ADMINISTRATIVE LEADERSHIP CONFLICTS AND CAUSES IN NIGERIA'S HEALTH SYSTEM

IHEONU, MICHAEL OKECHUKWU, B.Sc (Hon), MPA, MSc, PhD; AIMLT(Nigeria)
SULTAN MACCIDO INSTITUTE FOR PEACE, LEADERSHIP & DEVELOPMENT STUDIES, UNIVERSITY OF ABUJA, ABUJA, NIGERIA, oxmedicalsng@gmail.com

PROFESSOR UKE, IRO IRO
DEPARTMENT POLITICAL SCIENCE, & INT'L RELATIONS, UNIVERSITY OF ABUJA, ABUJA, NIGERIA

KEYWORDS
Administrative, Conflicts, Health System, Leadership

ABSTRACT
Identification of the existence of conflicts, and evaluation of stakeholders' opinions on the possible causative elements, are the main thrusts of this study. Survey research design was adopted on the informed populations of medical doctors, medical laboratory scientists, nurses, optometrists, pharmacists, physiotherapists and radiographers, practising in the six Area Councils of the Federal Capital Territory Abuja, Nigeria, using a stratified sample size of 1642. Primary data were opinions directly obtained from the respondents. Secondary data were from textbooks, journals and gazetted government documents. This study established that conflicts exist over Nigeria's health system leadership, with the major causes being:non-respect of lawful professional boundaries, arrogance among professionals, unacceptability of foisted leaderships, and ambiguities in Government regulatory guidelines and Minor causes are: inferiority complex among certain professionals, inter-professional congestions in pursuing compatible goal of patients' well-being, incompatibility of goals when professional interests are prioritised, scarcities of resources and positions. It is recommended that the respective curricular of health professions' training schools, should be reviewed to inculcate discipline, conviviality and team-spirit in the out-going graduates. The continuing professional development programmes for practising professionals should be expanded to have inter-professional cross-fertilization of ideas, for better tolerance among health professionals.

1.0 Introduction

1.1 Background to the Study

Differences in perceptions on the existence of administrative leadership conflicts in the health subsector of Nigeria have been observed. While some people insinuate that no conflict really exists, others call attention to some instances that could be palpable evidences of conflicts. In healthcare systems where splits of a second could make a difference between life and death, conflicts among the workforce would be least desirable. More so, improvements in health management demands teamspirit. Considering also the import of health on global economic stability (Collins 1993) and power, attention needs to be paid to all factors that would work synergistically to keep health systems in near perfect state. One of them is the identification and resolution of overt and covert conflicts within the system, and among professionals who have been independently developed right from their training institutions, and affiliated thereafter to different unions. To achieve the global Sustainable Development Goals' healthcare components in Nigeria, addressing conflicts in health institutions' leaderships would be highly desirable.

Conflicts at workplace could present important challenges that can affect one's career development (Wilmot &Hocker 2001), implying that there is a need to definitively identify the existence of conflicts, if it does, for the correct remedy to be administered. An unresolved and ignored conflict can set stress and destructive forces in motion, that can decrease productivity, spread conflicts to initially-unaffected parties, and ultimately decrease workers' morale, and retard physical and mental health. The already bleak walls of the Nigerian health system would face the danger of total collapse if conflicts are allowed to precipitate a disgruntled nurse, depressed pharmacist a grumbling medical laboratory scientist, a disillusioned medical doctor who complains and rejects a non-doctor as the health minister or commissioner. All these set the scenario to evaluate the question of conflict existence or nonexistence, in the Nigerian health system.

The following research questions are pertinent:

i. Do conflicts really exist over administrative leadership in Nigeria's Healthcare system?

ii. What are their major and minor causes?

1.2 Objectives of the Study

The main thrusts of this study are to:

i. Establish the existence of conflicts over administrative leadership in the Healthcare system of Nigeria.

ii. Ascertain if certain elements are major and some others minor causes of administrative leadership conflicts in Nigeria's health system.

To clarify the objectives above, the following hypotheses are propounded in the Null form:

i. There is no significant agreement among health professionals on the existence of conflicts over administrative leadership in Nigeria's health system.

ii. There is no significant dichotomy into major and minor causes of administrative leadership conflicts in Nigeria's health system.

1.3 Relevance of the Study

Theoretically, this study adds flesh to the body of knowledge in the areas of leadership and healthcare system administration, as well as conflicts studies. Empirically, the study would give insight to health policy-making, especially in leadership appointments in Nigeria's health system. Foreign governments and international organizations may find ituseful, as they may wish to compare the finding with their contemporary situations. Among healthcare professionals, it would help to reduce delusions, and challenge all to brace up with realities, in pursuance of the Sustainable Development Goals' Health Component.

1.4 Literature Review and Theoretical Framework

Conceptually, Leadership is as old as creation. It could be said to be instituted by God in (Genesis 1:28), (Goodnews Bible 2005), probably to avert the brutish and selfish characters of man in the State of Nature, which Thomas Hobbes (Ujo 2001) in the l7th C, lucidly theorized on. A summarised position of Scholars on leadership could be stated as: that band that holds people together and point them to the organizational

goal, catalytically motivating them to achieve organizational purpose. This implies that there ought to be reasonable harmony for leadership to be able to bind. It would be practically impossible to bind together riotous and disharmonious elements in pursuance of organizational goal. So, conflict must be reduced to the barest minimum for leadership to fulfill its mandate.

Williams et al (1984) description of leadership as the "Queen of all managerial functions", is an appreciation of Henri Fayol management functions principles: planning, coordination, commanding and controlling, with Gullick's addition of 'reporting, staffing, directing and budgeting' as critical components also. Nonetheless, some scholars conceptualized leadership as just a management duty that becomes most relevant at the supervisory level of management, but with a reduced relevance at the topmost levels (Plunkett, et al, 2002). However, it is instructive to note that leadership is required at all levels of management. Since leadership determines the progress, retrogression, or even death of any organization (Tyoor and Agada, 2003), conflict should be kept low within its rank and file.

The demand that a leader should be a team-player, and have high quotients (of intelligence, social, adversity-coping and emotionalstability), pre-supposes that ability to resolve conflicts, is required of him. Conflict, according to Caser, is a struggle or quarrel (in Wilmot and Hockey, 2001). His opinioncame from the USA-USSR Cold war background, as shown in his definition of conflict as a struggle over values and claims to scarce status, power and resources, aimed at neutralizing, injuring or eliminating opponents, in a win-or-lose mindset. Mary Parker Follet (Ujo 2005) expressed reservations about the extreme war opinion above. She opined that conflict may not be warfare, but a mere appearance of divergent opinions or interests, which of course, are normal and unavoidable components of societal existence. This opinion seems to capture the mood in this study of conflicts over leaderships in the Nigerian Healthcare sub-sector. However, the alleged threats to life and extinctions of profession(s) in Nigeria's National Hospital Abuja in 2015 by some health professionals seemed to give credence to the warfare posture of the seeming conflicts in Nigeria's Healthcare System.

There is a pre-emption of the fact that leadership emerges any time a human society gets organized (Ujo, 2001). However, that does not presuppose the spontaneous existence of followership. It is therefore important to identify conflict and address it, in order to have effective leadership and loyal followership, since, leadership without followership is questionable. Of all the possible general causes of conflicts, as reported by Wilmot & Hocker (2001), resource scarcity, selfesteem, emotional concerns and power affinity are implicated as prominent factors in conflicts. Elements such as incompatible interest, cultural dynamics, gender identity, religion and over-crowding according Mark and Synder (in Wilmot & Hocker 2001), were also suspected as possible causes of conflicts. The factors or elements possibly involved in Nigeria's healthcare system, if conflicts exist, need to be identified, for proper remedy.

Empirically, the Leader-Member relation principle propagated by Fieldler in 1971 (in Ujo 2003) implies that conflicts should be identified and addressed, and that would be a measure of a leader's favourableness to the led. This is also the idea shared by Robert House, etal (Ujo 2003) in his Path-Goal Theory of leadership, which is a watershed, as it combines behavior and situation to produce various leadership styles that help identify conflicts and proper resolutions, thus making themselves acceptable to the led.

In the UK, Patton (1996) reported that health policy analysts and health managers are brainstorming to address the persistent question of how to deliver and maintain improved healthcare in the face of acrimony, rancour and rivalries among healthcare professionals and in the presence of other social maladies. This implies that conflicts have been in the UK health system. In South Africa, Lloyd (1994) observed that the recognition of management as the overall in the health system's organograms did not stop the bossy superimposition of authority by medical superintendents, thus revealing the existence of conflicts in the health system leadership of South Africa. Mayaki and Stewart (2020), focusing on only three health professions, identified professional identities as a key factor in the Nigerian health system crisis, with elements of hierarchy, role ambiguity and poor communications, also playing out. Abdulraheem, Oladipo and Amodu (2012) had brought to focus the Imperativeness of health professionals responsibly building a new social order in health facility patronage. It can be adduced that conflicts should be identified and

addressed for the professionals to undertake that team work.

In all, the conceptual, theoretical and empirical reviews above revealed some gaps in the literature:

i. there was no statistical statement to declare the existence of conflicts over leaderships in Nigeria's healthcare system.

ii. none of the scholars included 'unacceptable leadership' and some others as possible causes of conflicts over leaderships in Nigeria's healthcare system.

These two gaps are spotted, and are to be filled by this study.

The **Game Theory,** of John Von Neumann and Oskar Morgenstern in 1940, as extensively developed by scholars in the 1950s (Varma 2008), is the theoretical framework of this study. It is applied in circumstances involving two or more participating players, interacting under conflict situations, requiring interdependence of interests to achieve an ultimate goal (patients' well-being), as is the situation in any health system. It implies that it is not feasible for a player to make an enduring independent decision without recourse to the decision of other parties, meaning that, solutions to problems are achieved via a joint and co-operative decision process (Igwe 2007).While the different professionals may tend to align with their respective professional interests, the overall goal remains the well-being of the patient.

1.5 Research Method

Survey research design was adopted, as it provides latitude for use of samples from populations, thus making authentic inferences possible. The primary data were from questionnaire and direct personal observations from informed stakeholders. Secondary sources of data were encyclopaedia, dictionaries, text books, institutional and research reports, government garzetted policy documents, journals, magazines and Internet materials.

The research population is constituted by nurses, pharmacists, medical doctors, medical laboratory scientists, physiotherapists, optometrists and radiographers practising within the six Area Councils of the Federal Capital territory (FCT) Abuja. These orthodox health professionals were chosen because they constitute the well-informed people on the subject matter of study.FCT is a suitable location because of its varying degrees of social strata, tribal and racial mix, cosmopolitan-rural settings, which are apt for authentic generalizations of findings.

The sample size of the FCT Health workers for the study was stratified and calculated using the Taro Yamane formula.

$$n = \frac{N}{1+N(e^2)}$$

Where n= Sample Size

N= Population of study

e= Error margin in the research.

1= a constant(www.academic.edu)

Table 1. Health Professionals in Federal Capital Territory Abuja.

Health Professionals	Population	Sample Size	% of Total Sample Size
Medical Doctors	10,508	385	23.4
Nurses	10.085	384	23.4
Pharmacists	1,681	323	19.7

Medical lab scientists	672	251	15.3
Physiotherapists	168	118	7.2
Optometrists	134	100	6.1
Radiographers	102	81	4.9
TOTAL	23,350	1,642	100

Source: Fieldwork, February 2023

Table 1 above reveals that Medical Doctors and Nurses are leading in numerical strength. It could be a reflection of admissions and graduations from training institutions based on government quota levels to the respective institutions considering facilities available.

On the design of Research Instrument, the question technique was used for the questionnaire. Also, the combination of 'closed response' and 'open response' pattern was used. On the sampling technique 'First come, First Served' among the stratified population was adopted. In each Area Council, locations were chosen to ensure even-spread as well as coverage of both public and private health practitioners. In all, a total of 2,189 copies of questionnaire were distributed, 1,700 (77.7%) recovered, and 1642 that were appropriately filled, were selected.

Results and Data Analysis

Table 2: Opinions of Health Professionals on Existence of Conflicts over leadership in Nigeria's Health System

Admittance of Existence of Conflicts	Healthcare Professionals								
	Nurses	Pharmacists	Medical Doctors	Medical Laboratory Scientists	Physiotherapists	Optometrists	Radiographers	Total	% of Grand Total
Yes	320	312	209	240	106	89	77	**1,353**	82.4
No	64	11	176	11	12	11	4	**289**	17.6
TOTAL	**384**	**323**	**385**	**251**	**118**	**100**	**81**	**1,642**	**100**

$X^2_{Cal.}$ = 300.30, x^2_{tab} a = 12.6 df6, e = 0.05

Source: Fieldwork February 2023

Table 2 above contains a major finding of this study. A large majority, 82.4%, of the surveyed workforce admitted the existence of conflicts over the leaderships of Nigeria's health system. Only a small minority of 17.6%, held a contrary opinion. It is possible that this minority, irrespective of professional leaning, may be part of the fringe beneficiaries of the present schewed appointments to leadership positions in the system. This finding is in agreement with public opinions as exemplified by Alhaji Atiku Abubakar (the erstwhile Vice President of the

Federal Republic of Nigeria) at the 40th Annual Scientific Conference of the Association of Medical Laboratory Scientists of Nigeria, that rancour exists among health professions in Nigeria (Okonkwo 2004).

The implication of the finding is that those skirmishes, bickering and rancour among the health workforce in Nigeria are not mere transient tantrums, rather, indications of deep-rooted conflicts that may not fizzle out with time, if not properly addressed.

Test of Hypothesis 1

H_o: There is no significant agreement among health professionals on the existence of conflicts over administrative leadership the health system

H_1: There is significant agreement among health professionals on the existence of conflicts over administrative leadership in Nigeria's health system.

Hypothesis 1 gave a statistical backing to the finding: $X^2_{cal.}$ = 300.3; X^2_{tab} = 12.6; df6; e0.05 indicating a significant relationship between conflicts over administrative leadership and Nigeria's health system. The high Contingency Coefficient of 0.98, calculated from the Chi-square, established a strong affirmation the existence of conflicts over leadership in Nigeria's Health System. Independent Curricular of the training institutions, coupled with unilateral Continuing Professional Development (CPD) of the health professionals, lacking in inter-professional cross-fertilization of ideas, could partly be responsible for the unacceptability, as opined by Adjei (1995), in his study in South Africa.

Table 3: Causes of Conflicts over Administrative Leadership in Nigeria Health System

Opinions on each cause of conflict	Non respect of Lawful Professional boundaries	Arrogance	Unacceptability of Leadership	Ambiguities in Government regulatory activities	Inferiority complex	Congestion due to compatible goals	Incompatible goals	Scarcity of Resources	Scarcity of Position	TOTAL
Yes (%)	89.7	76.5	74	71.6	24.9	17.4	9.1	**4.1**	3.8	371.1
No (%)	10.3	23.5	26	28.4	75.1	82.6	90.9	**95.9**	96.2	528.9
TOTAL	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**900**

$X^2_{Cal.}$ = 422.52;, X^2_{tab} = 15.5073; df8, e = 0.05

Source: Fieldwork, February 2023

Table 3 above reveals the causes of conflicts over Health System leadership in Nigeria. Four of the identified causes were seen to be major as shown by the 89.7%, 76.5%, 74.0% and 71.6% of health professionals, corresponding to non-respect of lawful professional boundaries by professions, arrogance and superiority complex, unacceptability of leadership foisted upon the workforce and ambiguities emanating from government regulatory agencies while five are shown to be minor causes.

It is indeed worrisome that government could complicate instead of clarifying regulatory boundaries. Corruption and power intoxication could be responsible for this factor.

The table also shows that there were low admittance (3.8% - 24.9%) on such factors as scarcity of positions, scarcity of resources, incompatible goals, congestion and confusion due to compatible goals and inferiority complex, respectively, as major causes of conflicts, but high admittance (75-96%) as minor causes of conflicts. Losing focus on the ultimate goal of patients' wellbeing to aggregate the professional group's interest could paint a false picture of incompatibility in goals.

Inferiority complex is seen to be a factor since human ego is always of essence in human relations.Scarcities of positions and resources are inherently constant assumptions that generate conflicts. It is even surprising that healthcare professionals identified them as being minor causes of conflicts in the health system of Nigeria. Self-aggrandisement could mask their real minds on this factor. The picture that conflicts over leadershipin Nigeria's health system have multi-factorial causes has resemblance with the findings of Habte et al (2003)in South African Health System.

Test of Hypothesis 2

Hypothesis 2: H_0: There is no significant dichotomy into major and minor causes of administrative leadership conflicts in Nigeria's health system.

H_1: There is significant dichotomy into major and minor causes of administrative leadership conflicts in Nigeria's health system.

From the staustical tests: X^{2tab} 15.5073 X^2 calculated 422.52; at degree of freedom 8 and error margin 0.05, it is established that 'there is a significant dichotomy into major and minor causes of conflicts over the administrative leadership of Nigeria's health system.

A Contingency Coefficient 'C' of 0.98 shows a strong affirmation that some of those elements are indeed major factors and the rest minor causes.

Conclusion And Recommendations

Conclusion

The study has empirically established that conflicts do exist over administrative leadership in Nigeria's Health System. Non-respect of lawful professional boundaries, arrogance, ambiguities in government regulatory activities and unacceptability of leadership, have been identified by the study, as major factors while inferiority complex, compatible goal congestion, incompatible goals, scarcities of positions and resources are minor causes of conflicts over administrative leadership in Nigeria's health system.

Recommendations

(i) The National Universities Commission should review the Curricula of Health Training Institutions to emphasize discipline and respect of professional boundaries and for one another, as well as inculcate the virtue of team-work.

(ii) Reviews of certain government policies and laws establishing regulatory agencies to avoid conflicting roles should be undertaken, by the Federal Executive Council and the National Assembly.

(iii) Professional health associations and their regulatory councils should design broad continuing professional development programmes that would cross-fertilize ideas from sister health professions.

(iv) Further researches on acceptability of Leadership in Health System of Nigeria should be undertaken.

References

Abdulraheem, A.I.S; Oladipo, A. R. & Amodu, M.O. (2012), *PHC Service in Nigeria Critical Issues and Strategies for Enhancing the use by Rural Communities*, J. of Public Health & Epidemiology 4(1): 5-13 (in Academy Journals.org)

Adjei, O. (1995), "Team Work for Infections Disease Control", Africa Health, 17:3, ed. Bryan person, Cambridge, FSG Communications.

Collins, C. (1993), *An Elixer or an Illusion,* African Health 15:2, ed Bryan Pearson, Cambridge, FSG Communications.

Epundu, U.U; Adinma, E.D&Ogbonna, B.C. (2017), *"Medical Tourism, Public Health*

& Economic Development in Nigeria: Issues and Prospects, research gate.net.

Goodnews Bible, *Today's English Version* (2005) New York, St Paul's Society.

Igwe, O. (2007), *Politics and Globe Dictionary*, 3rd ed., Enugu, Keny& Brothers Enterprises.

Igbo, E.M. (2008), *Basic Sociology,* Enugu, CIDJAP Publishing & Press.

Kilmann, R. & Thomas, K.W. (1975), *Interpersonal Conflicts-Handling Behaviour as reflections of JungianPersonality Dimensions,* Psychological Reports 37:971-80 (in Wilmot &Hocker 2001).

Lloyd, J. (1994), *Reflections from Southern Africa*, African Health, 17:1, ed Bryan Pearson, Cambridge, FSG Communications.

Mayaki, S. & Stewart, M. (2020), *Teamwork, Professional Identities Conflicts & Industrial Action in Nigeria Healthcare*, J. of Multi Disciplinary Healthcare, 13:1223 (in ncbi.nim.nih.gov).

Okonkwo, E.U. (2004), *"The Vice President calls for…"* The Medical Laboratory Scientist, 11(24):7, Lagos, MLSCN.

Paton, C. (1996), *Health Policy and Management.*The Healthcare Agenda in a British Political Contest; London, Chapman and Hall.

Plunkett, W.R., Attner, R.F. & Allen, G.S. (2002), *Management. Meeting and Exceeding Customer Expectation*, 7th ed, Ohio, South Western.

Thomas, K. (1976), *Conflicts and Conflict Management,* (in Wilmot &Hocker 2001).

Thompson, D. (1994), *A look at Leadership Africa Health* 16:4, ed Bryan Pearson, Cambridge, FSG Communications.

Tyoor, F.M.T. &Agada, A.J. (2003), *Milestones in Public Sector Management,*Makurdi, QDMRC.

Ujo, A.A (2005), *Theory and Methods of Political Inquiry:* The Philosophical Foundation, Lecture Monograph Series, Abuja, Department of Political Science, University of Abuja.

Ujo, A.A (2003), *Understanding Management Techniques & Process*, Kaduna, Joyce Graphic Printers & Publishers Ltd.

Ujo, A.A (2001), *Understanding Public Administration,* Kaduna, Anyaotu Enterprises & Publishers (Nig.) Ltd.

Varma, S.P. (2008), *Modern Political Theory*, New Delhi, Vikas Publishing House PVT Ltd.

Williams, S.K.T., Fenley, J.M. and Williams, C. E. (1984), 'A Manual for Agricultural Extension Workers in Nigeria, Ibadan, les Shyraden.

Wilmot, W.W. &Hocker, J.L. (2001), *Interpersonal Conflicts*, 6th ed., New York, McGraw Hill Companies Inc.

www.academic.edu, "How to Calculate a Reliable Sample Size".