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By Dr. Chukwuka C. Monye

The Hidden Cost of Poor Hospital Management in Nigeria

Introduction

I have walked into hospitals that looked right and felt wrong. Clean walls, functional equipment, trained doctors, good ambience, and yet, a quality of care that was consistently and inexplicably below what those inputs should have produced. Patients waiting in corridors because of a chaotic admissions process. Medicines running out mainly because nobody was in charge of monitoring the procurement timeline. Staff performing below their capability because there was neither a leader nor a manager.

Nigeria's healthcare crisis is discussed, almost entirely, in terms of funding. We need more money. More doctors. More facilities. More government commitment. All of that is true. But it is not the whole truth.

The part we don't discuss enough, and this is because it is harder to photograph and fundraise for it, is management.

Management is the way hospitals are run; the systems inside them; the accountability structures; the leadership culture; and ultimately, the staggering, measurable cost of getting all of that wrong.

The Management Gap

A 2024 study published in Health Affairs Scholar examined medical competence across 16,127 healthcare providers in eleven (11) Sub-Saharan African countries.[1] What they found was quite striking: 81% of the variation in provider competence was within countries, not between them. In other words, the gap between the best-performing and worst-performing providers within a single country was larger than the gap between countries. The quality of care you receive in Nigeria depends less on where Nigeria is than on which Nigerian hospital you walk into and how that hospital is managed.

The World Bank has documented extensively that health system performance in Sub-Saharan Africa is constrained not primarily by clinical capability but by governance and management

1 Daniels, Chang, Gatti & Das, 'Medical Competence of Health Care Providers in Sub-Saharan Africa: Evidence from 16,127 Providers,' Health Affairs Scholar, ` June 2024

2 Springer Nature, 'Navigating the Complex Terrain of Healthcare Systems in Sub-Saharan Africa,' Discover Health Systems, 2024

quality.[2] Africa has 12% of the world's population but employs only 3.5% of the global health workforce to serve 27% of the global burden of disease. Every person in that system needs to be operating at maximum effectiveness, but poor management makes that impossible.

I have seen this happen over and again. When we take over assets, we find that the first problem is rarely the clinicians. The doctors and nurses we work with are often extraordinarily capable, working under conditions that would have destabilized most people in similar roles in other parts of the world. The problem is usually the system around them.

What poor management looks like.

Hospital management failures are rarely dramatic, but they build up through absent systems and structures, until the cumulative effect becomes visible in patient outcomes and staff dissatisfaction and departure .

Sometimes, it is a procurement cycle that takes six weeks to complete because there is no standard supplier approval process, leaving the medication to run out for days while someone else is trying to get approvals. Sometimes, it is a shift handover where critical patient information is communicated informally, because there is no documentation protocol, and the patient's condition is changing but not being properly recorded. At other times, it is a consultant's preference overriding the standard treatment protocol, because nobody has established that protocols exist to protect patients, not to constrain doctors.

This affects the workforce morale as well, because you would have staff who are technically excellent and operationally invisible because nobody is measuring what they do, recognizing when they do it well, or addressing it when they don't. Over time, the excellent ones leave and the ones who remain learn that standards are aspirational.

The SafeCare Quality Improvement Programme, which has now assessed over 5,400 healthcare facilities across nineteen (19) African countries, consistently finds that management and administrative standards are the weakest dimension of hospital performance, weaker than clinical protocols or equipment adequacy.[3] The facilities that improve most dramatically are those where management practices change first, and then clinical quality will follow.

> *You can have excellent doctors in a poorly managed hospital and still deliver poor care. Management is the multiplier that determines whether clinical talent produces clinical outcomes..*

Rwanda: Management as a reform lever

Rwanda is the comparison I return to most often, as it is the most instructive. A country with fewer resources than Nigeria, a more recent and more devastating crisis, and consistently better systemic outcomes in healthcare. Part of the explanation is funding, because Rwanda meets the Abuja Declaration target, but most of it is governance

Rwanda's health system reforms, documented extensively by the World Bank and the Institute for Health Metrics and Evaluation, centred on three management interventions: performance-based financing (tying facility funding to measurable patient outcomes), community health workers operating within structured accountability systems, and hospital leadership training as a national priority.[4] Coincidentally, Nigeria has almost all the technology required, however, we do not have the system or discipline to be established or scale like our counterparts.

The NHS, where several of Nigeria's medical graduates have been running to, has its own management failures that are well-documented and widely debated. But even at its most dysfunctional, it operates within a framework of formal accountability, undergoing rigorous inspections, published quality ratings, documented clinical governance structures, and legal liability for management failures. Nigerian hospitals, public and private alike, mostly lack this system of governance.

The private sector's role

The private healthcare sector in Nigeria is growing, as investments are coming in and new facilities are opening. This is genuinely good news, however, the risk is that we get new investments reproducing old management cultures, well-funded hospitals that are poorly governed, and a lack of clinical governance buried deep underneath new signages and modern equipment.

The private sector's contribution to Nigerian healthcare should not be just capital, but also standards. Hospitals should measure patient outcomes and publish them internally, even if not publicly. Facilities should have documented procurement systems, shift handover protocols, and clinical governance frameworks. They should also have management teams that are trained in hospital administration, not just those who are promoted from clinical roles because they were the most senior doctor available.

This is much harder work than building a new ward or buying equipment, because it is less visible and less fundable, it also doesn't give room for photo ops, however, it is the difference between a hospital that delivers on its clinical capability and one that consistently underperforms.

I once believed that the healthcare crisis was fundamentally a funding problem, until we started operating hospitals. I still believe funding matters, but after over a decade of working inside Nigerian health institutions, I am equally convinced that management is the silent multiplier, the factor that determines whether any given level of funding produces the outcomes Nigerians deserve.

> *Building a healthcare system Nigeria can be proud of requires more than money. It requires institutions that are serious enough to be managed properly.*

This is what we have spent the past decade trying to build, and I believe that the private sector, at its best, is uniquely positioned to model.

3 BMC Health Services Research, 'Leveraging Local Health System Resources to Address Quality Healthcare Gaps in Sub-Saharan Africa: Lessons from Safe Care Ghana,' 2024

4 World Bank / IHME, Rwanda health system performance data; Institute for Health Metrics and Evaluation Global Burden of Disease

Conclusion

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