

*Full Length Research Paper*

# Management of Nigerian health care institutions: A cross sectional survey of selected health institutions in Abuja Nigeria

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Health services management, which is described as the process of mobilizing and deploying resources for the efficient provision of effective health services, has taken the center stage in business discussions across the globe. Poor management is unanimously blamed for the diminishing fortunes of most health industries. The present study was designed to review the managerial skills of health administrators and their effects on health care services in Nigeria. It was also programmed to test the assumption that poor management is a direct consequence of poor management training and skills. Using an exploratory cross-sectional survey, self administered questionnaires were administered to managers of health care institutions in Abuja, Nigeria, and data were analyzed using standard statistical techniques. Most Nigerian health managers lacked adequate management knowledge and skills. The analysis established a significant relationship between unidentifiable leadership styles/administrative training and poor management of Nigerian health institutions ( $X^2 = 9.68$ ,  $p < 0.005$ ). Training and improvement of management skills of health care managers will significantly ameliorate managerial problems of the health institutions ( $X^2 = 56.85$ ,  $p < 0.001$ ), and a contingent management technique (CMT) among other recommendations for an effective and efficient health care industry is hereby proposed.

**Key words:** Contingent management, health care, health managers, management, Nigeria.

## INTRODUCTION

Management is the basic integrating process of day-to-day activities that surrounds our daily lives. It is the process of taking responsibility for getting things done through people (Olumide, 1997). The management process is concerned with the achievement of results, through the efforts of people. However, health service management is defined as the process of mobilizing and deploying resources for the efficient provision of effective health services (Olumide, 1997). This involves planning, organizing, controlling and directing/leading.

It is believed that most problems of Nigerian health industry revolve around poor management (Osemwota, 1992). The need for management arises out of the scarcity of resources, which go to satisfy human wants. In Nigeria where these resources are very scarce, especially in the health industry, the need for an effective and efficient management system cannot be over emphasized. This led to the decision of the researcher to carry out this study.

## MATERIALS AND METHODS

This study is a cross sectioned carried out in Abuja, Nigerian Federal Capital territory in May, 2005. It is a non-experimental exploratory study. The study population was health administrators - mainly of the top and middle level cadres who live and work (in private and public health institutions) in Abuja irrespective of their places of birth, tribes or cultural inclinations. Abuja is geographically placed at the center of Nigeria and serves as a melting point of all tribes and tongues across Nigeria.

Through a multi-staged stratified sampling technique 120 administrators were selected for the study. After a pre-test of the instrument, a self administered questionnaire was distributed and collected from respondents within seven days. Several visits were made before most questionnaires were retrieved. Using simple percentages, proportions and test Chi squares, the data were analyzed.

## RESULTS

Out of 120 people selected for the study, only 116 (96.67%) were reached and participated in the study. The rest could not be reached within the period of the study. Of the 116, only 108 (90%) returned their questionnaires to the researchers of which 6 (5.55%) were not fully completed. Only 102 questionnaires were analyzed thus the overall response rate was 85.0%.

Mean age of respondents was 38.88 years with a range of 28 to 58, and modal age was within the fourth decade. Twelve (11.76%) respondents were above 50 years. Sixty seven (65.69%) of respondents were females with a male female ratio of 1:1.9. While 48 (47.06%) were at top management level, the rest 54 (52.94%) were middle level managers. However, 78 (76.47%) lacked any form of official formal training(s) in health management.

In all, 99 (97.06%) respondents agreed that health institutions were well defined with excellent organizational structure, jobs were well defined (100, 98.04%), there were proper departmentalization (99, 97.05%), and there were proper communication channels (102, 100%). However, while 24 (23.53%) stated that communication is only vertical, the rest stated that there is a combination of vertical and horizontal communication patterns.

On job security, 80 (78.43%) attested to job security, while 22 (21.57%) claimed that there was no job security in their health institutions. It will however be interesting to note that all those who claimed not to have any form of job security came from the private sector.

While 97 (95.10%) were allowed to use their initiatives at work, only 50% used their initiatives always, 9% sometimes and 41% occasionally.

Of the 88 (86.27%) respondents that answered the question in work groups, 42 (47.73%) agreed that it was allowed in their institutions.

The most commonly used motivational tool employed by health managers was in-service training (31.43%), followed by financial rewards for excellence (26.09%), accommodation (17.39%), good remuneration (13.04%) and transport (8.70%). However, issuing of query was the most commonly applied correction technique (42.42%), followed by punishment (30.30%), dismissal (15.15%) and counseling (12.12%). In about 22% of cases, combinations of methods were used.

The major problem faced by all health managers was poor funding of health institutions (35.29%), followed by faulty inter-personal relationships (29.41%), poor and ineffective communication (17.65%), lack of trainings (11.76%) and inadequate work tools (5.88%). According to respondents, these problems are still lingering, but in 14.29 and 28.97% of cases, through dialogue and improvising for obsolete tools, some of these problems are temporarily resolved.

Decisions are made by managers alone in 19.05%, by managers and some senior officers in 42.86% and with other workers in 38.09%. Furthermore, in 66.67%, sub-

ordinates are not allowed to take operational decisions and in 36.84% of cases, subordinates do not have a free access to the managers nor are they allowed to discuss freely with the managers. Of all the respondents, only 21 (20.59%) had a knowledge of what leadership style meant. Furthermore, they highlighted only democratic and autocratic leadership styles. While 19.05% of them claimed that hospitals and other health care institutions were managed in an autocratic manner, the rest (that is, 80.95%) stated that usually a democratic form of management exists in the health care institutions. Eighteen (85.71%) of all those that knew anything about management style had either a diploma, first degree or a certificate in management. The rest had no certified training in management (Table 1 and 2).

Out of the 102 respondents, 98 (96.08%) worked in institutions that had clearly stated objectives, 34 (33.33%) had a three year developmental plan, 68 (66.67%) had annual budgets, 96 (94.11%) submits annual reports, 75 (73.53%) worked in institutions that carried out annual auditing of accounts, and 63 (61.18%) undertook periodic performance appraisals. While qualifications was said to be the main criterion considered before employment in 59.26, 18.52% each said it was by quota system or rigid selection. However, job allocation was primarily due to qualification. On the criteria for selection into managerial positions, 37.50% of the respondents claimed that having a managerial qualification was a major criterion used to select people into managerial positions, followed by experience (33.33%), medical qualifications (26.67%) and years of experience (12.50%).

While 72.55% claimed that Nigerian health managers are effective (or very effective), 76.47% claimed that they were efficient (or very efficient). However, when asked on causes of managerial ineffectiveness, using square pegs in round holes was identified as the most common factor (50.00%), followed by corruption (26.92%), dishonesty and poor training (11.54% each).

Finally, 83 (81.37%) agreed that training is needed and will improve the performance of health managers, enhance their managerial abilities, reduce conflicts, improve effectiveness and efficiency, and promote inter-personal communications.

## DISCUSSIONS

Management, the fundamental requirement for effective and efficient utilization of resources demands more than just medical qualification and years of experience. In this study, both genders were well represented in the management cadre; even though there are more females than males (although there are more males at the very top of the hierarchy) . With a male: female ratio of approximately 1:2, the health industry stands out as one of the industries where there are little or no discrimination against the female gender. Could the fact that women are

**Table 1.** Leadership style and poor management of health care institutions.

Options	Have leadership styles	Lack leadership styles	Total
Good Management Standards	23	45	68
Poor Management Standards	1	27	28
Total	24	72	96

$\chi^2 = 9.68$  ( $p < 0.005$ ). Thus leadership styles affect management standard. Managers with define management style were more likely to exhibit good management standards in the health industry.

**Table 2.** Management training and poor management of Nigerian health care institutions.

Options	Have Management Qualifications	Lack Management Qualifications	Total
Have Knowledge of Leadership Styles	18	6	24
Have no Knowledge of Leadership Styles	3	75	78
Total	21	81	102

Management trainings improve knowledge of leadership styles and thus enhanced management activities within the industry ( $\chi^2 = 56.85$  ( $p < 0.001$ )).

always fighting within and among themselves explain the rampant crisis faced by the industry? Can it also explain the high level of interpersonal problems highlighted as a major bottleneck to managerial effectiveness in our health institutions? Future studies will explore this further. With only 23.53% of health managers having any form of management qualification, it is therefore not surprising that previous studies identified absence of good managers as the major problem of the health industry (Osemwota, 1992; Oyibo, 1992; Wehrich and Koontz, 1993; Akpala, 1990). Although the respondents claimed that management qualification was the most common criterion used to appoint people to management positions only 27% of them have ever attended a management course, workshop or seminar, with the rest having no form of management qualification. This supports Osemwota's (1992) assertion that those on whom the mantle of leadership falls in the health institutions are medical practitioners whose training is not rooted in the management sciences (Osemwota, 1992; Oyibo, 1992). Going by the very low level of management information and skills exhibited by respondents, it is not surprising that very few respondents (20%) had any idea of what management style is all about, with a statistically significant relationship between inability of managers to identify a leadership style and poor performance in office. Similarly, statistically, this study also shows that there is a significant relationship between management knowledge and good leadership styles ( $\chi^2 = 56.85$ ,  $p < 0.001$ ), with management training significantly improving leadership style. This is true, because you cannot give what you do not have. Thus, when leaders are ignorant of leadership skills and styles, misuse of office and powers are largely unavoidable. Management standard is however, enhanced by known and effective leadership style ( $\chi^2 =$

9.68,  $p < 0.005$ ). The bureaucratic structure may make management training imperative (Oyibo, 1992, Wehrich and Koontz 1993, and Akpala 1990). Charns and Schaefer (1983) also lend their voice to this common finding when they opined that health administrators, "in searching for means to make what they see as an irrational operation more rational, sometimes put in so much controls that total organizational performance is negatively affected."

Apart from glaring poor management skills, crisis in the health industry could also be linked to the absence of motivational tools and or the use of wrong tools in correcting erring workers. Osemwota's (1992) made a similar discovery. This results daily in brain drain to greener pastures in foreign countries, multiple crisis and strikes by unsatisfactory workers and frequent industrial disputes. With the issuing of query as the most popular form of correction followed by punishment and dismissal, one is not surprised that there are a lot of disaffections in the health industry. Counseling (or supportive supervision), which is the preferred choice, is even the least used method in the industry! Of late, management by objectives (MBO), as propagated by Peter Drucker (1974), it has been the preferred management approach in most well established institutions. But this is not the case in the health industry. The study showed that in more than 60% of cases, the decisions (and planning) in most health institutions are taken by the managers alone or in association with senior officers of the establishment. Only in about 38% are the principles of MBO implemented to various degrees. Thus, in most health care institutions, the enormous benefits of MBO are lost and the fact that operators are not allowed to take operational decisions slows the wheel of progress drastically in the health institutions.

That MBO is not being practiced is highlighted in the fact that the respondents only identified autocratic and democratic leadership styles, which agrees with other studies. The autocratic style of leadership, according to Likert (Filley et al., 1976; Belasco, 1981), could either be exploitative authoritative or benevolent authoritative. These constitute Likert's Systems 1 and 2. However, democratic leadership style (also called participative management or System 4 management by Likert, claimed by a majority (81%) to be the type commonly seen in health institutions, is not consistent with other studies (Osemwota, 1992; Oyibo, 1992). The researcher believes that consultative management style (also referred to as System 3 management by Likert) is more in line than democratic leadership style. What he is not sure of is whether the respondents were influenced by the present democratic environment in Nigeria and thus projected it into the study and therefore into the health care industry - an uncorrected confounder.

One is not however surprised that more than 80% of all those that had an idea of leadership style are those that had some formal management training. It is very interesting to note that the study identified qualification as the most relevant requirement for employment into the health industry. This must explain the 'cult-like' nature of the industry. Quota system is involved in employment, but only in about 18% of situations. The use of qualification and rigid selection criteria for the employment of workers into the industry underscores the bureaucratic nature of the system and its compliance with the classical theories of Fayol and others.

It is actually a surprise that despite the incessant strikes, crisis and trade disputes seen in the health industry, more than 70% of the respondents claimed that there are effective and efficient managers in our health industry. This finding is just the direct opposite from those of other researchers like Osemwota, 1992 and Oyibo, 1992. Is it that the managers are truly effective and efficient, or that the respondents are trying to save their jobs and make people believe that they are doing very well as managers, and thus deceive the world into leaving the system as it is now? Will other workers in the health industry have a similar opinion? Maybe a study should be carried out using non-managerial staff as respondents. Furthermore, the same respondents stated that wrong persons doing available jobs are the most important factor contributing to management's poor performance. One then wonders who the effective and efficient managers are. Are they not among these wrong persons occupying available positions? Other hindrances to good management identified in the present study included corruption, dishonesty and poor training.

Secondly, the fact that more than 99% of the respondents agreed to the need for training in administration and management for health managers and administrators lend credence to the fact that all is not well with the health industry - management wise and that all is not

not even as the respondents will like to make one believe. They all claimed that such exposures would enhance the effectiveness and efficiency of the health administrators. It must have been a similar finding that made the then government of Nigeria to propose the setting up of three management training centers for the exclusive training of health administrators. The fact that there is a positive relationship, as seen in this study, between lack of management training and poor performance of managers supports the urgent need for the implementation of the above policy.

## Recommendations

The management of all Nigerian health institutions should be left in the hands of professional health managers and trained administrators. To this end all new appointments to this position should be based on the acquisition of a good management certificate from a reliable institution or in Public Health. Furthermore, only core health administrators should be politically appointed into any health related position like commissioners and ministers of health, director generals and heads of health related parastatals.

Secondly, all those already in management positions across the country should be made to undergo a management course in health management in a reputable institution of management.

## Conclusion

Health management training is needed to rescue the health industry from maladministration and incessant staff unrest. To achieve this, health management training schools should be established, at least one in each geopolitical zone of the nation and a chair on health management created in all our first and second generation universities for the training of health administrators. Similarly, the curriculum of all medical institutions should be modified to include management either as a pre clinical course or a final year course.

Laws should be enacted to provide job security for all health workers, especially those working in private establishments; promote the use of counseling and psychological reprogramming as the most common correction technique; promote the regular use of incentives for good performance; promote the development of a humanistic working environment for health care officers; and mandate all top and middle level administrators to have a minimum of diploma degree in health management or lose their jobs.

To this end, the researcher will like to advocate for a contingency management technique (CMT) involving a matrix of consultative, management by objective and management by objectives principles. The proposed

theory should not be too restricted by the principles of bureaucracy, nor lose its relevance by being too flexible.

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