Chapter 3

INDUSTRIAL CONFLICTS AND HEALTH CARE PROVISION IN NIGERIA

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1.0 INTRODUCTION

Industrial conflicts usually arise due to a breakdown in negotiation as well as disagreements between employer(s) and the employees. Industrial conflicts connote a temporary stoppage of work resulting from the pursuance of grievance(s) by a given group of workers (Fashoyin, 1992; Fajana, 2000; Otobo, 2000; Adesina, 2003; Dauda, 2007). It could equally arise as a result of fall out in negotiation and also as a result of disagreements in the behaviour of the employer (and their association) and the employees (and their representatives). Though it is usually very difficult to disconnect one from the other as employers at times lock out workers and workers on the other hand can embark on strike actions and other forms of grievance expression. Both situations can be easily viewed as forms of the industrial conflicts (Nyong, 1998).

Industrial conflicts that show up in varying forms in nearly all cases are regarded as societal phenomena of enormous complexity. They are of many varieties and could involve different forms of tactics and strategies in their manifestations. Some of them include strikes (wildcat, sympathy), lockout, sit down, among others. They may be specific to a particular firm, within a given unit, or they may involve an entire industry, city or country. It may take place in order to mount pressure on the State, or may be a response to unsafe working conditions.

Otobo (1983; 2000) had noted that most industrial conflicts are deliberate and are results of conscious acts of the organization as workers have different view on what conduct or breach of agreement by which management deserves stiff response. It is very important to note that not all forms of industrial conflicts emanate from workers' deliberate decisions and actions. Management to a large extent plays a major role in the existence and duration of strikes because some management actions may inadvertently provoke certain actions from groups of workers that may violate agreements in a given manner.

In addition, as different members of management react differently to day-to-day developments, the conduct of certain members or their interpretation of the situation may hinder or bring closer the occurrence of some form of industrial conflicts. Majority of industrial conflicts (strikes) are non-violent because of restraint on both sides and the reason for such a caution is the realization that strike is a temporary action. However, some violent actions and protest can be the aftermath of strikes as aggrieved individuals vent their wrath on the society as a way of letting their voices to be heard leading to destruction of valuables (Morris, 2007; Sama, and Nguyen,2008; Vincent and Grugulis,2009).

Industrial conflicts in Nigeria have become rampant with various degrees of impacts. In recent times, industrial conflicts have manifested in general strikes that resulted from deregulation of the downstream oil sector with its aftermaths of regular hike in fuel prices. This has affected the nature of relationship between employers and employees as they are integral part of the economy. For instance, the cost of industrial conflicts in Nigeria measured as

man-day-lost in 2000 was about 6.3 million (Central Bank of Nigeria-CBN, 2007). Owoye (1991) examined the deleterious effects of strike in Nigeria between 1975 and 1990, Nyong (1998) captured a major strike effects in Nigeria-'June 12'), and Omotosho (2007) investigated the impact of privatization on workers' welfare using Power Holding Company of Nigeria (PHCN) Ado Ekiti as a case.

The occurrence of industrial conflicts becomes very worrisome when it affects sectors that provide essential social services like health. This is because the health sector has serious implications on the quality of human condition especially with respect to treatment of serious ailments and handling of emergencies. Thus, when there is a breakdown of activities in the health sector arising from industrial conflicts, it could lead to untold hardship for the society especially the patients. This can even lead to loss of lives as a result of poor medical attention. For instance, with respect to health care provision, the number of health practitioners, which was about 80,991 in 1997 reduced drastically to mere 7,970 in 2005 (National Bureau of Statistics-NBS,2005). The reason for this may not be unconnected to the low level of morale that health practitioners face with regards to inadequate reward system and the attendant industrial conflicts, which have led to exodus of qualified health practitioners to other countries of the world. In fact, the number of qualified health practitioners that emigrate from Nigeria to the West (Europe and America) is far higher than any other developing country in the world (Khaliq, Broyles and Mwachofi, 2009).

One of the major form in which industrial conflict is expressed by workers is strike. Besides, it is one of the most powerful tools. Thus, in this study, strike and industrial conflict would be used almost synonymously.

Health practitioners include the following: general doctors, dentists, optometrists, midwives, nurses, radiographers, physiotherapist, dental technologists, pharmacists, psychiatrist, orthopedics, pediatrician, and other health workers.

The scenario painted above should be a source of concern to Nigerians given the fact that the country's population growth doubles every 23 years as shown in Table 1.0. This is against the high infant mortality rate of 100 per 1000 and maternal mortality rate of 704 per 100,000 as well as under five mortality rate of 191 per 100, 000 live births. The case is serious given that only 30% of deliveries are made by trained health personnel. This gives indication that close to 70% of births in Nigeria are handled by quack/ untrained health personnel, which could be the reason for the high mortality rates mentioned above. The reason for this can be traced to the spate of industrial conflicts in the country. The situation has great implications for human conditions especially a situation where only about 10% and 27 % of complete immunization coverage before first birthday are recorded in rural and urban areas, respectively (see Table 1.0). This may be due essentially to low supply of health personnel.

It is the need to contribute to empirical literature on industrial conflicts that informed the study. Thus, this chapter is poised to examining the effects of industrial conflicts in the health sector in Nigeria using both national data and primary data from Lagos University Teaching Hospital (LASUTH). The reason for this is as a result of the key role the health sector plays and its unique services to humanity. The rest of the paper is structured as follows: section 2 is the literature review; section 3 is theoretical framework and methodology while presentation of data and analysis are covered in 4.The last section is the conclusion.

Table 1.0 Some Demographic and Health Indicators in Nigeria

S/N	Health/Demographic Issues	Indicators
1	Population Doubling Time	23 Years
2	Total Fertility Rate	5.7
3	Rate Of Natural Increase	46 per 1000
4	Crude Birth Rate	45 per 1000
5	Infant Mortality	100/1000
6	Maternal Mortality Rate	704/100000
7	Under Five Mortality Rate	191 per 100000
8	Life Expectancy at Birth	Live Births 52 Years (1992;2004)
9	Percentage of Under Five Malnourished	36%
10	Complete Immunization Coverage Before first Birthday (Urban)	27%
11	Complete Immunization Coverage Before First Birthday (Rural)	10%
12	Delivery By Trained Attendant	30%
13	Access to Safe Water (Rural)	48%
14	The ratio of population to primary health care (PHC) in 2000	5629
15	Ratio of population to health care facilities	4829
16	Poverty incidence	65.6(1996); 54.4 (2004)

Source: National Bureau of Statistics- NBS (2005).

2.0 LITERATURE REVIEW.

Industrial conflicts occur when employees refuse to work until an employer changes its position on certain employment issues (Morris, 2007; Chan, 2009). It is fundamentally an expression of protest and dissatisfaction intended to pressure the employer by withholding their labour services. The origin has been traced to the British Sailors

who lowered their ships' sails in 1768 and at times brought shipping to a stop until their demands for a higher wage is met. It can be pointed thus that industrial conflicts is a general term used to describe the broad areas of disagreement and difficulty between employees and employer(s). Industrial conflicts can show up in the following manners: high labour turnover, picketing, absenteeism, sabotage, overtime bans, work-to-rule, walk in and sit down, strike, lockout and so on (Dauda, 2007). For this study, the term industrial conflicts will be used to broadly describe the various forms of dispute listed above.

Industrial conflicts entail the full withdrawal of labour, failure to discharge all employment duties and breach of contract that an employer should accept, rather than relinquish. This implies the refusal on the part of employees to perform their duties resulting from the inability of the management of the organization to meet an offer demanded by workers' union. And it can also occur as a result of deadlock in the bargaining process between the employer and the employees (Otobo, 2000; Adesina, 2003). Banjoko (2002) observed that even in the absence of any empirical evidence, experience itself has shown that industrial conflicts generally have a negative and unpleasant consequence on the employers themselves and the society at large. When a conflict occurs in the organization, the employer suffers substantial financial losses in terms of lost revenue, opportunity cost of unutilized equipment, machineries and other resources, loss resulting from decline in productivity, extra cost of hiring, replacements of damaged materials or accidental expenses incurred for using non-union supervisory personnel and the possibility of losing market share and valuable workers, and declined profitability.

Industrial conflicts affect the effectiveness and efficiency of the organization. In a very broad term, Industrial conflicts occur as a result in breakdown in negotiation due to the divergence in the optimizing behaviour of the two parties. This breakdown in negotiation can be caused by myriad of factors. This can be grouped into economic and non-economic factors. The economic factors of industrial conflicts include the following: unemployment; wages and salaries; inflation; profits. Most industrial actions are as a result of breakdown in negotiation over economic issues. For instance, it has been found that there is a negative relationship between unemployment rate and incidence of industrial conflicts. While inflation had positive effects (Osabuohien and Ogunrinola, 2007). Increase in the organization's profit can have a positive relationship with the propensity to 'down tool', especially when workers have made great efforts that resulted in larger profits and the management fails to meet workers' demand.

Other factors that have been found to brood industrial conflicts include political and institutional factors such as restructuring of the socio-economic and political systems in a given organization or in the economy at large e.g. privatization (Otobo, 1983; Owoye; 1991; Omotosho, 2007). Fashoyin (2002) noted that strike in most cases could be attributable to an enduring power struggle between workers and their employers over the control of various aspects of work, inequality in the distribution of the proceed of the firm, job insecurity, and poor management strategies. Fajana (2000) noted that industrial conflicts can result from a number of issues rather than a single one and the actual occurrence depends on some prevailing circumstances. Industrial conflicts especially strike are not the exclusive result of workers' deliberation. Management actions may indirectly instigate a

strike action by violating agreements that were previously reached.

Jansen, Dassen and Jebbink (2005) explored the attitudes of health care workers towards inpatient aggression and analyzed the extent to which attitudes were addressed in the selected studies reviewed. They found that self-report questionnaire was the most common instrument used. While Ironside and Seifert, (1999) used evidence gained from managers and trade union representatives in health care services in France, Finland and the UK. The authors argued that all aspects of training provision are best handled through traditional collective bargaining procedures. This suggests the need to provide training for managers and union representatives to enable them to understand both training issues and collective bargaining procedures in their organization.Workers in the public sector have commonly been subject to a more restrictive labour law regime than their private sector counterparts. This article argues that this has become anachronistic and proposes a more sophisticated model for according differential treatment to particular groups of workers (Morris, 2007).

Chan (2009) furthered the debate on global capitalism and labour politics in focusing on China using data from fieldwork on a Taiwanese-invested factory, where a strike that occurred in 2004 spread from one department to the whole factory. He submitted that the expansion of capitalism in China has raised the marketplace and workplace power of workers but their associational power is impeded by the state socialist legacy. Vincent and Grugulis (2009) explored the employment relations consequences of cost minimization in the management of inter-organizational contracts for less-skilled work. The case-study data reveal that cost minimization creates and exacerbates employment relations problems, with the result of

particular tactics dependent on the relative tractability of broader economic conditions and social relationships within the organization.

Industrial conflicts represent withdrawal of labour services from a given organization. These individuals' rights are harnessed by trade union to embark on a collective action. The union strength in an organization/industry, therefore, largely influences the occurrence of industrial conflicts. If it is successful i.e. their demands are meant, it improves the economic well being of the members of the trade union. On the other hand, it makes the management to take the union seriously in future negotiations. Thus, it leads to enhancement of the bargaining power of the union in future negotiations. However, if it fails to meet the union's demand, the workers stand some risks and frailly power in future negotiation. The workers suffer emotional distress and temporary loss of income as long as the strike persists and in some cases it can lead to layoff (Mas, 2004). For instance, resident doctors at LASUTH that embarked on industrial action on 28th December, 2005, were sacked two days later by the government, which called it an 'illegal action'.

The effects of industrial action on the employer (and the organization) usually include lowered productivity, idling of organizational resources like equipment, inability to meet customer's demands/orders on schedule. These will have negative effects on the ability of the organization to meet its goals. Other losses include the loss of contract year as clients avoid a company likely to face an industrial action. It may also include loss of skilled and technical personnel to other firms who may probably not return even it is later resolved. The effects of industrial crises are usually more severe

This was revealed from interview that was carried out.

when it affects sectors that have direct bearing on human capital formulation- health and education. This is because when industrial crisis occurs the quality of human capital (human condition) would diminish and given the key role of human capital in any economy, it would affect the national productivity (*Ninalowo, 2003;* Osabuohien and Ogunrinola, 2007).

Industrial conflicts can also disrupt the achievement maximization of desired economic growth for the nation due to the loss of output in the industry affected. Sometimes the work stoppage is a general strike spanning the whole nation. More so, it has political implications between the government/Labour relations. This is because it could arouse political agitations from the civil society and the citizenry especially when it affects key sectors of the economy such as health. In addition, a country that is easily prone to industrial conflicts is not likely to attract significant foreign investment, thereby constituting a barrier to achievement of the nation's developmental goals (Fashoyin, 1992; Onyeonoru, 2004).

From the literature, though there are studies on the causes of industrial action, little has been done to empirically examine the effect of industrial conflicts on health care provision in Nigeria. Most of the work and studies were based on aggregate industry level rather than at the level of individual organization. It is on this note that this study examines an organization- LASUTH, in addition to the national data.

3.0 THEORETICAL FRAMEWORK AND MODEL FORMULATION

3.1 Theoretical Framework

The study employs Hicksian theory of the causes of conflicts which is

somewhat similar to the Marxist theory. The latter argues that the pro-cyclical movement in occurrence of industrial conflicts demonstrates that industrial conflicts are products of the bargaining power held by labour (employees). The former analyzes the role played by industrial conflict leverage in shaping negotiated outcomes assuming that the parties are negotiating only over items that can be reduced to monetary terms represented by wages. This indicates that the bargaining powers of the employees and employers of industrial conflicts are characteristically essential during negotiation, not just only that of labour. In the Hicks model bargainers (employees-and their union and employer-its representatives) that form the bargaining unit have an expectation of what they will eventually agree on. Thus, resolution of industrial conflicts would lead to wage settlement, *ceteris paribus*.

In this case the two teams i.e. workers and the management search for ways to maximize its own interest. The organization seeks to maximize productivity using workers' services, while the employees maximize their utilities that are obtainable from offering their labour services such as comfortable wages and the likes. It is proposed that they (workers and the management) will prefer to resolve any form of industrial conflicts (especially work stoppage) and would not allow it to degenerate owing to the fact that they incur some form of losses (Mas, 2004). The employees will forgo their income while the organization will lose output (resulting in low productivity). For instance, in construction equipment resale market in U.S.A over 240 billion US dollars was lost due to a single industrial conflict in 2004 (Mas, 2004).

In addition, it could be noted that not only the workers and the

management of the affected organization bear the effects of industrial conflicts alone but it robs off on the society in form of low output, poor products qualities, not meeting the customers' welfare. This is as result of fall in demand, reduction in the hope of those that depend on the workers for their livelihood, damage done on property during demonstrations, among others (Mas, 2004). The Important point that can be noted from the framework is that there would be no contract zone if the parties have different expectations of the strikes outcome. It should be noted that industrial conflicts occur principally as a result of miscalculations between the workers and the management, which imposes a great deal of cost (loss) on both of them and the society at large. The cost to the society becomes enormous when crucial sector like health is involved given the threat to human lives that such industrial action would precipitate.

3.2 Model Formulation

Following the points in the previous sections, this study models an equation that relates the quality of health care provision (HCP) as function of industrial conflicts. This is premised on the fact that when workers 'down-tool', it will reduce amount of services rendered by health practitioners. And the various components of industrial conflicts (INC) include: man-day-lost (MDL), i.e. number of hours lost as result of industrial conflicts; work stoppages (WSP) indicating number of times work is totally stopped as a result of industrial conflict; number of times industrial conflicts occur, which is also known as number of trade disputes (TD), showing frequency of industrial conflicts.

In furtherance, Health Care Provision (HCP) can be captured by the number of health care practitioners, which will give indication on the

number of patients attended to in a day. This would reflect the number of personnel on call (duty). Thus if the number is high it would influence the number of patients attended to. However, when there are industrial conflicts it would affect workers on call. At times the industrial conflicts may lead to total temporary withdrawal of the services of affected union members such as Nigerian Medical Association-NMA (involving all doctors) and association of nurses. Even if one union is affected say NMA, it would still reduce the number of patients attended to. And given the inelastic demand for health care, any decline in the supply of health services occasioned by industrial conflicts, there will be serious implications on health and the human conditions in the country. Thus, the low provision of health care would denote that a chunk of the population will not meet up with it or make do with what is available (usually the traditional method that is not subjected to any form of safety and control measures).

From the foundations above, this study models a linear relationship between HCP and other industrial components.
This is represented in a functional form below:

$Cp_t = f(INC_{it}, Govt_t, U_t)$ ----------1

Where:

HCP: Health care provision

INC_{it}: Components of industrial conflicts, which made up of man-day-lost (MDL); work stoppages (WSP); number of times industrial conflicts occurred (TD).

Govt : Government disposition toward the health sector, which is proxied by the percentage of budgetary allocation to the health sector in total recurrent expenditure.

U_t: the error term showing other possible variables not explicitly captured in the model.

Bringing the components of if INC, equation 1 can be re-written as:

$HCP_t = f(MDL_t, WSP_t, TD_t, Govt_t, U_t)$ ----------2

Equation 2 can be written in an explicit form as:

$$HCP_t = a_0 + a_1 MDL_t + a_2 WSP_t + a_3 TD_t + a_4 Govt_t + U_t \text{---------} 3$$

The expected sign of the variables are a_1, a_2,a_3 <0 and a_4>0. This indicates that a negative relationship is expected between HCP and the various components of industrial conflicts. However, a positive relationship is expected to exist between *HCP* and government disposition towards the health sector. The data for variable *HCP* was sourced from National Bureau of Statistics, while the others were sourced from Central Bank of Nigeria Statistical bulletin.

4. DATA PRESENTATION AND ANALYSES

4.1 Introduction

The presentation of data and analyses of the study was done in two parts. The author first presented national data on the related issues and assessed statistically how the incidence of industrial conflicts has influenced the provision of health care in Nigeria. While the second section of the empirical analyses used a case study from Lagos State University Teaching Hospital (LASUTH) in order to assess current views on the issues. The data collected was analyzed with Statistical Package for Social Sciences (SPSS).

4.2 Health Care Provision and Industrial Conflicts in Nigeria (1996-2006)

This sub-section presents and discusses the national data on some indicators of health care provision as well as the components of

industrial conflicts.

From Table 2.0, some analyses could be made on the variables presented. With respect to health care provision (*HCP*), the number of health practitioners which was about 84,159 in 2000 reduced drastically to mere 7,970 in 2005. This shows the low supply of health care facilities in the country. In which the supply of health care facilities is not in any way close to the demand and as a result of this, people are made to 'pay through their nostrils' to access the few available ones.

On the other hand, the people have to make do with the ones in their neighbourhood not minding the quality of services provided. This has serious implications on health and the human conditions in the country because low provision of health care would mean that a large proportion of the Nigerian populace will not be able to have access to adequate health care. Thus, they will 'manage anything' available (which is usually the traditional alternative). This situation becomes more complicated given the high poverty incidence which was about 65.63% in 1996 and 54.43 in 2004%. In fact some international organization reports that it was high as 70% in recent times (Diejomaoh, 2008), which connotes that majority of Nigerians cannot even afford the health care facilities that are even available.

The reason for the low supply of health practitioners in Nigeria, which is an indication of health care provision in the country, can be linked to the disposition of government towards the health sector. A look at the percentage of the budgetary allocation earmarked for the health sector stresses this point further. The budget allocation to health as percentage of total recurrent expenditure never approached

6% between 1996 and 2006 as shown in Table 2.0. The value was even as low as 1.98% in 1997 and 3.38% in 2003, which marginally increased to 4.58% in 2005 but later dropped the following year.

There could be a kind of correlation between the industrial conflicts and budgetary allocation and number of health care practitioners in Nigeria. With respect to the components of industrial conflicts the value for man-day-lost increased from 94,664 in 1996 to 5,505,322 in 2002. This could be traced to the low value of the allocation to the sector as presented below in Table 2.0. When compared to the downward movement of health practitioners from 84,159 in 2000 to 7970 in 2005, a great disconnect between them is observed.

Recurrent expenditure was used because it is believed to have direct effect on workers as it involves payment of salaries and other employment benefits. The non-payment and delay in payment have often ignited the fire of industrial conflicts.

Table 2.0 Some Health Care Provision and Industrial Conflicts in Nigeria (1996-2006)

Year	Health Practitioners	Trade Dispute	Work Stoppages	Man-day Lost	Budget Allocation to Health as % Total Recurrent Expenditure
1996	72,287	29	101	94,664	2.26
1997	80,991	31	89	359,801	1.98
1998	75,629	16	108	47,631	2.66
1999	78,657	52	37	3,158,087	3.98
2000	84,159	49	27	6,287,733	3.29
2001	7,242	51	37	4,722,910	4.23
2002	7,214	50	42	5,505,322	5.83
2003	6,701	149	42	4,518,321	3.38
2004	7,562	152	308	3,032,112	3.67
2005	7,970	155	489	2,085,903	4.58
2006	n.a	46	112	2,446,085	4.48

Sources: NBS (2005); CBN Statistical Bulletin (2007), CBN Annual Report and Statements of Accounts (2007).

To capture the picture better and more clearly we presented the graph between logarithms of health practitioners, man-day-lost, and budgetary allocation to the health sector as a percentage of total recurrent allocation (*LogHCP, LogMDL; LogBHS*). The logarithmic values were used due to the fact that the logarithmic values show the rate of changes in the variables more than their face values (Gujarati, 2003; Osabuohien and Egwakhe, 2008). Figure 1.0 shows that *LogMDL* has increased upwardly within the period presented while the Log*HCP* experienced sharp decline within the same period. That of *log BHS* remained constant at low ebb.

In order to assess the model formulated in previous section and further examine the nature of relationship between the variables, the

correlation matrix is herein presented. The higher the absolute value of coefficient of correlation, the stronger the strength of the relationship, positive or negative, as the case may be.

Table 3.0 shows that the components of industrial conflicts had the expected negative signs with health care provision. However, with respect to the magnitude of effect, number of occurrence of industrial conflicts has the highest effects, followed by man-day-lost and work stoppages, in that order. The variable representing government disposition to the sector had negative values, contrary to the expected positive sign. This implies that the government has not been positively disposed to adequately supporting the sector. The mass emigration of trained health personnel to other parts of the world for greener pasture- brain drain is a good testimony to this finding.

The study used just correlation matrix to show the kind of relationship between the variables without going to the extent of the various econometric tests such as unit root, cointegration etc due to the sample size and focus. Rather it supports the debate with field survey using LASUTH with a view to providing very current views on the issue.

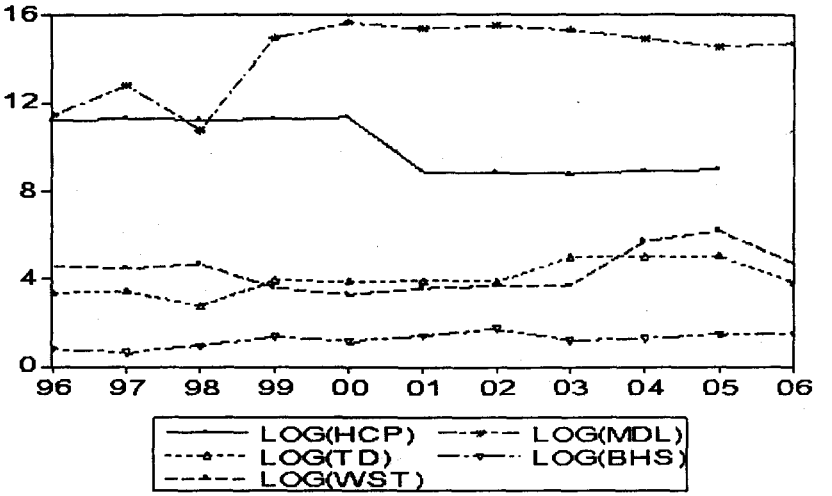

Figure 1.0: Health Care Provision and Industrial Conflicts in Nigeria (1996-2006).

Table 3.0 Correlation Matrix between Industrial conflicts and Health Care Provision

Variables	LOG(HCP)	LOG(TD)	LOG(WST)	LOG(MDL)	LOG(BHS)
LOG(HCP)	1				
LOG(TD)	-0.73711	1			
LOG(WST)	-0.23672	0.343053	1		
LOG(MDL)	-0.47447	0.389448	-0.310856	1	
LOG(BHS)	-0.29128	0.314284	-0.063071	0.236804	1

Source: Computed by the Author from the data.

4.3 Case study - LASUTH

To support the analyses presented in the previous sub-section based on national time series data, the study went further to undertake case study employing questionnaire and interview methods. This was carried out at Lagos State University Teaching Hospital (LASUTH). The choice of LASUTH lies in the fact that it is owned by the state and it is a teaching hospital. This implies its role in both the health and educational sectors- key areas of human capital formation.

LASUTH, which is owned by the Lagos State Government, is located at No. 1- 3 Oba Akinjobi, Street, Ikeja, Lagos, Nigeria. It was founded to serve as a training centre for medical students and offers health services to members of the public especially those in Lagos and its environs. It initially started as Cottage Hospital serving a handful of patients (about 200 per day) but it has grown to become a full scale hospital. Its foundation laying ceremony was done on the 25th June, 1955 by the minister of Public Health of the then old Western Region (Hon. S.O.Igbodare) (Lagos State University Teaching Hospital-LASUTH, http://lasuth.org/aboutus.html).With increase in population and its resultant increase in demand for health care services, it is expected to provide improved health care services not only to the people around Ikeja but the entire indigenes of Lagos State and other neighbouring areas.

The dawn of the political dispensation led to the transformation of the hospital to a teaching hospital in April, 2001 by Bola Tinubu (then State Governor), although the moves had being on for some years. With this status, the hospital now has its own medical school to train medical personnel. Presently, the hospital has the following clinical departments: medicine *(about 13 staff members);* Surgery with an

average of 125 patients' admittance weekly; Pediatric, Radiology, ENT (that work on ear, nose and throat problems; Ophthalmology; Psychiatry; Family Health, Morbid Anatomy (also called Anatomic Pathology); and Nursing. The day-to-day affairs of the hospital is run by a management board (anchored by a Chief Medical Director), which reports to the hospital governing board.

Primary data was used in this case study, which was done by administering structured questionnaire to the staff of LASUTH. This was complemented by some interviews with management staff and union leaders. The categories of staff that comprised the sample space for the questionnaire cut across different cadres of health personnel, which include doctors with different specialization, technologist, nurses, and ward attendants. A representation was drawn from the sample space cutting across the different cadres of staff. A total of one hundred copies of questionnaire were administered. The questionnaire had two sections A and B. Section A covers the personal bio-data of the respondents while Section B covered the causes of industrial conflicts, the consequences and effects and possible solutions.
Out of 100 copies of the questionnaire distributed, 72 of them were retrieved and found useful. In Table 4.0, the social demographic features of the respondents, which include gender, age, highest educational qualification and marital status, were reported. From Table 4.0, it is obvious that majority of the respondents were female (about 80.56%).

Turning to another social demographic factor, Table 4.0 also reveals that majority of the respondents are within the age bracket of 40-49years representing about 44.44%. This is followed by age group

30-39years. This is not out of place given the high gestation period of human capital formation that usually characterizes health personnel. The implication of this is that given sufficient period of time to qualify as health personnel, there should be a kind of reward system that would encourage the younger generation to develop interest in that area. However, the situation in Nigeria is that the health sector is not close to having such priority. This, among other factors, has accounted for the high rate of qualified health personnel emigrate in search of 'greener pastures', which has made Nigeria to record the highest number of health personnel emigration among other developing countries in the world (Khaliq, Broyles and Mwachofi, 2009).

Efforts were made to distribute equal number of questionnaires to the respondents. However, high response rate were recorded among the females more than the males. This would not have any effects to the study's objective given the fact that it involves general issues. Notwithstanding, the low response rate from the males was compensated (kind of) by the interview with labour union leaders and directors who are males.

Table 4.0: Distribution of Some Socio-Demographic Variables of Respondents

Socio-DemographicFactors	Number	Percent (%)
GENDER		
Male	14	19.44
Female	58	80.56
AGE GROUP (YEARS)		
20 -29	9	12.50
30 -39	23	31.94
40 -49	32	44.44
50and above	8	1.11
HIGHEST EDUCATIONAL QUALIFICATION		
Primary	4	5.56
Secondary	3	4.17
OND (Ordinary National Diploma)	4	5.56
Degree (B.Sc/HND)	11	15.28
Postgraduate/Professional	50	69.44
MARITAL STATUS		
Single	4	5.56
Married	66	91.67
Separated/Divorced	2	2.78
TOTAL	**72**	**100.00**

Source: Field Survey

In terms of their marital status, it was found that most of the respondents are married while few were separated (2.78%) and single (5.56%). Moving to the highest educational qualification, it is obvious from Table 4.0 that close to 70% of the respondents have either or both postgraduate degree and professional qualifications. This may be one of the reasons for the long gestation period for health personnel earlier observed.

In addition, the study present results on the key issues of industrial conflicts and health care provision. From 5.0, it is revealed that one of the major reasons for the occurrence of industrial conflicts in the health sector is the non-fulfilment of promises made by management (government).

It is not uncommon to find management recede and outrightly "pay deaf ears" to collective agreements reached with the union(s). The interviews granted by the union leaders also supported this fact. Here is an excerpt:

> *We had crisis with the then Lagos State Government led by his Excellency Marwa. It was very tough, over wages/salaries; at the end we got 75% of what we were agitating for i.e. salaries and other benefits. At unit level (in government hospital.), workers in teaching hospital for instance could be infected of all manner of diseases ranging from tuberculosis so their job is a very delicate one. Thus, they ought to be paid as at when due to enable them take care of their own health. So withholding workers salaries could easily mean endangering their lives.*

TABLE 5.0: Relationship Between Industrial Conflicts And Health Care Provision

Some Perception about Industrial Conflicts and HCPN	umber	Percent (%)
What Are The Major Causes Of Industrial Conflicts		
Poor Working Conditions	8	11.11
Delay In Payment Of Allowances	11	15.28
Non-Fulfillment Of Promises Made By Management/Government	53	73.61
Others (Specify)	0	0
Industrial Conflicts Affect Health Care Delivery/Provision		
Strongly Disagree	2	2.78
Disagree	6	8.33
Indifferent	0	0
Agree	18	25
Strongly Disagree	46	. 63.89
Who Are The Major People That Bear The Brunt Of Industrial Conflicts		
The workers (employees)	3	4.17
The employees	10	13.89
The patients(society/third party)	59	81.94
How Can The Occurrence Of Industrial Conflict Be Reduced		
Prompt payment of Salaries/Allowances	9	12.5
Provision of Better Working Conditions	22	30.56
Adherence to Terms of Agreement	41	56.94
Others (Specify)	0	0
TOTAL	**72**	**100.00**

Source: Field Survey

Table 6.0: Analysis of Variance on Whether Industrial Conflicts Affect Quality of Health Care Delivery

	Sum of Squares	Degree of Freedom	Mean Square	F-value	Sig.
Between Groups	1.198	1	1.198	**8.318**	**0.005**
Within Groups	10.080	70	0.144		
Total	11.278	71			

Source: Field Survey

This study revealed that non adherence to collective agreement is the major reason for industrial conflicts, followed by the delay in payment of salaries/allowances (15.28%) and poor working conditions (11.11%). The national industrial action embarked upon by the Nigerian Union of Teachers (NUT) in March 2009, lends credence to the above finding. The major cause was the refusal of most states government to implement the 27.5% raise in salaries which was agreed in August 2008 to kick-off January, 2009 (Olusola, Tunde, Obasola and Adelani, 2009).

In addition, Table 5.0 establishes that the occurrence of industrial conflicts affects health care delivery/provision a great deal. With regards to who majorly bears the brunt of industrial conflicts in the health sector, this analysis confirms that the patients/ their family (by extension society) suffer most (over 81%). However, the employees and workers also bear the brunt (13.9% and 4.17%) respectively. This is like a typical maxim where the 'innocent ground' suffers when 'two elephants fight'. Thus, the industrial conflicts between health practitioners and employers (government) make patients suffer more. This is due to germane role played by the sector. Consequently, any industrial conflicts in it leaves the society worse-off as it would not only make the patient not to be treated but also other opportunity costs that pertain to it.

The above is further supported by significant F-statistic reported in Table 6.0, which points out that the null hypothesis that industrial conflicts do not affect quality of health care delivery be rejected at 1% level in favour of the alternative. This has great implications to human conditions especially as it affects the human capital essential for any economy. In terms of possible solution in resolving the spate

of industrial conflicts in the health sector, this study reveals that the major way forward are adherence to terms of agreement, provision of better working conditions (facilities and equipment) and prompt payment of salaries/allowances, in that order.

5.0 CONCLUSION

The chapter examined the effects of industrial conflicts in the health sector in Nigeria. This became crucial given the germane role the sector plays in both human capital formation and the general well being of humans. The analysis in the chapter was done in two forms. The first was the discussion of national level data on some indicators of industrial conflicts and health care provision. The other was a case study carried out at a teaching hospital- LASUTH.

The findings from both aspects established the fact that Nigerian government has not placed key priority on health care provision. The chapter also found that the major factors that lead to industrial conflicts, among others, is the non-adherence to agreement that has been reached on the part of management. It is also interesting to find that neither the health personnel nor management (government) bears the major burden of industrial conflicts in the sector but the patients (society). This is a typical case of 'innocent grass' suffering when 'two elephants fight'.

The chapter concludes that for the Nigerian health sector to live up to its bidding of providing health care services and improve the people's well-being there is need to reduce the occurrence of industrial conflicts in the sector. This can be achieved by strict adherence to terms of agreement once reached, prompt payment of salaries/allowance and provision of better working condition. This

will not only improve health care provision but it will equally reduce the high level of emigration of trained health personnel to other countries. The above will in the long-run make health care provision in Nigeria available to majority of the populace as a result improve human condition for the betterment of the country.

Acknowledgments

The support of Sorkpor, Courage O., Department Of Business Studies, Covenant University Ota Ogun State in the process of data collection is appreciated. Also the author thanks Adewole, M.A for valuable suggestions.

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