

Variance in Call Duty and Hazard Allowances: Implication on Health Workers' Commitment and Work Relations in Nigeria

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Abstract

This study examines disparity in call duty and hazard allowance and its implication on health worker's commitment and industrial dispute in tertiary hospital in South-South, Nigeria. A survey method that allows for the use of structured questionnaire was adopted. The study used a combination of purposive and random sampling techniques in determining a sample of 1191 participants from 4 tertiary hospitals in South-South Nigeria. Data gathered from the field was coded and analyzed using Linear Regression at 0.05 level of significance. Results revealed that call duty discrepancies and hazard allowances significantly affect health workers' commitment and industrial disputes in tertiary hospitals. The study recommended, among others, that National Salaries, Incomes and Wages Commission should carry out a comprehensive review of all health worker's wages and allowances in Nigeria with the view of harmonizing them. The commission should also evolve a periodic pay reform for health workers in Nigeria.

Keywords: Call duty, hazard allowances, health workers, commitment, work relations.

1. Introduction

Health workers are the most essential resources needed for the functioning of any health system. This is because providing effective healthcare depends on their commitment. Thus, the importance of committed health workers cannot be overemphasized. In Nigeria, like in most African countries, the health system faces several problems: corrupt practices, lack of a good working environment, obsolete equipment, brain drain, inadequate pay, and workers' allowances.

Payment of salaries and allowances stands out as one of the pressing problems in the health sector, affecting service delivery and the entire system. Salaries and allowances are hygiene factors that motivate and lift employees' morale and help employers retain their best workers (Angioha, Agba, Kenneth & Ishie, 2021; Agba, Angioha, Akpabio, Akintola & Maruf, 2021; Adah, Angioha, Ugwuonwu & Akomaye, 2020; Attah & Angioha, 2019). Inadequate allowance or low pay in the health sector may inform health workers to moonlight to supplement their income by providing services privately, engaging in other income-earning activities, thereby leaving their primary assignment unattended (Ushie Agba, & Plang, 2015; Angioha, Omang, Ishie, & Iji, 2020; Agba, Mbotto & Agba, 2013). Every year the problem of available allowances system for health workers burdens the government. Not only do the issues of allowance and salary come up frequently, but they also give rise to the most significant number of disputes, which most times lead to conflict of interests and lack of commitment on the part of workers.

According to Agba, Ushie, and Agba (2009), allowances and salaries induced disputes in the Nigerian healthcare system is alarming. There is no one time in healthcare history in Nigeria that health workers have enjoyed an untied

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salary and allowance structure. The proportion and frequency of these disputes are unprecedented. In 36 months between 2015 and 2018, the health sector experienced up to eight industrial disputes involving health workers due to disparity wages and allowances. These disputes have negatively affected healthcare delivery in the nation resulting in several avoidable deaths, complications and health tourism of the rich who can afford foreign medical bills. The rising rate of industrial disputes and lack of commitment in public hospitals despite government efforts is worrisome and requires urgent and pragmatic actions. This study sought to examine whether disparity in call duty and hazard allowance constitutes a significant threat to health workers' commitment to duty and industrial conflicts.

2. Literature review

2.1. Call duty allowance, worker's commitment and industrial disputes

Call duty allowance is earned by an officer who performs call-duty according to the existing call-duty roster in their organizations. Call-duty here refers to the necessity to carry out a task either by a military, police, medical or highly important officer. It includes the legal mandate that an officer or staff must perform a job because it is his/her duty to do so. It is a critical task carried out by an officer to save lives and property, meaning a staff can be called at any time to perform such duties. Call duty allowance in the medical field entails privilege remuneration paid to health workers because of their task's sensitivity and complexity (Adebowale, 2013).

In Nigeria, call-duty allowance in the health sector is often associated with medical doctors, which largely accounts for the upheavals/industrial conflicts in the industry. Consequently, in 2001, the Federal Government readjusted and approved a new and more inclusive call duty allowance for medical and dental doctors, pharmacists, nurses, laboratory and other health workers. It shows that doctors, laboratory scientists, and pharmacists will receive 4 per cent of their basic salary as call duty allowance. Nurses and other health workers will collect 1.7 per cent of their basic salary as call duty allowance (Umar-Omale, 2001).

The wage structure (including call-duty allowance) as approved by the government in 2001 discriminated against other staff in favour of only doctors, pharmacists, nurses and laboratory scientists. The differentials continue to be a source of industrial conflict in the health sector. The government in 2013 approved a special Consolidated Medical Salary Structure (CONMESS) and associated allowances for medical and dental staff. This approval reduced industrial disputes in the health sector for only a short while but did not remove wage discrimination as another wage crisis started in 2014 up to 2015 (Medical World Nigeria, 2013).

After the approval of call duty allowance in federal hospitals/the health sector, medical doctors demanded yet another improved package in 2014/15. They argued that the government should correct medical doctors' existing allowance and commence immediate payment to avoid further industrial conflict in the health sector, especially in federal hospitals. As these agitations continue in national hospitals, doctors in state hospitals also embarked on one form of industrial dispute or the other to demand similar wages as their federal counterparts (Medical World Nigeria, 2013).

As the allowance/wage gap widened between doctors and other staff in the health sector, especially as nurses carry out similar or close functions with doctors but with different pay package, industrial conflict becomes inevitable. In 2015, nurses call for a new salary scheme because they felt discriminated. Apart from wage discrimination, nurses are employed on grade level 7 while other health practitioners start their career from grade level 9 and above. This situation is unhealthy for workers' commitment and harmonious industrial relations in both states and federal hospitals (Agunloye, 2015; Agba, Mbotto, & Agba, 2013; Agba & Ushie, 2010).

According to Agunloye (2015), placing medical doctors above nurses and other medical workers is unfair since some of these staff are even more dutiful than doctors and spend some time in their course of training. For instance, a nurse spends five years like doctors and six years for housemanship, but medical doctors attract more remuneration. Again, most nurses stay 24 hours in the hospital against medical doctors who only come on routine check-ups or calls. The situation is even worst in some state hospitals; nurses are exempted from call-duty allowance.

2.2. Hazard allowance, worker's commitment and industrial disputes

Hazard allowance, also called "service danger pay", is a special allowance or remuneration that accrue to workers carrying out hazardous jobs (United Nations, 2015). It is special or additional allowance/pay apart from basic salary given to workers who are required to work in duty stations or situations where hazardous conditions prevail. Non-payment of hazard allowance and differentials in paying this allowance has been a source of low workers' commitment and industrial conflict in state, federal, and private organizations in Nigeria. For instance, in 2015, federal workers in the agricultural sector threatened industrial unrest because of government refusal and selective payment of hazard allowances. The workers argue that some of their livestock and veterinary colleagues categorized as health employees had been paid and enjoyed their allowance. In contrast, other workers facing the same dangerous working conditions are discriminated against (Agbonkhese, 2015).

The education sector is not left out of industrial disputes occasioned by hazard allowance. In 2015, the non-academic staff of Obafemi Awolowo University (OAU) went on strike over non-payment of 64 months hazard allowance backlog. Before the strike, there were several protests, which disrupted the service delivery of the institution. This is because the university gates were locked, preventing people's smooth movement and vehicle outside the campus. They argue that if other workers in Nigeria who are carrying out dangerous jobs are paid hazard allowance, they should be discriminated against. This suggests that wage discriminations or differentials are a significant cause of industrial disputes in Nigeria (Information Nigeria, 2015).

Again, in the fire service, health workers and other state workers involved in hazardous jobs are paid a flat rate of N5,000 hazard allowance. This situation is frowned at by this category of workers because they saw such pay as inadequate and discriminating compared to their colleagues in the federal service and some in the private sector (Oyebade, 2015). Similarly, Adeyemi (2014) posited that differentials, poor and non-payment of hazard allowance, are mainly responsible for the high rate of industrial disputes and workers' low commitment in Nigerian hospitals. Nigeria Medical Association (NMA) and other unions have embarked on several strikes because of hazard related allowances. For instance, NMA in 2014 embarked on various industrial actions demanding that government should increase their hazard allowance from a maximum of N6,000 to N10,000 for medical and dental practitioners.

3. Theoretical framework

The study adopts Victor Vrooms Expectancy theory of 1964. The theory tries to explain an employee's mental process as it relates to his interpretation of his organization's motivational strategies leading to work commitment and increased output. The theory holds that employees' motivation to work is influenced by his belief that his efforts will lead to performance and performance will lead to a specific outcome beneficial to him. The theory argues that organizational compensation packages, including allowance, are futuristic and influence expectancy behaviour and employee attitude to work performance. Vroom's theory is based on three expectancies; effort- performance expectancy (E-P), which is the belief that a positive relationship exists between effort and productivity, performance – outcome expectancy (P-O), which refers to employee prediction that increased output will result in positive outcomes in the form of allowances and rewards, and Valence (V) which is the value expectation of the employee towards the allowances and rewards. When applied to this study, the theory implies that health workers carrying out their duties expect to reward their work.

4. Materials and methods

This study adopted a survey research design. The design was opted for because it interprets, synthesizes and integrates data and points to relationship among variables. It enables the researcher to focus on respondents' opinion, attitude, and behaviour in relation to call duty allowance, hazard allowance, workers commitment and industrial disputes. The design enabled this study to draw a sound sample from the population (staff) in the selected institutions. Therefore, this study utilizes this advantage by using a well-structured questionnaire to elucidate and analyze data on the correlations between identified variables.

The study was carried out in South-South, Nigeria. The research covers teaching hospitals in the area. South-South Nigeria consists of six states: Akwa Ibom, Bayelsa, Cross River, Delta, Edo, and Rivers States (Agba, Ikoh, Ushie & Bassey, 2010). Each of the six states have a state or federal teaching hospital. Surprisingly, all these hospitals have witnessed different form of industrial disputes. This study's concern is to determine the relationship between call duty and hazard allowance and its implication on health workers commitment and industrial dispute. The population, however, consists of a total of 8,416 staff from selected university teaching hospitals in South-South Nigeria. This figure 8,416 comprises of junior and senior staff of the chosen hospitals but exclude all casual staff. However, the sample size was determine based on convenience, of which 1191 participants were selected. The study employed the purposive sampling technique to select four (4) teaching hospitals out of six in South-South Nigeria. These four (4) hospitals were purposively selected because of their unique attributes, area coverage, organization, and strategic locations. More so, the actual respondents from the selected hospital were randomly selected for the study. Information collected from respondents was coded into a statistical package for social sciences (SPSS) version 18. The statistical tool was opted for because of the nature of the variables involved. Hypotheses were tested using linear regression statistics at 0.05 level of significance.

5. Results

5.1. Demographic information of participants

The respondents' responses in this study are presented in Tables 1 shows frequency counts of personal/demographic information of respondents. Responses grouped by nature of hospital on age shows that, out of the 691 staff of federal hospitals who responded to the questionnaire, N=380 were between the ages of 30-40 years, N=207 respondents were between 41-50 years, while N=104 respondents were below 30 years. Out of 500 staff of state-owned hospitals, N=289 respondents are between the ages of 41-50 years, while N=207 and N=4 respondents are between the ages of 30-40 years and below 30 years, respectively.

Responses on gender grouped by nature of hospital expresses that out of the 691 staff from federal hospitals who responded to the questionnaire, 374 respondents were female while 317 were male. Out of 500 staff from state-owned hospitals, 309 were male, while 191 respondents were female. Responses on job designation, out of the 691 staff from federal hospitals who, 612 were senior staff, 76 respondents were junior staff, while three were management staff. A similar trend occurred among staff from state hospitals. Out of 500 respondents, most of the participants (N=428) were senior staff, 44 respondents were junior staff, while 28 respondents were management staff.

More so, responses on the highest level of education revealed that, out of the 691 staff from federal hospitals who participated, most of them (N=322) have either B.Sc/HND as their highest level of education, 166 had NCE/OND as their highest level of education, 98 respondents have either a master degree and above as their highest level of education, followed by 56 and 49 respondents respectively for holders of GCE/SSCE/NECO and FSLC as their highest level of education. Out of the 500 respondents from state hospitals, most of them (N=207) have either B.Sc/HND as the highest level of education, 122 respondents have a master degree and above as highest level of education, while 101 respondents, 50 respondents and 20 respondents, respectively have NCE/OND, GCE/SSCE/NECO and FSLC as their highest level of education.

Table 1. Personal/demographic information of respondents based on ownership of hospital

Demographic Variables				Total
AGE				
	Below 30 years	30-40 years	41-50 years	
Federal owned	104	380	207	691
State-owned	4	207	289	500
Total	108	587	496	1191

Demographic Variables					Total	
GENDER						
	Male		Female			
Federal owned	317		374		691	
State-owned	309		191		500	
Total	626		565		1191	
JOB DESIGNATION						
	Junior staff	Senior staff	Mgt staff			
Federal owned	76	612	3		691	
State-owned	44	428	28		500	
Total	120	1040	31		1191	
HIGHEST LEVEL OF EDUCATION						
	FSLC	GCE/SSCE/NE CO	NCE/OND	B.Sc/HND	M.Sc. & above	
Federal owned	49	56	166	322	98	691
State-owned	20	50	101	207	122	500
Total	69	106	267	529	220	1191

5.2. Descriptive Presentation of Results

5.2.1. Responses on sub-scale one

Table 2 shows participants' responses to the sub-scale on-call duty allowance with four options of either "strongly agree, agree, disagree and strongly disagree". As revealed in Table 2, more than half of the respondents from the federal owned hospitals and state-owned hospitals indicated that they either strongly disagreed or disagreed with 2 items out of the six items in this sub-scale. These items are: "items 1, (My hospital pays call duty allowance to all staff) and item 3 (In my hospital call duty allowance is only for doctors and other staff are against it). For items 2, 4, 5 and 6, more than half of the respondents from the federal owned hospitals and state-owned hospitals indicated that they either strongly agreed or agreed. "Item 2 (In my hospital the procedure used to pay call duty allowance causes conflict); item 4 (Call duty allowance in my hospital is on a national scale); "item 5" (The variance in call duty allowance of doctors to other hospital staff causes low workers commitment in item 6 (Non-payment of call duty allowance incite industrial conflict).

Table 2. Responses on-call duty allowance by nature of hospital

S/N	Statement	Nature of Hospital	SA	A	D	SD	Total
1	My hospital pays call duty allowance to all staff	Federal owned	78	81	109	423	691
		State-owned	23	6	21	450	500
		Total	101	87	130	873	1191
2	In my hospital, the procedure used to pay call duty allowance causes conflict	Federal owned	302	153	117	119	691
		State-owned	480	9	7	4	500
		Total	782	162	124	123	1191
3	In my hospital, call duty allowance is only for doctors, and other staff are against it	Federal owned	131	139	343	78	691
		State-owned	106	23	324	47	500
		Total	237	162	667	125	1191
4	Call duty allowance in my hospital is on a national scale	Federal owned	254	197	194	46	691
		State-owned	392	37	65	6	500
		Total	646	234	259	52	1191
5	The variance in call duty allowance of doctors to other	Federal owned	286	176	136	93	691
		State-owned	491	9	0	0	500

S/N	Statement	Nature of Hospital	SA	A	D	SD	Total
	hospital staff causes internal conflicts	Total	777	185	136	93	1191
6	Non-payment of call duty allowance incite industrial conflict	Federal owned	376	158	117	40	691
		State-owned	500	0	0	0	500
		Total	876	158	117	40	1191

5.2.2. Responses on sub-scale two

Table 3 shows respondents' responses to the sub-scale on hazard allowance with four options of either "strongly agree, agree, disagree, and strongly disagree". As revealed in Table 3, more than half of the respondents from federal and state-owned hospitals indicated that they either strongly disagreed or disagreed with 4 items out of the six items in this sub-scale. These items are: "item 1, (My hospital pays hazard allowance); item 3 (Hazard allowance can be ignored for other staff except doctors); item 4 (Hazard allowance differs among hospital staff and it incites conflict and low commitment among workers) and item 6 (Non-payment of hazard allowance can incite industrial conflict). For items 2 and 5, more than half of the respondents from federal and state-owned hospitals indicated that they either strongly disagreed or disagreed. "item 2 (Hazard allowance paid in my hospital depends on nature of hazard) and item 5 (Hazard allowance in my hospital is paid to staff who sustain injury and is unsatisfactory).

Table 3. Responses on hazard allowance by nature of hospital

S/N	Statement	Nature of Hospital	SA	A	D	SD	Total
1	My hospital pays hazard allowance	Federal owned	342	263	66	20	691
		State-owned	464	6	13	11	500
		Total	806	269	79	31	1191
2	Hazard allowance paid in my hospital depends on the nature of the hazard	Federal owned	41	132	212	306	691
		State-owned	40	48	52	360	500
		Total	81	180	264	666	1191
3	Hazard allowance can be ignored for other staff except doctors	Federal owned	228	116	161	186	691
		State-owned	396	0	21	83	500
		Total	624	116	182	269	1191
4	Hazard allowance differs among hospital staff, and it incites conflict	Federal owned	271	111	159	150	691
		State-owned	461	9	7	23	500
		Total	732	120	166	173	1191
5	Hazard allowance in my hospital is paid to staff who sustain injury and is unsatisfactory	Federal owned	73	104	220	294	691
		State-owned	37	0	108	355	500
		Total	110	104		649	1191
6	Non-payment of hazard allowance can incite industrial conflict	Federal owned	398	189	53	51	691
		State-owned	475	9	4	12	500
		Total	873	198	57	63	1191

5.3. Test of hypotheses

5.3.1. Hypothesis one

In the null form, hypothesis one states that call duty allowance does not significantly affect workers commitment and industrial disputes in tertiary hospitals in South-South Nigeria. This hypothesis has two variables: call-duty allowance, which serves as the independent variable, while the dependent variables are workers commitment and industrial dispute. Linear regression analysis was used to test this hypothesis at $p < .05$. The result is presented in Table 4. Linear regression was conducted to determine the best linear relationship between call-duty allowance and workers

commitment and industrial dispute. The result in Table 4 shows that the predictor variable call duty allowance significantly predicted workers commitment and industrial disputes, $F(1,1189) = 316.308$, $P < .05$. The correlation is positive and moderate ($R = .458$). More importantly, they accounted for 45.8 per cent of the variance in workers commitment and industrial disputes.

The beta weights suggests call duty allowance contribute significantly to the prediction of workers commitment and industrial disputes ($\beta = .458$, $t = 17.758$, $p < .05$), the adjusted R Squared value of .209, which is a measure of effect size, indicate that the model explained 20.9 per cent of the variance in industrial conflict. According to Cohen (1988), this is a small effect size. This result implies that the null hypothesis, which states that call-duty allowance does not significantly affect workers commitment and industrial dispute in tertiary hospitals in South-South Nigeria, is rejected while the alternate is upheld.

Table 4. Linear regression of call duty allowance, workers commitment and industrial disputes

Variable	Mean	SD	r-value	Sig.
Call duty allowance	17.79	2.64	0.458	.000
workers commitment and industrial disputes	17.47	2.74		

Model summary				
Model	R	R Square	Adjusted R Squared	Sd. Error of the Estimate
1	0.458	0.210	0.209	2.35

ANOVA					
Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	1753.21	1	1753.211	316.308	0.000
Residual	6590.312	1189	5.543		
Total	8343.523	1190			

Regression Coefficients					
Model	B	Std. Error	Beta	t.	Sig.
Constant	10.076	0.439		22.950	0.000
workers commitment and industrial disputes	0.441	0.025	0.458	17.758	0.002

*significant at 0.05; df = 1, 1189; critical r = 0.062; critical F = 3.86

5.3.2. Hypothesis two

In the null form, hypothesis two states that hazard allowance does not significantly relate to workers commitment and industrial disputes in tertiary hospital in South-South, Nigeria. This hypothesis's two variables are hazard allowance, which serves as the independent variable, while workers commitment and industrial disputes stand as the dependent variable. Linear regression analysis was used to test this hypothesis at $p < .05$. The result is presented in Table 5.

Linear regression was conducted to determine the best linear combination between hazard allowance and worker commitment, and industrial disputes. The result in Table 5 shows that the predictor variable hazard allowance significantly predicted workers' commitment and industrial disputes, $F(1,1183) = 68.088$, $P < .05$. The correlation is positive and small ($R = .233$). More importantly, they accounted for 23.3 per cent of the variance in workers commitment and industrial disputes.

The beta weights suggests that an increase in hazard allowance contribute significantly to the prediction of workers commitment and industrial disputes ($\beta=.269$, $t=8.252$, $p<.05$), the adjusted R Squared value of .054, which is a measure of effect size, indicate that the model explained 5.4 per cent of the variance in workers commitment and industrial disputes. According to Cohen (1988), this is a small effect size. This result implies that the null hypothesis, which states that hazard allowance does not significantly relate to workers commitment and industrial dispute in tertiary hospitals in South-South Nigeria, is rejected while the alternate hypothesis is upheld.

Table 5. Linear regression of hazard allowance, workers commitment and industrial disputes

Variable	Mean	SD	r-value	Sig.
Hazard allowance	16.710	2.29	0.233	0.000
workers commitment and industrial disputes	17.77	2.64		

Model summary					
Model	R	R Square	Adjusted Squared	R Sd. Error of the Estimate	
1	0.233	0.054	0.054	2.577	

ANOVA					
Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	452.479	1	452.479	68.088	0.000
Residual	7861.594	1183	6.645		
Total	8314.073	1184			

Regression Coefficients					
Model	B	Std. Error	Beta	t.	Sig.
Constant	13.284	0.550		24.159	0.000
Workers commitment and industrial disputes	0.269	0.033	0.233	8.252	0.000

*significant at .05; df = 1, 1183; critical r = .062; critical F = 3.86

5.4. Discussion of findings

The first hypothesis analysis revealed a significant relationship between call duty allowance, workers commitment, and industrial disputes in South-South tertiary hospital, Nigeria. This result implies that when health workers are paid call duty allowance promptly, they tend to be committed, and industrial disputes are avoided, vice versa. This result is because the predictor variable call duty allowance significantly predicted workers commitment and industrial dispute, $F(1,1189) = 316.308$, $P<.05$. The correlation is positive and moderate ($R=.458$). More importantly, they accounted for 45.8 per cent of the variance in workers commitment and industrial dispute. The beta weights suggest call-duty allowance contribute significantly to the prediction of workers commitment and industrial dispute ($\beta=.458$, $t=17.758$, $p<.05$), the adjusted R Squared value of .209, which is a measure of effect size, indicate that the model explained 20.9 per cent of the variance in industrial conflict.

The findings are corroborated by the study of Medical World Nigeria (2013), whose finding revealed that the wage structure (call duty allowance) as approved by the government in 2001 discriminate against other staff in favour of only doctors, pharmacists, nurses, and laboratory scientists. The differentials continue to be a source of industrial conflict in the health sector. Agunloye (2015) maintains that placing medical doctors above nurses and other medical

workers is unfair since some of these staff are even more dutiful than doctors and spend some time in their training course. This accounts for most industrial disputes in hospitals across the country.

The second hypothesis's analysis revealed that hazard allowance significantly relates to workers commitment and industrial disputes in South-South tertiary hospital, Nigeria. This result is so because the table shows that the predictor variable hazard allowance significantly predicted workplace satisfaction, $F(1,1183) = 68.088, P < .05$. The correlation is positive and small ($R = .233$). More importantly, they accounted for 23.3 per cent of the variance in workplace satisfaction. The beta weights suggest that an increase in hazard allowance contribute significantly to the prediction of workplace satisfaction ($\beta = .269, t = 8.252, p < .05$), the adjusted R Squared value of .054, which is a measure of effect size, indicate that the model explained 5.4 per cent of the variance in industrial conflict.

This finding is similar to that of Oyebade (2015), who argued that wage discrimination is frowned at by staff and accounts for a significant number of conflicts at the workplace and work community. Similarly, Adeyemi (2014) posited that differentials, poor and non-payment of hazard allowance is largely responsible for the high rate of industrial disputes in Nigerian hospitals. Again, the NMA and other unions have embarked on several strikes because of hazard related allowances.

6. Conclusion and recommendations

The statistical analysis indicated a significant relationship between call duty allowance, hazard allowance, worker commitment, and industrial disputes in tertiary hospitals in South-South Nigeria. Based on these findings, the study concludes in the following manner. Disparity in the payment of call duty allowances, hazard allowance, induces low commitment among health workers and incites industrial disputes in tertiary hospitals in South-South Nigeria. Based on these findings, the following recommendations are made:

- (1) National Salaries, Incomes and Wages Commission should carry out a comprehensive review of all health workers wages and allowances in Nigeria to harmonize them. The commission should also evolve a pay reform for health workers in teaching hospitals.
- (2) Vertical earning discrepancy should be checked in teaching hospitals through periodic review of allowances and other fringe benefits.

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