Socio-Economic Outcomes of Health Care Industrial Conflicts in Ondo State, Nigeria

Abstract: The health sector is vital to the productivity, growth and development of any political system. When the health sector collapses, the human capital is seriously undermined and mortality rates increases and thereby induces poverty in the long run. As vital as these workers in this sector are, many health workers have threatened and embarked on strike at various times and even in this period of COVID 19 pandemic. This study seeks to investigate, from the point of view of health workers, the causes, types and consequences of industrial actions in the health sector. A cross-sectional study of public health facilities in Ondo State, was employed using a survey design involving data collection from 600 participants, across the various departments of the health institutions. Participants were drawn from the three senatorial districts of the study area. Data analyses involved the use of descriptive and inferential statistics. From the study, many factors are responsible for industrial actions, especially the non-fulfillment of promises made by government to the workers. Also the study affirmed that strike actions, protest, lockout and boycott of emergencies are noticeable ways of conflict displays at the health institutions. Furthermore findings indicated causes of conflict correlate strongly with negative impacts on patient, health workers and society. The study concludes that industrial conflict in health care could result into increases in mortality, spread of diseases in the society, and exploitation of patients. Therefore, complications to health matters were affirmed to be an outcome of industrial conflict in the health care centers. Study therefore recommends that in the light of the COVID-19 pandemic, and negative effects of strikes, governments should ensure that conflicts are prevented by quick response and swift enforcement of the decisions reached at negotiations.

Keywords: COVID-19, health, mortality, outcomes, strike, workers, patients, emergencies, exploitation, pandemic.

INTRODUCTION
The importance of good health to the life of a nation cannot be overemphasized. The Millennium Development Goals and the Sustainable Development Goals have placed a high priority to the provision of health to the citizens of every nation. This is because there is a very strong link between health and economic development and growth (Piabuo and Tieguhong 2017). Therefore, the National Health Policy in Nigeria has as its major thrust, the attainment of a healthy citizenry (NHP 2004).

However the nation’s health sector has not performed at its optimal level as to achieve the MDG or SDG goals over the years. The Nigeria Health sector suffers from inadequate funding, personnel, infrastructures and equipment to cater for the health need of her citizens (Ayo Abelebe 2020) It is also needless to say that due to these challenges, life expectancy is low and medical personnel are overwhelmed. In view of this many wealthy Nigerians and public office holders have found it necessary, though costly to seek for medical care in foreign countries. However, with the advent of the COVID 19, Nigerians are forced to make do with health facilities in the country.

There has been a brain drain in the Nigeria’s health sector for more than forty years, such that the nation had remained one of the major exporters of health personnel in Africa, which in turn had led to worsening health indices (Oluwabunmi et al., 2009). The various challenges faced by Nigeria’s health sector have also led to industrial disharmony between the government and members of the Nigeria Medical Association. Therefore there have been cases of strikes borne out industrial conflicts. Oleribe, O.O., Udofia, D., Oladipo, O. et al., (2018), in their study had identified poor staff welfare, salary, inability to implement agreements and dysfunctional leadership as common causes of health worker strikes in Nigeria. For example, conflict between union of staff and management especially those affecting the core concerns of the staff like salaries and wages, working conditions and so on can lead to temporary stoppage of services with resultant detrimental effects on population health (Obinna, 2011).

While various studies have also investigated the cause of strikes, this research seeks to investigate the implications of strikes from the perspective of health workers in order to mitigate against looming strikes in this sector during COVID 19 pandemic.
**LITERATURE REVIEW**

Conflict, is a disagreement between two or more individuals within an organization as a result of differences in status, scarce economic resources, goals and interdependent nature of work activities. According to Osaghae (2000), while viewing it from the angle of community interactions opines that conflict could occur between people of different communities normally over the determination of rights. Thus when certain groups of people feel that their rights in existence, profession and access to resources are being denied, conflicts inevitably occurs. Conflict has also been perceived as a representation of a felt struggle between two or more interdependent individuals over perceived incompatible differences in beliefs, values and goals, or over differences in desires for esteem, control and connectedness (Hocker and Wilmot, 2011). Conflict therefore in its raw sense occurs as a behavior that seeks to obstruct the achievement of other people’s goals within an organisation in a given period of time. However, while conflicts are sometimes perceived as being a negative means to an end, Fasunwon (2006) had argued that conflicts have also been a means of getting portions from the scarce resources in various political systems.

Within the health sector there are several causes and types of conflicts. Amongst the workers there exist task and relationship conflicts. Task conflicts occur where there is a disagreement in the method, procedure and techniques of performing a task at hand. Thus, in several cases, conflicts are borne out of the disagreement on the means to an end, and not the end in itself. The relationship conflict on the other hand occurs when individuals or groups experience negative emotions on the perception that the actions and or inactions of another individual or group restricts or is likely to restrict a personally valued goal (Hartwick J. and Barkl, H. 2002). Conflicts that arise from any or both forms described above could have both positive and or negative impact on the health workers and clients. While task conflicts could lead to the development of result oriented work procedures, it could also engender lukewarm attitude towards prescribed work procedures and lead to relationship conflicts. While relationship conflicts may engender a formal approach to work, it could also prevent cooperation towards the attainment of a goal. However the focus of this research goes beyond the stated conflicts to incorporate relationship conflict, as it relates to the health workers and their employers that is industrial conflict.

Industrial conflict has been described as the whole range of behavior and attitudes which expresses opposition and divergent orientations between entrepreneurs and managers on one hand, and working people and their organisations on the other hand (Kornhauser, Dubi and Ross 1954). From this, it is plausible to ascertain that industrial conflict is borne out of a perception of unparallel interests between workers and management. Often times, as observed in the health sector, issues of disparity often bother on staff welfare, conditions of service and work tools. Viewed from the lens of Marxist theorists, it could be viewed as the agitation that occurs between the haves and the have-nots over the control of the surplus value.

According to Bloomsbury (2002), the presence of various opposing attitudes to a particular situation, persons or issues could lead to industrial conflicts. Industrial conflicts have however been differentiated from strikes. Strikes do not necessarily have to occur in industrial conflicts. Fayankinu (2008) had defined strike as a temporary stoppage of work by a group of employees in order to express a grievance or enforce a demand., which is informed by the perceptions of exploitation and deprivation deriving from resource allocation and distribution. Thus while strike is often avoidable, it has become the last and most effective option in industrial conflicts.

With regards to the health sector, Bloomsbury had submitted that several studies have explained that strikes in the medical profession are often embarked upon due to poor working conditions, followed by wage, and other incentives. Furthermore, problematic working conditions; unrealistic work expectations, discriminatory behaviors, poor communications and disregards for organizational norms or values are also causes of industrial disharmony in the health sector. During the period of the pandemic in Nigeria, Doctors in Enugu, and Ondo States had threatened to go on strike due to the nonpayment of salary arrears, non availability of Personal Protective Equipment (PPE) as well as poor remunerations for service rendered.

In every society, the health of the people determines to a large extent their availability for work, and consequently, their contributions to the development of such society. A healthy population therefore is indispensable to the economic and socio-political well being of any nation. This assertion is made more explicit by the global outbreak of the COVID 19 pandemic. The pandemic has resulted in the loss of manpower through death, isolation, quarantine and lockdowns thereby stagnating the global economy and moving many nations towards recession. However, before the outbreak of the pandemic and in the course of it, health workers, despite the Hippocratic oath have had to embark on strikes in order to press home their demands.

In this light, (Oluwabunmi O. et al., 2009) argue that the absence of non monetary factors which include improved staff welfare, managerial support for career development, improved quality of supervision and adequate availability of tools and equipment to work with has been shown to lead to daily unresolved frustrations of workers in the health care sector, which...
in turn reduce their willingness to exert and maintain efforts towards attaining the stated organizational goal of providing high-quality care. However it is pertinent to add that while these issues may be the root causes of industrial disharmony, strikes are usually the outcome of breakdowns in negotiations over these issues between the employers and employees.

Beyond the breakdowns in negotiations, strikes have also been embarked upon even when there are agreements. For example in Nigeria, the Academic Staff Union of Universities (ASUU) have embarked on several strike actions even when, there are documented agreements with government. This scenario has also played itself with the Nigeria Medical Association (NMA). In explaining this phenomenon, Animashaun and Shabi (2003) had submitted that partial, and non-implementation of agreements, as well as disagreement with government on the minimum service level agreement was cited as reasons for doctors and health care workers strike.

Therefore, strikes in the health sector may well be situated within the framework of the Systemic theories which proposes that the friction in the interdependences and inter-relations that exists with the systemic society in which the health sector finds itself produces conflicts. In the first instance, and within the systems theory, when the government fails to convert the demands of the health workers into concrete outputs that would generate supports, then frustration on the part of the health workers leads to aggressive behaviors which are demonstrated in strikes and actions against their Hippocratic oaths. As a panacea, Faleti (2006) proposed such conflict could be resolved or prevented by meeting the demands with appropriate satisfiers, that is government providing to the health workers those things denied in the first instance.

Several researchers like (Jehn, 1997; Amason, 1996) however have submitted in separate submissions that the substantive and affective dimensions of workplace conflict should be considered. While the substantive dimension entails issues relating to tasks, organization’s, workplace satisfaction, remunerations and workplace policies, the affective dimension entails issues that are caused by the negative reactions of members of the organizations to behavioral attitudes amongst colleagues, and between the employers and employees. However, Rahim (2002) had contended that there would not be need to consider these dimensions as separate entities. This research therefore would toe the line of argument and treat the various conflicted issues in Ondo State’s health sector as a singular entity.

With regards to the effects of disruption of health services due to conflicts, Obinna, (2011) had warned that conflict affecting the core concerns of the staff like salaries and wages, working conditions between union of staff and management can lead to temporary stoppage of services with resultant detrimental effects on population health. These in turn produces long term difficulties such as economic hardship, social burdens and yet more suffering.

**OBJECTIVES OF STUDY**

Stemming from the literature review and the interest in the determination of the outcomes of industrial conflicts from the point of views of health care workers, this study seeks to examine the cause of industrial conflict in Health care of Ondo state; investigate the causes and methods of conflict displays and also determine the effects of industrial conflict on health care system in Ondo State Nigeria. These would be done in order to mitigate the occurrence of strikes, especially with the outbreak of the COVID 19, and other communicable diseases in Nigeria.

**METHODOLOGY**

The study was designed to investigate the implications of strikes in the health sector, using Ondo State as a case study hence the research approach adopted for this study was quantitative method. The study employed survey design which involves the investigation and data collection. The study was a cross-sectional study of state-owned health facilities in Ondo State, Nigeria, comprised of health care workers in selected health delivery facilities. The population for this study involved all workers in government owned health institutions in the State.

Two health institutions were each selected from the three senatorial districts of the State, while the Federal Medical Centre, Owo and Ondo State Specialist Hospital, Akure were specifically chosen given that a pilot study revealed that other health institutions make more referrals to them. Thus respondents included medical doctors, nurses, Pharmacists, Technologists, Technicians, Health Assistants, Administrative Staffs, and Medical Social Workers. While these categories of workers were purposively selected, the nature of their jobs did not allow the researcher to allocate same numbers of questionnaires but rather employed simple random sampling technique to seek for answers from willing respondents.

A five-point Likert-scale was used where the respondents were asked to rate from 1 to 5 their agreement to the statements enlisted on the questionnaires with 1 indicating weak agreement and 5, strong agreement. Data analyses are done manually and electronically. The collected questionnaires are screened and subsequently coded. The coding procedures require that a numerical value is assigned to individual responses to the questions on the questionnaire to make them feasible for further electronic analysis. The Likert scale based questions are coded with reference to the associated numerical values in the questionnaire. For instance, with the 5-point Likert scale say strongly agree responses are assigned ‘5’ whilsts strongly disagree responses are assigned ‘1’.
RESULTS

This section contains the analysis and interpretation of the gathered research data. Frequency and percentage summary was adopted to test the respondents’ bio-social characteristics. The research questions were addressed using frequency, mean ranking, chi Square and Pearson Product Moment Correlation (PPMC) analysis.

From the bio-social characteristics of the respondents, majority (80%) of the sampled respondents were females, while 20% of them were males. The age distributions revealed that 20.7% of the respondents were aged between 20 and 30 years, 30% of them were aged between 31 and 40 years, and 36.7% of them aged between 41 and 50 years, while 12.7% of them were aged between 51 and 60 years. The result on marital status shows that 18.7% of the respondents were single, 73.3% of them were married, while 8% of them were widowed. Their Educational qualification revealed that 12% of the respondents were senior secondary school leavers, 28% of them had either National Diploma or Nigerian Certificate of Education, 36.7% of them were holders of either Higher National Diploma certificate or First degree, 22% of them had Masters Qualification (MBBS/BDS), while 1.3% of them had professional certifications. On the measure of occupational qualification, 13.3% of the respondents were doctors, 25.3% were nurses, only 4% were pharmacist, 16% of them were technologist, 26.7% of them affirmed they were technician, 13.3% of them were health assistant, 0.7% of them were administrative staff, while a similar percentage (0.7%) were medical social worker. Their job experience revealed that 38.7% of the respondents were less than 10 years on the job, 25.3% of them had been working between 10 and 15 years, 22% of them had been in serves for years ranging between 16 and 20 years, 3.3% of them had working experience ranging between 21 and 25 years, while 10.7% had been on the job for above 25 years.

Causes of Industrial Conflict in Health Care Centres

The test on statements explaining the causes of industrial conflict in health care centers was presented indicated that larger percentage (75.3%) of the respondents felt poor working condition contributed to conflict in their organization, 4% felt indifferent, while 20.7% felt contrary. A good number (60%) of the respondents also affirmed that poor remuneration of workers is a major cause of conflict in their organization, 14.7% of them were not specific in decision, while 25.3% thought differently. On a similar trend, 77.3% of the respondents said it’s non-increment of workers salary that could result in conflict within the health sector, 4% were neither accepting nor refuting this idea, while 18.7% refuted the idea. The statement that said non-fulfillment of promises made by government is a major cause of conflict in the health sector was supported by 80.7% of the respondents, 3.3% of them were indifferent, while 16% of them did not bide this idea. A good number (68.7%) of the respondents were of the opinion that the differences in value and goals are part of the reasons for conflict in an organization, 13.3% of them were not specific in decision, while 18% of them were of a contrary opinion.

The result further revealed that 82.7% of the respondents gave consent that inadequate health facilities in the health centers springs up conflicts most times, 6% of them were neither in support nor against this impression, though 11.3% of them thought otherwise. It was indicated that 75.3% of the respondents affirmed that it’s the non-implementation of collective agreement causes conflict in the industries, 10.7% of them were equivocal, when 14% of them thought differently. Majority (70%) of the respondents said the delay in payment of workers’ salaries, bonus and allowances is a major cause of conflict in their organization, 12.7% of them felt indifferent, while 17.3% reported contrarily. That conflicts are been motivated by either political or institutional factors (Socio economic and political system) or by both factors was supported by 60.7% of the respondents, 19.3% of them were not specific in decision, when 20% of them thought otherwise. Lastly, 69.4% of the respondents agreed that it’s the disagreement between management and workers representatives on management style that result to conflict in most occasion, 17.3% of them were equivocal, while 13.3% of them disagreed.

The average summary revealed that majority (71.3%) of the respondents consent with the above identified factors as causes of industrial conflict in health care centers. This was such that 34% of them strongly agreed with the statement, 42.7% of them agreed, though 12% were indifferent, and 10.7% disagreed, while 6% strongly disagreed. The result was further confirmed with a chi square summary (X^2) value of 253.067 and df of 4 with a significant p value that was less than 0.05 level of significance. This justifies that the result is valid for conclusion, therefore it could be summed that the identified factors above are responsible for industrial conflict in health care centers, most especially the non-fulfillment of promises made by government to the worker.

Relationship among Socio-Economic Status and Causes of Conflict

It was noted that age had no significant relationship with the causes of conflict [r (598) = -0.03, p > .05]. The relationship between gender and causes of conflict was significant [r (598) = -0.19, p < .01]. Based on coding, this means that males tend to instigate and engage more in industrial conflict than the females. Marital status had a significant relationship with vote buying [r (598) = -0.22, p < .01]. The relationship between educational qualification and causes of
industrial conflict was positive significant \( r (598) = 0.31, p < .05 \). Therefore, it could be inferred that staffs of higher qualifications tends to engage more and instigates industrial conflict. Occupational distribution \( r (598) = 0.26, p < .05 \) had a relationship with causes of industrial conflict, this justifies that job classification in work place determines the possible causes of conflict. Job experience \( r (598) = 0.04, p > .05 \) had no significant relationship with causes of industrial conflict.

The findings therefore implied that out of all the identified socio-economic status, only Gender, Marital status, Educational qualification and Occupational distribution were related with causes of conflict in the work place, while Age, and Job experience did not indicate possible determinants of causing industrial conflict.

**Methods of Conflict Display in the Health Care Centers**

On statements relating to ways of conflict display in the health care centers, majority (84.7%) of the respondents affirmed that strike action in which workers refuse to work for their employer is a way of conflict display, though 15.3% felt contrary. Similarly, 78% of the respondents were of the opinion that other action short of strike; where workers express their conflicting character such as boycott of emergencies, shift, calls etc, however 22% of them had of a contrary opinion.

The same percentage of the respondents (78%) agreed with the statement that protest or demonstration against management was a way of conflict display in the health care centers, while 22% of them disagreed. On a different note, 44% of the respondents felt the being sabotage; such as cutting off hospital electricity or water supply is a way of conflict display in the health care centers, however, 56% felt contrary. Lastly, 66% of the respondents were in support of the statements that lock out, a situation whereby the employer stops the workers from working, is also a way of conflict display in the health care centers, though 44% of them did not bide the idea.

On the average, it was observed that large percentage (70%) of the respondents consented with most of the itemized statement above as the possible ways of conflict display in the health care centers, though 30% had a contrary perception. The chi square summary \( X^2 \) value of 96.00 df of 1 and a \( p \) value less than 0.05 level of significant reflect possible confirmation of the result. Therefore it was affirmed that there are several noticeable ways of conflict display in the health care centers, and these include; strike actions, protest, lockout and boycott of emergencies.

**The Outcomes of Industrial Conflict In Health Care Delivery**

The analysis on the possible outcomes of industrial conflict in the health care centers indicated that 70% of the respondents affirmed that industrial conflict in the health care could result into increase in mortality, 8% of them were neither in support nor against this idea, while 22% of them thought otherwise. A reasonable number (64.7%) of the respondents opined that industrial conflict in the health care will result to the spread of diseases in the society, 9.3% of them were equivocal, while 26% had a contrary opinion. On a similar trend 62% of the respondents felt that industrial conflict in the health care may lead to exploitation of patients, especially when they want to access treatment in private health care centers, though 12% of them were not specific in decision, while 26% felt contrary.

A large number (70.7%) of the respondent’s consent that drug abuse and self-medication might be on the increase during industrial conflict in the health care centers, 10% of them were indifferent, while 19.3% of them thought otherwise. That patients may be dissatisfied and as well sad in the course of industrial conflict in the health care centers was supported by 70.7% of the respondents, though 8% of them were not specific in response, while 21.3% of them did not bide this idea. Complication to health matters was affirmed to be an outcome of industrial conflict in the health care centers by 80.7% of the respondents, 4.7% of them were neither in support, nor against this impression, when 14.6% of them were of a contrary view. Similarly, 80% of the respondents consented that industrial conflict in the health care centers will result into lack of ability to access affordable health services, 6% of them were not specific in their opinion, while 14% of them thought differently. Emotional distress was thought to be the yield point of industrial conflict in the health care by 70% of the respondents, though 8% of them were equivocal, while 18.7% of them thought otherwise. A similar percentage (70%) of the respondents asserted that neglect and feeling of rejection might set in as a result of industrial conflict in the health care, 10.7% of them were indifferent, while 19.3% of them did not support this impression.

Majority (76.6%) of the respondents opined that rise in tension might be the outcome of industrial conflict in the health care centers, 6.7% of them were neutral in response, while 16.7% of them thought otherwise. A reasonable number (69.3%) of the respondents agreed that suspicion among co-workers might be the product of industrial conflict in the health care centers, 10% were indifferent, while 20.7% disagreed. In like manner, 67.3% of the respondents felt depression on the job may be the aftermath of industrial conflict in the health care centers, 10.7% of them were not specific in decision, while 22% of them felt contrary. The statement that said lack of concentration is an end result of industrial conflict was supported by 70% of the respondents, though 8.7% of them were neither on support nor against this perception, while 21.3% of them refuted. Hoarding of vital information was attributed to one of the outcomes of industrial conflict.
in the health care centers by 64.6% of the respondents, 12.7% of them were equivocal, while 22.7% of them thought differently. Rumors was agreed to be on the increase during industrial conflict in the health care centers by 62% of the respondents. 15.3% of them were not specific in decision, while 22.7% of them disagreed. Similar number (64.6%) of respondents asserts that false reporting is the order of the day during industrial conflict in the health care centers, 12% of them were indifferent, while 23.4% of them negates this idea. Lack of trust among workers was also identified to be the outcome of industrial conflict in the healthcare centers by 64% of the respondents, 12% of them were not specific in decision, while 24% of them thought contrarily. Poor employee retention been offshoot of industrial conflict in the health care centers was consented by 69.4% of respondents, 12% of them were indifferent, while 18.6% of them were negated the impression.

In a similar trend, 68% of the respondents felt that negligent attitude towards work is also very paramount during industrial conflict in the health care centre 12% were not in support of this idea while 20% of them negated this idea. That industrial conflict in the health care centers result to psychosomatic illness was supported by 56.7% of the respondents, 20% of them were equivocal, while 23.3% of them negated this impression. Income depletion was also thought to be the aftermath of industrial conflict in the health care centers by 63.4% of the respondents, 14.6% of them were not specific in decision, while 22% of them thought differently. That industrial conflict result into waste of resources was consented by 62% of the respondents, 18% of them were indifferent, while 20% of them thought otherwise. Furthermore, it was agreed by 68.7% of the respondents that industrial conflict in the health care centers can result to the expiration of drugs, 11.3% of them were not specific in decision, while 20% of them disagreed. A reasonable percentage (65.3%) of the respondents affirmed that industrial conflict can be time wasting, 8.7% of them did not agree nor deny this idea, while 26% of them refuted the idea. Similarly, 64.7% of the respondents felt the possibility of increase in staff turnover during industrial conflict in the health care centers, 14% of them were not specific in response, 21.3% of them felt contrary. Reduced productivity was also seen to be the end result of industrial conflict in the health care centers by 68% of the respondents, 12.7% were equivocal, when 19.3% of them were of a refuting perception. Disturb to health sector was viewed as an offshoot of industrial conflict in the health care centers. This was supported by 74% of the respondents, 12.7% of them were not specific in decision, while 13.3% of them thought otherwise. Similar percentage of the respondents agreed that industrial conflict do result into blames to present government, 15.3% of them were equivocal, when 10.7% of them disagreed. Lastly, same percentage (74%) of the respondents affirmed that quick switch to orthodox or traditional method of treatment is always the yield point of industrial conflict in the health care centers, 12.7% of them were not specific in decision, while 13.3% of them refuted this idea.

The average summary revealed that majority (66.8%) of the respondents were in consent with the above identified factors as possible outcome of industrial conflict in the health care centers. This was such that 26.3% strongly agreed with the statements, 40.5% agreed, though 11.8% were not specific in decision, while 21.7% disagreed. The chi square square with the X^2 value of 213.200, df of 4 and a p value less than 0.05 level of significance proves that the result was valid for further conclusion. Therefore it was affirmed that the identified factors above are the possible outcomes of industrial conflict in the health care centers.

Table 1: Correlation Matrix showing the relationship between Socio-economic status and outcomes of industrial conflict in the health care centers

<table>
<thead>
<tr>
<th>Variables</th>
<th>Age</th>
<th>Gender</th>
<th>Marital Status</th>
<th>Educational Qualification</th>
<th>Occupational Distribution</th>
<th>Job Experience</th>
<th>conflict outcome on Patient</th>
<th>conflict outcome on Co-worker</th>
<th>General Outcome of Conflict</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td>1</td>
<td>.05</td>
<td>.50**</td>
<td>-.19**</td>
<td>.14</td>
<td>.71**</td>
<td>.02</td>
<td>-.09*</td>
<td>-.01</td>
<td>40.14</td>
<td>9.42</td>
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<tr>
<td>2. Gender</td>
<td></td>
<td></td>
<td></td>
<td>- .29**</td>
<td>.10</td>
<td>.27**</td>
<td>-.08*</td>
<td>-.21**</td>
<td>-.19*</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3. Marital Status</td>
<td></td>
<td></td>
<td></td>
<td>- .17</td>
<td>.21**</td>
<td>.09</td>
<td>-.25**</td>
<td>-.15</td>
<td>-.03</td>
<td>37.51</td>
<td>8.86</td>
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<tr>
<td>4. Educational Qualification</td>
<td></td>
<td></td>
<td></td>
<td>- .17</td>
<td>-.53**</td>
<td>.04</td>
<td>.25**</td>
<td>-.01</td>
<td>.71**</td>
<td>35.77</td>
<td>8.76</td>
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<tr>
<td>5. Occupational Distribution</td>
<td></td>
<td></td>
<td></td>
<td>- .29**</td>
<td>- .53**</td>
<td>.04</td>
<td>-.15</td>
<td>.03</td>
<td>.72**</td>
<td>31.91</td>
<td>6.03</td>
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<tr>
<td>6. Job Experience</td>
<td></td>
<td></td>
<td></td>
<td>- .17</td>
<td>- .53**</td>
<td>.04</td>
<td>.25**</td>
<td>-.01</td>
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<tr>
<td>7. conflict outcome on Patient</td>
<td></td>
<td></td>
<td></td>
<td>- .21**</td>
<td>-.15</td>
<td>.04</td>
<td>.25**</td>
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<td>8. conflict outcome on Co-worker</td>
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<td>- .21**</td>
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<td>-.01</td>
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<td>9. General Outcome of Conflict</td>
<td></td>
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<td>- .21**</td>
<td>-.15</td>
<td>.04</td>
<td>.25**</td>
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<td>.25**</td>
<td>-.01</td>
<td>.71**</td>
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Note: ** p < .01, * p < .05, N=600
Source: Field work 2020
The relationship between socio-economic factors and outcomes of industrial conflict was presented in Table 1 above. It was noted that age had no relationship with conflict outcome on patients \[ r(598)= 0.02, p > .05 \]. On the other hand, gender \[ r(598)= -0.08, p < .05 \] had a significant relationship with conflict outcome on patients. This means that male tend to the express more of the negative outcomes of conflict on patients compared to females employees. The relationship between marital status and conflict outcome on patients was significant \[ r (598)= -0.21, p < .05 \]. This means that the marital status determines how people expressed the outcome of conflict on patients. The relationship between educational qualification and conflict outcome on patients was positively significant \[ r (598)= 0.25, p < .01 \]. This thus implied that employees with higher qualifications expressed more severe outcomes of conflict patients. Occupational distribution had no relationship with conflict outcome on patients \[ r (598)= -0.15, p < .05 \]. Also, job experience \[ r (598)= -0.01, p > .05 \] had no significant relationship with conflict outcome on patients.

On the measure of relationship between socio-economic factors and conflict outcome on co-workers, it was observed that age had a significant relationship with conflict outcome on co-workers \[ r(598)= -0.09, p < .05 \]. This was such that younger employees express fiercer outcome of conflict compared to older ones. Gender had no significant relationship with conflict outcome on co-health workers \[ r(598)= -0.07, p > .05 \]. The relationship between marital status and conflict outcome on co-workers was significant \[ r(598)= -0.21, p < .05 \]. It means that the marital status of employees (single, married, etc.) could determine the perceived fierceness of conflict outcomes on co-workers. Educational qualification was significantly related to conflict outcome on co-health workers \[ r(598)= .28, p < .01 \]. This implied that health workers with higher qualifications tend to perceived fiercer outcomes of conflict on co-workers. Occupational distribution was also significantly related to conflict outcome in the work place \[ r(598)= -0.27, p < .01 \]. This shows that job classification as an health worker will determine how such health worker will perceive the fierceness of conflict outcomes on co-workers. Job experience was not significantly related to conflict outcome on co-health worker \[ r(598)= -0.07, p > .05 \].

The relationship between socio-economic factors and general outcome of conflict revealed that, age had no significant relationship with general outcome of conflict \[ r(598)= -0.01, p > .05 \]. It was observed that gender has a significant relationship with general outcome of conflict \[ r(598)= -0.19, p < .05 \], and based on coding, this means that males tends to perceived fiercer outcomes of conflict generally than their female counterparts. Marital status had a significant relationship with general outcome of conflict \[ r(598)= 0.22, p < .01 \]. Educational qualification had a positive significant relationship with general outcome of conflict \[ r(598)= 0.24, p < .01 \], such that staffs with higher qualifications tend to perceive fiercer outcomes of conflict generally. Occupational distribution was also significantly related to general outcome of conflict \[ r(598)= -0.19, p < .05 \], therefore it could be said that staffs job classification to an extent will determine their perception of the fierceness of conflict outcomes generally. However, job experience had no relationship with general outcome of conflict \[ r(598)= -0.03, p > .05 \].

The findings thus implied that from the identified socio-economic factors, only gender, marital status and educational qualification were related with conflict outcome on patients, while age, occupational classification and job experience were not indicating any possible determinants of conflict outcome on patients.

Age, marital status, educational qualification and occupational distribution were correlates of possible conflict outcome on co-health worker, while gender and job experience were not correlates.

The relationship between socio-economic status and the general outcome of patients identified gender, marital status, educational qualification, and occupation distribution as correlates of general outcome of conflict, while age and job experience were not correlates of general outcome of conflict.

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Conflict outcome on Patient</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Conflict outcome on Co-worker</td>
<td>.71**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. General Outcome of Conflict</td>
<td>.71**</td>
<td>.72**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4. Causes of Conflict</td>
<td>.59**</td>
<td>.52**</td>
<td>.46**</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>37.51</td>
<td>35.77</td>
<td>31.91</td>
<td>38.21</td>
</tr>
</tbody>
</table>
Table 2 above presents the result on the relationship among the outcomes of conflict and the causes of conflict. It was observed from the result that causes of conflict has a significant positive relationship with conflict outcome on patients \( r(598) = 0.59, p < .01 \). This means that the fiercer the causes of conflict brought about a fierce or worsened conflict outcome on patients. The causes of conflict similarly has a significant positive relationship with conflict outcome on co-health workers \( r(598) = 0.52, p < .01 \). This means that the more they attributed causes of conflict, the higher the negative outcomes on co-workers. The general outcome of conflict was also positively related with the causes of conflict \( r(598) = 0.46, p < .01 \). This symbolized that severity in the causes of conflict also has its attached fierce general outcome on individual.

The findings indicated that the causes of conflict correlate strongly with the patient, the co-health worker and all at large. Therefore, it could be summated that as the attributed causes of conflicts increases, there also tend to be an increase in the destructive outcomes of such conflict. Since it was inferred in the result that causes of conflict has relationship with its outcome on patients, co-health worker and other general outcomes.

**Table 3: Correlation Matrix showing the relationship between methods of conflict display and the outcomes of conflict**

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. conflict outcome on Co-worker</td>
<td>.71**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. General Outcome of Conflict</td>
<td>.71**</td>
<td>.72**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4. Methods of conflict Display</td>
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<td>.39**</td>
<td>.34**</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>37.51</td>
<td>35.77</td>
<td>31.91</td>
<td>3.51</td>
</tr>
<tr>
<td>SD</td>
<td>8.86</td>
<td>8.76</td>
<td>6.03</td>
<td>1.47</td>
</tr>
</tbody>
</table>

*Note: ** p < .01, * p < .05, N=600*
*Source: Field work 2020*

It was indicated in the above table that conflict outcome on patient had significant positive relationship with method of conflict display \( r(598) = 0.30, p < .01 \). This means that the more methods utilized in conflict display, the more the observed negative outcomes on patients. Similarly, method of conflict display was also significantly positively related to conflict outcome on co-health worker \( r(598) = 0.39, p < .01 \). This implied that increased methods of conflict displayed correlates with fierce outcomes of conflict on co-workers.

The general outcome of conflict had a positive significant relationship with methods of conflict display \( r(598) = 0.34, p < .01 \) and this means that the fierceness of conflict outcomes generally increases with the increase in the methods through which conflicts were displayed. Therefore, it could be concluded that the methods of conflict display also have impact on the outcome of conflict.

**Table 4: Multiple Correlation Matrix showing the relationship between the expected outcomes of conflict**

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. conflict outcome on Patient</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. conflict outcome on Co-worker</td>
<td>.71**</td>
<td>1</td>
<td></td>
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<tr>
<td>3. General Outcome of Conflict</td>
<td>.71**</td>
<td>.72**</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>37.51</td>
<td>35.77</td>
<td>31.91</td>
</tr>
<tr>
<td>SD</td>
<td>8.86</td>
<td>8.76</td>
<td>6.03</td>
</tr>
</tbody>
</table>

*Note: ** p < .01, * p < .05, N=600*
*Source: Field work 2020*

Table 4 shows the relationship between the expected outcomes of conflict. It was indicated in the result that a significant positive relationship exist between conflict outcome on patient and conflict outcome on co-health worker \( r(598) = 0.71, p < .01 \). This implied that as conflict outcomes on patients gets more severe, the general conflict outcomes also gets more severe. Conflict outcome co-health workers had a significant positive relationship with general outcome of conflict \( r(598) = 0.72, p < .01 \). This was such that the severity of general conflict
outcomes increases with increase in the impact of conflict on co-health workers. This therefore showed that there was relationship among all the outcomes of conflict.

CONCLUSION

This study concluded that conflicts in the health sector are outcomes of factors already explained within the body of this study. However, total strikes which disrupt the health care delivery are often due to the non-fulfillment of promises made by government to the worker during conflict negotiations. In other words, irrespective of the other causes of conflicts, if Governments can fulfill their end of the bargain to time, and degree of agreement, then strikes would not occur, and conflicts can be nipped in the bud. Failure to toe this line and the eventual downing of tools has implications both to the health sector workers, the patients and the society as a whole.

The study concludes that industrial conflict in the health care could result into increases in mortality, spread of diseases in the society, exploitation of patients, especially when they want to access treatment in private health care centers. This in turn could lead to increases in the rate of drug abuse and self-medication Therefore, complications to health matters was affirmed to be an outcome of industrial conflict in the health care centers, which in turn promotes emotional distresses. More importantly, as conflict outcomes on patients gets more severe, the general conflict outcomes also gets more severe.

In light of the COVID 19 pandemic, the contagious nature of the virus, the fragility of the health sector in Nigeria, and its high mortality rate, and devastating effects of the disease, governments should ensure that conflicts are nipped in the bud by quick response and the swift enforcement of the decisions reached at negotiations.

REFERENCES