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Hospital Governance and Appropriation of user Services by Medical and Social Staff: The Case of the Douala-Cameroon Hospitals

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Hospital Governance and Appropriation of user Services by Medical and Social Staff: The Case of the Douala-Cameroon Hospitals

Christian Kenne Mafouo Ngnintsa [α] & Henri Wamba[σ]

Abstract- The transposition of the mode of corporate governance to hospital governance for several decades (J. Vallejo, 2018) has led to the study of the possible causal links between governance systems aimed at regulating the behavior of medical staff and the improvement of services to users of these hospital structures. Analyzing this problem within the Douala Hospital Centers, this article raises the following question: How and in what way does hospital governance impact the appropriation by medico-social staff of services to users of Douala hospital centers? This point led us to the mobilization of a qualitative-quantitative methodology that allowed us to collect and analyze data from 250 people (administration, medical staff, users, Etc.), thanks to online data collection tools (stat- survey). The figures and qualitative data thus collected were analyzed using SPSS software and interpreted in light of the agency's theories. The results show that the Douala hospitals have undergone profound administrative reforms, which have facilitated the motivation of the medical staff, which in turn has considerably improved the quality of care for users. Our analysis leads to a significant improvement in the satisfaction of users of Douala Hospital Centers.

Keywords: hospital governance - ownership of user services - medical and social staff - patients - douala hospital – Cameroon.

I. Introduction

A new transformation of hospital policy has emerged in recent decades through implementing a set of managerial concepts that will gradually diffusely take place in the public hospital environment. In the words of J. Vallejo (2018), this is an attempt to industrialize care to control costs while improving the quality of services offered to users of hospital services. Therefore, since the last decade, the Cameroonian authorities have directed their governance efforts towards establishing new governance mechanisms from the universe of companies within health facilities to ensure the efficient management of their strategic and operational activities (Kervasdoué, 2004). The transposition of this issue from corporate governance to hospital governance leads to the study of possible causal links between governance systems aimed at regulating the behaviors of hospital managers and the performance of this type of organization. Analyzing this problem within the Douala Hospital Centers, this article raises the following question: "How and in what way does hospital governance impact the appropriation by medico-social staff of services to users of Douala hospital centers? ».

Therefore, this article mobilizes a method of qualitative-quantitative analysis, postulating that through the application of the new standards of hospital governance, the managers of Douala hospital centers lead the medical-health staff to greater efficiency in the appropriation of services to users. As a result, we combined interviews and questionnaires administered to more than 250 people (administration, medical staff, users, Etc.), using data collection information tools (stat-survey). The figures and qualitative data thus collected were analyzed using SPSS software and interpreted in light of the agency's theories.

The work revolves around three central moments. The first articulation presents the mechanisms for adopting hospital governance and the subsequent organizational transformations in the Douala hospital centers. The second analyzes hospital governance on the improvement of services to hospital users. Finally, the last articulation reports on the research results. As a result, the Panel analyzes and interprets these results.

a) Mechanisms for Adopting Hospital Governance and Subsequent Organizational Transformations Allow Development in Douala Hospitals

From the 1980s onwards, the hospital issue became a significant concern for the public authorities, the bête noire of the supervisory ministries (Arliaud, 1987). At the root of this concern is a set of dysfunctions that have forced governments to implement hospital reforms to help hospitals better care and spend in a complex and specific context characterized by unlimited demand and limited resources (Ezziadi & Gharrafi, 2019; Baptiste, 2003).

With this in mind, the public authorities have directed their efforts toward introducing specific managerial tools from the universe of firms within health establishments to ensure the efficient management of their strategic and operational activities (Kervasdoué, 2004). A new transformation of hospital policy has emerged in recent decades through managerial

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concepts that will gradually diffusely take place in the public hospital environment. In the words of J. Vallejo (2018), this is an attempt to industrialize care to control costs while improving the quality of services offered to users of hospital services.

In the specific case of Cameroon, in the 1970s, under the inspiration of the World Health Organization and, more recently, under the impetus of the World Bank, the country embarked on a process of almost permanent reform of its health system. Following the Alma Ata conference in 1978, Cameroon ratified the African Health Development Charter, which made primary health care the essential strategy for achieving the goal of "Health for All by the Year 2000". It was a failure. Subsequently, Cameroon joined several subsequent initiatives in Africa, including the Lusaka (1985), Hararé (1987), and especially the Bamako (1987) conferences, which laid the foundations for cost recovery.

The current Primary Health Care Reorientation Policy, officially adopted in 1992, aims to restructure the national health system from the health district. From 1998 to 2008, the Ministry of Public Health (M.S.P.) set up a National Health Development Plan (PNDS). The main strategic orientations adopted are to reduce the morbidity and mortality of the most vulnerable groups by one-third, to set up a health structure delivering the Minimum Activities Package (P.M.A.) within one hour of90% of the population, and practicing efficient and effective resource management in 90% of health facilities until 2008 is a success.

More recently, in 2018, a new impetus was given to the governance of Cameroonian hospital centers following what should be called the "*Monique Koumatekel case*," which hit the headlines in Cameroon and mobilized the national and international media. Monique Alivine Koumatekel was the eldest of four children (three daughters and one boy) and the mother of three daughters. This 31-year-old woman lived in P.K. 14, Douala, with her partner. After stopping her studies in the fourth year class at the College of Industrial and Commercial Technical Education of Yabassi, she moved to Douala, where, without stable employment or profession, she managed, as people say in the common language in Cameroon (National Order of Physicians of Cameroon 2016). She earned a living through a small business: selling food, clothing, and shoes. Monique's fate changes as she waits for twins. Upon completion, Monique was transported to the services of the Laquintinie hospital for medical attention on March 12, 2016, after having passed to the District Hospital of Nylon and the PK13 medical center (National Order of Physicians of Cameroon 2016).

Laquintinie Hospital is one of the reference hospitals in Cameroon. The hospital is supposed to be a quality health institution where therapeutic services are guaranteed, hospitality is friendly, and services generate forms of solidarity and reduce the risks associated with marginalization, exclusion, and contempt (Nkoum, Socpa 2015). After waiting more than five hours without medical care, Monique and her family will return from the emergency pavilion, where they report on arrival to the maternity ward and receive an icy welcome. Without prior consultation, the nurses conclude that the patient no longer lives and that she must go to the morgue (Dita, 2016). Without a death certificate or a declaration of the type of death, the morgue cannot receive a body. Was the patient unconscious or dead? Movements in the belly of the latter will attract the attention of the morgue and the family. Back in the maternity ward and faced with the categorical refusal of the staff to intervene, Monique's niece becomes a surgeon to extract the binoculars from Monique's belly. The images of this act will go around the social networks. Monique's death on March 12, 2016, in front of the Laquintinie maternity ward, was a chronicle and shocking national and international public opinion. In the aftermath of these events, several voices lift either to denounce what has happened or to release the hospital authorities from any responsibility. Monique's mother says she was still alive before she arrived in Laquintinie (Dita, 2016). Some people, including Monique's niece, the morgue, the maternity major, and the midwife from the same hospital, are arrested (Jacquineau Azetsop et al., 2018).

In recent years, the health sector in many African countries has undergone several disruptions, including implementing various government measures to control costs. Hospitals are currently facing extreme changes requiring them to control their performance better. In this context, management control is an opportunity to implement the tools and methods to achieve this objective. However, the management control system at the hospital must adopt a specific structure around specific objectives, such as optimal allocation of resources, not profit (Cauvin, 1999). One of the critical issues facing healthcare administrators is cost control. Therefore, the use of health needs can change depending on supply and demand. For several reasons, these two factors are growing faster in rich countries than in countries with limited resources. From a supply-side perspective, rich country governments have higher incomes with which to pay for services, and technological innovations are expanding the range of these services. In addition, people in rich countries have optimal information because of the health messages encouraging them to consult their health professionals.

On the other hand, since the end of the twentieth century, scientific and technological progress has led, among other things, to an increase in life expectancy throughout the world. Cameroon, despite this progress, has always been the subject of many concerns about its ability to implement an effective health policy. The hospital, a public institution, is the place par excellence that best reflects a country's health

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policy, and its primary purpose is to provide quality care of a humanitarian nature.

Furthermore, an analysis of the Cameroonian healthcare system highlights the fundamental problem of "poor access of populations to quality health care." These populations, in this case, the most affluent, turn to private clinics; on the other hand, those who do not have enough means and who constitute the majority fall back, either to traditional methods or to the informal sector, with all the health risks that this entails. This problem results from four major causes: unequal access to health care.

In populations, the training provided to staff is sometimes incomplete and not adapted to the needs of the sector, the quality of care provided is very average, and governance in this training could be better. However, it must be noted nowadays, particularly in hospital centers, that the actors in the hospital sector still need to perceive the importance of Management Control, which could contribute to considerably improving the quality of care provided to users. However, they explain this by the fact that, by its very nature, management control is more easily justified within profit-making organizations since it ensures that they use the resources made available to them effectively to obtain profits and thus sustain their existence; it seems absurd to find it within the hospital which operates with state resources and which has no obligation of result. However, we have to note that the hospital, a non-profit humanitarian organization, receives its funds from the State, but this does not preclude the fact that it must use them (converted into financial and material resources) effectively, if not efficiently, to be able to provide the best care to patients at the lowest prices, which therefore includes the need for management control within the hospital to ensure the best use of its resources. In addition, the primary mission of hospital governance is to carry out efforts to guarantee financial balance, maintain staff turnover, optimize the occupancy of beds, avoid excessively long periods of stay, respect the standards of caregivers, obtain a high percentage of patients satisfied with their stay, reduce the waiting time for consultations, ensure a warm welcome to patients and reduce the number of deaths while ensuring a better quality of care, Etc. These various elements are part of hospital performance, which is the counterpart of hospital governance.

On the other hand, an increasingly far-reaching decentralization policy is at the heart of the long reform process, which, if completed, should radically transform the health system. The issue has resulted in a series of legal and regulatory measures that people still need to complete. More recently, in July 1999, during the joint World Bank-IMF mission to review the economic and financial policy framework, the Cameroonian government agreed with its partners to draw up a sectoral strategy paper for health. The M.S.P. set up a steering committee bringing together all partners to develop this strategy. This document falls within the context of the three-year agreement under the Enhanced Structural Adjustment Facility signed with the F.M.I. on August 20, 1997. In addition, Cameroon has become eligible for the Revised.

Relief Debt of the Poor Countries and the Government has decided to include the elaboration of sectoral strategies in the sectors of health, education, agriculture, and infrastructure, during the third year of its structural adjustment program. As a prerequisite for the forgiveness of external debts, the relief granted should be devoted to structural reforms and the development of the social sectors.

However, studying the process of decentralization of the health system in Cameroon poses a particular problem since it is not a question of taking stock of reform already carried out but of studying, at a given moment, the dynamics of reform in the process of gestation remains unfinished. Legislative and regulatory development is underway and has yet to finish all implementing legislation. A practice is, however, being developed based on uncoordinated directives and initiatives without always having a precise legal basis. It aggravates this confusion through the balkanization of international aid that shares the territory. The donors have already launched projects within the provinces, which they have divided, each on their own and without coordination, in the direction of decentralization. The result is a situation that needs to be accurately summarized. Nevertheless, a dynamic of reform is developing, which makes decentralization its guiding principle, and whose logic it is interesting to update.

Decentralization is introduced into the public health system in Cameroon as a set of techniques aimed, through the empowerment of health structures, at profoundly transforming the dysfunctional behavior of health, medical and paramedical personnel; people consider it at the root of the crisis in the health system. Like all administrations in Cameroon, the public health sector suffers from the combined effects of bureaucracy and patrimonialism. Bureaucratism, an expression that aims to cover all the perverse effects of bureaucracy, has the effect, through a shift of goals, of a corporate and collective appropriation of the administration by its staff. The problem is a situation we are familiar with in France. Heritage, characterized by confusion between the public and the private, has the effect of privately and personally appropriating the administration by its staff. It manifests itself in systemic and widespread corruption. The result of these two combined evils is a structural dysfunction of the health system because it is the staff, not the sick, who become the “raison d'être” of the organization. People hope that decentralization will lead to changes in the behavior of health workers and refocus the health system on its objective of public

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health, that is, the population's health. The fundamental idea that emerges is that the problem, before being a simple question of funding, a question of "big money," and first of all, a problem of human resources. Therefore, the purpose of this work is to highlight the governance mechanisms that should impact the governance system of Cameroonian hospitals with a view to the appropriation of services to users, based on the case of hospital centers in the city of Douala.

Overall, the negative assessment of the health situation in Cameroon, on which all observers agree, reflects a deep crisis in the Cameroonian health system; this is very noticeable in the Douala Hospital Centers. Hence the need to examine, like the new mechanisms of hospital governance, the appropriation of services to users of these hospital structures in Douala.

b) The Theoretical Impact of Hospital Governance on Improving Services to Users Helps Improve Douala Hospital Centers

To better understand these implications of the New Hospital Governance in Douala, we have mobilized the theory of the agency. Since the 1980s, agency theory has greatly influenced the transformation of hospital policies. It has promoted the emergence of a realistic neo-liberal theory of hospital governance to replace the original neo-classical approaches that obscure information asymmetries and structural problems (Béjean, 1999; Domin, 2015). According to M. Mougeot (1986), the agency theory is the only approach capable of taking into account the dysfunctions of a hospital system characterized by the existence of a set of actors, logic, and divergent objectives in a situation of imperfect information.

Despite the diversity and complexity of the relationships between hospital workers, the agency theory is ubiquitous in the managerial sphere of the hospital; it applies to all hierarchical levels and all relationships established in the hospital universe: Doctor- Sick, Insured-Insurer, Medical Director, Hospital Supervisor, Etc. (Sebai, 2016).

However, all these relationships have the characteristics of information asymmetry between the principal and the agent. As a result, J. Sebai (2016) emphasizes the need to put in place specific incentive mechanisms to limit opportunistic behavior, which is a source of inefficiency, and to control the adverse effects of this information asymmetry.

On the other hand, J. P. Domin (2014) argues that interactions between the hospital's internal and external actors can be considered agency relationships. It specifies that the relationship between guardianship and the hospital is an agency relationship with anti-selection (or adverse selection) and moral hazard (or moral hazard), which leads to difficulties for the principal (guardianship) in the decision-making and the control of the actual activities of the agent (hospital). Similarly, the relationship between the (principal) director and the medical profession (agent) has an agency relationship, except that this relationship is often "parasitized" by uncertainty, information asymmetry, and opportunistic behaviors of agents seeking to maximize the usefulness to increase the budgets allocated to their services (Domin, 2014). The Director/Physician relationship is an agency relationship with anti-selection (ex-ante opportunism). Moral hazard (ex-post opportunism) since the principal (director) cannot measure the level of effort made by the agent and the weight of the costs incurred for the production of care, implicitly, he cannot measure the degree of compliance with the contract by the medical profession (Domin, 2015).

In short, the hospital describes a contractual relationship node that adheres perfectly to agency theory. Referring to the two approaches to agency theory (normative and positive), S. Béjean (1999) identifies two different models of hospital operation. This theory, therefore, makes it possible to account for the processes by which hospital governance applied to Douala hospital centers leads medical and health personnel to greater efficiency in the appropriation of services to users. It thus illustrates the relationships between governance actors at different levels of decision-making. Distinguishing the agent from the principal each time, according to the hierarchical line on which one positions oneself, and analyzing the resulting sets of actors.

Hospitals are currently facing extreme changes requiring them to control their performance better. Management control is an opportunity to implement the tools and methods to achieve this objective. The system of hospital governance implemented makes it possible to respond to the complexity and uncertainty that characterizes the Cameroonian public hospital today and how it participates in promoting the appropriation of services by medical and social personnel. This process leads to better patient care and staff suffering in an environment characterized by work pressure and high procedural requirements.

The first work on the role of hospital staff dates back to the 1960s. These are precisely those of Strauss, who devotes a large part of his studies to the medical environment, including an article on medical nurses (Strauss, 1966), allowing the author to develop concepts that inspire more contemporary authors. This point is the theory of occupational segmentation and negotiated orders (Strauss, 1959, 1966, 1992). The concept of professional segmentation, taken up by Freidson in his many works on the hospital (Freidson, 1970, 1971, 1985), brings a new reading on medical organizations by observing a diversity of medical practices, allowing him to speak of a "differentiation internal to the professions" (Champy, 2009, p. 107). Champy, for his part, speaks of a "gap" between managers and

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practitioners working in the hospital. The second concept, the negotiated order, of which Strauss is responsible and part of the constructivist trend, makes it possible to conceive the professions no longer as a monolithic block but as something heterogeneous. Moreover, the hospital is often cited as a reference because they have conducted many studies there (Freidson, 1971; Champy, 2009).

The evolution of the environment, including the "bureaucratization" of the organizations in which many professionals work "(Champy, 2009, p. 32), motivates authors such as Schön, Abbott, and Freidson to dissect the subject matter of the professions by focusing on their content. In his book *The System of Professions. In an Essay on the Division of Expert Labour*, Abbott examines the "territories" of occupations by analyzing how occupations divide tasks or, in other words, how work in an institution divides. In this vein, the question of the autonomy of professions will emerge.

The understanding and effects of neo-management reforms on actors within public organizations provide fertile ground for the question of professional autonomy. The "discretion" of public officials and their direct contact with the citizen form the two properties that form the basis of the concept of S.L.B., a concept theorized by Lipsky and taken up by many sociologists (Lipsky, 1980; Brodkin, 1997; Bovens, 1998, 2007; Maynard-Moody et al., 2003; Riccucci, 2005; Nielsen, 2006; Hupe & Hill, 2007). N.P.M.s may threaten public sector actors' discretionary dimension and autonomy on the ground, although they recognize it as necessary for adequately implementing public policies (Lipsky, 1980; Maynard Moody & Musheno, 2003). Extensive literature informs about this dynamic by referring to the reforms of the social State and shows that the S.L.B.s are actual *policymakers* in the delivery of services (Dubois, 2010; Keiser et al., 2004; Lipsky, 1980; Maynard Moody & [1]Musheno, 2003). Other authors explain the behavior of S.L.B.s more by professional culture, by the standards of the profession (Riccucci, 2005), and by characteristics of the actor, such as gender and education (Scott, 1997) than by organizational factors.

Scientific interest in paramedical professions, such as nursing or nursing assistants, is relatively recent. This desire to "make visible the work of know-how [remained] invisible" until they claim several authors such as Arborio, Acker, Bourret, and Molinier. While Arborio deals with the issue of nursing assistants and their "dirty work" (Arborio, 2001), Acker, in an article published in the *French Journal of Social Affairs,* explains the "reconfiguration of nursing work in hospitals" (Acker, 2005) in the French context of hospital reforms. His study shows that changing working conditions in hospitals changes the content of nurses' work (Acker, 2005, p. 161) and forces them to prioritize their tasks (Acker, 2005, p. 176). She notes that "the high professional standards that lead to the promotion of patient listening and support tasks are vulnerable by the time available to each patient" (Acker, 2005, p. 179). Moreover, in his numerous publications on the nursing profession (Acker 1997, 2000, 2003, 2005, 2009, 2011), the author points out the following paradox: the responsibility of the relational and human dimension in the action of nursing staff, while "rarely demanding accountability for this work" (Acker, 2009, p. 64).

The Anglo-Saxon literature is also rich on the issue of the role of nurses in N.G.P. In a collective work on the sociology of *care* (Abbott & Mirabeau, 1998), the authors discuss the role of these professions in the context of social state reforms. John Clarke's contribution addresses the issue of *New Public Management*[1] (N.P.M.) in the health sector. It highlights how managerial logic, coming from the private sector, comes up against *care professions,* including nursing.

Numerous studies have highlighted the impact of M.P.N. on the status and role of hospital nurses (Ackroyd, 1995, 1996, 1998; Bolton, 2004; Kowalczyk, 2002; Hogget, 1996; Noblet & Rodwell, 2009a; Strong and Robinson, 1990). There is almost an agreement.

There was unanimity in the scientific community that the N.P.M. is leading to a transformation of the care culture and, more specifically, the nursing profession in public hospitals. However, some of these studies (Bolton, 2004; Kowalczyk, 2002) maintain that the managerial reforms introduced in hospital structures have left nurses' autonomy intact (Bolton, 2004, p. 330) and allow nurses to be *empowered* at the top of the hierarchy, thanks to a "materialization" of their profession (Kowalczyk, 2002, p. 128). For a synthetic exploration of the tension between the N.P.M. and the professions of the public sector, the collective article *New Public Management and profession in the State: beyond the oppositions, what recompositions?* (Bezes et al., 2011) serves as a reference. More specifically, contributions like that of Fagermoen study nurses' professional identity and highlight the importance of the human dimension among caregivers.

Cameroon, despite this progress, has always been the subject of many concerns about its ability to implement an effective health policy. The hospital, a public institution, is the place par excellence that best reflects a country's health policy, and its primary purpose is to provide quality care of a humanitarian nature. Furthermore, an analysis of the Cameroonian healthcare system highlights the fundamental problem of "poor access of populations to quality health care." This problem results from four major causes: inequitable access to care by the population, training provided to staff is sometimes incomplete and unsuitable for the needs of the sector, the quality of care provided is very

[1] New Public Management (N.P.M.) is the English-speaking concept of the N.P.M. In the context of this work, they are synonyms.

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average, and governance in this training is very unsatisfactory.

On the other hand, they have launched an increasingly far-reaching decentralization policy at the heart of the long reform process, which, if completed, should radically transform the health system. This concern has resulted in several legal and regulatory measures that need completion. More recently, in July 1999, during the joint World Bank-IMF mission to review the economic and financial policy framework, the Cameroonian government agreed with its partners to develop a sectoral health strategy document that is the basis of its hospital governance system.

One of the measures taken to improve the governance of the hospital sector is decentralization. Decentralization has been introduced into the public health system in Cameroon as a set of techniques aimed at, through the empowerment of health structures, health, to profoundly transform the dysfunctional behavior of health, medical, and paramedical staff, which they consider to be at the root of the health system crisis. Heritage, characterized by confusion between the public and the private, has the effect of privately and personally appropriating the administration by its staff. It manifests itself in systemic and widespread corruption. The result of these two combined evils is a structural dysfunction of the health system because it is the staff, not the sick, who become the "raison d'être" of the organization. They hope that decentralization will lead to changes in the behavior of health workers and refocus the health system on its objective of public health, that is, the population's health. The basic idea that emerges is that the problem, In Cameroon, before being a simple question of financing, is a question of "big money" and, first of all, a human resources problem.

In short, all the literature on the subject makes it possible to highlight the governance mechanisms that should impact the governance system of Cameroonian hospitals with a view to the appropriation of services to users, based on the case of hospital centers in the city of Douala. What about the empirical data?

c) *Analysis of Survey Data with Stakeholders of Douala Hospital Centers*

To understand how the Cameroonian public hospital suffering from multiple ailments tries to cope with it thanks to the new hospital governance, the analysis of the data addressed aspects as varied as the following:

- Adoption of Hospital Governance Mechanisms
- Structure of the management bodies and the material articulation of the services
- Adoption of new management methods in Douala hospital centers.
- Consideration of users in the governance of S.M.C.s and their satisfaction.

In general, through applying the new standards of hospital governance, the managers of Douala hospital centers are leading the medical and health staff to greater effectiveness in appropriating services to users.

Indeed, the new mechanisms of hospital governance, the growing emancipation of users, and the adoption of new quality standards participate. The improvement of services to users of the hospital centers is analyzed here. This issue is the flagship hypothesis that guided the development of our data collection tools from the very beginning. In other words, we planned to establish a link between the correction of the inadequacies of the models that have marked the governance of public hospitals in Cameroon and the innovative managerial practices of S.M.C.s. Similarly, we keep in focus the analysis of the impacts of participatory management on the level of commitment of medical and health personnel in appropriating services to users of Douala hospital centers.

Thus, it is necessary to recall the significant trends that emerge to understand better the results we present from our research. The analysis and interpretation of the data collected led to the following results:

- From our interviews with senior hospital administration officials in Douala, we note several aspects addressed in all hospital reforms initiated in the 2010 decade. As mentioned above, the Cameroonian public hospital suffered from several evils to which the new hospital governance provided several solutions.
- With the dynamics of hospital reforms in Cameroon, the mapping of the administrative organization of the public hospital has changed considerably. At the legal level, the texts have gradually established more extensive administrative and management structures than in the past, capable of closely monitoring daily the entire operation of public hospitals. In terms of administrative practice, services proper have developed and multiplied, thus considerably increasing the complexity of the administrative organization of public hospitals. All this has also necessitated the implementation of management techniques adapted to the imperatives of modern management.
- Concerning the practical structuring of services, the transformation of public hospitals has brought about significant changes over the past two decades compared to the small institutions of the past. This particularity reflects the dynamics of the new hospital governance under consideration. Whereas in the past, a light administrative superstructure implements care facilities with a few employees, the current organizational charts of the Douala hospital centers have hospitals with an

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administration in all respects comparable to large industrial or commercial establishments. Services have categories in medium and large hospitals such as the General Hospital and the Laquintinie Hospital. On the one hand, there are available services and, on the other, operational services.

- The financial management autonomy granted to the H.C.s will pose a real problem of price harmonization, contributing to considerably reduced user satisfaction when the cost of care is available.
- The inclusion of users in the Cameroonian health system stems from the socio-legal evolution of the doctor-patient relationship on the one hand and the modernization of the relationship between the public administration and its citizens.
- Health workers work in conditions ranging from very good to very bad at six levels; in our analysis, the most visible levels are fair, reasonable, perfect, and wrong, with a cumulative percentage of 87.2% for the first three levels, which shows the existence of favorable working conditions.
- The ransom of patients has ended in most services, thus allowing staff to be more present with patients and therefore to listen to their different needs; these remarks are available in the indications on the graph, which shows that 66.8% of staff reveal that these actions which tainted the offers of services are absent from the hospitals of the city of Douala.
- The requirement of patients increases, and this thus allows the staff to be more present with the patients to assist them in pursuing the vision of the hierarchy, which is the improvement of the quality of services by the staff of the hospitals of the city of Douala; these statements are verifiable at the indications on the graph which shows that nearly 50% of the staff reveal that the majority of patients reflect an unbearable character during their care.
- The cost of caring for patients has increased, and this allows staff to be more present with patients; therefore, the quality of services by the staff of hospital centers in the city of Douala needs improvement; these statements are available at the indications on the graphwhich shows that 68%of staff reveal that quality of service impacts the cost of patient care.
- Staff recognizes the role of management evaluation in improving the quality of service in hospital centers; this result is verifiable by the information on the graph, which shows that 74% of staff agree with the improvement measures put in place by the hierarchy.
- All respondents are unanimous in acknowledging the system's progress through improvements in the provision of health care and services related to implementing the new governance of CHDs.
- The many opportunities identified and the strengths inherent in the system, highlighted by management evaluation, need to be sufficiently exploited due to the need for integrated coordination, planning, and monitoring/evaluation in implementing the new governance of S.M.C.s.
- The hospital governance processes applied to Douala hospital centers lead medical and health personnel to greater efficiency in allocating services to users. This point was evident from interviews with hospital managers and the quantitative results of questionnaires submitted to medical staff and users.
- The mechanisms for adopting hospital governance and the subsequent organizational transformations in Douala hospital centers integrate managerial openness, the consideration of all stakeholders, the effectiveness of the boards of directors, hospital fees, the accountability of staff to the user, the inalienable rights of patients, Etc.
- The increasing emancipation of users and the adoption of new quality standards in the health sector contribute to improving services in Douala hospital centers.
- This method of participatory management implemented within the S.D.C.s has impacted medical and health personnel's commitment to appropriating services to users of Douala hospital centers.
- As a result, the impact of management evaluation on improving the quality of services to users of Douala hospital centers is no longer a demonstration.
- Thus, we confirm our assumptions at this stage of our analysis of our results. The correlation tests generated based on the SPSS application have sufficiently certified this and allow us to assert that thanks to applying the new standards of hospital governance, the managers of Douala hospital centers lead the medical and health staff to greater efficiency in the appropriation of services to users.

Indeed, field interviews with hospital administration officials and desk research show that user participation in the Cameroonian health system stems from the socio-legal evolution of the doctor-patient relationship on the one hand and the modernization of the relationship between the public administration and its citizens on the other. Through these developments, users have obtained rights, particularly the right to represent on the board of directors of hospitals. The satisfaction surveys recommended by the P.B.F., the community surveys, are so many developments that have facilitated the involvement of users in hospital governance in Cameroon in general and in Douala in particular.

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"*This patient outbreak (…) disrupts the traditional organization of the hospital based on a structure by profession and specialty*" (Claveranne J.-P., Pascal C. 2004, p.27).

The strong involvement of medical and social staff in re-appropriating care for the uses of S.M.C.s comes essentially from this dynamic of managerial openness. Thus, the results reveal that users are well-informed stakeholders, albeit with little training, which puts their power in decision-making, particularly in the hospital. Moreover, "*secular expertise*" as an element of user power remains an *intuitive personae* expertise because it distinguishes different types of users, which allows us to propose a typology of users, not as a single stakeholder but as multiple stakeholders with various powers.

However, we can note many deficiencies. These shortcomings relate to aspects as varied as:

- ✓ Burdensome financial procedures, including the procurement process which hampers the implementation of several programmed activities.
- ✓ We note inadequate funding. Not only have the available funds not been used effectively and efficiently, but their mobilization has remained aconstant concern, mainly due to the administrative burden and delays in disbursement. This concern leads to an improvement in care costs, as patients deplore:
- The quantitative and qualitative deficit in human resources remains a significant concern or threat to the successful implementation of the new governance, as current workforce upgrading efforts fall far short of needs.
- The poor performance of the health information system could have allowed for accurately identifying the actual performance of the implementation of N.G.H. in these CHDs; most of the reliable data came from parallel health information systems in different programs. This situation severely handicaps the system of integrated monitoring/evaluation of the implementation of the N.G.H.

The above analysis of the situation summarizes below the information necessary for an objective assessment of the performance of the implementation of the N.G.H. during the period studied.

Evaluation work reveals a conclusion in the form of a general trend with some highlights as well as recommendations for updating this strategy and its alignment by 2035 by Cameroon's emerging objectives.

II. Conclusion

The present heuristic investigation questioned the impact of hospital governance on the appropriation of care for users of Douala hospital centers. Overall, presenting the negative assessment of the health situation in Cameroon, agreed by all observers, to agree on a deep crisis in the Cameroonian health system, it emerges a question that has been the guiding theme of this research: How and in what way does hospital governance impact the appropriation by the medico-social staff of services to users of Douala hospital centers?

We started with the observation of the difficulties faced by Cameroonian public hospitals. We noted that these difficulties exist in implementing management tools, medical pricing procedures, and hospital care and performance management. We questioned the existence of a management system set up in public hospitals in Douala, allowing the reduction of costs, the factors likely to influence the performance of these hospitals, and finally on, how medical procedures and hospital care are valuable. In particular, the aim was to analyze the governance systems implemented in response to the complexity and uncertainty characterize the Cameroonian public hospital, clarify the context in which the Cameroonian public hospitals fit in to understand the framework in which control will take place, and finally propose ways to reduce costs to improve Cameroonian hospital performance.

Thus, thanks to these lines, we were able to mobilize the tools for analyzing survey data, as well as a theoretical framework developed from stakeholder theory, arguing on a managerial approach by the agency in the health field. He thus made the theory of the agency the foundation of the analysis of hospital governance here in question or the best reading grid of managerial reality in hospital settings. In conclusion, we can say that the architecture of this work has enabled us to demonstrate, through our data collection and analysis tools, that the hospital governance mechanisms applied to Douala hospital centers lead medical and health personnel to greater effectiveness in the appropriation of services to users.

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