutions/agencies, and it is believed by doctor that the status of “consultant” is their exclusive preserve which other health professionals cannot aspire to. Furthermore, evidence suggests that there is wide disparity in the remuneration of health workers of the same grade level across the federal, state, and local governments, as well as in the remuneration of health workers of different professions. In addition to this, there is a widespread belief among other health professionals, that the Nigerian health system is designed to favor medical doctors, who due to their perceived autonomy and authority over other health professionals continue to dominate. The Joint Health Sector Union (JOHESU) was set up to challenge this dominance. This role of a counterbalance to the NMA/NARD has led to more industrial disharmony as the groups engage in a battle of the scarce resources within the health sector. Often one strike of NARD/NMA is resolved only for JOHESU to commence their strike to maintain relativity or vice versa. This is the bane of non-collective bargaining.

The medical, non-medical health professional dichotomy has been a major hindrance to the effective delivery of health services. The development of the health system and health services
are often disrupted because of this unending battle for supremacy. This battle of the titans affects poor and vulnerable populations who must rely on public health facilities, the most, as the unaffordability of private health care services means that such people cannot access healthcare when public health facilities are shut down. Those that seek care either engage in self-medication or patronize traditional healers and alternative medicine dealers, and many have suffered or died because of this. (Aregbesola, 2018).

In recent years, migration to foreign countries declined but is now re-emerging thus compounding the inadequate production and inequitable distribution of health workers in Nigeria. The health workforce is concentrated in urban tertiary health care services delivery in the southern part of the country, particularly in Lagos. This inequity has been attributed to:

- lack of public and private sector coordination (the former being over-subscribed, and the latter undersubscribed)
- favoring hires, indigenous to the region
- work environments that contribute to low motivation, less-than-optimal productivity, high attrition - especially from rural areas;
- lack of planning based on staffing projection needs resulting in an overproduction of some categories of health workers and a lack of others. These challenges are further compounded by the fact that the federal government accepts and regulates 3 systems of health care delivery: orthodox, alternative, and traditional. (WHO 2021).

The location and distribution of human and material resources are often politicized such that health institutions are sited without adequate consideration of the needs of the community. On the human resources, health personnel are still over stressed as Nigeria health sector is yet to meet the WHO template ratio 1 doctor to 500 patients. Gross underfunding is a serious social
cankerworm devouring the essence of the Nigerian health institutions. As a result of the lean budgetary allocation to the health sector, the Nigerian health system is below the World Health Organisation standard of 15% of the total national budget. By implication, the fund is not adequately budgeted for and released, timeously to the health institutions, the life-saving organizations for that matter. This underfunding of the health sector has been an issue for years. Arising from the underfunding of the health sector institutions is the weak infrastructure and logistic supports which are weak, obsolete, and defective. This is due to inadequate maintenance of buildings, medical equipment and vehicles, shortage of drugs, faulty compounding of drugs, poor management of drugs, the expiry of drugs and vaccines and other essential requirements for patients’ care. These pose huge problems for management teams and committees handling and managing facilities for the institutions. The utility boards in Nigeria often make the problem worse by engaging in irregular supply of water, erratic or rather epileptic supply of electricity and poor telecommunication services. In cases where there are these amenities are supplied or available, usually poor maintained is the result which leads to waste and degradation. Absence or inadequacy of equipment had been found deficient in most of Nigerian hospitals. Worse still, the poor network of roads and neglect of road transportation do not make accessibility to many health institutions easy. Hence, most patients referred from the primary level of care, or secondary find it difficult to get to where they can obtain a respite for their ailment and most times worsen the case that ordinarily requires minor treatment. (Omoleke & Taleat 2017).

The health professionals in Nigeria are yet to be adequately remunerated with comparison to their counterparts in other advanced countries of the world. The consequential effects of poor motivation are facile. Such effects include frustration, poor service delivery, psychological warfare at work, industrial strikes and brain drain, just to mention few absurdities arising from
poor financial motivation. Furthermore, various immunization programmes put in place under Preventive Medical Care have not been very successful to meet WHO standard due to few problems confronting implementation of immunization policy/programme. For instance, the storage of vaccine which requires cold condition is often defective. The immunization officials contacted complained of poor remuneration, inaccessibility of rural areas as they are landlocked, worse still the roads are bad. Regrettably, it appears that the Nigerian Government seems of have been trivializing the consequences of this attitude which are low productivity and poor performance. This is not in tandem with good administration of health care delivery. The unsettled political order in the country, insecurity of life and property coupled with the restiveness of the youths and various self-determination groups like the IPOB, MEND, OPC that heat up the polity and create added problems of safe access to healthcare. The Boko Haram, Islam State for West African Province insurgencies are continuous making occurrence, implementation of health policy in such hostile environments is a mirage/ruse. This is because no doctors, pharmacists, nurses, and others and would want to lose their life untimely or prematurely, by serving in such areas. (Omoleke 2017).

The Policy Implementation, the Monitoring and Evaluation of the health sector is a challenge in a country where corruption has gone deep, tearing the fabrics of the society. It replaces meritocracy with mediocrity. Corruption in the health sector has eaten deep in such a way that, teaching hospital had been visited for accreditation of its facilities and human resources and some Chief Executives of health institutions hire temporary specialists and other health care workers just to meet the percentage set by the visitors or regulators and after the accreditation, it is back to square one – shortage of human resources. Other examples of corruption and ethical indecency is diversion of patients to privately owned hospital by a public hospital healthcare worker.
Corruption is seen in every facet in Nigeria, as seen with the politicians. However, one advantage the health sector has is that each of the team has professional oaths to restrain its professionals if ethically and professionally complied with e.g.

(1) Physician Oaths (Hippocratic Oath)
(2) Code of Ethics for Nursing Profession
(3) Pharmacist Oath etc.

The Declaration of Geneva (Physicians Oath Declaration) adopted by the General Assembly of the World Medical Association at Geneva, Switzerland, September 1948 and amended by 22nd World Medical Assembly, Sydney, Australia, August 1968, is antithetic to corruption if complied with and respect strict senso. Again, like the Doctors’ Hippocratic Oath, the Nurses pledge is in alignment with the anticorruption crusade. In recent times, these oaths have been violated to the extent of less regards for them and most are losing their worth. (Omoleke & Taleat 2017).

In our ever-changing world, with technological advancements and digital upgrades, the health sector has experienced a lot of cutting-edge technology and have impacted on the cost of health care delivery. In advanced economies, health care systems are deemed financially unstable, while in emerging economies, they are still being shaped. In Nigeria, the nation is experiencing a lot of economic instability and insecurity which is impressing on every sector of the economy, the health being the most affected in terms of harmony instability. Funding which can be use in the improvement of the health sector is channeled to medical tourism by both the government officials and the people (the rich). The health sector in any economy forms the backbone of its growth and development. Factors affecting the overall Nigerian health system performance include: inadequate health facilities and structures, poor management of human resources, poor motivation and remuneration, inequitable and unsustainable health care financing, skewed
economic and political relations, corruption, illiteracy, decreased government spending on health, high user fees, absence of integrated system for disease prevention, surveillance and treatment, inadequate access to health care, shortage of essential drugs and supplies and inadequate health care providers. (Anyinka 2014).

3.5. Human Resources for Health

According to World Health Organization’s report in 2006, “human resources for health can be defined as all people engaged in actions whose primary intent is to enhance health.”

This is a very important part of healthcare system of any country because without the workforce, nothing can be done or achieved, therefore the leaders must lay down policies for this workforce to carry it out their duties diligently and empathically. Employees must be there to use the information systems put into place. It is also the employees that carry out the service delivery to the citizens. Therefore, without these workers, there will a big gap in the healthcare system. The healthcare workforce is very important to improving the service delivery of the health care in an effective manner which is also very professional. The health workforce includes the doctors/physicians, nurses/midwives, pharmacy specialists, laboratory scientists/specialists and sanitary workers who can work as public health workers, private health workers, salaried and non-salaried health workers, NGOs. According to Afri-Dev.info in 2014, between 2006 and 2013, in a population of about 168,134,000, the rate of doctors was 4.1 per 10,000 people; while the rate of nurses and midwives was 16.1 per 10,000 people and rate of Pharmacists was 1.1 per 10,000 people.

Human health resources can consist of clinical and non-clinical staffs responsible for enhancing human health. The performance, benefits and successes of a health care system depends largely on the skills, experience, expertise, and knowledge of individuals who are responsible for healthcare service delivery. In the public and private health sectors, the balance between
workforce supply and the ability of the experts to work efficiently and effectively must be maintained because having practitioners without adequate or sufficient tools is the same as having adequate tools without practitioners.

The Nigerian health system has been faced with a great challenge on its human resources. Nigeria has the largest health work force in Africa, but worthy of note is that there has never been an accurate record of deaths, migrations, retirements of the health workers. This can be corrected using information technology to capture all the details of a health worker accurately.

3.5.1. Factors that may influence the human resources for health in Nigeria

Below are some factors that may influence human resource for health care for Nigeria for this study.

3.5.1.1. Size and Distribution of Health Workers in Nigeria

The size of the population of a country determines mostly the quality of health care delivery services and intervention that will be obtained. The amount of professional health experts also influences the rate of health services and health development of a country. From the rate of health professionals per 10,000 people, it is interesting to note that more health workers bring about quality delivery and vice versa. The few health care workers in Nigeria are unevenly distributed to favor the urban areas at the detriment of the rural areas. Efforts are made to provide more incentives to health workers who volunteer to work in the rural areas, but more work still needs to be done to get more practitioners stay in these rural areas without them feeling isolated or at any disadvantage. Some of these rural health staffing deficiencies are covered by NGOs, religious missions and the National Youth Service Corps members. Working in the rural areas for at least a year can be made as one of the compulsory conditions for getting promotions. (Somoye, 2015).
3.5.1.2. Training of Workforce

The future of work will generally require mechanisms that ensure lifelong learning, flexible education, and training systems that can anticipate the skills demanded by the labor market. It is important to train health workers to enhance their skills and professionalism. Seminars, workshops, education, and in-service training are necessary to equip the health workforce to be prepared to carry out an effective and efficient health care service delivery system. In Nigeria, health workers are trained in different health institutions accredited by the national health bodies.

3.5.1.3. Migration of Health Workers: Globalization

Health is no exception to the globalization of services, as indicated by the increasing presence of multi-national companies in the healthcare sector, as well as the growing, international mobility of health workers. Migration of health professionals is common to all countries as workers migrate to urban areas. Health worker migration, an important feature of global health labor markets, is increasing and becoming more complex. Whereas general push and pull factors such as labor market dynamics are recognized as drivers of migration, perceived better working conditions and higher incomes are among the most common factors driving individual health worker migration. Irrespective of health workers’ motivations, the phenomenon of health workforce migration brings challenges to all national health systems, affecting the origin and destination countries in terms of both equity and efficiency. The effects of health workforce migration on origin and destination countries vary.

In destination countries, concerns include the unsustainability of health systems relying on foreign trained highly skilled health workers and the high costs for health services associated with international recruitment, including language training and induction, as well as failing to
utilize migrant health workers’ skills and knowledge to their full potential because of the lack of recognition of qualifications. In countries of origin, health workforce migration might exacerbate already existing shortages and disparities in health workforce distribution and can lead to increased workloads for the remaining health professionals in understaffed regions and institutions. Some migrant health workers return home, but their reasons for doing so are mixed: this might be, for example, for family reasons, or with the aim of starting a business (Philippines) or to retire (Ghana), so they are not necessarily returning to provide health services.

In Nigeria, many health workers migrate to developed countries with better health facilities and opportunities annually. The reason is multifactorial which includes payment structure, lack of motivation, lack of training, job security and inadequate healthcare management system. These issues must be succinctly addressed for a better healthcare delivery system. (International Labour Office, 2019).

3.5.1.4. Level of Economic Development

The growth rate of health workforce is dependent on the level of economic development of a country. Countries with high GDP (Gross Domestic Product) have greater amount of health workforce because they spend more on them than countries with lower GDP. Nigeria is a country with a low GDP; the more reason why health workers migrate to developed countries. The federal government can amend this by improving other sectors of the economy (like Agriculture) instead of focusing only on oil and tax.

Improving financial performance and operating margins is likely to remain a top issue. Many public and private health systems have been experiencing revenue pressure, rising costs, and stagnating or declining margins for years. The trend is expected to persist, as increasing demand, funding limitations, infrastructure upgrades, and therapeutic and technology
advancements strain already limited financial resources. Combined health care spending in the world’s major regions is expected to reach USD $8.7 trillion by 2020, up from USD $7 trillion in 2015. As has been the case for the past several years, spending is expected to be driven by aging and growing populations, developing market expansion, clinical and technology advances, and rising labor costs (exacerbated by many markets’ competition for health care workers). (Somoye, 2015).

Fig.11. The rapidly rising healthcare costs. Source: World Industry Outlook, Healthcare and Pharmaceuticals, The Economic Intelligence Unit, June 2016

3.5.1.5. Socio-Demographic and Geographical

Socio-demographic features such as ethnic group and socio-economic status are very vital in determining the health systems of a country, whereas geographical factors such as climate and topography would determine how health care services will be delivered. For Nigeria, health facilities should be built in every region of the country without bias. (Somoye, 2015).
3.5.1.6. Technological Advances

The debate surrounding the impact of technology on future work covers a wide spectrum, with some arguing technology will outdate the need for laborers, and others asserting it will create jobs. Research indicates that technological change is non-linear, and will destroy, create, and transform jobs in different phases depending on the ability of societies and institutions to support social dialogue and learning. Technological advances are likely to have a significant impact on health services and ways of working. Technological innovations, such as online and mobile health applications (apps), 3D- and bio-printing, artificial intelligence (AI), block chain, electronic health (health) and mobile health (m-health, involving mobile phones), genomics and proteomics, are already affecting health professionals’ day-to-day work. On a broader level, technological innovations may radically reshape the health sector, as evidenced by the creation of a fully virtual care facility, where healthcare personnel exclusively provide “telehealth” services to patients, whereby medical advice and provision is given remotely through telecommunication technologies.

Technology is increasingly seen as a means in addressing today’s health service challenges, including rising healthcare costs and population growth and ageing. Robotic technology is already being used in nursing care, with Japan leading its implementation. In its “Investments for the Future Strategy 2017”, the Government of Japan outlined its plans to use robots as lifting aids and mobility aids, for bathing and toilet assistance, and in direct nursing-care services. Technologies can also help facilitate care delivery in non-traditional settings, including in the home, and have the potential to improve access to healthcare in rural and remote areas. Unfortunately these services are far from the reach of developing countries like Nigeria.
Additional impacts include improving the delivery of health and disaster management services to poor and remote locations, increasing the transparency and efficiency of governance, integrating related ICT usage into continuing education, and allowing health workers to be trained and kept up to date with the most recent information. Technology has achieved positive impacts in personnel training through simulation techniques, by facilitating access to information via handheld devices, and in online training. New technologies have the potential to improve the prevention of diseases and to encourage patients to be actively involved in monitoring their own health, conditions, and treatment. In the digital age, patient data will be easier to collect and monitor, including remotely, making it possible to improve healthcare delivery in new ways. In some ways this is patient driven and due in large part to the high level of smartphone ownership globally. By 2015, there were 165,000 mobile health apps in circulation, and m-health is increasingly being used for prevention, diagnosis, treatment, and monitoring. As some developments with potential implications for diagnostics and care include cognitive computing, cloud-based interoperable electronic health records, and the “internet of things” (IoT), employers must invest in their employees’ ability to navigate challenges related to data management, data protection compliance, and cyber risks. (International Labour Office, 2019).
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CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1. Introduction

This chapter sets to respond to the questions and understand the causes, the impacts on the sector and the country also examine how it affects other countries which will help us to study how the government of Nigeria have responded and if international communities and organisation have stake in the industrial disharmony that occurs in Nigeria.

In other chapters we have seen how the origin of the Nigeria Health care system affects the stability and continuity of the services rendered, we have also seen the funding and the employment pattern in the industry. Inter-professional rivalry is also seen to cause conflict in this sector and likewise the quest for leadership of the healthcare workforce. The following questions will point us to studies done on this subject. The appendix shows Newspaper clippings which elucidates some of the answers to the questions.

i. What are the causes of industrial disharmony in the Nigerian health sector?

ii. What are the impacts and consequences of industrial disharmony in the Nigerian health sector?

iii. What are the strategies used by the Nigerian government in settling industrial disharmonies in the health sector? How effective have the strategies been in settling the disharmony?

iv. What are the practical ways of ensuring industrial harmony in the future?
4.2. The causes of disharmony in Nigerian health systems

In recent years, there have been frequent reports of conflicts between core health professionals of different disciplines in the workplace as well as conflicts within the same discipline. These conflicts are widespread and dysfunctional, occurring at all levels of healthcare delivery. In extreme cases, violence between cross-disciplinary professionals has been reported.

The Nigerian health system is burdened by rapid population growth, scarcity of skilled health workers, late presentation of patients to hospital and infrastructural decay. These problems, which are nested within a quandary of negative social, economic, and political pressures, are major contributory factors to the country’s poor health indices. (Mayaki et al, 2020). The life expectancy at birth in Nigeria remains at an abysmal 60.87 years and this is 2 decades lower than that of many developed countries and lower than that of our neighbors like Ghana which have a life expectancy of 64.42 years (Macrotrends 2021). Conflict is a dynamic process that can be positive or negative, healthy, or dysfunctional, within a work environment. Conflict is the consequence of experienced or perceived variation in common goals, values, ideas, attitudes, beliefs, feelings, or actions. Conflicts arise for many reasons: it can originate because of competition among professionals and variations in economic and professional values. Scarce resources, poor crafted, poorly defined roles and expectations, the ability to work as a team, interpersonal communication skills, and expectations about level of performance in various nurses’ roles are all sources of conflict in health care organizations. This kind of conflict is not limited to the nursing profession but can be found in all the other health disciplines. (Higazee 2015).

The Nigerian health system has been plagued with numerous healthcare worker strikes (industrial action) at all levels. In the last decade, no sector has been more affected by disputes
and strikes in Nigeria than in the health sector. This year alone, 2021, there have been at least 3 strikes by the NARD, one by JOHESU and one by the MDCAN (see Newspaper clips). Poor staff welfare, low wages and leadership and management inability to implement agreements mutually entered were the common causes of healthcare worker strikes in this study. These industrial actions or “strikes” result in disruption to service delivery and training programmes, increased morbidity and mortality of patients and loss of confidence in the hospitals and the healthcare professions. This in turn leads to late or non-presentation of people to public health institutions and the attendant poor health indices the country is notorious for (Oleribe et al. 2018). Ethical consideration and inter-professional rivalry are the main concern attracting much debate in the health sector.

Workers’ strike or industrial action is defined as “the collective withholding of labor/services by a category of professionals, for the purpose of extracting concessions or benefits, typically for the economic benefits of the strikers. Workers’ strike by any group or unit will therefore have far reaching implication on the progress toward achieving universal health coverage (UHC). It is seen as an essential element in the principle of “collective bargaining,” as some have put it, “collective bargaining without the right to strike amounts to collective begging.” Striking is generally the last resort to solving a problem and occurs when the collective bargaining process makes insufficient inroads, and the unions are not satisfied with the Management’s offer to correct the situation. Strikes are considered a fundamental right and therefore an essential weapon in the armory of organized labor in democratic societies. Some proponents say to deny any group of workers, including “essential workers” the right to strike is akin to enslavement. National constitutions respect these rights. Nigeria is a party to the International Covenant on Social, Economic and Cultural Rights establishing the right to strike. The right to strike for the purposes of collective bargaining is one of the fundamental rights
enshrined in Section 27 of The South African Constitution. The right of workers’ strike is enshrined in most African countries’ legal system with varying clauses. (Nyango et al 2021). Tensions created by incessant strikes in the country have become alarming. This would prompt a discerning mind to enquire for an understanding as to the reasons and causes of industrial conflicts. Though there may be ready answers to this, the following are some of the identified reasons why workers and their unions answer Marx’s clarion call of ‘revolting against capital’.

Adopting a micro theory of conflict, identified the following causes of industrial conflicts: structural-organizational causes; inadequate decision-making power; management policies; intra-organizational policies; interpersonal and personal sources; and procedural sources. However, in addition to identified causes of strikes, the following issues are identified to bring about industrial conflicts and strikes. (Wokoma, 2011).

Lack of harmony and teamwork among health workers have been reported as the greatest factor resulting in unproductive teams. Reports show that there is lack of harmony and teamwork among health professionals in Nigeria. This is traceable to many factors which include, struggle for supremacy of “who is who” and “who is above who” in our hospitals. Self-glorification, superiority, ego, self-realization and feeling of being an island of knowledge are all root causes of disharmony in the Nigerian health sector. Literature and reports from previous studies indicate that harmony among health workers is very vital to improving health indices. Unfortunately, the various trade unions/professional bodies champion the cause of their members rather than that of patients and further divide the health care force, making their service below par. Harmony is an agreement or being in one accord. It is a pleasing combination of elements that makes things successful, while a team is a group of people involved in the same activity or work. However, with harmonious agreement, a group of health professionals involved in the management of patients could accomplish a better patient recovery
outcome. Health professionals in Nigeria include Medical Doctors, Medical Laboratory Scientists, Nurses, Physiotherapists, Radiologists/ Radiographers, Occupational Therapists, Pharmacists, Social care professionals, Cleaners, etc. These are all meant together seamlessly for the benefit of their patients but often don’t. Teamwork cannot be accomplished in the presence of disharmony. Global best practice advocates that patient management through teamwork and harmonious working relationship between health professionals’ results in better patient outcomes. (Uko, 2015).

The key drivers of disharmony and unhealthy rivalry among health professionals in Nigeria include among others, the struggle for the leadership position of health care team, with some health professionals claiming superiority over others; and the disparity in remuneration of cadres and groups of health workers. The problem has been allowed to fester for decades without adequate intervention by policy makers and the government. Over the years, medical doctors have laid claim to the leadership of Federal and State Ministries of Health, as well as other health institutions/agencies. It is also believed that the status of “consultant” is the exclusive preserve of doctors to which other core health professionals and non-medical health professionals cannot aspire to in the health sector. Furthermore, evidence suggests that there is wide disparity in the remuneration of health workers of the same grade level across the federal, state, and local governments, as well as in the remuneration of health workers of different professions. In addition to this, there is a widespread belief among other health professionals, that the Nigerian health system is designed to favor medical doctors, who due to their perceived authority over other health professionals continue to dominate (Alubo & Hunduh 2016). The Joint Health Sector Union (JOHESU) and other bodies like Medical and Health Workers Union of Nigeria (MHWUN) was set up to challenge this perceived or real dominance. The medical, non-medical health professional dichotomy has been a major hindrance to the effective delivery
of health services and the development of the health system. For this reason, health services are often disrupted because of this battle for supremacy. (Aregbesola, 2018).

The appreciation of the meaning of the concept of global best practices in industrial relations and its obligations by medical and non-medical professionals has continue to generate intractable and intense furor between and among medical and non-medical professionals in government owned hospitals in Nigeria. This development has been identified by several pundits as a critical cog to the Herculean and patriotic obligation of medical and non-medical professionals pledge to always redeem their oath of fidelity with the much-cherished Hippocratic Oath; for example, placing dignity of human life above every personal or altruistic consideration by every professional in the inter-territorial task of health promotion is vital.

The old and new media are consistently awash with the unequivocal reservation of Non-Medical Associations in the Nigerian health sector through the Joint Health Sector Union (JOHESU) on the propriety of the officially sanctioned dominance of Physicians above other professionals, despite the inter-territorial nature of the Hospital. Osakede & Ijamakinwa (2014) contend that “Nigeria healthcare sector has been rocked by strikes and near misses, since 1991 till date. Healthcare workers across the country have engaged or threatened various forms of strike action. According to the “Nigeria Health Watch”, on online medical blog, the Federal Teaching Hospital, Ido-Ekiti was crippled for about Four Months (July 2014-October 2015). In 2015, the University College Hospital, Ibadan and Ladoke Akintola University of Technology, Ogbomosho were paralyzed for four and five months respectively. In LUTH between 2015 and 2018 there were more than 12 months of cumulative periods of strikes, some by resident doctors, some by nurses, some by JOHESU, etc. (Olushola and Oludare, 2017). The Nigerian health care has suffered several down-falls. Despite Nigerian's strategic position in Africa, the country is greatly underserved in the health care sphere. Health facilities (health
centers, personnel, and medical equipment) are inadequate in this country, especially in rural areas. While various reforms have been put forward by the Nigerian government to address the wide-ranging issues in the health care system, they are yet to be implemented at the state and local government area levels.

According to the 2009 communiqué of the Nigerian national health conference, health care system remains weak as evidenced by lack of coordination, fragmentation of services, dearth of resources, including drug and supplies, inadequate and decaying infrastructure, inequity in resource distribution, and access to care and very deplorable quality of care. The communiqué further outlined the lack of clarity of roles and responsibilities among the different levels of government to have compounded the situation. Unarguably, problems in the health care system of any country abound to a certain extent. Although health has the potential to attract considerable political attention, the amount of attention it receives varies from place to place. The Nigerian health care sector has had to contend with several infectious disease outbreaks and mass chemical poisoning for several years. Hence, there is immense need to tackle the problem. (Menizibeya, 2011). Over the years however, obvious rivalries have occurred between other health professionals and doctors such as those between Anesthetists and Anesthetic Nurses, between Ophthalmologists and Opticians and Radiologists and Radiographers in the sector, but increased lately, is the rivalry that is presently on-going between Pathologists (Doctors in training and Consultants Doctors) and Medical Laboratory Scientists over the activities in hospital laboratories. This battle for supremacy between these two professional giants has resulted in incessant industrial strike actions and numerous lawsuits filed against Pathologists in some tertiary hospitals at the National Industrial Court. There have also been cases of physical harassment between members of the two parties over the affairs of the laboratory in some tertiary hospitals in the country (Oluyemi & Adejoke, 2020). It has
relived their rivalry on the implications of availing non-medical professionals the privilege of a government sponsored and supported residency training programme to attain the status of consultants in their areas of specialty like physicians. A whooping percentage of sampled and interviewed physicians disagreed. Interviewed physicians were of the view that the policy will make hospitals chaotic. The nonmedical professionals in the study’s universe were largely of the view that allowing them to train to become consultants would boost their self-esteem, career prospect and mitigate the burden and pressure on the grossly limited number of physicians in the country. (Moka & Ajijola 2017).

The study conducted by Okonta & Okonta (2017) examined the perspective of a major team player in the recurrent strikes in the country: resident doctors. The study was to find out what their main grievances were. They found out that the perception of most residents attributed these strikes to the following factors: administrative lapses, poor welfare packages, non-payment, or delay in the payment of salaries and believed that prompt attention to these would through dialogue and institution of committees to investigate their plight would obviate most strikes.

According to Nyango and Mutihir, (2021) they identified the agitators and trend of workers’ strike in a tertiary institution. It shows that 13.2% of the working period was interrupted by worker’s strike. This agrees with the previous studies which show that workers’ strikes severely disrupt the provision of health-care services with significant social, political, organizational, and financial implications. They further found that non-doctors accounted for over half (58.1%) of the duration of the strike suggesting an inter-professional rivalry [Figures 12]. This finding is in line with studies showing that struggle by different professional bodies to improve their social and political position within the society is a motivator for strike actions. Another
An important finding in this study is the fact that resident doctors were the main agitators among doctors, accounting for 45.2% of the total period.

![Distribution of strike action by professional bodies. Source: (Nyango and Mutihir, 2021)](image1)

Fig. 12. Distribution of strike action by professional bodies. Source: (Nyango and Mutihir, 2021)

![Distribution of Industrial Actions by months of the year. Source: (Nyango and Mutihir, 2021)](image2)

Fig. 13. Distribution of Industrial Actions by months of the year. Source: (Nyango and Mutihir, 2021).
This may suggest challenges with support for their training program not necessarily about compensation package. This agrees with findings which shows that strike actions are sometimes used to pressure governments to change policies that affect working conditions. This may be related to findings from advanced capitalist societies including the United States which show a paradigm shift in the role of doctors from medical practice based on benevolent paternalism, to consumer rights and managed healthcare. The factors driving this change have been ascribed to “the complex corporate environment coupled with the stress of high malpractice rates, the struggle for reimbursement, administrative duties, and the general risks and burden of solo to small group practice. (Nyango & Mutihir, 2021)

A total of 42 strike actions, about 2 strikes/year. The trend shows a multi-modal pattern, with the highest peak of 5 strikes in 2004 and 2013 [Figure 14].

Figure 14. Trend of strike actions by health workers. (Nyango and Mutihir, 2021).

There were cumulatively 58.5 months of strikes out of the 442 months of the period of study, giving a percentage of 13.2%. While doctors had more frequent strikes (52.3%), non-doctors under the umbrella of Joint Health Sector Union and nurse/midwives accounted for over half
of doctors’ strike accounting for about half (45.2%) of the total period, while NMA accounted for only 3 (9.4%) [Figure 15]. Most strike actions occur at the end of the year, with spill over into the first quarter of the following year [Figure 13]. (Nyango & Mutihir, 2021).

The desire for divergent objectives, aspirations, and importance by an individual or groups of individuals within a given society often leads to the idea of widespread conflicts in all aspect of human existence. Though, conflict is generally believed to be extraordinarily dysfunctional, destructive, unpleasant, and abnormal situation, it is equally seen as an avenue for constructive occurrence if handled in a positive manner. However, the concept of conflict has been understood by various scholars in various context denoting different meaning. Conflict is an association existing between individuals or group of individuals constituting a social unit who may have believed of possessing conflicting goals. Another school of thought viewed conflict as a means through which individuals express their anger, disagreement, and unsatisfied needs with perceived organizational benefits. It was averred conflict is a means through which issues originating from differing interest as well as issues relating to social stability are being resolved. Industrial conflict as opined as the inability to reach an agreement between employers and employees or their unions over terms of industrial relations, without the considering if the lack of such ability will result into negative industrial actions or not. Similarly, industrial conflict is seen as the total manifestation of anger displayed by service unions, especially those involved in wage agreement with the motive of making better bargain. Though, conflicts are expressed in different forms in the workplace ranging from absenteeism, sabotage, work to rule, organizational unrest, as well as strikes and lockout, the most widely exhibited form of conflict existing in the work organization is strike. (Elenwo & Ignatius).
Strikes have remained common occurrences in Nigeria as there are local, state, regional and sometimes national industrial action on a regular basis. A recent review shows that between April 2016 and April 2017, there were at least 17 different strike actions in Nigeria involving public workers. Of the 17 documented and reported strike actions, six were primarily within the healthcare sector. Also, apart from two national industrial actions, Nigeria Union of Petroleum and Natural Gas Workers (NUPENG) and Nigerian Union of Allied Health Professionals strikes, the rest occurred in the southern region of Nigeria. (Oleribe et al).
The Tab. 1 below shows the number of strikes, institutions/sectors, and dates

<table>
<thead>
<tr>
<th>S/N</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>All Imo State Doctors</td>
<td>February 2016</td>
</tr>
<tr>
<td>2.</td>
<td>Imo State University</td>
<td>March 2016</td>
</tr>
<tr>
<td>4.</td>
<td>University of Lagos</td>
<td>April 2016</td>
</tr>
<tr>
<td>5.</td>
<td>Adekunle Ajasin University, Akungba-Akoko (AAUA)</td>
<td>April 2016</td>
</tr>
<tr>
<td>6.</td>
<td>University of Ibadan</td>
<td>April 2016</td>
</tr>
<tr>
<td>7.</td>
<td>Obafemi Awolowo University</td>
<td>June 2016</td>
</tr>
<tr>
<td>8.</td>
<td>Federal Medical Centre, Ondo</td>
<td>Mid 2016</td>
</tr>
<tr>
<td>9.</td>
<td>Ladoke Akintola University</td>
<td>June 2016</td>
</tr>
<tr>
<td>10.</td>
<td>Federal University of Agriculture, Abeokuta</td>
<td>August 2016</td>
</tr>
<tr>
<td>11.</td>
<td>Ebonyi State University</td>
<td>October 2016</td>
</tr>
<tr>
<td>13.</td>
<td>Nigeria Union of Petroleum and Natural Gas and PENGASSAN</td>
<td>January 2017</td>
</tr>
<tr>
<td>14.</td>
<td>National Orthopaedic Hospital, Igbobi, Lagos (NOHIL)</td>
<td>March 2017</td>
</tr>
<tr>
<td>15.</td>
<td>Nigerian Union of Allied Health Professionals (dental therapists, medical physicists, health information officers, clinical psychologists, and medical social workers)</td>
<td>March 2017</td>
</tr>
<tr>
<td>16.</td>
<td>Federal Medical Centre, Yenagoa</td>
<td>May 2017</td>
</tr>
<tr>
<td>17.</td>
<td>Benue State University Teaching Hospital Joint Health Sector Union (JOHESU) chapter</td>
<td>May 2017</td>
</tr>
</tbody>
</table>

4.3. The impacts and consequences of industrial disharmony in the Nigerian health systems

The consequences of strikes on the healthcare system are enormous. As health workers’ strikes continue to be seen and accepted as normal behaviour in the Nigerian health sector, we decided to study the characteristics of health workers’ industrial action in Nigeria. These strikes have negatively impacted on the healthcare system, leading to several avoidable deaths, complications, and outgoing medical tourism, as the wealthy seek health services abroad. The impact of these strikes is worst when they occur at periods of national health emergencies such as the Ebola viral disease outbreak a few years ago, the more recent Lassa fever or cholera outbreaks or even man-made emergencies like Boko Haram suicide bombings with mass casualties. Reasons abound why healthcare workers go on strike in true underlying causes of industrial action in Nigeria, and these include career stagnation, perceived discriminatory policies and demoralization from working in systems with poor infrastructure, manpower shortages, poor personal remuneration and poor retirement or pensions benefits. However, in recent times, there has been a division of opinion on pinpointing the true underlying causes of industrial action. (Oleribe et al, 2016). The incessant stoppage of work owing to industrial conflicts has a lot of socioeconomic effects on the development of Nigeria. No matter the logic behind strike actions, it is obvious that there are attendant socio-economic misfortunes. While to an economist, strike causes economic fracture, which has serious negative economic consequences, to a sociologist, strike causes a dislocation in the sociological importance of work as well as the socialization process. Economically, strikes and other forms of industrial conflict and work stoppages obliterate the desired growth and development in the economy. This effect is twofold: while it hinders national productivity, it on the other hand, scares away the needed foreign investment as a strike ridden industry holds no allure to local and foreign investors. Human productivity is an important index in calculating national productivity. This
is because it is the human element that transforms all other resources toward achieving an increased national productivity. However, trade disputes and conflicts instigate work stoppages, which result in man-days lost. Thus, when labor productivity depreciates, in form of man-days lost, it automatically results to a reduction and loss in productivity which affects the nation’s Gross Domestic Product (GDP) as well as the Gross National Product (GNP).

Incessant strikes reflect the unhealthy nature and structure of our industrial society. Thus, local, and foreign investors are scared away, and are not encouraged to invest in an environment of unstable industrial peace and harmony, where their return on investment will be distorted because of strikes and work stoppages. Sociologically, industrial conflicts, strikes and work stoppages have serious consequences. Foremost, we need to understand that work is a fundamental connection among humans, creating the basis for social integration. Grounded on the demonstrable societal significance of work as an elementary human condition, and as a principal means to fashion and preserve mores (socialization), we could concur therefore that: beyond the mere provision of income to cover basic needs, it is through the social bonding of work which links individuals to society, gives them social standing and status, serves as a basis for the construction of their personal identity. Given our cultural heritage, work is for most an existential necessity, providing livelihood and meaning in life. (Wokoma, 2011).

Respondents also cited disruption of patient care (96.7 %) as the most common implication of health worker strikes in Nigeria. Perceived consequences and reasons for further discontent were high referral rates to private hospitals (66.0 %), patient loss to follow-up (56.0 %), mismanagement by alternative healers and high private hospital costs (17.3 %). Other common effects of strikes by healthcare workers on patients and healthcare systems cited by the respondents were an increase in financial burden on patients; increased morbidity and mortality, especially amongst the poor; collapse of publicly funded health facilities; loss of confidence in the health system; unequal access to quality medical care; emigration of qualified
health workers; increased spread of contagious diseases; and negative impact on national productivity (Oleribe et al, 2016).

4.4. The incidence and consequences (indicators and outcomes) of “strike actions” in the healthcare sector in Nigeria

Doctor and healthcare worker strikes have become a global phenomenon with increasing incidence in many countries and the potential to impact negatively on the quality of healthcare service delivery and the doctor-patient relationship which is based primarily on the fiduciary duty of trust. Health care worker not limited to any society, group, or country regardless of their level of socio-economic development. In most democratic societies, strikes are a legitimate part of collective bargaining during labor negotiations. Doctor and Health care worker strikes have been reported in highly developed countries such as USA, UK, New Zealand, Germany, and France. Also, in less developed countries such as Nigeria, Malawi, and Zambia to name but a few. These strikes occur globally, it appears the impact of strikes are more severely felt in less developed countries because of the poorer socio-economic circumstances and embedded infrastructural deficiencies. Such countries are generally confronted by issues of inadequate manpower, poor wages and working conditions, poor organizational ethics, and lack of viable alternative means of obtaining healthcare for the general population, thereby fulfilling the international criteria for vulnerability as defined by UNAIDS and other authorities. (Osakede & Ijimakinwa, 2014).

It is pertinent to observe that there is paradigm shift in the organization of healthcare services and doctors’ employment options in Nigeria with a change in the role of doctors from self-employment, and medical practice based on benevolent paternalism, to consumer rights and managed healthcare. Historically, doctors had the sole responsibility within the doctor-patient relationship, to determine the costs of medical care to their patients, however, current trends
show that doctors are increasingly becoming employees of managed healthcare organizations (HCOs) or employees of public health services. These changes in physician’s practices and methods of payment may impact on patient trust, physician behavior and decision-making, thereby permanently altering the doctor-patient relationship was noted that in advanced capitalist societies like the United States, that there is an on-going shift in doctors practice options from self-employment as owners of their own practices, to doctors becoming employees of HCOs in a managed healthcare environment. (Osakede, K.O & Ijimakinwa, S.A, 2014).

The factors driving this sea change in physicians’ employment options have been ascribed to “the complex corporate environment coupled with the stress of high malpractice rates, the struggle for reimbursement, administrative duties and the general risks and burden of solo to small group practice”. One can therefore anticipate that soon there could be more wage negotiations and collective bargaining between doctors as employees and the employing HCOs. This will be like the practice in systems where medicine is centralized or socialized, and where doctors. (Osakede, KO & Ijimakinwa, SA, 2014).

4.4.1. Service Delivery Impacts

Skeletal services are carried during this period and in the case of a major disaster or disease outbreak these services would suboptimal. Patients are unable to access healthcare services leading to poor patient care and long suffering. Patients suffer as the needed care and attention are denied specialist attention and beneficial departmental activities are stalled/cancelled, leading to the disruption in service rendition. (Anyinka 2014). However, for some professional groups, including health workers, strikes might have implications beyond the involved parties. Health workers’ strikes has been purported as putting patients at risk of serious harm and
potentially contradict health workers’ duties to care for their patients and evidence from high income settings shows that nurses’ strikes can affect hospital mortality data. (Bull World Health Organ 2019). Dilapidated health care systems compounded with have facilitated medical tourism, for instance, leading to over 5000 people leaving Nigeria every month for various forms of treatment abroad and about 1.2 billion US dollars lost from the Nigerian economy to medical tourism yearly. Moreover, the health workers in Nigeria are poorly distributed in favor of urban areas, southern zones, secondary and tertiary health care facilities. This inequitable distribution of skilled birth attendants is very apparent in the northern parts of the country and primary health care facilities in rural areas. (Susa, 2020).

4.4.2. Morbidity and Mortality Impacts
The disruption of services results in prolonged morbidity and poor prognosis, eventually, lives are lost. Increased morbidity and mortality are particularly easily seen in maternal and child health, HIV and AIDS, Hepatitis infections, cancers and other morbidities leading to co-morbidities, overall increase in mortality and morbidity. These amount to increase in medical bills, as patients seek care in private facilities and for patients who cannot afford private facility bills, they may end up dying. (Anyinka 2014).

4.4.3 Institutional Impacts
The funds meant for public institutions end up in private and/or foreign hospitals there by leading to reduced revenue generation by the hospitals. Loss of confidence in the health care system build by these industrial actions weaken the health care system and constantly drag the system backwards also impacting negative effects on the productivity of the affected institution(s). This increases distrust of the public health system by the often-traumatized public because of dissatisfaction of clients/patients. Conflicts between employees and management
can ensue because of lack of skills on the employees due to the lack or little exposure of various diseases during the training programmes of residents and the gap in the expertise thereby reducing internally generated revenue. Disruption in key health services including immunization and Prevention of Mother-to-child Transmission of HIV (PMTCT) services, these services entail continue care and treatment to avoid complications and even death. Leading to low productivity. For the who can afford travelling abroad for medical services, will do so, this forward draining funds and expertise due to lack of confidence in the health delivery system. (Anyinka 2014).

4.4.4. Professional Impacts

Decent work is fundamental to ensuring effective and resilient health systems and to achieving equal access to quality healthcare. For example, improving working conditions through safe staffing approaches such as appropriate health worker to patient ratios, also improves patient comes. However, workers in these forms of employment tend to be more exposed to decent work deficits, including job insecurity, lower pay, social protection gaps, and increased health and safety risks. They often have more limited organizing capacities and collective bargaining power, impacting fundamental principles and rights at work and restricting opportunities for meaningful social dialogue in the sector. (International Labour Office, (2019). Loss of dignity and respect for the medical professionals across board because they are seen wanting and always asking for increase in salaries and wages, funding of the residency programmes for the doctors and fight for leadership positions between the doctors and the allied health staff, JOHESU. Poor public perception of medical personnel is leading to a surge of quacks in the sector and all practicing for medical gain but not for patients benefit. Unhappy doctors and other medical professionals seek greener pastures outside the shores of the country leading to
brain drain. Reduced efficiency of human and material resources and unhealthy inter- and intra-
health workers relationships.

4.4.5. Healthcare Outcomes Impacts

Distortions of patient care outcome parameters (both clinical and patient satisfaction) will be
less achieved. (Anyinka 2014). Healthcare outcomes improvement cannot happen without
effective outcomes measurement. In the healthcare industry’s administrative and regulatory
complexities, and the fact that health systems measure and report on hundreds of outcomes
annually. Reviewing the top seven outcome measures, will include definitions, important
nuances, and real-life examples. The top seven categories of outcome measures are:

4.4.5.1. Mortality: Mortality is an essential population health outcome measure and Nigeria
has one of the highest maternal mortality rates (814/100,000 live births Ope BW 2020), infant
mortality is 14th highest in the world (58.23/1000 Varrella S 2021, O’Neill 2021) and neonatal
mortality (35.9/1000).

4.4.5.2. Readmissions: Readmission following hospitalization is a common outcome measure.
Readmission is costly (and often preventable). During strikes patients are often hurriedly
discharged. They are readmitted after the strike and usually in the worse state. Unfortunately,
the country has few data on impact of readmission. In fact, researchers estimate that in one year
in the US, cost between $25 to $45 billion is spent on avoidable complications and unnecessary
hospital readmissions. After increasing efforts to reduce their hospital readmission rate, the
University of Texas Medical Branch (UTMB) saw a 14.5 percent relative reduction in their 30-
day all-cause readmission rate, resulting in $1.9 million in cost avoidance. UTMB reduced their
hospital readmission rate by implementing several care coordination programs and leveraging
their analytics platform and advanced analytics applications to improve the accuracy and timeliness of data for informing decision making and monitoring performance.

**4.4.5.3. Safety of care:** Safety of care outcome measures pertain to medical mistakes, in diagnosing, medication, in its entire process. Reduction in the workforce of medical professionals will lead to clinician and staff burnout, which will further impact more burden on the very volatile system. The delegation of these duties will bring about management issue with the employers.

**4.4.5.4. Effectiveness of care**

Effectiveness of care outcome measures evaluate two things:

2. Achieved outcomes (e.g., lower readmission rates for heart failure patients).

The rapid changes that occur within healthcare ensures best practice care guidelines are current is critical for achieving the best care outcomes. It is important to track clinician compliance with care guidelines as well. It is equally important to monitor treatment outcomes and alert clinicians when care guidelines need to be reviewed.

**4.4.5.5. Patient experience:** Patient-reported outcome measures (PROMs) fall within the patient experience outcome measure category. According to the Agency for Clinical Innovation (ACI), a US based agency PROMs saw the assessment of patient’s experience and perception of their healthcare to provide a more realistic gauge of patient satisfaction as well as real-time information for local service improvement and to enable a more rapid response to identified issues. An example is a patient might be asked to complete a satisfaction survey (on a scale of
1-5) about the care they received. Patient experience may also be used as a balance metric for improvement work.

4.4.5.6. **Timeliness of care:** Timeliness of care outcome measures assess as the patient access to care. Overcrowding in the emergency department has been associated with increased inpatient mortality, increased length of stay, and increased costs for admitted patients, as care is delayed, and health deteriorates.

4.4.5.7. **Efficient use of medical imaging:** The efficient use of medical imaging is an increasingly important outcome measure. According to the European Science Foundation, the medical imaging plays a central role in the global healthcare system as it contributes to improved patient outcome and more cost-efficient healthcare in all major disease entities. (Tinker, 2016).

4.4.6. **Governmental Impacts**

Government agencies responsible for dialogue, resolution of strike actions respond to the needs of aggrieved healthcare workers only when it is in their favor or to avert unpopularity or general unrest or when an external concern about the subject of the disharmony is brought to international attention. When the government does not support or help in developing the healthcare system, it has failed in its key function, therefore, incessant disharmony/ industrial actions in the healthcare sector. (Epundu et al, 2017).

Medical tourism: The practice of medical tourism dates back thousands of years. In ancient times, thousands flocked to the Greek healing temples dedicated to the Greek gods Asclepius, Delphi, and Zeus. Medical tourism, the phenomenon of leaving one’s home country to obtain medical care in another, often incorporating a period of sightseeing during recovery has gained
popularity in recent times. However, in recent times, it is a fast growing, lucrative industry, grossing about 60 billion United States (US) dollars annually. (Epundu et al., 2017). Its growth has been linked to globalization, economic development, and acceptance of health services as a market commodity. Medical tourism is fast assuming a global competitive dimension. During the 20th century, people from developing countries travelled to developed countries to obtain health care that was unavailable in their own countries. (Newspaper clips). This is gradually giving way to the 21st-century trend where individuals from developed nations travel to developing nations to access health care. Nigeria is not known to be a tourist destination for healthcare but serves as an important source country to destination countries such as India, Turkey, South Africa, United States, United Kingdom, Saudi Arabia, and Germany, with many Nigerian medical tourists sourcing services such as orthopedic surgery, oncology, and cardiology. (Epundu et al., 2017).

India is widely renowned for her prowess in nephrology, oncology, orthopedic, neural, and cardiac surgery. In 2013, there were 34,522 Nigerian tourists to India, out of which 42.4% were medical tourists. The Indian High Commission in Nigeria estimated that in 2012, Nigerians spent about 260 million US dollars on medical bills in India. Many of these tourists are attracted by the high-class, modern health care facilities, availability of skilled health professionals and the wide variety of complex medical procedures, friendly climate, and lower treatment costs relative to Western countries. These factors made it possible for the efflux for such patients. Factors for this include poor infrastructure, outdated equipment and technology, lopsided staff mix in many of Nigeria’s public health institutions and poor knowledge about the few existing private multi specialist hospitals. These have culminated in lack of confidence in the nation’s public health care system and have, in turn, led to an ever-increasing number of outbound medical tourists from Nigeria. Government health spending is poor, valued at 5% of the
nation’s Gross Domestic Product in 2012; very different from the Abuja Declaration recommendation of 15%. This has contributed to infrastructural decay in hospitals. Disgruntled health workers, in seeking redress resort to recurrent strike actions leading to poor quality services in most of the public state and tertiary health institutions. (Epundu et al, 2017).

The effects of medical tourism weigh heavy on both source and destination countries. When high-income patients leave a country, it leads to a reduction in revenue for sustaining the country’s local health services. Losses of such clients also reduce the pressure to invest in certain beneficial health technologies, as well as reduce political support for developing the health system of the country. This, in turn, has led to a sense of distrust in the populace of the public health system. Individuals who can afford to, leave for other countries such as India, taking with them the much-needed income for the country. Some tourists return to their countries with medical complications or multiple births arising from fertility treatment abroad. The cost of treating these complications and/or managing these births is enormous. For others who can barely afford to pay, yet require specialized treatment, travelling abroad is a life-saving necessity, which leads to catastrophic or impoverishing health expenditure. Loss of health manpower due to immigration not only leads to a worsening of the health services of the country; it is also a loss of the funds used in training these workers. (Epundu et al, 2017).

4.4.7. The Training Program of Medical Professionals

Training doctors in health management and leadership towards building skilled physician leaders is a strategy that is long overdue in Nigeria. Health workers need to be reminded of their respective professional and ethical oaths which places the patients’ need before their own. This is important for the global move towards a more patient-centered approach to the delivery of health services. The Federal Government also must respect agreements made with the
management of healthcare institutions. (Susa, 2020). Residents especially in clinical
departments, do not get to do enough procedures to meet the requirement of the various clinical
training colleges in good time. Poor performances in postgraduate examinations which are
multifactorial accompanied with huge financial losses. Overcrowded classrooms, poor
amenities, too many distractions for medical students and lack of essential equipment for skill
acquisition. Delayed clinical posting of medical students leading to overstay in the university,
also the incessant and very prolonged “strike actions” by the Academic Staff Union of
Universities (ASUU) and the Non-academic Staff Union (NASU), has caused a lot of
disruptions in academic calendar of the universities.

The future of work will generally require mechanisms that ensure lifelong learning, flexible
education, and training systems that can anticipate the skills demanded by the labor market.
The transformations in work driven by new technologies mean that education and training will
have to better prepare health workers for their new tasks and roles. Investment in continuous
skills development will be critical to ensure that technologies and AI are properly supervised
and managed, and do not add to the workload of health workers. It will be essential to analyses
those tasks that may be automated in the future, and to identify those that will continue to
require hands-on human expertise. Education and training in the health professions will most
likely be influenced by the larger factors shaping the future of work, characterized by a
continuous decrease in the need for physical and manual labor and basic cognitive skills. Due
to these factors and the growing importance of Artificial Intelligence (AI), it is expected that
the relative weight of certain skills will grow in value. This includes interpersonal and soft
skills like communication, social and emotional skills, higher cognitive and technological
skills, as well as teamwork and team-building abilities. The changing relationship between
patients and health workers due to technological advances will require tailored training related to social media, and education through simulation training. (International Labour Office, 2019).

4.4.8. Disruption of Research Activities

There is also the challenge of poor funding, obsolete teaching methods and facilities, inadequate funding of the health sector. Poor health system funding is the lack of government interest in the sector. As say above, the Government of Nigeria will only fund beneficial projects or sectors, with medical tourism in place, they care less for the sector. Lack of sponsorship for research in tertiary institutions. The major deficiencies are lack of investigative materials. (Oleribe et al).

4.4.9. Capital Flight

The health system financing is an important part of the building blocks of health system because without finance, nothing can be achieved. They allocate these funds to all levels of government units and subunits under them and assess how these funds have been utilized to better the health of the citizens. The governments of countries should cater for the healthcare by spending on the health of its citizens, though, this is a question that is often done differently by the different countries based on their economy and imposed by healthcare challenges. As a country increases in population, increase in health care funding will have to be allocated for in the annual budget to cater for the increased demand on services. Funding health care is a major challenge for every country due to increase in birth rate, increased life expectancy, immigration of foreigners, obsolete technological equipment, natural disasters, and exposures etc. In Nigeria, financing health care is through revenue from taxes, out of pockets payments, health insurance and funding by donors. Financing health care in Nigeria has constantly faced so many challenges forcing out of pockets payment to increase while the poor who do not have the
money to pay for proper health care suffer a great loss, even death. (Giuliano Russo, Lihui Xu, James Campbell et al, 2019). According to Knoema database of 2018, out of pocket expenditure on health bill is 76.6%, in Nigeria which is in the third place in the world.

In 2001, the government of Nigeria signed the Abuja Declaration which was to encourage them allocate about 15% of the total national budget to health but in 2013, over a decade later only 5.6% of the total budget was allocated to health at the federal level and successive budgets have all hovered around 4-6% even during the COVID pandemic. The low allocation on budget is the major cause, why Nigeria has a low performance of health care delivery in Africa. Most of the resources of the government of Nigeria come from the oil revenue which is shared according to an allocation formula among the federal, state, and local governments. The state and local governments can spend their own allocation of the funds, without any supervision or monitoring from the federal government. This results into non-accountability on health expenditures by both the state and local governments which should be tackled if the Nigerian government want to have an impact on the health of the citizens. (Somoye, 2015).
4.5. The strategies used by the Nigerian government in settling industrial disharmonies in the health sector and how effective these strategies have been in settling the disharmony

A newspaper review with the guardian Nigeria by health worker, Josiah the JOHESU spokesperson said the following the two months old NARD National Strike which started in August 2021, “In time past, sealing a memorandum of understanding with employers of labor was enough for industrial unions to suspend industrial action. But not anymore as the partial or non-implementation of such agreements is fast becoming a major threat to stability in workplaces. While this new trend of ‘labor maladministration’ on the part of the Federal Government is not limited to any sector, it is more visible in the health and education sectors”.

The review went on site the ineffective management by the government as the government rushes into signing agreements and not keeping its part, went on to say, “Incidentally, the two sectors have witnessed more industrial actions than any sector of the Nigerian economy. Again, the two sectors are categorized as ‘social sector’ because of the benefits they offer to the people. Therefore, a few days of strike by hospitals and education institutions are immediately felt because the sectors render social services that affect the everyday lives of the people. This, perhaps, is the reason government rushes into agreements to ensure smooth operations in the sectors even when implementing such agreements could be cumbersome. While the Academic Staff Union of Universities (ASUU) has consistently lampooned the Federal Government for reneging on agreements and threatened to go on strike, members of the National Association of Resident Doctors (NARD) have remained out of work due to the non-implementation of the agreement by the Federal Government”. (Olayinka C, 2021).
The decline in the quality of public healthcare delivery and infrastructure in Nigeria is evident. This assessment is apt given the efforts of various agencies (governmental and non-governmental) which have yielded marginal successes, especially in terms of the relatively low access to basic health services. Public healthcare workers have over the years, engaged in recurring negotiations with government at different levels to bring about necessary and important reforms to the public health sector. The results have however been inconsistent in terms of implementation at the State and Local government levels. Available evidence also reveals that Nigeria’s public health sector is still relatively weak, majorly because of the lack of coordination and integration amongst the human and material resources attributable to this sector. It is this impractical and unproductive situation that underpins the need to construe and appraise the specifics of a pattern that is synonymous with collective bargaining in the Nigerian public health sector. This inquiry becomes complex but necessary considering the series of engagements that have occurred at different periods amongst the stakeholders, as well as the various agreements that have resulted. In effect, the outcomes of previous negotiations bring to the fore the divergence in policies and practices as it relates to the sanctity of the collective bargaining process.

The idea of collective bargaining is almost as old as the formal employment relationship. There are diverse definitions of the concept in terms of its structure and content. Flanders defined collective bargaining as a method of settling the terms and conditions of employment; it culminates in a final agreement which has a regulative attribute and limits the employer’s freedom of action to the issues covered by the collective agreement. The concept can also be viewed in terms of negotiation, interpretation and administration of an agreement derived from a bilateral or multilateral engagement. There are various theories connected with the process of collective bargaining and each lays emphasis on different aspects of the process. The diversity in different models lends credence to the flexibility and practical relevance of
collective bargaining to different sectors of the operating environment. The result of any collective bargaining process is a consensual and collective agreement. The relevance of the bargaining process depends on the legal effect of the agreement that has been concluded between or amongst the involved parties. The game theory and the group theory are also at play in the bargaining process as the proportion of funds allocated to health sector in Nigeria rarely changes hence there is struggle for the fixed resources when it comes to remuneration. (Oyewunmi and Oyewunmi, 2014).

A theory is a body of reasoned supposition submitted to offer explanations to ideas, issues, or hypothetical propositions. In view of this, it is pertinent to attempt a theoretical exploration as to the incidence of industrial conflict especially within the Nigerian environment. In doing so, this study borrows from the Unitary and Radical/Marxist theories of industrial relations.

4.5.1. Unitary theory

This theory identifies an organisation as comprising of groups of individuals who have and share same goals, and work as members of one team. The unitary view recognizes an organisation as one big happy family. Unitarists view the enterprise as a unitary system with one source of authority – Management, and one focus of loyalty – labor. This simplistic theory is far from the reality on aground as management and labour rarely have the same goals. (Oleribe et al, 2016).

4.5.2 Marxian (conflict) theory

In view of the inherent weakness of the unitary theory in recognizing that an organisation consists of people who have often conflicting interests, the Marxists theorized that conflict is an inherent characteristic of the society. This view of industrial relations looks at the nature of
the capitalist society, where there is a fundamental division of interest between labor and capital and sees workplace relations against this background. The conflict theory is embedded in the works and ideas of Karl Marx. This theory explains that conflict is inevitable and stems from inequalities of power and economic wealth inherent in a capitalist economy or society. In the Marxist analysis, conflict is attributable to an enduring power struggle between workers and their employers over the control of various aspects of work. (Oleribe et al, 2016).

4.5.3. Collective Bargaining

Collective bargaining and the consequential collective agreement have diverging implications for the broader economic context, and this informs why the settlement of disputes at the workplace has been captured in various academic papers and texts. The impact of collective bargaining may vary because of the complex and evolving nature of different societies, however the process of collective bargaining, where applicable, has the capacity to produce identifiable and tangible results. Collective bargaining is synonymous with the employment relationship in Nigeria’s public sector. This is evidenced by the existence of several trade unions and professional bodies vested with the primary objective of protecting the interests of the workers that they represent. The first concerted collective bargaining that resulted in a wage increase was pioneered by Nigerian Civil Service Union in 1960. The initial post-independence period was characterized by the tussle between emerging trade unions and employers who did not accept collective bargaining, and the arrest of union leaders by the ruling military class of the period. The 1970s was characterized by the emergence of several trade unions, however the seizure of power by late General Sani Abacha in 1993 led to the proscription of union activities. Consequently, the military Provisional Ruling Council (PRC) decreed the abrogation of workers’ right to collective bargaining in both public and private sectors of the economy. In 1997, Nigeria’s Federal Government restored collective bargaining rights to all employees in
both the public and private sectors with the aim of incorporating principles of industrial relations law and practice. (Oyewunmi and Oyewunmi, 2014).

Workers often resort to strike so that the employer would recognize them as a union and thus, make them parties in collective bargaining. This is perhaps, the most singular reason why labor embarks on strike actions. Unconducive working environment, inadequate pay packages, poor welfare services, etc., are some plights of the workers that spur them to strike. For example, in 2010, medical doctors in Edo State embarked on strike to protest the level of insecurity in the state which had led to the kidnapping and killing of some of its members. Also, in 2010, the Nigeria Labour Congress (NLC) and Trade Union Congress (TUC) directed its members to down tools (as a warning) to press home their demand for an enhanced ‘living’ wage. This is another major reason for industrial conflicts and strikes. “The main justification for industrial action is the failure of collective bargaining”. When workers and employers engage in collective bargaining, there is no guarantee that it will be successful. Even when successful, there is no guarantee that it will be honored. Consequently, unsuccessful bargaining and failure to adhere to agreed terms naturally lead to industrial conflicts and dislocation of industrial harmony and peace. For example, On August 2nd, 2021, members of the National Association of Resident Doctors (NARD) commenced an indefinite strike. The strike lasted 63 days as resident doctors continue to seek compensation for issues related to accumulated unpaid salaries, owed Covid-19 inducement hazard allowance, and the general lack of care of the government towards essential health professionals risking their lives in hospitals and COVID-19 treatment centers during the most significant public health crisis of this century. (Tireni, 2021).

Over the years, the structure of health administration has evolved. Presently, the Federal government appropriates funds for healthcare from the national budget and the State and Local
governments also perform the important and concurrent responsibility of ensuring quality healthcare within their respective geo-polities. The question, however, is whether these tiers of government are collectively providing quality and affordable healthcare to the average Nigerian as the present state of public healthcare delivery in Nigeria suggests the contrary view. The prevailing situation is inconsistent with the lofty goals of the various health development plans that have been put in place over the years and this is further affirmed by the continuous low ranking ascribed to Nigeria’s health sector by the World Health Organization. (Oyewunmi and Oyewunmi, 2014). It is on record that industries, and Nigeria at large have been battling with the management of industrial conflicts since the colonial era. The enormity of such conflicts has led to the enactment of the 1976 Trade Disputes Act, which was amended in both 1977 and 1990. The Act provides internal and external dispute settlement machineries including, voluntary and compulsory procedures. The Act requires that within seven days, the declared conflicts should be resolved through the application of internal machineries, the failure of which makes external machineries necessary. Such external machineries include mediation and conciliation groups, the Industrial Arbitration Panel (IAP), and the National Industrial Court (NIC). Unfortunately, however, Nigeria has not had significant solutions to industrial conflicts. According to some authors, the observed situation in the management of conflicts in Nigeria can be attributed to such factors as corruption, favoritism, and bias. Conflict is generally viewed as one of the central principles of an organization’s life. However, the interpretations of its origin, nature and effects of conflicts vary substantially. Starting with 1980s, researchers often argued that conflict was being eliminated, given the industrial experiences of Japan. This view contrasts with the earlier view that conflict was inevitable and even desirable: the issue was not the elimination or minimization of industrial conflict but its management. (Onyemaechi, 2014). Negotiations and conflict management strategies, however, more light will be thrown by outlining the specifics in the following
discussions. Looking at a broad guideline for managers and supervisors in the Nigerian oil and gas industry for handling grievances and disciplinary actions under given collective bargaining agreements, similar strategies can be applied to the healthcare sector to bring about industrial harmony. Note that effective grievance management can only be accomplished through additional experience and by applying the concepts outlined here.

Grievances that are often accompanied by industrial actions require the following supervisory and management responsibilities:

1. Treat every grievance as though it were to wind up in arbitration but avoid being adversarial in your approach.
2. Allow employees and/or unions a full opportunity to present their points of view. Listen, do not interrupt.
3. Ensure that time limits and other procedural requirements under the grievance procedure have been observed.
4. Know the background of the grievance and know the existence of prior similar cases and their outcomes. Know the applicable provisions of the agreement and any information relating to past policies and practices.
5. Ensure that the employee and/or union has presented the full story, specified the exact nature of the alleged cause of grievance, and stated the precise remedy being sought.
6. Make a detailed and accurate record of the results of all investigations. Such record should include:
   a. Any pertinent payroll documents
   b. Work, personnel, or disciplinary records
   c. A summary of the employee’s and/or the unions and management positions
   d. Names and statements of witnesses
e. The nature of any evidence presented by either side of the parties

It is also important to find out who, what, when, where, and why. Ask questions and ensure that you have all the facts. (Onyemaechi, 2014).

4.6. The ways of ensuring industrial harmony in the future

The incessant industrial conflicts and strikes in Nigeria needs to be urgently addressed and checkmated. In view of the identified effects of industrial conflicts, the following measures, amongst other things, are recommended as ways of reducing industrial conflicts and effects. There should be proactive and corrective mechanisms put in place. These should be non-partisan and carry all the trade unions along. The Yayale-Ahmed led Presidential Committee of Experts in Interprofessional Relationship in the Health was meant to be his vehicle of harmony and integration, but the report was dead on arrival as the JOHESU/MHWUN roundly rejected its recommendations. (Newspaper refs). Proactive actions should be able to detect and prevent the possibility of an industrial conflict, and corrective actions should quickly resolve the conflict when it arises. One of such mechanisms is the institutionalization of industrial democracy. There is the need for a legislation which will give legal backing to collective agreement. Such legislation would give statutory recognition to collective agreement and make it enforceable within a legal framework. This will go a long way in containing the propensity to default in honoring collective agreements. (Ezeagba, 2014).

(a) Strategies for negotiation and collective bargaining.

(b) Strategies for managing conflicts in the health care sector; and,

(c) Strategies for handling grievances, industrial action, and employee discipline. (Onyemaechi, 2014).
i. A Well-Defined Industrial Relations is inevitable, industrial relations provide a legal basis for the conduct of labor-management relationship.

Every organization should readdress its industrial relations, Provisions must be made for:

(1) the rights of the employee
(2) the registration and conduct of trade unions and employee association
(3) strikes and lockouts
(4) the reforms of collective bargaining.

ii. Good Leadership and Motivation are indispensable, leadership and motivation that are based on the internal and external environments will strengthen the labor-management relationship thus reduce strike frequency.

To achieve these, employers or Management must:

- Learn to carry employees along.
- Set clear, moderate, and achievable goals.
- Take calculated risks,
- Desires feedback on performance.
- Adopt incentive pay method, which is more effective motivator than straight salary

iii. Honoring Agreements. Agreements are meant to be honored once an agreement is reached between an employer and the employees the parties must work hard to meet the obligation. Agreement must not be entered into lightly as will the sole aim of stopping the crisis unfortunately, government often renege on their side of the agreement, citing lack of funds or resources or allude to the ripple effect of agreeing with one group and the fear of others asking for their own increment too or enacting some form of relativity.
iv. Prompt Payment of Salaries and other emoluments are imperative; these can be achieved with the following:

1. Budgets, stating reliable sources of recurrent expenditures,
2. Adequate cash management, credit terms must recognize payments of salary period.
3. Revolving overdraft facility can be arranged with a financial house.

v. Relating with Other Organizations in the Same Industry is essential, sympathy strikes ‘do occur in Nigeria. This is a situation whereby a group of trade unionists and not in dispute with their employer(s) in support of and in sympathy for strikers in a trade dispute. When there is strike in one organization, the organizations without strike should show sufficient understanding and concern quickly to avoid a sympathy strike. (Ezeagba, 2014).

1. Regular review of wages and/or allowance
2. Appropriate placement and remuneration (refer to Yayale Ahmed report)
3. Clear definition of roles and expectations (Standard Operation Procedure and work guideline to
4. Limitation of the power of trade and professional unions to down tools for more than a few days

Decent work is fundamental to ensuring effective and resilient health systems and to achieving equal access to quality healthcare. For example, improving working conditions through safe staffing approaches, such as appropriate health worker to patient ratios, also improves patient outcomes. Healthcare systems are continuously challenged to adapt to an ever-changing environment, which requires constant adjustments in the delivery of health services. This has consequences for both how work is carried out and the demands made on the health workforce.
Based on WHO health workforce data, increasing demand for health services is expected to generate around 40 million new jobs for health workers by 2030, mainly in high- and middle-income countries. Other estimates suggest additional job creation potential due to multiplier effects in related industries, including important opportunities for the establishment and sustainability of small and medium-sized enterprises. (International Labour Office 2019).
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CHAPTER FIVE

SUMMARY, CONCLUSION& RECOMMENDATIONS

5.1. SUMMARY OF FINDINGS

This chapter examines the structure of healthcare in Nigeria, the health indices in the health sector as it relates to the country and all the factors that impact on the health indices including the professional training, migration of health professionals and the pressures that the healthcare workers face. These factors play a major role in the genesis of disaffection of these staff and the ensuing conflict that leads to agitations and where these are not quickly solved lead to industrial crises (strikes). The chapter also chronicles the frequency of these strikes and the different groups that are the drivers of these strikes.

Industrial harmony is a much sought-after state that will benefit both the patients and the providers of health care in Nigeria. This extensive review of the subject has shown that the major reasons for industrial disharmony are irregular or poor remuneration, poor working conditions, failure of collective bargaining and non fulfilment of agreements mutually entered. Other causes for industrial harmony also include apparent domination of the health sector by doctors with the resultant disaffection of the other health workers.

To create harmony and lasting peace in the health sector, health sector reforms are required with a view to proper placement of wages and allowances, holistic and collective bargaining. In Nigeria the Salaries and Wages Commission play a large role here. Adoption of global best standards relating to the work-place conditions, provision of tools and instruments to encourage good service. Reversal of the brain drain; improved leadership and management of resources will go a long way to addressing the shortcomings of the health sector which fuel industrial disharmony. Also, an increase of the budget for health at all tiers of the federation and increased number of all health care workers across the nation will also promote a happy healthy
workforce which will give their best to ensure we enjoy a good state of health, by improving the bleak indices of health to a better one.

The figure (17) below illustrates how management can strive to achieve industrial harmony in the organizational life while figure (18) shows the strategies for employees working in line with management strategies to achieve the organizational goal which invariably resonates industrial harmony. When these strategies are put in place management and employees can work in harmony to achieve the organizational aim. In this case, service to the Nigeria population through the health care system can be achieved if government and healthcare worker solves conflict, lesser strikes and a healthy nation and thriving health sector economy boom can be achieved because medical tourism will be discouraged, investors and international organizations will be attracted and better and trusting health services will be delivered which will be in tune with modern technology available. The unions will from time to time engage in productive collective bargaining activity with government to achieve Pareto Optimism.

Figure.17: Conceptual Framework of the Relationship between Conflict Management Strategies and Industrial Harmony Source: Desk Research, 2019
5.2. CONCLUSION

Health workers strike remains a perennial problem. Interprofessional rivalry is a major challenge in the health sector with far reaching implications without immediate government intervention. Addressing challenges in the residency training program will go a long way in reducing doctors’ unrest in the health sector.

1. Government and managers of health institutions should give residency training the attention it deserves. (Nyango and Mutihir, 2021). Education and training in the health professions will most likely be influenced by the larger factors shaping the future of work, characterized by a continuous decrease in the need for physical and manual labor and basic cognitive skills. Due to these factors and the growing importance of Artificial Intelligence it is expected that the relative weight of certain skills will grow in value.

The future of work will generally require mechanisms that ensure lifelong learning, flexible education, and training systems that can anticipate the skills demanded by the labor market. The transformations in work driven by new technologies mean that education and training will have to better prepare health workers for their new tasks.
and roles. Investment in continuous skills development will be critical to ensure that technologies and Artificial Intelligence are properly supervised and managed, and do not add to the workload of health workers. It will be essential to analyses those tasks that may be automated in the future, and to identify those that will continue to require hands-on human expertise. This includes interpersonal and soft skills like communication, social and emotional skills, higher cognitive and technological skills, as well as teamwork and team-building abilities. The changing relationship between patients and health workers due to technological advances will require tailored training related to social media, and education through simulation training. (International Labour Office, 2019).

2. Implement legitimate collective bargaining agreement. (Nyango & Mutihir, 2021). It is crystal clear from the available records that dialogue failed to resolve Nigeria’s Medical Doctors, Nurse and JOHESU strikes because of abuse of agreement, stringent demands by the medical professionals, abandonment of professional ethics and so on. These among other factors made it impossible for dialogue to work in resolving the incessant strikes of health workers. (Nsude et al, 2016). Bargaining is ubiquitous. Married couples negotiate over a variety of matters such as who will do which domestic chores. Government policy is typically the outcome of negotiations amongst cabinet ministers. Laws enacted by the National and State Houses of Assembly are also a product of negotiations. As we have seen, strikes need not just be the result of asymmetric information or mistakes as earlier research might have led. There can be long-term, strategic reasons, and power asymmetries, solidarity, union identity, and differing interests between union leaders and members that could also contribute to strikes. How collective action is organized in unions is a central issue that has not been seriously tackled by economic researchers thus far. The emergence of solidarity and
union identity have been important historically and attempts would be a promising to resolving health workers and government disputes. (Chun et al, 2020).

Collective bargaining is suggested as a settlement mechanism. Both the government and labor unions must allow room for dialogue adjustments and readjustments of demands based on socioeconomic conditions during the period of negotiations. Once agreements are reached and signed, both the employees and employers must seek to respect and abide by the dictates of the accord. There is the need for a legislation which will give legal backing to collective agreement. Such legislation would give statutory recognition to collective agreements (mutually entered without coercion or just as an escape mechanism) and make it enforceable within a legal framework. This will go a long way in containing the propensity to default in honoring collective agreement. Where the negotiation process fails to resolve the discontent, the process of arbitration must prevail. Government should always respect and implement agreements reached with workers' unions to forestall unpalatable face-off with the unions. (Wokoma, 2011). Negotiation should be conducted in an atmosphere that is open, honest, and devoid of domineering tendencies. The Productivity being the agency of the government charged with the responsibility of labor and industrial relations matters should put in place alternative dispute resolution mechanisms in view of the drudgery inherent in the statutory dispute settlement procedure to facilitate speedy resolutions of disputes. (Kabuoh et al, 2014).

3. Promoting inter-professional relationship will motivate healthcare workers. (Nyango and Mutihir, 2021). There is the need to strengthen and utilize existing labor-relations mechanism to facilitate continuous interface so that differences are narrowed, and frustrations are re-channel into useful productive ends to ensure that conflict is minimized, and services are not disrupted.
The success of solutions to salient professional identities and interprofessional disputes may lie in the ability to question emanating assumptions and incorporate the understanding into meaningful health policies.

4. Improve quality of health-care service delivery in tertiary institutions. (Nyango and Mutihir, 2021). The consequences of dialogue failure to address these continuous strikes in Nigeria Health System (NHS) is what gave rise to brain drain, medical tourism, increased death rate in the public hospitals, medical quackery, etc. These are what Nigerians reap as consequences of neglecting dialogue as means of resolving industrial conflicts in Nigeria Health System. For dialogue to work therefore, the results of the study show that sustainable and democratic dialogue is needed by stakeholders in the Nigeria Health System as a way of resolving industrial conflict in the Nigeria health sector. Key players in this sector should learn how to compromise when issues of divergent interests are bargained. Through a sustainable dialogue a lot of health crisis can be avoided for the sake of hapless Nigerians who cannot afford three-square meals not to talk of overseas medical trip like the politicians and elites. Nsude et al, (2016).

5. The Federal Government should implement the Nigerian National Health Act which intends to positively impact universal health coverage, access to and cost of healthcare. (Nyango and Mutihir, 2021). Nigeria has lost huge foreign exchange and human resources for health to foreign countries due to poor infrastructural development, sub-standard health working conditions, poor policy implementation and inadequate funding for health). This has been compounded by poor human capital and economic indices. Much smaller countries like Kenya and Ghana for instance do many more open and closed heart surgeries than Nigeria. (Dr Adeyemi Johnson interview granted to
The Nigerian government should create an investor-friendly, terror-free, safe environment, and reduce bureaucratic bottlenecks; these will serve to encourage direct foreign investment in the country. Together with the leaders of professional health and legal bodies, there should be a framework for monitoring and regulating medical tourism to ensure strict adherence to all ethical procedures. Creating a regulatory framework is a means of ensuring the safety of these tourists. It will also serve to check, as much as possible the two-tiered effect of medical tourism on the health system. Medical tourism in Nigeria remains relatively unexplored, as there is a dearth of research-based data on the topic. Promoting research through improved funding and grants on the subject will go a long way in addressing this. Medical tourism is a fast-growing industry. Despite its drawbacks and potential ethical implications, it promises great rewards for low and middle-income countries like Nigeria, especially in terms of employment generation, brain drain reversal, health infrastructure development, availability of standard, up-to-date health facilities for the citizenry, reduction of health care costs and foreign exchange generation. (Epundu et al, 2017)

6. Funding and insurance facilities (Nyango & Mutihir, 2021). The flow of funding of the health system in the public sector comes majorly from the federation account. This is distributed across the three tiers of government to finance the tertiary, secondary and primary levels of care. However, it is important to note that allocation of funds is based on population size of each state or region, using a federal quota system. This therefore leaves worst hit regions with high disease burden with limited allocation of funds. the South-south region of the country has the lowest population in Nigeria, but the highest rate of infant mortality of 120/1000 live births, yet receives the lowest funding to its
health sector. However, the nation’s low health funding is a result of only 3.5% proportion of the GDP on health. This is also compounded with mismanagement and corruption at each level of healthcare delivery especially in the public health sector, leading to lack of accountability of the limited health funds. It should also be noted that amongst the current state of poverty in the Nigeria (approximately 60% of the population), household out-of-pocket expenditure on health of 80% remains the single largest source of health financing in Nigeria. This can be argued to be true, as majority of the population (predominantly rural) patronizes private for-profit healthcare providers. In addition, the limitation of the National Health Insurance Scheme (NHIS) to the working elite increases the spending on health from most of the population not covered by the scheme. Thus, the inability to pay for health services provided by the private-for-profit increases the inequities in utilization of health care services. (Olaniyan T. A, 2012).

7. Practice by health-care providers. From an early phase in the training of healthcare professionals there should be overlap in training of the different professions to enable each understand the other’s profession better and foster a good relationship between them all.

8. Quality and standards, patient care, and health outcomes. When people’s health conditions get worsened or there is high mortality rate due to strikes, they become unable to shoulder their responsibilities effectively and hence cannot make progress that will contribute to the growth of the society. Essien, (2018). Improvement of institutional, professional, and healthcare outcomes can only be brought about in a spirit
of collaboration. This will help rebuild the lost confidence of the people in the healthcare system and improve community health. (Oleribe et al, 2018).

The Joint Learning Initiative on Human Resources for Health and Development, Report, in response to the demotivation of healthcare workers which moves them to strike action, states that “a key action is a significant upward revision of the total compensation package to a level that reflects the value placed on the work they do, is likely to discourage staff from wanting to leave public sector services”. (Nyango & Mutihir, 2021)

5.3. RECOMMENDATIONS

The health sector cannot afford to be a passive actor as the world of work evolves; shaping the future of work we want for the health sector requires active leadership, collaboration between sectors, participatory approaches, and strong social dialogue. Transformative changes in the health sector require enhancing service delivery models, improving health labor market policies, updating education, and training, and harnessing valuable technological developments. Population dynamics, globalization, technology, and environmental and geopolitical factors will radically alter the way health workers deliver health services in the future. Bold transformative change is needed to ensure sustainable health systems and health workforces. Yet this change must be framed by the needs of all stakeholders in the health sector, including patients, workers, employers, and governments. It must encompass meaningful collaboration between public and private actors and be underpinned by decent working conditions. Decent work is critical to ensuring the sustainability of the health sector and health workforce as future developments like changing demographics introduce new challenges. Investments in the health sector and its workforce are expected to create positive social returns and enhance inclusive economic growth. A commitment to investing in health systems is hence
a commitment to investing in people and in societies. To maximize the contribution of the health sector to the Social Development Goals, the future of work in the sector must be shaped by all the actors involved, in a way that ensures equal access to health services and guarantees resilient health systems. The goal is to ensure access to a health worker for everyone, everywhere. (International Labour Office, 2019).

Mediation being one of the most favorite dispute resolution alternatives, mediation is a way that warrants due attention, depending certainly on the prevailing condition. It furnishes the parties, when integrated with a congenial legal system, with a prospective direction as well as a greater sense of satisfaction than do other methods of conflict resolution. The prevailing aim of industrial relations is to espouse the spirit of peaceful relations between labor and management. This goal is achieved through the instrumentality of collective bargaining which avails the concerned parties the opportunity for interest adjustment and compromise under an atmosphere devoid of imposition and trepidation. The unimaginable difference in the wage and salary gap between political office holders and other appointees and those of public servants has been at the center of raising agitation by the latter for corresponding improvement in the wages of their members. These agitations and submissions to the government to effect the change in the spirit that is emblematic of fairness and equity has continued to resonate on deaf state ears thus provoking labor to take the hard path of trade dispute via strike. This last action had forced the government to reconsider its position and follow the path of negotiation which saw the introduction of the new national minimum wage law. Sadly, rather than for the government.

The incessant industrial conflicts and strikes in Nigeria needs to be urgently addressed and checkmated. In view of the identified effects of industrial conflicts, the following measures, amongst other things, are recommended as ways of reducing industrial conflicts and effects. There should be proactive and corrective mechanisms put in place. Proactive actions should be
able to detect and prevent the possibility of an industrial conflict, and corrective actions should quickly resolve the conflict when it arises. One of such mechanisms is the institutionalization of industrial democracy. There is the need for a legislation which will give legal backing to collective agreement. Such legislation would give statutory recognition to collective agreement and make it enforceable within a legal framework. This will go a long way in containing the propensity to default in honoring collective agreement. There is the need for government, as an employer, to emulate the human resource management and employee relation strategies applicable in the private sector. This is because, strike propensity is very high and predominant in the public sector and infrequent in the private sector (Awe and Ayeni, 2010). Towards achieving this, public sector employers should accord premium to labor. Employee morale should be boosted possible. Employers should recognize that human resources are the soul of the business and not the sole, to be trampled on. That the practice of extolling the ‘primacy of the human resource’ yet of all assets, people are the first to be got rid of in times of trouble – shrinking government, reengineering (Aimiuwu, 2004), privatisation, etc. is not proper. In view of globalization, employers should arm the workers with necessary morale boosters, respect, and recognition to ensure industrial peace and harmony. This will go a long way in aiding both parties achieve both individual and collective interests and objectives within a world of intense interconnectivity and integration. In line with Wokoma & Iheriohanma’s (2010) recommendation for a PEST (political, economic, social, and technological) repositioning of the country, there should be, specifically, a serious and important political re-arrangement, restructuring and re-organisation of the country to reflect the meaning and spirit of true federalism. The issue of having a centralized trade union within a supposedly federal republic is uncalled for. Thus, if the country is properly arranged and governed along federal principles, it will translate to the division of trade unions along federating units. This will put an end to a situation whereby trade unions respond to the dictates of the central labor union without
recourse to the industrial situation of their locality. Finally, the place of collective bargaining cannot be jettisoned. Collective bargaining has been identified as a means through which the protection of the economic and social interests of parties involved in an employment relation can be achieved. However, for effectiveness, collective bargaining must be embedded within the concept of social dialogue – which includes all types of negotiation, consultation or simply exchange of information between, or among, representatives of government, employers, and workers, on issues of common interest relating to economic and social policy. Nwokoma CU, (2011).
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Appendix (i) - Clippings from various National Newspapers

Picture 1. from The Nation Newspaper

Picture 2. from A National Newspaper
Addressing health workforce crisis and strikes in Nigeria: a policy framework

You could count how many days Nigerian health professionals were at work in the year 2014. It’s not much and a particular trend or situation would have been due to some local issues with their health medical or hospital management. Then their salary or other parts of the country would be victim of their actions and outcomes. Besides, health is vital to everybody in the society. However, the government and health workers are among those whose publics are those who freely surgery and health care is not affected by any economic difficulties. The strike on medical personnel is a form of protest against the government

Strikers and union solidarity meeting constitutes significant percentage of the time. Restless doctors are supposed to spend in their training to become medical practitioners. Their training when practitioners are on strike, hence they can’t be attended to until they can’t be attended to until they resume their training and those who know them about the strike. Medical training programs in Nigeria are often disrupted by work stoppages, particularly when doctors and other health workers are on strike. Strikers are those who are always sound to access affordable healthcare in government hospitals.

It is possible to reverse this terrible trend by creating a robust health workforce policy while executing some with a sincere political will across all levels of government.

National Human Resources for Health Strategic Plan 2008-2012 was a key policy document drafted by the Department of Health (NHS) and the national primary healthcare development agency. It was published in 2010 by the African Health Workforce Observatory. In principle, the plan set out for the national health workforce was designated to "improving access" to health service, and "improving quality" to the health workforce. The plan set out to improve the number and quality of health professionals, while reducing the number of health workers and increasing the number of health professionals. It was a key challenge of recruiting and retaining health professionals, as well as practical solutions were discussed. Yet, surprisingly the Human Resources for Health Strategic Plan 2008-2012 led to increase the number of health workers, but without which they may ultimately withdraw some of their services and the number of health workers, while demanding accountability, excellent health services and an armed agreement to work from health workers.

Nigeria’s healthcare system is complex and hierarchical. The government’s response to the strike by health workers is to ensure that the healthcare sector is well-staffed and that patients can access care. The government has also sought to address the root causes of the strike, including low salaries and inadequate working conditions. In response to the strike, the government has sought to negotiate with the healthcare workers to address their concerns. However, the government has faced challenges in negotiating with the healthcare workers, and the strike has continued for several months. The situation is complex and difficult, and it is essential to address the root causes of the strike to ensure that the healthcare sector is well-staffed and that patients can access care.
ZONING: PDP, govs hit back at Umahi

•Deal with your frustrations

By Patrick Ukubokiri

The Chair of the Eket LG, Mr. Obi Okon Edet, has called on members of the PDP to deal with their frustrations or fears through the democratic channel and not by enacting illegal acts.

Health workers issue fresh strike notice

By Chinwe Onwurah

Health workers in the state have issued a fresh strike notice over the alleged non-payment of their salaries. The strike notice was addressed to the state government. The workers threatened to disrupt the health sector if their salaries are not paid within 72 hours.

Police in Edo kill passersby while chasing suspect

By T. A. Adepoju

The police in Edo state were accused of shooting and killing passersby while chasing a suspect. The incident occurred during a high-speed chase in Benin City. The police were alleged to have ignored the warning shots from the crowd.

Police said the suspect was armed and dangerous and fired at police officers. The suspect was eventually shot dead by the police.

Police in Lagos battle to contain communal tension

By Folashade Ogunleye

The Lagos state police command have stepped up efforts to contain communal tension in the state. The command has set up a special taskforce to monitor the situation and prevent any further incidents.

The taskforce has been given the power to arrest and detain anyone found to be inciting trouble or causing unrest.

Police sepulted anchor who committed suicide

By Emmanuella Onyeoma

The police have identified and buried the body of the man who committed suicide in the police headquarters. The man was identified as a police officer who had been2023 residing in North.