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Extrinsic Sufficiency and Intrinsic Stagnation: A Thematic Analysis of Motivation-Productivity Dynamics in Jos Hospital Systems

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Abstract

Background: The healthcare ecosystem in Jos Metropolis, North-Central Nigeria, faces a productivity paradox marked by high public demand, severe operational strain, and staff disengagement. Extrinsic survival incentives buffer precarity, but administrative bottlenecks threaten service delivery. *Objectives:* This study investigates how healthcare professionals negotiate structural bottlenecks and resource constraints to maintain clinical productivity, using an integrative synthesis of Cognitive Evaluation Theory, Public Service Motivation, and Herzberg's Two-Factor Theory. *Methods:* Utilizing an interpretive philosophy and social-constructionist paradigm, the research combines an integrated qualitative case design with structural equation modeling survey parameters (n = 234 personnel across Jos University Teaching Hospital, Bingham University Teaching Hospital, and Plateau State Specialist Hospital) and a documentary evidence corpus. *Results:* Findings establish a compensatory motivational model where robust extrinsic provisions (fringe benefits and direct compensation) act as vital survival anchors. Conversely, intrinsic career advancement mechanisms display statistical insignificance and low evaluations, indicating systemic intrinsic stagnation. *Conclusion:* Sustaining healthcare productivity in low- and middle-income settings requires balancing material sufficiency, procedural justice, and psychological recognition. Reforms must integrate transparent promotion audits, performance-linked reward structures, and institutionalized welfare.

Keywords: *Healthcare Productivity; Extrinsic Sufficiency; Intrinsic Stagnation; Compensatory Motivational Model; Public Service Motivation; Jos Metropolis.*

Introduction

The Healthcare Productivity Paradox in North-Central Nigeria

The healthcare delivery ecosystem in North-Central Nigeria, particularly within the urban metropolis of Jos, Plateau State, operates under severe operational strain and escalating service demands (Agunyai & Ojakorotu, 2024; Opeke *et al.*, 2019). As a major healthcare hub in the region, Jos hosts a critical concentration of tertiary and secondary medical facilities—most notably Jos University Teaching Hospital (JUTH), Bingham University Teaching Hospital (BUTH), and Plateau State Specialist Hospital—which collectively accommodate an immense influx of patients seeking specialized and general care (Afolaranmi *et al.*, 2021; Agunyai & Ojakorotu, 2024; Opeke *et al.*, 2019). These institutions face compound challenges: staff-to-population ratios remain substantially below World Health Organization benchmarks, brain drain accelerates human capital depletion, and infrastructural deficits exacerbate daily ward pressures (Akinwale & George, 2023; Kurah, 2025; Lasebikan *et al.*, 2020).

This environment has precipitated a significant institutional paradox. While societal demands for accessible, high-quality healthcare continue to rise, hospital workforces across Jos experience severe occupational fatigue, chronic burnout, elevated stress, and widespread disengagement (Afolaranmi *et al.*, 2021; Akpor *et al.*, 2023; Kurah, 2025). The resulting disjunction between societal expectations and healthcare delivery manifests in persistent behavioral lapses, including high rates of absenteeism, delayed clinical interventions, low organizational commitment, and reduced work output (Agunyai & Ojakorotu, 2024; Idowu, 2025; Opeke *et al.*, 2019). While government interventions have historically focused on structural decentralization and performance-based schemes, operational outcomes remain volatile because the underlying motivational climate—the core psychological mechanism sustaining employee effort—has been neglected or poorly managed (Agunyai & Ojakorotu, 2024; Idowu, 2025; Kurah, 2025).

Moving from Statistical Outputs to Interpretive Realities

To understand the drivers of healthcare worker performance in Plateau State, recent empirical research has established quantitative baseline models. Specifically, structural equation modeling of Jos hospital personnel by Kurah (2025) demonstrated that employee motivation accounts for nearly half of the variance in health worker productivity ($R^2 = 0.487$). However, statistical estimates alone fail to capture the lived experiences, behavioral adjustments, and psychological nuances of hospital staff operating under structural strain (Massoudi & Hamdi, 2017; Pepple *et al.*, 2024; Ukeje *et al.*, 2024).

Qualitative interpretation reveals that this statistical model is driven by a profound institutional dichotomy: *Extrinsic Sufficiency* versus *Intrinsic Stagnation*. On one hand, extrinsic motivators—specifically fringe benefits ($\beta = 0.584, p < .001, f^2 = 0.525$) and direct compensation ($\beta = 0.326, p < .001, f^2 = 0.164$)—function as indispensable baseline survival anchors that buffer health personnel against regional economic precarity (Aman-Ullah

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et al., 2023; Ezekiel *et al.*, 2024; Kurah, 2025; Okoroafor *et al.*, 2022). On the other hand, intrinsic motivators are severely compromised; promotion mechanisms ($\beta = 0.037, p = .240, f^2 = 0.004$) display statistical insignificance and record the lowest descriptive evaluations ($M = 2.84$) among healthcare personnel (Kurah, 2025). This institutional stagnation signals that career progression is perceived as an arbitrary administrative ritual, decoupling professional effort from institutional recognition and stifling self-actualization (Duru *et al.*, 2023; Kelechi *et al.*, 2016; Kurah, 2025; Pepple *et al.*, 2024).

Purpose and Scope of the Study

This study investigates how healthcare professionals across tertiary and secondary hospitals in Jos Metropolis negotiate these structural bottlenecks, administrative opacities, and resource constraints while attempting to sustain clinical productivity (Afolaranmi *et al.*, 2021; Agunyai & Ojakorotu, 2024; Kurah, 2025). Grounded in an integrative synthesis of CET, Public Service Motivation (PSM), and Herzberg's Two-Factor Theory (Deci & Ryan, 1985; Herzberg, 1959; Perry & Wise, 1990; Pepple *et al.*, 2024; Ukeje *et al.*, 2024), this inquiry explores the qualitative realities of healthcare workers in JUTH, BUTH, and Plateau State Specialist Hospital (Kurah, 2025). By examining how extrinsic survival anchors interact with intrinsic stagnation, the study provides a context-specific framework to inform hospital administration, health policy, and human resource governance in North-Central Nigeria (Agunyai & Ojakorotu, 2024; Idowu, 2025; Kurah, 2025).

Theoretical Framework & Conceptual Grounding

CET and Professional Autonomy

CET, as a sub-theory of Self-Determination Theory, posits that social-contextual events—such as administrative evaluations, rewards, and feedback—can engender feelings of competence and autonomy, thereby enhancing intrinsic motivation, or conversely, undermine self-determination through perceived external control. Within healthcare and public service delivery in developing contexts, external administrative controls and opaque evaluation systems frequently function as suppressors of professional competence and intrinsic drive. Performance appraisal systems, when executed through rigid or non-transparent mechanisms, are perceived by personnel as bureaucratic instruments of control rather than developmental tools for professional growth (Samuel *et al.*, 2014).

When organizational justice—specifically procedural and distributive fairness—is compromised, employees experience a profound sense of alienation (Elechi *et al.*, 2020). Opaque promotion practices and unpredictable career progression paths signal to healthcare professionals that discretionary effort and clinical excellence are decoupled from institutional reward (Kitole & Mwita, 2025). In environments characterized by bureaucratic rigidity and weak supervisory support, health workers experience curtailed autonomy, leading to psychological reactance, diminished intrinsic motivation, and a retreat into disengagement (Afolaranmi *et al.*, 2021; Akpor *et al.*, 2023). Consequently, rather than fostering a sense of mastery, external bureaucratic structures reinforce feelings of powerlessness and exacerbate job dissatisfaction.

Re-evaluating Herzberg's Two-Factor Theory in Low- and Middle-Income Countries (LMICs)

Herzberg's Two-Factor Theory traditionally distinguishes between hygiene factors (salary, working conditions, job security), which prevent dissatisfaction, and motivators (achievement, recognition, advancement), which generate job satisfaction. However, applying this rigid dichotomy in LMICs—and specifically within resource-constrained settings in Nigeria—requires significant theoretical re-evaluation. Under conditions of macroeconomic volatility and acute economic precarity, the boundary between hygiene and motivational factors collapses.

Empirical investigations across developing-country service sectors demonstrate that baseline survival needs elevate hygiene provisions, such as direct compensation and basic welfare packages, into primary determinants of operational stability and job performance (Aman-Ullah *et al.*, 2023; Syahreza *et al.*, 2017). When basic remuneration fails to cover the cost of living, financial compensation ceases to be a mere hygiene factor; instead, pay dissatisfaction becomes the primary driver of low morale, high turnover intentions, and industrial withdrawal (Sebera *et al.*, 2024; Lifuleze *et al.*, 2025). Furthermore, research evaluating Herzberg's model in developing-country contexts reveals notable contradictions: traditional motivators, such as promotion and career advancement, frequently fail to generate satisfaction when foundational financial and infrastructural guarantees are unmet (Sobaih & Hasanein, 2020). Thus, in high-stress institutional environments like those found in Jos, securing adequate compensation and baseline working conditions is a prerequisite for any higher-order motivational strategy to take effect.

Public Service Motivation (PSM) and Prosocial Resilience

PSM highlights the altruistic, mission-driven, and value-based orientations that compel individuals to commit to public-sector work and societal welfare. Among healthcare workers in Jos, Plateau State, PSM manifests as deep-seated professional dedication, resilience, and a willingness to provide critical medical services despite severe infrastructural deficits and heavy workloads (Akpor *et al.*, 2023; Lasebikan *et al.*, 2020). This prosocial orientation acts as an internal psychosocial buffer, enabling clinical personnel to endure demanding hospital environments, equipment shortages, and institutional pressures (Okoroafor *et al.*, 2021).

However, PSM is not an inexhaustible reservoir; it operates within strict operational boundaries. When unreciprocated sacrifice—driven by chronic staff shortages, toxic workplace behaviors, and inadequate welfare support—persists over time, healthcare professionals experience the onset of moral fatigue and severe occupational burnout (Afolaranmi *et al.*, 2021; Akpor *et al.*, 2023). Without supportive supervision, fair promotion structures, and reliable organizational trust, the intrinsic altruism under-pinning PSM becomes eroded (Edosomwan *et al.*, 2024; Lambert *et al.*, 2022). Ultimately, sustained public service delivery relies heavily on institutional reciprocity; when systemic neglect outweighs prosocial resilience, healthcare workers manifest withdrawal behaviors, decreased commitment, and migration intentions (Salihu *et al.*, 2025).

To conceptually synthesize these theoretical lenses within resource-constrained healthcare environments, Figure 1 illustrates how CET, Herzberg's Two-Factor Theory, and PSM converge through the institutional filter of North-Central Nigeria. As depicted in the theoretical integration grid, localized economic precarity and administrative bottlenecks collapse traditional motivational boundaries, filtering these global frameworks into a singular *Compensatory Motivational Model* that sustains baseline clinical productivity despite intrinsic stagnation.

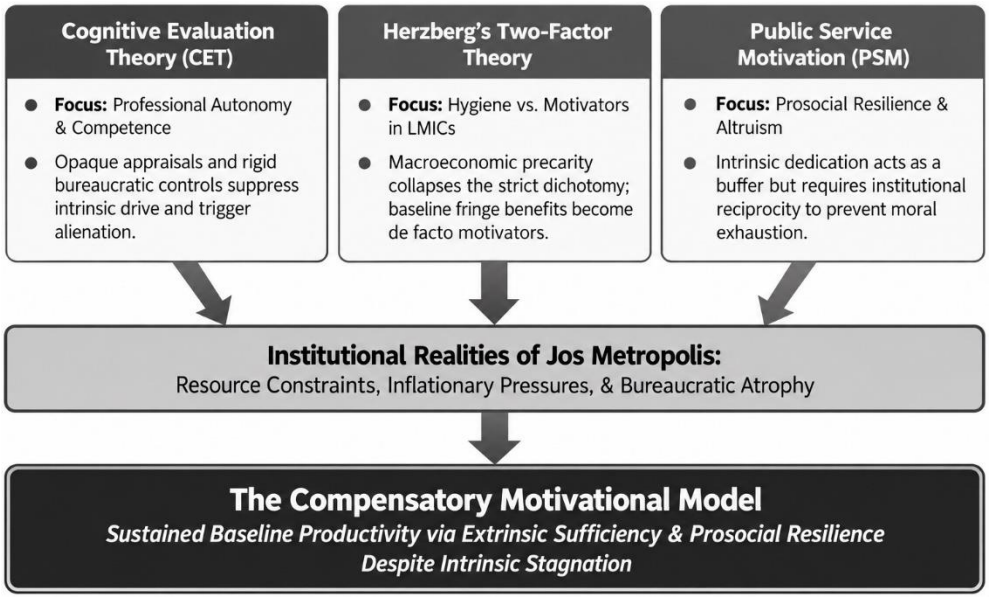


Figure 2. Theoretical Integration Grid for Healthcare Workforce Motivation in LMICs

Methodological Design and Interpretive Approach

Research Philosophy and Interpretive Orientation

This study is anchored in an interpretive research philosophy underpinned by a social-constructionist paradigm (Elechi *et al.*, 2020). Within the context of hospital systems in Jos Metropolis, administrative realities, motivational climates, and professional experiences are not viewed as objective, context-free facts, but rather as socially constructed phenomena shaped by daily interactions, institutional policies, and structural pressures (Afolaranmi *et al.*, 2021). Drawing on applied interpretive principles for practice-based qualitative inquiry (Thorne, 2025), this orientation allows the study to move beyond descriptive performance metrics to examine how healthcare professionals—including resident doctors, nurses, and administrative personnel—subjectively experience, interpret, and make sense of bureaucratic controls, opaque promotion mechanisms, and resource constraints. By prioritizing lived experiences and participant meaning-making, this philosophical stance uncovers the cognitive and emotional pathways that link administrative structures to employee engagement and withdrawal behaviors.

Research Design, Context and Case Boundaries

The research adopts an integrated qualitative case design focused on tertiary and secondary healthcare institutions located within Jos Metropolis, Plateau State, Nigeria—most notably JUTH, BUTH, and Plateau State Specialist Hospital (Lasebikan *et al.*, 2020). These institutional settings constitute bounded cases operating under severe regional operational strains, including high patient-to-staff ratios, infrastructural deficits, chronic stress, and macroeconomic volatility (Akpor *et al.*, 2023; Okoroafor *et al.*, 2021). The spatial and sectoral boundaries of the study are strictly defined around public and private healthcare delivery systems in North-Central Nigeria, capturing the unique interplay between urban medical demand, bureaucratic complexity, and clinical workforce precarity.

Evidence Corpus, Selection and Provenance

To ensure analytical depth and multi-dimensional insight, the study compiles a rigorous evidence corpus comprising both quantitative baseline parameters and qualitative documentation. The empirical corpus incorporates survey datasets 234 healthcare personnel, encompassing resident doctors, nurses, and administrative officers) alongside regional health policy texts, institutional administrative reports, and peer-reviewed literature focusing on service sectors in developing countries (Noviyanti *et al.*, 2025; Syahreza *et al.*, 2017). The provenance of these sources is meticulously verified to guarantee relevance to public health administration, human resource management, and workplace dynamics in Nigeria and comparable LMICs (Aman-Ullah *et al.*, 2023).

Data Extraction, Management and Preparation

Documentary evidence, survey indicators, and policy texts were systematically assembled, cataloged, and organized into thematic repositories. Data extraction protocols focused on core administrative and behavioral categories: performance appraisal outcomes, salary structures, promotion transparency, working conditions, supervisory leadership, and fringe benefit provisions (Samuel *et al.*, 2014). Management of the evidence corpus involved cross-referencing qualitative policy declarations against empirical survey outcomes to eliminate discrepancies, evaluate organizational justice perceptions, and establish a unified, structured database for interpretive synthesis (Elechi *et al.*, 2020).

Analytical Framework and Interpretive Procedures

The analytical procedure utilizes an iterative thematic coding protocol structured around open and axial coding cycles, informed by comparative frameworks for qualitative data analysis (Isik, 2026). Initial open coding decomposes textual records, policy frameworks, and survey transcripts into discrete conceptual codes reflecting workplace stress, compensation dissatisfaction, and career stagnation. Subsequent axial coding reconnects these codes by mapping empirical evidence against established theoretical lenses—such as CET, PSM, and promotion policy dynamics (Kitole & Mwita, 2025)—as well as Herzberg's Two-Factor Theory. This systematic alignment ensures that raw qualitative data and statistical findings are rigorously interpreted through robust organizational behavior frameworks.

Cross-Source Synthesis & Construction of Interpretive Claims

Interpretive claims and conceptual models are constructed through triangulation across the multi-source evidence corpus. Quantitative parameters regarding compensation-productivity

linkages and satisfaction drivers (Noviyanti *et al.*, 2025; Syahreza *et al.*, 2017) are synthesized with qualitative insights concerning workplace bullying, supervisory support, and infrastructural decay (Lasebikan *et al.*, 2020; Okoroafor *et al.*, 2021). This cross-source synthesis demonstrates how empirical data coalesce into broader thematic categories, illustrating how extrinsic survival anchors and intrinsic motivational deficits interact to shape healthcare worker performance and retention in Jos Metropolis.

Researcher Reflexivity, Trustworthiness and Ethics

To establish research rigour, trustworthiness was evaluated through criteria of credibility, transferability, dependability, and confirmability, guided by advanced methodological considerations in qualitative and interpretative research design (Relja & Ward, 2026). Researcher reflexivity was actively maintained throughout the inquiry by acknowledging the researcher's positioning within the academic and administrative landscape of North-Central Nigeria, thereby mitigating potential interpretive bias (Afolaranmi *et al.*, 2021). Ethical research practices were strictly observed in the handling, aggregation, and interpretation of institutional data, ensuring confidentiality, academic integrity, and fidelity to source documentation.

Methodological Limitations and Boundaries of Inference

Several methodological limitations bound the scope of inference in this study. First, the reliance on secondary empirical datasets and documentary evidence restricts direct real-time behavioral observation within hospital wards (Thorne, 2025). Second, the geographical and institutional focus on Jos Metropolis, Plateau State, means that findings reflect specific regional economic, administrative, and socio-cultural dynamics. Consequently, while analytical generalizations can be robustly applied to similar resource-constrained healthcare settings in LMICs, broad empirical generalizations to disparate industrial or macroeconomic contexts should be exercised with caution.

Thematic Analysis and Findings

Theme 1: Extrinsic Sufficiency as a Baseline Survival Anchor

The Dominance of Welfare and Remuneration

Qualitative evaluation of hospital systems in Jos reveals that extrinsic incentives—specifically fringe benefits ($f^2 = 0.525, \beta = 0.584$) and direct compensation ($f^2 = 0.164, \beta = 0.326$)—operate as powerful survival anchors that dictate operational stability and staff engagement (Kurah, 2025). Within the resource-constrained environments of JUTH, BUTH, and Plateau State Specialist Hospital, baseline remuneration functions as an indispensable economic buffer (Kurah, 2025). Rather than acting merely as passive hygiene factors under traditional frameworks, direct pay and welfare provisions constitute active determinants of productivity because they alleviate acute financial anxieties among healthcare workers (Kurah, 2025). When economic precarity threatens daily living standards, employees depend heavily on these extrinsic mechanisms to sustain their physical presence and psychological focus in clinical wards.

Buffering Economic Precarity

Allowances, institutional welfare support, and health insurance provisions—such as National Health Insurance Scheme (NHIS)-linked benefits documented by Ezekiel *et al.* (2024)—play a critical role in shielding hospital personnel from macroeconomic volatility (Kurah, 2025). In the face of inflationary pressures and demanding workloads, employer-backed welfare schemes, housing support, and subsidized healthcare access provide vital security that stems professional brain-drain (Ezekiel *et al.*, 2024; Kurah, 2025). Without these material safeguards, clinical personnel experience heightened stress and economic vulnerability, which accelerates turnover intentions and migration out of the public health sector (Kurah, 2025). Consequently, extrinsic sufficiency functions as a necessary structural defense mechanism maintaining workforce retention across North-Central Nigerian hospitals (Kurah, 2025).

Theme 2: Intrinsic Stagnation and Bureaucratic Atrophy

The Promotion Bottleneck

In stark contrast to the dominant influence of extrinsic welfare, career advancement mechanisms exhibit severe institutional dysfunction. Statistical evaluation reported by Kurah (2025) reveals the non-significance of promotion ($\beta = 0.037, p = .240$), accompanied by the lowest descriptive rating ($M = 2.84$) among all evaluated motivational dimensions. This statistical anomaly highlights a profound structural bottleneck within hospital administration. Healthcare professionals encounter rigid, opaque promotion pathways where career progression is disconnected from clinical excellence or daily effort (Kurah, 2025). Rather than serving as an intrinsic motivator that fosters professional growth, promotion functions as an unpredictable and sluggish administrative hurdle.

Organizational Cynicism and Loss of Autonomy

The opacity of advancement criteria and the influence of bureaucratic delays foster widespread organizational cynicism and a loss of professional autonomy (Kurah, 2025). When promotions are stalled or perceived as subject to external patronage rather than merit, employees realize that discretionary effort and exceptional clinical performance go unrewarded (Kurah, 2025). This decoupling of effort from recognition strips career advancement of its psychological value, transforming promotion into an arbitrary ritual that suppresses self-actualization (Kurah, 2025). Deprived of developmental progression, healthcare workers experience diminished intrinsic drive, leading to psychological withdrawal and a heavy reliance on minimum compliance rather than proactive service delivery (Kurah, 2025).

Theme 3: Psychosocial Frictions and the Work Environment

Workload Pressures and Infrastructural Deficits

The lived reality of healthcare delivery in JUTH, BUTH, and Plateau State Specialist Hospital is characterized by severe operational strain, high patient-to-staff ratios, chronic equipment shortages, and weak supervisory support (Kurah, 2025). Qualitative insights indicate that infrastructural deficits and overwhelming patient volumes create an environment of relentless pressure (Kurah, 2025). Nurses, resident doctors, and administrative personnel must navigate broken utilities, insufficient medical supplies, and extended shift hours, which collectively erode the physical and emotional capacity of the workforce (Afolaranmi *et al.*, 2021; Akpor *et al.*, 2023; Kurah, 2025). Under these conditions, the physical workspace transforms from an enabling setting into a source of chronic operational friction (Kurah, 2025).

Effort-Reward Imbalance (ERI) and Burnout

This operational strain generates an acute Effort-Reward Imbalance (ERI), where high professional exertion is met with minimal institutional reciprocity (Kurah, 2025). Qualitative feedback highlighted by Afolaranmi *et al.* (2021) and Akpor *et al.*

(2023) indicates that workplace stress, professional bullying, and compromised psychosocial environments severely damage staff morale. When heavy workloads are compounded by unsupportive supervision and hostile interpersonal interactions, personnel experience rapid emotional exhaustion and burnout (Afolaranmi *et al.*, 2021; Akpor *et al.*, 2023; Kurah, 2025). Consequently, working conditions operate as a persistent source of dissatisfaction that threatens both employee well-being and institutional retention (Kurah, 2025).

Theme 4: The Prosocial Resilience Paradox

Enduring Altruism Amidst Neglect

Despite severe administrative neglect and infrastructural bottlenecks, healthcare professionals in Jos exhibit remarkable prosocial resilience (Kurah, 2025). Grounded in professional medical ethics, spiritual resilience, and collegial solidarity, clinical personnel frequently draw on internal altruistic values to sustain patient care when formal administrative systems falter (Kurah, 2025). This intrinsic dedication reflects high PSM, where workers derive deep professional meaning from alleviating patient suffering and serving community welfare regardless of structural hurdles (Kurah, 2025). Collegial networks and peer support act as vital psychological shock absorbers, enabling staff to weather daily institutional crises (Kurah, 2025).

The Limits of Reciprocal Altruism

However, the study emphasizes that PSM is not an inexhaustible resource; it operates within strict operational boundaries (Kurah, 2025). Unreciprocated sacrifice—where institutional demands continuously outweigh welfare support and recognition—ultimately triggers terminal moral exhaustion and psychological detachment (Kurah, 2025). For prosocial resilience to endure, hospital management and public health policymakers must establish institutional reciprocity through fair compensation, reliable welfare, and supportive supervision (Kurah, 2025). Without this structural backing, the intrinsic altruism of healthcare workers becomes depleted, culminating in irreversible brain-drain, disengagement, and compromised healthcare delivery across the region (Kurah, 2025).

Discussion: The Compensatory Motivational Model

The empirical findings from the structural equation modelling (PLS-SEM) and qualitative evaluations across hospitals in Jos Metropolis provide a strong foundation for conceptualising healthcare workforce motivation in resource-constrained developing economies. By demonstrating that employee productivity is significantly predicted by fringe benefits ($\beta = 0.584, p < .001, f^2 = 0.525$), direct compensation ($\beta = 0.326, p < .001, f^2 = 0.164$), and working environment parameters ($\beta = -0.106, p < .001$), while career promotion exerts no statistically significant effect ($\beta = 0.037, p = .240, f^2 = 0.004$), the results challenge simplistic applications of classical motivational theories (Kurah, 2025). Instead, the evidence reveals a *compensatory motivational structure* wherein robust extrinsic sufficiency serves as an indispensable survival anchor that offsets severe structural stagnation in professional development, career progression, and administrative growth (Kurah, 2025).

Unpacking the Compensatory Dynamic

The core logic of the Compensatory Motivational Model rests on the functional asymmetry between extrinsic maintenance mechanisms and intrinsic growth drivers within public and mission healthcare institutions in Jos, such as JUTH, BUTH, and Plateau State Specialist Hospital (Kurah, 2025). In an ideal organizational environment, intrinsic drivers—such as merit-based career advancement, professional autonomy, and institutional recognition—serve as primary catalysts for high-level employee engagement and self-actualization (Deci & Ryan, 1985; Pepple *et al.*, 2024). However, within the institutional realities of North-Central Nigeria, career progression is frequently characterized by rigid bureaucratic bottlenecks, opaque evaluation processes, and delayed advancement schedules ($M = 2.84$) (Kurah, 2025; Opeke *et al.*, 2019).

When administrative structures fail to provide credible developmental pathways, healthcare personnel experience structural demotivation and career stagnation (Duru *et al.*, 2023; Kurah, 2025). Under these conditions, direct pay, hazard allowances, National Health Insurance Scheme (NHIS)-linked welfare packages, and housing benefits act as critical psychological and economic shock absorbers (Ezekiel *et al.*, 2024; Kurah, 2025). Rather than functioning as passive background hygiene factors, robust extrinsic welfare provisions actively absorb acute macroeconomic shocks, mitigate domestic financial anxiety, and stabilize baseline workplace attendance and operational effort (Bassey *et al.*, 2026; Kurah, 2025). Extrinsic sufficiency temporarily compensates for the severe structural deficit in intrinsic advancement, enabling clinical and non-clinical personnel to sustain daily productivity despite administrative neglect (Kurah, 2025).

As visualised in Figure 2, the structural dynamics across hospitals in Jos Metropolis reflect an asymmetric compensatory structure. While intrinsic career promotion is stalled by administrative bottlenecks ($\beta = 0.037, p = .240, f^2 = 0.004$), robust extrinsic provisions—specifically fringe benefits ($\beta = 0.584, f^2 = 0.525$) and direct compensation ($\beta = 0.326, f^2 = 0.164$)—operate as primary survival anchors that actively buffer macroeconomic precarity and bridge the intrinsic stagnation gap to maintain baseline healthcare productivity.

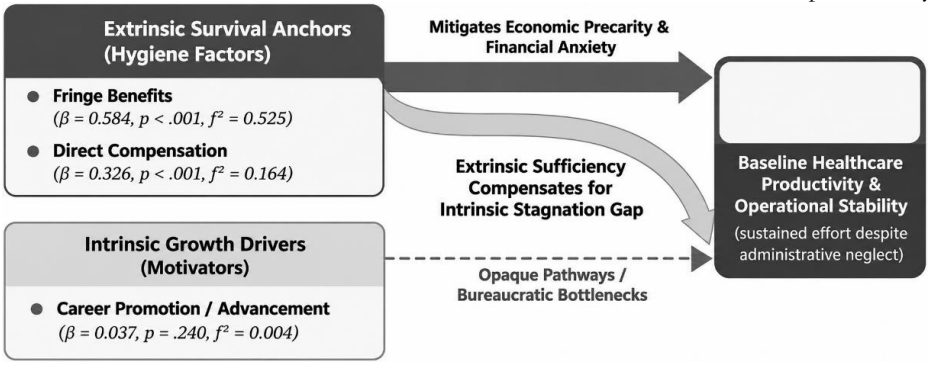


Figure 2. Theoretical Integration Grid for Healthcare Workforce Motivation in LMICs

Dialoguing with Regional and Global Literature

This compensatory dynamic mirrors broader service-sector and healthcare workforce trends observed across Nigeria, sub-Saharan Africa, and other low- and middle-income country (LMIC) settings. Across various Nigerian service institutions, including tertiary education, banking, and public administration, empirical evidence consistently highlights that fair compensation and predictable non-wage welfare packages are the dominant predictors of workforce retention and operational stability under inflationary pressures (Adaeze *et al.*, 2018; Duru *et al.*, 2023; Olatunji *et al.*, 2021; Zirra *et al.*, 2019). In healthcare settings specifically, where clinical staff face intense patient loads, physical risk, and equipment deficits, the absence of equitable pay and reliable welfare rapidly accelerates turnover intentions, absenteeism, and professional brain-drain (Akinwale & George, 2023; Lasebikan *et al.*, 2020; Okoroafor *et al.*, 2021).

Furthermore, regional health system evaluations in East and Central Africa reinforce the finding that financial and welfare incentives dictate baseline clinical engagement, though their impact varies based on administrative equity (Gupta *et al.*, 2021; Kitole & Mwita, 2025; Sebera *et al.*, 2024). For instance, studies across hospitals in Rwanda, Kenya, and Tanzania demonstrate that while healthcare personnel possess high intrinsic PSM grounded in professional medical ethics and community service, severe deficits in basic remuneration and working conditions precipitate burnout and moral exhaustion (Akpor *et al.*, 2023; Lifuleze *et al.*, 2025; Salihu *et al.*, 2025). Conversely, global studies in hospitality and corporate service sectors demonstrate that intrinsic motivators can drive performance when baseline economic needs are stably met (Bello *et al.*, 2021; Oo & Khurana, 2026). In low-resource public health systems, however, financial precarity forces employee focus downward toward economic survival, validating the primacy of extrinsic safeguards as essential preconditions for institutional continuity (Kurah, 2025).

Theoretical Refinement

These empirical patterns necessitate a context-specific refinement of classical motivation frameworks—specifically Herzberg's Two-Factor Theory and CET (Deci & Ryan, 1985; Herzberg, 1959; Kurah, 2025). Classical Two-Factor Theory posits a strict dichotomy between hygiene factors (salary, benefits, working conditions), which merely prevent dissatisfaction, and motivators (advancement, growth, achievement), which actively create satisfaction and drive superior performance (Herzberg, 1959; Kelechi *et al.*, 2016). Similarly, CET asserts that external financial rewards can crowd out self-determined intrinsic motivation by impairing perceived autonomy (Deci & Ryan, 1985; Pepple *et al.*, 2024).

The findings from Jos hospitals demonstrate that in socio-economically precarious and bureaucratically rigid environments, the boundary between hygiene factors and motivators becomes fluid and hybridised (Kurah, 2025). Where macro-economic instability threatens daily livelihood and promotion systems are stagnant, fringe benefits and direct compensation transcend their traditional preventive role; they operate as *de facto motivators* that signal institutional care, affirm personal worth, and actively stimulate daily task exertion ($f^2 = 0.525$ and 0.164) (Bassey *et al.*, 2026; Kurah, 2025).

Furthermore, CET is extended by demonstrating a *hierarchical-sequential requirement* in developing health systems: intrinsic self-actualization, developmental growth, and prosocial altruism cannot function as primary operational motivators until baseline economic precarity is neutralized through extrinsic sufficiency (Kurah, 2025; Pepple *et al.*, 2024). Institutional welfare provides the requisite economic and psychological floor that prevents moral detachment, allowing workers' inherent public service orientation to endure despite operational strain (Agunyai & Ojakorotu, 2024; Kurah, 2025; Ukeje *et al.*, 2024). Consequently, the Compensatory Motivational Model refines organizational behavior theory by proving that in LMIC public service institutions, extrinsic maintenance and intrinsic growth do not operate as independent or opposing forces, but as a sequential system where material welfare acts as the structural foundation for sustained workforce productivity (Kurah, 2025).

Conclusion, Policy Implications, & Future Research

Summary of Insights

The investigation into healthcare workforce motivation across Jos Metropolis—specifically examining institutional dynamics at JUTH, BUTH, and Plateau State Specialist Hospital—illuminates the intricate realities governing public and mission health service delivery in North-Central Nigeria (Kurah, 2025). The findings underscore that sustaining institutional productivity requires maintaining a delicate equilibrium among material sufficiency, procedural justice, and psychological recognition. While robust extrinsic provisions, such as direct compensation and fringe benefits, act as vital survival anchors that buffer health personnel against regional macroeconomic instability (Kurah, 2025; Ezekiel *et al.*, 2024), severe administrative bottlenecks in career promotion and professional growth create deep intrinsic stagnation (Opeke *et al.*, 2019; Kitole & Mwita, 2025). Without concurrent improvements in organizational fairness and developmental transparency, the operational stability afforded by baseline material welfare remains constantly vulnerable to erosion and professional burnout (Elechi *et al.*, 2020).

Recommendations for Management and Governance

To translate these empirical insights into effective administrative practice, targeted interventions are necessary across both institutional management and public health governance:

- *Hospital Management:* Administrators must actively institute-onalize transparent promotion audits, performance-linked reward systems, and structured staff welfare schemes to eliminate bureaucratic opacity and restore institutional trust (Samuel *et al.*, 2014; Kurah, 2025). Establishing merit-based career advancement criteria ensures that clinical effort and professional excellence are visibly recognized and rewarded (Kelechi *et al.*, 2016).
- *Health Policy:* Regional and national administrative frameworks within Plateau State and across Nigeria must integrate motivation-centred indicators into their human resource governance structures (Agunyai & Ojakorotu, 2024; Ukeje *et al.*, 2024). Policymakers should embed regular workforce climate assessments, equitable remuneration benchmarks, and retention strategies into public health planning to mitigate professional brain-drain and stabilize healthcare delivery systems (Akinwale & George, 2023; Okoroafor *et al.*, 2022).

Methodological Boundaries and Future Horizons

Notwithstanding its conceptual and empirical contributions, this study is bounded by specific methodological constraints. Primarily, the reliance on cross-sectional data restricts definitive causal inferences regarding the long-term evolution of the compensatory motivational dynamic (Thorne, 2025; Kurah, 2025).

Future research should adopt longitudinal tracking models to evaluate how shifting macroeconomic conditions alter the balance between extrinsic sufficiency and intrinsic motivation over time. Furthermore, expanding multi-site comparative studies across diverse geopolitical zones in Nigeria will significantly enhance the generalizability of these findings, offering a robust framework for healthcare workforce governance in LMICs (Okoroafor *et al.*, 2021; Kurah, 2025).

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