

Challenges of Clinical Leadership in Nigeria

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Abstract

Nigeria like the rest of the world is facing a universal health work force 'crunch' that is epitomized by widespread shortages of medical practitioners in positions of authority and consultation, this variance have led to inadequate distribution of healthcare professionals between and within healthcare institutions with poor working conditions and paucity of information and knowledge on best practice due to poor management of the health sector by politicians instead of medical professionals who take care of patients and who holds the best interest of the patients they care for (Conference of African Ministers of Health, 2005). Trending in Nigeria is the conventional view that medical practitioners should look after patients, while administrators look after organizations. Yet several pioneering healthcare institutions have turned this assumption on its head and achieved outstanding performance in the UK and in central Europe. This can be replicated in Nigeria through the adoption of clinical leadership practices and the restructuring of the healthcare system in Nigeria, which has been characterized by strike actions from medical practioners. Clinical leadership still, has a long road to travel in its expansion in healthcare management. To achieve the best and most sustainable quality of care, however, a commitment to building high-performing organizations must complement traditional values. All the evidence suggests that patients will see the benefit.

Keywords: Clinical leadership; Clinicians; Healthcare practitioners; Healthcare management

Introduction

Nigeria like the rest of the world is facing a universal health work force 'crunch' that is epitomized by widespread shortages of medical practioners in positions of authority and consultation, this variance have led to inadequate distribution of healthcare professionals between and within healthcare institutions with poor working conditions and paucity of information and knowledge on best practice due to poor management of the health sector by politicians instead of medical professionals who take care of patients and who holds the best interest of the patients they care for [1]. This is characterized by agitations, remonstrations and industrial actions which have cascaded into loss of lives and property, the migration of health workers to rich nations which is draining human resources for health in poor countries, which is then intensified by insufficient training of adequate number of health workers (FMOH, 2004) [2].

Documents and decisions of the 2nd Ordinary Session of the Conference of African Ministers of Health, Gaborone, October reported that Africa has 10% of the world population, it bears 25% of the global disease burden and has only 3% of the global health work force of the four million estimated global shortage of health workers one million are immediately required in Africa (Conference of African Ministers of Health, 2005) [1]. These predicaments have developed as a result of long standing neglect, unfavorable international development policies and practices among Nigerian and African leaders (Conference of African Ministers of Health) [1]. In line with this and contingent upon the Abuja Declarations, some countries have increased their health expenditure, while development partners have increased their development aid for health beyond US\$10 billion per annum. However, health funding in Nigeria remains below what is

required to achieve a functional basic health system, even if resources available were optimally used. Only two out of the 53 African countries have met the Abuja 2001 target of 15% of total government expenditure to be allocated to health, of which Nigeria is not among (Assembly of the African Union [3]. At the same time as it faces challenges, Nigeria is at a time of unique opportunities to significantly impact on its disease burden, notably through ensuring that adequate investments in health systems are made and that healthcare professionals should run the administration and control of medical institutions in the country which often interfered with by politics. There is increasing recognition that health creates wealth and advances GDP.

Trending in Nigeria is the conventional view that medical practioners should look after patients, while administrators look after organizations. Yet several pioneering healthcare institutions have turned this assumption on its head and achieved outstanding performance in the UK and in central Europe with hospitals like Kaiser Permanente and the NHS [4]. This can be replicated in Nigeria through the adoption of clinical leadership practices and the restructuring of the healthcare system in Nigeria, which has been characterized by strike actions from medical practioners and including the Pharmacological Society of Nigeria.

The evidence of the impact of good investments and effective interventions on burden of disease and on economic indicators is becoming stronger. Nonetheless, the reality remains that Nigerian's face a huge burden of preventable and treatable health problems whose solutions are known, proportionately far beyond the reach of its citizens due to poorly accessed and developed grassroots programmes. The triple burden from communicable and non-communicable diseases and injury and trauma including the social impact of these, has adversely affected development in Africa. While Nigeria is still not on track to meet the health Millennium Declaration targets and the

prevailing population trends could undermine progress made. Life expectancy on the continent, already low, has been reduced further to an average of 52 years by many factors including structural adjustment programmes (SAPs) and the AIDS epidemic. Women and children carry a disproportionate share of Africa's heavy disease burden, with 4.8 million children dying annually, mostly from preventable diseases. Women carry the major responsibility for care and poor education may add to their oppressed position.

AIDS, tuberculosis and malaria pose the greatest challenges. However, they should not overshadow the severe burden of other communicable diseases including pneumonia, diarrhea and measles in children and other diseases that severely debilitate communities affected by them. These include Onchocerciasis, Trypanosomiasis, Schistosomiasis, Dracunculiasis (Guinea Worm) and Filariasis. Cholera, Meningitis, Ebola and Marburg outbreaks continue, while intermittent cases of Human Avian Influenza remind the continent of the pandemic threat that mutation poses (Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa, 2010) [5].

The alarming rate of growth of the burden of both death and disability from non-communicable diseases in Africa is ever more recognized, with chronic diseases becoming ever more prevalent, linked to demographic, behavioral and social changes and urbanization. Hypertension, stroke, diabetes, chronic respiratory disease and the consequences of tobacco use, alcohol abuse and illicit drugs, are growing as serious public health challenges (Documents of the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria) [6]. Injuries from violence, wars, traffic accidents and other mostly preventable causes result in widespread death and physical disability, while the impact of mental ill-health has previously been underestimated. Sickle Cell Disease is the most prominent genetic disorder, while the prevalence of specific cancers is extremely high in some parts of the continent (Documents of the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria) [6].

Unlocking Healthcare Performance

How then do we unlock high performance in the healthcare sector? This can be achieved by putting clinicians at the heart of shaping and running clinical services, so as to deliver excellent outcomes for patients and populations, not as a one-off task or project, but as a core part of clinicians' professional identity. This is referred to as clinical leadership [7]. The attention being given to clinical leadership worldwide has given rise to many competency frameworks which make clinical leadership empirically researchable. In the UK, the Medical Leadership Competency Framework has been developed specifically for doctors, with the explicit intention that it should be embedded nationally in all curricula and at every level of education and training [8]. For a country to deliver basic health care to its people, it requires a fully functional health system. There are many ingredients that make up a functional health system, including human resources for health, transport, ICT, facilities and medicines and supplies. Health is a human right that is increasingly being recognized as enforceable.

The Nigerian governments have a responsibility for guaranteeing health care for all their citizens in an equitable manner and with clean and efficient governance, while using resources accountably. Governance includes providing stewardship, including vision and direction accompanied by transparent leadership. This is accomplished in developed societies by placing clinicians in the heart

of healthcare administration in their country. There should be committed inter-sectoral action for health involving other ministries and levels of government [9].

The Health Ministry's stewardship role goes beyond the Ministry of Health's leadership in the health sector and the strategic management of the health system to addressing the inter-sectoral, socio-political environment within which the health system operates. However, legislation and consequent regulation are key tools in giving effect to policy [10]. Nigeria should review her health legislation and promulgate new legislation and regulations as needed to ensure that their policy intent is supported and that legislative gaps are filled, creating an environment for effective delivery of affordable, appropriate, equitable, and accessible quality care for the entire population. Governments alone cannot assure the health of its population. Partnerships with communities, private sector, civil society organizations as well as development partners are essential to make an environment conducive to good health status as well as to deliver health services.

Making clinicians' organizational leaders is a huge and costly task. Is it worth it—especially given the many competing demands on clinicians' time? They and others will rightly seek evidence of the link between clinical leadership and a health organization's performance, both clinical and financial [4]. Proof of a direct correlation will remain elusive, thanks to the inherent complexity of health systems, whose performance is affected by multiple, overlapping variables of which clinical leadership is only one. Nonetheless, a diverse and growing body of research suggests the impact of clinical leadership. A recent study by McKinsey and the London School of Economics, involving over 170 general managers and heads of clinical departments in the UK NHS, found that hospitals with the greatest clinician involvement in management scored some 50% higher on key measures of organizational performance than hospitals with low clinical leadership.

Amongst the growing base of academic evidence, an NHS study found that in 11 examples of attempted service improvement, organizations with stronger clinical leadership were more successful in delivering change (National Co-coordinating Centre for NHS Service Delivery and Organization, 2006). Another recent study found that high-performing NHS organizations were distinguished by CEOs who had collaborative and consultative leadership styles and who engaged clinicians in dialogue and joint problem-solving [11].

In the US and elsewhere, studies published in academic journals are now establishing that high performing medical groups are distinguished by their explicit emphasis on clinical quality, by the relationships between clinicians and non-clinicians, and by the ability of the organization to learn. Numerous case examples, such as those cited above, suggest very strongly that involving clinicians in the shaping and day-to-day running of services leads to higher service performance, both clinically and financially. Indeed, across Europe there are no high-performing healthcare organizations which have low levels of clinical leadership [12].

Although, engaging clinicians in the leadership and management of service becomes even more demanding in the face of a global economic recession. Health care is expensive, and the need for improving quality of care within a dwindling resource base is a major limitation. Once more, clinicians possess significant clout over these grossly insufficient resources, and are able to contend from an authoritative and realistic position how these resources are best utilized [13]. Clinicians by virtue of their profession do occupy the

moral high ground of patient advocacy and in actual fact patients want their clinicians to be involved in the decisions making process of regulating and allocation of these insufficient resources [14].

For example, in the United States and the United Kingdom after three decades of increasing managerial abilities in the UK's National Health Service, the focus of government attention had shifted to 'engaging' clinicians. In 2007, a talented London surgeon, (now Lord) Ara Darzi, was appointed as health minister, and under his leadership the English Department of Health launched a wave of policies encapsulated in their policy document "A High Quality Workforce: NHS Next Stage Review". The vision was to put quality at the core of health service provision, and for clinicians to accept three key roles: practitioner, partner and leader. This new emphasis on clinical leadership, which other successful health providers (such as Kaiser Permanente in the USA) have adopted, has since captured the national interest because of its phenomenal success in improving patient care. The subsequent publication of a UK-wide Medical Leadership Competency Framework by The Academy of Medical Royal Colleges with the NHS Institute for Innovation and Improvement, and the creation of a National Leadership Council, have further embedded clinical leadership as central to the onwards development of the NHS (Academy of Royal Medical Colleges and NHS Institute for Innovation and Improvement, 2008). Following a change of government in May 2010, there has been no lessening of this emphasis on a professionally led health service, with the dissolution of central health care management structures and the introduction, in England at least, of general practitioner (GP)-led commissioning [15].

Nigeria can take a cue from this step and implement policies to sustain it, this is because, health care systems that are serious about transforming themselves must harness the energies of their clinicians as organizational leaders [16]. So change is needed, despite years of progress in the quality of health care around the world. This transformation will require leadership and that leadership must come substantially from doctors and other clinicians, whether or not they play formal management roles. Clinicians not only make the vanguard decisions that determine the quality and efficiency of care but also have the technical knowledge to help make thorough strategic choices about longer-term patterns of service delivery. Unfortunately, the orthodox perception of health care management discriminates treatment from administration as in, doctors and nurses look after patients, while administrators look after the organizations that treat them. But we can learn from a number of pioneering health care institutions especially in developed societies that have achieved outstanding performance by completely challenging this notion.

Despite accumulating evidence of the positive impact of clinical involvement in the delivery and improvement of service, health care organizations in Nigeria and elsewhere often struggle to achieve participation from clinicians. To understand the barriers to clinical leadership, conducted interviews and workshops involving nearly 100 clinical professionals [17]. The research highlighted three main concerns which are expansively and realistically applicable to the contemporary Nigerian situation.

First, it found an 'in-built suspicion' among clinicians about the value of time spent on leadership, as contrasting to the obvious and immediate value of treating patients. Participants explained that involving in organizational-leadership role was not seen as beneficial either for patient care or their own professional success and therefore look as if irrelevant to the self-esteem and profession of clinicians.

Second, it became clear there were undesirable reasons for clinicians to take on service leadership roles. This may be due to the fact that leadership potential is not a benchmark for entry into the clinical professions and often is not a key factor in promotion and advancement in clinical practice. Peer recognition is low or nonexistent for those who seek leadership positions as opposed to clinicians who engage in research. This is due to importance that is attached to clinicians' careers which is widely acknowledged, and the reasons to undertake it are clear for example research publications are crucial to securing the top jobs or professorships, which carry great prestige and influence and (frequently) financial rewards.

Thirdly, leadership and management training is frequently absent from core curricula for undergraduate or postgraduate trainees and for the continuing professional development of clinicians both in Nigeria and elsewhere. The programs that are available to clinicians are often run externally rather than in house, making it harder to focus on the practical experience on the real day-to-day challenges. The biases of clinicians are at play as well having had years of training to perform their clinical role many assume that months or even years of formal, rigorous training are required before clinicians can safely become a proficient leaders.

Conceivably the highest limitation for clinicians in engaging in clinical leadership is that of perception. This notion influences the motivation and interest to involve in clinical practices. One way to address this problem is to highlight the value of great clinical leadership, as organizations can create a formidable set of role models. This value should reflect the benefits both to patients and to the teams delivering care benefits such as greater independence or simply the sense of self-esteem in accomplishment. In Boston, for example, Partners HealthCare celebrates distinctive clinical leaders not only at annual award ceremonies but also day to day, through e-mail, in-house journals, and informal conversations [17].

In Nigeria however, health care organizations need to build a formidable, credible evidence base to show the importance of clinical leadership. Organizations have to track measures of clinical-leadership development and correlate them with their impact on quality and costs. Regional health care systems or authorities in Nigeria have an influential role to play here, given their scope for gathering analysis across a number of organizations [2]. Healthcare policy makers and organizations in Nigeria must also reorganize and reprioritize incentives, by removing lack of encouragement for clinicians to become service and system leaders these disincentives include paying clinicians significantly less in such roles than they would make by remaining in full-time clinical practice. Correcting these problems is important not only for direct financial reasons but also because of the wider indications that incentives propel about the value and esteem attached to clinical leadership. In the United Kingdom and the United States, where it flourishes, in organizations such as Health Partners, in Minnesota, clinicians in formal leadership roles typically receive a small premium over colleagues who focus solely on direct patient care. However, caution should be addressed as too great a financial premium, however, would make patient care less attractive and damage what ought to be the peer-to-peer relationship between leaders and other clinicians [2].

As people come to appreciate the link between performance and enhanced clinical leadership, health systems can also encourage it indirectly by finding appropriate ways to reward organizations that perform well and by creating meaningful consequences for those that do not. For instance, Nigerian healthcare institutions can operate on

the principle of earned autonomy wherein, high-performing regions and organizations receive substantial freedom to operate with less central oversight, whereas those that underperform are scrutinized closely [17,18]. Any effort to encourage clinical leadership has to include support for professional development. On the other hand the best starting point is not to create or commission a training course. Health care organizations must first define what they want from their clinical leaders what skills and attitudes they hope to encourage, whether there are differences across professions or roles, and where the need to develop leadership is greatest. They can then target their efforts wisely and help clinicians identify and overcome any shortcomings [17].

As with all training efforts for clinicians regardless of cadre or creed, it will be necessary in addressing the practical issues clinical leaders face. There are obvious benefits to programs that are truly centered on real work the power of learning by doing, the importance of immediate feedback, the integration of concept and application, and the encouragement that comes from seeing a noticeable impact. And for clinicians, development programs with real work at their heart can help enormously in demonstrating how patients benefit when clinicians lead the improvement of services. It also will create enthusiasm for leading service improvement and efforts, with enduring benefits after the formal program had ended. Health care organizations should consider introducing processes to select participants in order to underline the value of the programs and, more broadly, the prestige associated with being on the organizational leadership track. The Nigerian healthcare can take a cue from the Singapore's National Institute of Education (NIE) which scrutinizes the whole teaching staff to identify highly prospective candidates to be future head teachers in their country. Entry into the head-teacher track is highly competitive, and a series of gates determines a candidate's subsequent progression. This approach helps signal the value the NIE attaches to teachers who step up to become leaders [16].

In Nigeria, with periodic political interferences, policy formation and implementation clinical leadership still has a long road to travel in its expansion in healthcare management. But it is an essential path for both clinicians and their patients. A deep commitment to patient care and to traditional clinical skills will always remain the core of a clinician's identity [16,18]. Effective assessment and performance appraisal is essential for clinical leadership to see the light of day; this implies that HR practices will be effectively applied to the practice of clinical leadership. To achieve the best and most sustainable quality of care, however, a commitment to building high-performing organizations must complement these traditional values. All the evidence suggests that patients will see the benefit [19,20,21].

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