Government hospital management structure and the challenges of industrial disharmony in Nigeria

MOKA Olushola O.¹* and AJIJOLA Oludare²

¹Department of Peace and Conflict Studies, Federal University Oye-Ekiti, Nigeria.
²Department of Sociology, University Of Kwazulu, Durban, South Africa.

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One theme that has continued to resonate in narratives, conversations and prognosis of factors that underpin Nigeria's appalling health indicators, medical tourism and intermittent unrest in government owned hospitals is the Policy of government on the headship of publicly owned hospitals. The call for the re-assessment of policy on the headship of government owned hospitals and her Industrial Relations Protocol and Practices has continued to elicit intense interest, criticisms and unpalatable comments from several stakeholders. This research thus reveals that a number of critical stakeholders whose views were acknowledged are of the opinion that the appalling appreciation of the meaning, importance and implications of ethical and globally competitive industrial relations protocol and practice by government may have an inducing effect or relationship with the intractable and intense animosity between and among medical and non-medical professionals in government owned hospitals in Nigeria; thus creating a regressive distraction and an undue neglect of the primacy of health care delivery. The research involved the collection of data through survey from a purposively sampled population. Interacting with respondents with more than a fair knowledge on industrial relations/policy, health policy and hospital administration dynamics, this research concludes that the government policy that conceded or sanctioned the permanent headship of government hospitals to physicians in a multi-professional environment is globally strange and belies the protracted crises that have tainted the Nigerian health sector over time.

Key words: Government, Management structure, Industrial disharmony.

INTRODUCTION

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 furore 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 redeem their oath of fidelity with the much cherished Hippocratic Oath at all time; by putting the dignity of human life above every personal or altruistic consideration by every professional in the inter-territorial task of health promotion. One recurring theme in the plethora of narratives and conversations on factors that underpin the intermittent unrest that has for some time plagued government owned hospitals in Nigeria which, plays a pivotal role in the health and wellbeing of the sizeable portion of Nigerians across the length and breadth of the nation is the official exclusive reservation of hospital headship to physicians.

There is a strong consensus that the frosty and mutually suspicious relationship between Medical Doctors (Physicians) and Non-Medical professionals which comprises of specialists that Pharmacist, Laboratory Scientists, Radiographer, Physiotherapists, Speech Therapists, Hospital Administrators, Accountants and Social Workers to mention but a few speaks to the
impropriety of government policy on hospital management. The drawbacks of the industrial Relations policy is said to have implications on the incessant industrial crisis that has plagued the Nigerian health sector. There are strong but unverified insinuation that the existing policy of government on hospital leadership through the controversial Decree 10 of 1985, which has become an Act of the Nigerian Parliament provided the legal basis for the Physicians sole right to government hospital headship.

The old and new media are consistently being 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, in spite of the inter-territorial nature of the Hospital. Osakede and 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, 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 paralysed for four and five months respectively.

A respondent in the JOHESU in an interview granted in the course of this study, alluded to the above assertion. He submitted that members of his union “were being subjected to discrimination and industrial marginalization in the health sector in favour of Nigeria Medical Association.” The perennial strikes and a number of determined and pending litigation give incontrovertible vent to the consequences of the festering animosity between physicians and non-medical professionals.

Nigeria’s life expectancy going by the 2014 estimate stands at 52.62 years. Physician and Nurse national population ratio as at 2014 is 1 to 53,333 and 1 to 1066. This reference particularly claimed there are less than 30,000 practicing physicians in Nigeria. In similar vein, a paltry 38% of births are attended to by skilled professionals (www.data.worldbank.org).

Nigeria’s maternal and infant mortality rate going by the 2011-2015 estimates is 814 deaths from every 100,000 delivery, while it is 74.09 deaths/10000 live births (www.indexmudia.com/nigeria.infant.mortality-rate). What the analyses in the above underscore is that the Nigerian health sector is in a palpable situation which should provoke and elicit an uncommon synergy and concerted commitment of policymakers, physicians, non-medical professionals, civil society organisations and patriots to the protection and elevation of human dignity; by instituting a health regime that will improve the nation’s key health indicators.

This study from the foregoing therefore, seeks to empirically interrogate the relationship between Nigerian health policy on government hospital headship and the festering Industrial disharmony in the Nigerian health sector.

**Conceptual clarifications**

**Industrial relations**

It is an incontrovertible fact that the development of an informed and workable industrial relations law, template or practice is a necessary and sufficient condition for industrial harmony. The implications of the aforementioned are that the incorporation of the principles of industrial relations by every employer of labour creates the condition and environment that make productivity and industrial harmony possible. This is simply because employees can lend their voice through a structured and convivial channel to management policies that may have implications on their work environment, welfare and other issues that may be of concern to them.

Dale opines that industrial relations are the process of management linking with one or more unions with a view to negotiate and subsequently administer collective bargaining or labour contract. Industrial relations can be seen as the study of laws, conventions and institutions that regulate the workplace. It is a fundamentally important aspect of our life, our culture and society. Industrial relations means different thing to different people. What it means to workers for example include better pay, workplace safety, job security and safety.

Dunlop also sees industrial relations as "a complex interrelations among managers, workers and agencies of government." More so, industrial relations can also be perused as the practice of individual, group of employee and employers who engage themselves in a way to maximize their productive activities. Industrial Relations therefore is an undertaking which “involves attempts at arriving at solution between conflicting objectives and values, between profit motive and social gain, between discipline and freedom, between authority and industrial democracy, between bargaining and cooperation, between the conflicting interest of the individual, groups and communitywww.naukrhub.com.”

The Industrial Relations mechanism through which the interest of professionals, group or interest in a work or industrial environment is pursued and harmonised is Collective Bargaining. Collective Bargaining is defined as:

a process of consultation and negotiation of terms and conditions of employment between employers and workers usually, through their representatives. It involves a situation where the workers union or representatives meet with employer or representative of the employer in an atmosphere of mutual cooperation and respect to deliberate and reach agreement on the demands of workers (www.nigerialawguru.com).
One common denominator from the above definitions is that the consent and favourable disposition of workers to work is a necessary and sufficient condition for productivity and industrial harmony. Industrial Relations simply put, is concern with the intricate charge of involving and factoring every stakeholders interest into the policy thrust of an organisation. This is because Industrial Relations laws, policies and practices more often than not, have implications on employee welfare, organisations corporate objective attainment, industrial harmony and national prosperity.

**Industrial relations practice in Nigeria**

Industrial Relations as a management function dates back to the days of Colonial occupation in the geographic space now called Nigeria. Commercial relationship with Europeans and the British in particular led to the consummation of formal and semi-formal relationship with the British. At the Berlin conference of 1884-1885, the British succeeded at formalising its claim to Nigeria Basin and the activities of some private entrepreneurs were brought under the control of the Royal Niger Company headed by Sir Taubenber George Goldie (Ubeku, 1993).

Adebiyi (2013) in his incisive allusion and historical analysis of Industrial Relations trajectory in Nigeria contends that:

One administrative or political action of the British led to another, and eventually led to the amalgamation of the Northern and Southern protectorates in 1914 to form Nigeria. This new country was led by Lord Lugar, a British colonial administrator. As the country advanced both in age and development, the British colonial masters carried out a number of reforms in the labour sector, which created the legal framework for Industrial Relations in the country. Therefore by 1960, when Nigeria gained political independence from Britain, what constituted Industrial Relations in the country was largely derived from the Anglo-Saxon model of Industrial Relations.” The military coup of 1966 kept the military in power till 1979, a period of about thirteen years. During this period, the military suspended the supremacy of the constitution and instead ruled by decrees. These developments in the labour sector were no doubt without the activities of the nationalist and labour agitators at the time.

Bassey et al. (2012) in their study on the effect of conflict between Line and Staff Employee on productivity in the workplace recommended equal and human treatment of all employees whether staff or line”.

It could be deduced from the above references and assertions that Industrial Relations practice in Nigeria derives from its colonial history. Nigeria was colonized by Great Britain. The nation’s Industrial Relations protocol, ideology and practice still eulogise the philosophy bequeathed by former colonial masters. The premium regimes in Nigeria attach to wide consultation with labour through their associations and frequent disregard for terms and agreements reached are largely a reflection of the root of the nation’s industrial conflicts. The economic interest of colonial masters at all-time took precedence over any human, professional or ethical consideration.

**The Nigerian health sector; interrogating the industrial relations discourse**

One sector of the Nigerian economy that has the highest record of incessant and avoidable industrial unrest is the Nigerian health sector. This unpleasant development without equivocation comes with advertent and inadvertent implications on the nation’s health indices, loss of foreign exchange, medical tourism and the categorisation of Nigeria as a failed state. The close to three decades upheaval plaguing the nation’s health sector is said to have its root in a Federal government circular on hospital leadership under the late Professor Olikoye Ransome Kuti, the Minister for Health between 1985 and 1993. Adepoju (2014) in his allusion to the above assertion argued that “the current crisis started during the tenure of Professor Olikoye Ransome Kuti. The Professor of Paediatrics improved the working condition of Nigerian Doctors but, left other professionals out”. Professor Olikoye Kuti initiated and sold the policy that made headship of government owned hospitals the sole privilege of Physicians to the exclusion of other health professionals.

Ihekwazu (2015), in her corroborative account and assertion argued that “no part of the public service has experienced more strike than the health sector.” She further contends that “the University College Hospital, Ibadan was crippled for 108 days by the Association of Residents Doctors in 2015”.

The Joint Health Sector Union (JOHESU), the umbrella body of non-medical professionals also withdrew its members’ services for three months in 2015. JOHESU hinged her recourse to industrial action to government’s sole concession of its hospital leadership and its preferential treatments of issues that boarder on discrimination and industrial marginalization in favour of Nigeria Medical Association. He further contended that members of JOHESU are demanding improved working condition, including the implementation of skipping of Grade 10-12, implementation of new circular on
promotion of their members on from CONHESS 14 to 15, amendment of decree 10 of 1985 (CAP U15 463) LFN 2004, which formalised the marginalisation of all health workers by doctors in the lopsided composition of the board of management of federal health institutions, appointment of Chief Executives Officers of federal health institutions and training of health professionals among others. The National Industrial Court in a landmark judgment of July 2013 vindicated their position on a number of other issues which were referred to it by the honourable Minister of Labour and Productivity after the Honourable Minister for health refused to accede to their demands.

It could be deduced from the above analysis that the protracted and incessant industrial unrest in the nation’s health sector may be a reflection of the fact that the advances in Industrial Relations and its incredible benefits has not had an inroad into the industrial relations protocols and practices in Nigeria’s beleaguered health sector. It is curious and distasteful to note that the government is not in a hurry to re-examine the power relations configuration of public hospitals and the health sector in general and its implications on the protracted and incessant industrial unrest in the country. Keltner (2003) in his analysis on power opined that “even though power is felt everywhere, it is important to demarcate the boundaries of power with some level of control.” The misuse of power by management could lead to resistance by employees, which could lead to loss of control, discipline and orderliness, which is not a desired outcome.

The process of power and control therefore are both independent and interrelated in the workplace (Branch, 2006). The more power possessed, the higher the likelihood of it being abused and used negatively (Salin, 2003; Vartia, 2003). The inequality within the networks of power relations, can lead to a situation whereby a group within the organisation is more powerful than the other, the convergence of the weaker groups can lead to resistance, although most employer/employee relations are still based on unequal relations (Branch, 2006).

The festering, entrenched distrust and relative disharmony in the nation’s health sector, its consequences and unequal power relations between medical and non-medical professionals cast serious doubt on the propriety and responsiveness of the nation’s Industrial Relations practice in the health sector. A proactive Industrial Relations template in a multi-professional environment should be designed in a way that allows every professional the space and fair latitude to be the best they can with the survival, development and global competitiveness of the health sector as the objective of every stakeholder.

**Industrial conflict in Nigeria health sector**

The study of industrial conflict is largely interdisciplinary, involving thinking in academics, health, politics, religion and many other fields of human endeavours that require labour commitment and expectation of wages. Disciplinary Perspective notwithstanding, scholars generally agree on certain conclusions; that conflict is a pervasive element of social life in the workplace and it occurs at all levels from interpersonal to the inter-organisational levels. Referring to Gleason (1997), Akanji (2008) opines that disputes are cultural events evolving within a framework of rules about what is worth fighting for, what is the normal or moral right way to fight, what kind of wrongs warrant action and what kind of remedies are acceptable.

Another conclusion is that most conflicts in workplace are of mixed motives and usually involve the parties with both competitive and cooperative interests. While it is safe to say that employers are usually interested in maximizing profits and workers are interested in higher wages, the two sides still manage to work in the same organization and the survival of either side is dependent on the existence of the organization. More so, conflict in workplace may not have any bearing on wage or profit. This conclusion therefore explains conflict as an expression of struggle between at least two independent parties, who perceive incompatible goals, scarce rewards, and interference from the other party in achieving these goals. They are in position of opposition in conjunction with cooperation.

The most important of scholarly thinking of conflict understanding is the fact that conflict can be constructive or positive if properly managed. However, management efforts are frequently affected by the attitudes of disputants. The parties in conflict are the primary contributors to conflict outcomes, regardless of the management initiatives to the resolution. The outcome can either be negative or positive depending on the approach.

The fact that man is a product of nature and that interaction within the environment often leads to conflict has made some scholars to believe that conflict is a way of life. Thus, the social/human problems arising from disagreement or differences between two or more parties over an issue in an industrial system is referred to as industrial conflict. Statutory definition of trade dispute explains industrial dispute as any dispute between employers and workers or between workers and workers which are connected to employment, non-employment or conditions of work of any person (Trade Union Act, 1973).

The three key-actors in industrial relations system are Employer-owners of capital (represented by management or employers’ associations), Workers-owners of labour (represented by labour unions), and Government-regulators (represented by policy makers, arbitrators, government and civil societies).

Acknowledging the social interface that must exist between and among these key actors, Dunlop (1958) is...
of the view that industrial relation system is a social system arising from industrialization which creates workers and employers, and a complex interlay of relationship between managers, workers and regulatory agencies. The European Foundation for the Improvement of Living and Working conditions defines industrial conflict as the clash of interests, and resulting disputes of varying intensity, between individuals, groups and organizations in the industrial relations system. Industrial conflicts may centre on differences in values and objectives, relationships in term of power or status distribution as well as the common disputes that arise from wage related issues. However, various research works have been done in respect of industrial conflict from which two major schools of thought have emerged.

The first holds that industrial conflict, like most other conflict is inevitable, but that if properly managed, the phenomenon can be turned to a desirable part of human interaction in the workplace. This school of thought is known as the pluralist perspective or conflict school. Its adherents are of the opinion that with the expansion of an industry, conflicts emerge and steps are always taken to develop institutions for reducing or managing them (Omolé, 1989). Buchanan and Gay (1970) also share the pluralists view by attributing industrial conflict to the disparity in power distribution between labour and management; among various skills within an industry and between industry and consuming populace. They tag this “Power Theory and Industrial Conflict”. According to them, where there is an obvious gap in the strength of either party in conflict, there will be more cases of conflict. In agreeing with the above assertion, Harbison and Cole (1975) advocate the cooperation of labour and management, respect for each other, mutual trust and confidence in the capabilities of both sides and the acceptance of the difference in goals and objectives of all parties. They assert that conflict is not always destructive, but of manifestation of individual interests.

On the other hand, and for the purpose of this work, the cooperative school contends that there is a basic similarity between the interests of employers and employees, primarily because they are members of, and are dependent on the same organization. In the same vein, the school articulates that conflict is dysfunctional and even injurious because it oftentimes interferes with the efficient and effective running of an organization (Akanji, 2008). It creates an unpleasant atmosphere in a workplace and often leads to violence against persons and properties. To the adherents of this opinion, conflicts occur much less from clash of interest but more from communication breakdown, lack of understanding and trust. Thus, it is imperative to avoid conflict at all cost as its cost far exceeds it benefit.

Observing either thought, Fax (1971) identifies four basic layers of industrial conflicts which occur between:

(a) Individuals – usually at the Management level.

(b) An individual worker and Management.

(c) Workers’ Unions and Management.

(d) Workers’ Unions.

In all, Sherif and Sherif (1965), Blake and Morton (1964) and Albert (2001) all concluded that organisational structure or conflict which creates winners and losers displays predictable pattern of interaction and also have predictable effects on intellectual, emotional and perceptual progress. Akinnyosoye (2014), the First National Vice President of the National Association of Nigerian Nurses and Midwives complemented the above claims. She specifically contended that “healthcare is teamwork and the team members should be treated with respect. There is the need to allow every cadre to flourish and realise their fullest potentials.” She further argued that “we are opposed to the creation of the office of the Surgeon-General of the Federation, without the consensus of all health workers in the country. In the United State and United Kingdom where we imported this idea from, they have had nurses and pharmacists as surgeon general. Will that be the case in our country? In line with universally recognised democratic ethos and culture within the health system, overall headship should of health facilities should be open to all cadres, subsequent to training in health administration.”

Looking at conflict from a psychological view point, Freuille and Chancere (1995) align with the Sheriffs. According to him, conflict is “a struggle over values or claims to status, power and scarce resources in which the aim of the conflicting parties are not only to gain the desired values but also to neutralize, injure or eliminate any threat or rivals.”

Feud’s view reflects a degree of sinister consequences which can be injurious to a budding health sector in a developing nation such as Nigeria. Shorter and Tilley (1979) attribute conflict and unrest, especially as it plague the health sector in Nigeria today, to non-recognition of labour demands by their employers, hence labour always strive to make their position felt. To Bisno (1988), conflict is as a result of power struggle and the desire of both parties for the control of decision-making function of the industry. This agrees with the position of Chamberlain (1969) who sees conflict as having its root in the differences in value of the actors. In looking at the origin of industrial conflict, Akanji (2010) opines that individual conflict has its origin in the social organization, the political forms, religious and ethical norms and attitudes to acquisition in the given society. This in essence, means that conflict is a manifestation of the goals of the parties in achieving what each party thinks belongs to him by right. In other words, there must be something to be acquired before there is a struggle for its acquisition.

Conflicts among employees and between employees and management, as the result of social interaction and higher interdependence at workplace, can be traced to a variety of causes. These range from structural features of
the workplace, frustration and personality characteristics, to differences in culture, race, value, gender, personal preference and social status. In Nigeria, where the laws permit recognition of multiple unions within an industry, many conflicts are structure-based; ditto the health sector where there are multiple professional practices with corresponding unionized disciplines.

Gmelchand Carol (1991) identified various sources of conflict based on the structure of a complex industry such as the health sector:

(a) The level of bureaucratic hierarchy.
(b) The rule and regulation influencing job structure and role clarity.
(c) The degree of departmental specialization.
(d) The demographic and psychological similarities and differences among the staff and degree of staff stability.
(e) The degree of use of close supervision.
(f) The degree of employee’s participation in decision making.
(g) The types of power used by management to achieve goals.
(h) The type of reward and recognition in place and implementation policy.
(i) The degree of staff interdependence.

Industrial conflicts may have their origin either in the individual rights of a single employee or the collective rights attributable to the personnel of an organization, or any other kind of establishment.

From the above conceptualization of industrial conflict, one can conclude that the phenomenon is related to power sharing between or among actors, to a large extent and that where power tilts in favour of one to the disadvantage of others, the use of power in such a situation may be subjected to certain restraints. For instance, if the powerful party does not exercise restraint, the power may be used in a situation that the working relationship may disrupt the production of goods and – in the case of health care giving – services. The health sector management structure as currently designed in Nigeria is such that gives room for incessant and protracted industrial dispute.

Neglecting collective bargaining: an albatross of industrial harmony in the health sector

According to Rose (2008), collective bargaining as a concept was coined by Beatrice Webb as a way to describe the process of agreement of terms and conditions of employment through representatives of employers (and possibly their associations) and representatives of employees (and probably their unions). Rose (2008) posits that collective bargaining is the process whereby representatives of employers and employees jointly determine and regulate decisions pertaining to both substantive and procedural matters within the employment relationship. The outcome of this process is the collective agreement. Collective bargaining as one of the processes of industrial relations performs a variety of functions in work relations. It could be viewed as a means of industrial jurisprudence as well as a form of industrial democracy. It is a means for resolving workplace conflict between labour and management as well as the determination of terms and conditions of employment (Anyimet et al., 2011). Davey (1972) views collective bargaining as “a continuing institutional relationship between an employer entity (government or private) and labour organization (union or association) representing exclusively a defined group of employees of said employer (appropriate bargaining unit) concerned with the negotiation, administration, interpretation and enforcement of written agreements covering joint understanding as to wages/salaries, rates of pay, hours of work and other conditions of employment”. International Labour Organization (ILO) (1960) further views “collective bargaining as negotiations about working conditions and terms of employment between an employer, a group of employers or one or more employers organization, on the one hand and one or more representative workers’ organization on the other, with a view to reaching agreement.”

The term public health sector comprises therefore the government as employer at the federal, state and local government levels as well as various parastatals, agencies, departments and other state-owned companies. The public sector constitutes the largest employer of labour in Nigeria among which the health sector is a key.

Perusing the trade union practices, Damachi and Fashoyin (1986) opine that trade unionism and labour relations originated in the civil service in 1912; but it is in this sector that unions are weaker and labour relations is most minimally observed. The weakness of the unions in this sector was attributed to a well-documented problem of union factionalism, multiplicity and leadership squabbles which characterises Nigerian unions up to date (Anyim et al., 2011).

According to Omole (1987), the features of industrial relations in the developing countries when compared to the practice in the developed countries differ in many unique ways. In the developed countries, industrial relations practice in the public sector was modeled after the practice in the private sector. In the developing countries, the opposite was the case; especially with Nigeria where industrial relations system in the private sector of the economy sprouted from the practice in the public service. To account for the trend, he states that the idea of negotiation by workers emerged first in the private sector in developed countries and its law and procedures are well-established. In Nigeria on the contrary, the origin of trade unionism can be traced to the public sector, which arose during the colonial rule when paid
employment was first introduced into the country by the colonial administrators.

One of the focuses of this research therefore is to evaluate the efficacy of collective bargaining machinery (if any) in managing the crises of headship in the health sectors in Nigeria; and with an aim of bringing to the fore the peculiarities associated with management structure therein.

Collective bargaining in the health sector

The practice of industrial relations as a discipline and that of collective bargaining in particular emanated from the private sector the world over (Anyim et al., 2011). Thus, much of the practices of public sector collective bargaining are modelled after the private sector collective bargaining. However, in Nigeria, the reverse is the case as collective bargaining gained its root in the public sector owing to the near absence of private sector at the turn of the century (Fashoyin, 1992). Hence, in Nigeria, the public sector pays lip-service to the collective bargaining machinery. Governments at all levels (Federal, State and Local) have continued to set aside collective bargaining and to give wage awards to score political points in spite of its commitment to the ILO Convention relegated to the background (Ibid). Wage tribunals or commissions offer little opportunity for workers’ contribution in the determination of terms and conditions of employment and can hardly be viewed as bilateral or tripartite. Thus, the State preference for wage commissions is anti-collective bargaining (owing to the fact that the issues involved in industrial relations far exceed the discourse of wages and salaries). In spite of Nigeria’s commitment to conventions of the ILO with particular reference to such conventions as 87 of 1948 and 98 of 1949 which provide for freedom of association and the right of workers to organize and bargain collectively. The stance of the State (Employers) has stifled effective collective bargaining between the Doctors on one side, other health workers on the other and government in the health sector. Hence, Wage Commissions or committees of inquiry are being constituted since independence era for the purpose of wage determination and other conditions of service in the public sector. Chidi (2008) opines that the use of ad-hoc commissions in addressing workers’ demands such as wage determination and other terms and conditions is unilateral and undemocratic as it negates good industrial democratic principles. Thus, it is antithetical to democratic values.

Thus collective bargaining in the public health sector is faced with practical difficulties one of which concerns the issues of bargaining. Many of the substantive issues which are within the scope of the hospital management are decreed either by legislative or executive acts or through political commission periodically set up by government as employer of labour. Also, promotion, discipline, transfer, etc. have consistently been regulated by rules as purportedly determined by the Medical Doctors who are subtly forced on other health workers. Thus, the role of Collective Bargaining in Nigeria is virtually irrelevant owing to the decisive role and influence of Medical Doctors and their backers in government and its health related agencies. These developments have undermined the relevance of negotiations in the public health sector. Damachi and Fashoyin (1986) criticize the structure of bargaining in the public sector in which the same management negotiates with each level of union.

Another feature as observed which seems to be amusing but equally instructive is the fact that the staff side in the civil service is the official or management side; as senior civil servants represent the official or management side when negotiating with members in lower cadre on behalf of the government. The triangular relationship seems to have created room for ripple effect in which whatever concession made by the official side to the unions will also be extended to the official or management side. In sum, both sides can be seen as working towards the same end. It can also be seen that the dilemma arising from conflict of interest in public health sector’s labour relations probably accounts for reluctance or lukewarm attitude of the government to effectively employ collective bargaining for adjusting conditions of service in the sector.

Banjoko (2006) sees government as having arrogated to itself the role which both employers and employees ought to perform in industrial relations. Even though government as a state authority set up councils to negotiate for salary increases and other conditions of employment in the public sector, events in recent years have shown that government had taken over the system of wage fixing in Nigeria. Instead of allowing collective bargaining to prevail, government resorted to establishing wage tribunals as a means of fixing and reviewing wages. Consequently, like in other sectors, collective bargaining has been relegated to the background in health sector (Imafidon, 2006).

Aligning with Kester (2006), Anyim et al. (2011) observes that Nigeria has no definite and effective wage determination policy hence the industrial relations system has been witnessing a spate of industrial unrest and tensions at every attempt to adjust wages and over the years, issues relating to wages and hospital management structure have dominated industrial disputes and work stoppage in the Nigerian health sector.

RESEARCH METHODOLOGY

The research involved the collection of data through survey questionnaire from a purposively sampled population. This study’s universe is 100 while, five in-depth interview was undertaken. The samples are people
Statement of hypothesis

**Hypothesis testing**

(H\(_0\)) (Null Hypothesis): The policy of government on hospital leadership has no significant relationship with the incessant industrial unrest in government owned hospitals.  

(H\(_1\)) Alternative Hypothesis): The policy of government on hospital leadership has a significant relationship with the incessant industrial unrest in Nigeria’s health sector.

Dependent variable: incessant strike in government owned hospitals  
\[ R = 0.193, \text{ R}^2 = 0.037, \text{ Adj. R}^2 = 0.032 \]

The regression model will be specified as follows:

\[ P\Delta I = a + b + AEP + U_1 \]  

Where

- \( P\Delta I \) = Incessant Strike  
- \( AEP \) = Government’s concession of hospital headship leadership solely to physicians  
- \( a \) = Constant – Intercept  
- \( b \) = Constant – Slope  
- \( u_1 \) = Error term or Stochastic variable

**RESULTS**

The result in Table 1 shows that government policy on hospital headship is significant on incessant industrial unrest in the health sector (t = -2.714) P = 0.007). The value of t-value indicates or implies an inverse relationship. From the foregoing, the policy of government that made doctors the sole occupant of the exalted seat of Medical Director or Chief Medical Director or director is a significant on incessant industrial unrest in the health sector. The null hypothesis on the strength of the above is rejected. Hence, there is significant effect of policy of government that made physicians the sole occupant of the exalted. The value of \( R^2 \) was 0.037. This statistically implies government policy on hospital headship in Nigeria explained about 3.7% variation in relation to incessant strike in government owned hospitals. The remaining 96.3% variations in incessant strike were largely due to other variables outside the specified regression model. The adjusted \( R^2 \) was 0.032; that is, introducing new variables into the model would subsequently lead to drop in \( R^2 \) value to 0.032 (3.2%); the relationship the government policy on hospital headship as represented by \( R \) (0.193) is low, although positive. The regression model is significant in terms of overall goodness of fit \((F = 7.365, P = 0.007)\)

**DISCUSSION**

From the result analysed above, it is empirically evident that the government policy that conceded or sanctioned the permanent headship of government hospitals to physicians in a multi-professional environment is globally strange and belies the protracted crises that has tainted the Nigerian health sector in recent time.

Respondents and interviewees regardless of their professional leanings were largely of the view that the business of health promotion is inter-disciplinary, complimentary and inter-territorial. There was substantial disagreement among professional leanings on the propriety of government policy on hospital headship. The cross tabulation of respondents responses revealed the fact that professional leaning of respondents affected their responses to questions raised. While the chunk of physicians in this study were of the view that funding and government refusal to implement agreements reached are at the root of the unrest in the health sector, non-medical professionals are largely of the view that the dominance of physicians fuels industrial unrest and hampers their welfare and career prospect.

Responded were again divided along professional membership on whether physicians sole right to government hospital headship is appropriate. Sampled physicians were absolutely of the view that hospital headship is their inalienable right. The non-medical professional did not only disagree but also underscored the fact that the Nigerian government policy on hospital headship has no global reference.

Respondents also relived their rivalry on the implications of availing non-medical professionals the privilege of a government sponsored and supported residency training programme in order 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 hospital chaotic. The non-medical 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 also mitigate the burden and pressure on the grossly limited physicians in the country.
In conclusion, this study on the strength of insight deduced from In-depth-Interview and Survey Questionnaire empirically established an appalling appreciation of the benefits of Hippocratic Oath among healthcare professionals and a positive and strong relationship between government policy on hospital headship and the incessant industrial crises in Nigeria’s health sector. Government is enjoined to reinforce the Hippocratic Doctrine in the curriculum of medical related courses in Nigeria’s tertiary institutions. The government should also take a second look at the policy that bar non-medical professionals from honing their specialist capacity to become consultant in different clinical specialty through a government structured, regulated and funded residency training scheme. Government is also advised to open hospital headship to consultants from every clinical department in the hospital.

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