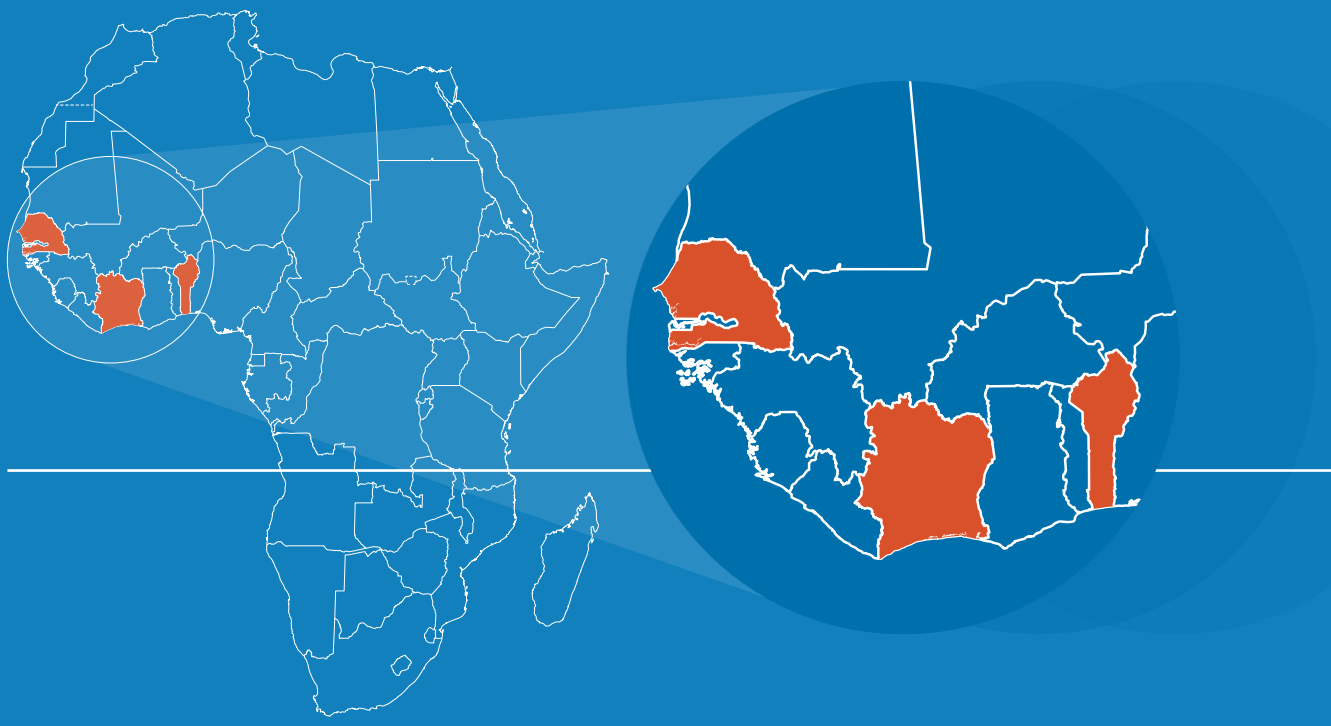


Governance of Public Hospitals

BENIN | CÔTE D'IVOIRE | SENEGAL

Regional Trends and Country Cases

Alexandre Arrobbio and Christophe Lemière

September 2017

WORLD BANK GROUP

Governance of Public Hospitals

Regional Trends and Country Cases
Benin—Côte d'Ivoire—Senegal

Health, Nutrition & Population (HNP)
Governance (GOV)

Main Abbreviations and Acronyms

ACE	Agent Contractuel de l'Etat	Contractual State Agent
ACP	Agent Comptable Particulier	Accounting Officer
APE	Agent Permanent de l'Etat	Permanent State Agent
CHD	Centre Hospitalier Départemental	Departmental Hospital
CHR	Centre Hospitalier Régional	Regional Hospital
CHU	Centre Hospitalier Universitaire	University Hospital
CLIN	Comité de Lutte contre les Infections Nosocomiales	Committee for the Fight against Hospital-based Infections
CME	Commission Médicale d'Établissement	Hospital Medical Commission
CODIR	Comité de Direction	Management Committee
CPOM	Contrat Pluriannuel d'Objectifs et de Moyens	Multiyear Contracts specifying Objectives and Resources
CNHU	Centre National Hospitalier Universitaire	National University Hospital
CRDP	Cellule de Revue des Dépenses Publiques	Public Spending Review Unit
CTE	Comité Technique d'Établissement	Hospital Nonmedical Commission
DAF	Direction des Affaires Financières	Directorate of Financial Affairs
DAGE	Direction de l'Administration Générale et de l'Équipement	Directorate of General Administration and Equipment
DCEF	Direction de la Coopération Economique et Financière	Directorate of Economic and Financial Cooperation
DDS	Direction Départementale de la Santé	Departmental Health Directorate
DEPS	Direction des Établissements et des Professions Sanitaires	Directorate of Health Facilities and Professions
DES	Direction des Établissements de Santé	Directorate of Health Facilities
DFR	Direction de la Formation et de la Recherche	Directorate of Training and Research
DGB/DB	Direction Générale du Budget/Direction du Budget	General Directorate of Budget/Budget Directorate
DGS	Direction Générale de la Santé	General Directorate of Health
DIEM	Direction des Infrastructures, de l'Équipement et de la Maintenance	Directorate of Infrastructure, Equipment, and Maintenance

DIPE	Direction de l'Information de la Planification et de l'Evaluation	Department of Information, Planning, and Evaluation
DMS	Durée Moyenne de Séjour	Average Length of Stay
DNEHS	Direction Nationale des Établissements de Santé et de Soins	National Directorate of Health and Care Facilities
DPP	Direction de la Programmation et de la Planification	Directorate of Programming and Planning
DPPS	Direction de la Prospective, de la Planification et des Stratégies	Directorate of Forecasting, Planning, and Strategies
DRFM	Direction des Ressources Financières et du Matériel	Directorate of Financial Resources and Materials
DRH	Direction des Ressources Humaines	Directorate of Human Resources
DRS	Direction Régionale de la Santé	Regional Health Directorate
EPA	Établissement Public à Caractère Administratif	Administrative Public Agency
EPIC	Établissement Public à Caractère Commercial	Industrial and Commercial Public Agency
EPN	Établissement Public National	National Public Agency
EPS	Établissement Public de Santé	Public Health Facility
GDP	Produit Intérieur Brut	Gross Domestic Product
HG	Hôpital Général	General Hospital
HP	Hôpital Psychiatrique	Psychiatric Hospital
IGE	Inspection Générale de l'Etat	General Inspectorate of State
IGF	Inspection Générale des Finances	General Inspectorate of Finance
IGM	Inspection Générale du Ministère de la Santé	General Inspectorate of the Ministry of Health
IGS	Inspection Générale de la Santé	General Inspectorate of Health
MS	Ministère de Santé	Ministry of Health (and Social Action)
OCDE/OECD	Organisation de Coopération et de Développement Economiques	Organisation for Economic Co-operation and Development
PNDS	Plan National de Développement Sanitaire	National Health Development Plan
PNS	Politique Nationale de Santé	National Health Policy
PRSS	Programme de Renforcement du Système de Santé	Health System Strengthening Program
PSP	Pharmacie de Santé Publique	Public Health Pharmacy
RBF	Financement Basé sur les Résultats	Results-Based Financing
SACG	Service de l'Audit et du Contrôle de Gestion	Department of Audit and Management Control
SASED	Service d'Appui aux Services Extérieurs et à la Décentralisation	Department of External Services and Decentralization Support
SIGFIP	Système Intégré de Gestion des Finances Publiques	Integrated Public Financial Management System
SNIGS	Système National d'Information et de Gestion Sanitaires	National Health Information and Management System

SOE	Entreprise publique	State-Owned Enterprise
WAEMU	Union Economique et Monétaire Ouest Africaine	West African Economic and Monetary Union
WBI	Institut de la Banque Mondiale	World Bank Institute
WHO	Organisation Mondiale de la Santé	World Health Organization

Currency Equivalents

Exchange Rate Effective September 8, 2015

Currency Unit	Franc CFA
1 US Dollar	CFA F 586.86

Fiscal Year

July 1 to June 30

Contents

Table of Boxes

Table of Figures

Table of Annexes

Acknowledgments

The World Bank is grateful for the close and fruitful cooperation with the governments of Benin, Côte d'Ivoire, and Senegal, without which the preparation of this report would not have been possible. The team would especially like to thank the hospital sector stakeholders in each of the three case study countries for their support, availability, and advice throughout the preparation of this report. Institutions that contributed to the preparation of this study included ministries and institutions at the central level (ministries of health and hospital directorates, ministries of finance, general inspectorates, and supreme audit institutions) and stakeholders at the level of public hospitals (departments, boards of directors, and advisory boards).[1]

This study was conducted jointly by the World Bank's Health, Nutrition and Population Global Practice and Governance Global Practice. The team was led by Alexandre Arrobbio (Practice Manager, Governance) and Christophe Lemière (Program Leader, Health). Team members included Immanuel Steinhilper (Senior Public Sector Specialist), Charlotte Suc (Consultant), Pierre Ménard (Consultant), Gilles de Pas (Consultant), and Renaud Beauchard (Consultant).

This study benefited from the strong support of World Bank country and sector management. The team would especially like to thank the Country Directors Louise Cord, Vera Songwe, Pierre Frank Laporte, and Ousmane Diagana, as well as Trina Haque and Gaston Sorgho (Practice Manager Health, Africa Region), for their strategic guidance and support.

Finally, the team wishes to thank the Governance Partnership Facility, funded by the United Kingdom, Australia, Norway, and the Netherlands, for financial assistance in the preparation of this study.

1 The individual country reports provide detailed acknowledgments.

Executive Summary

This study was carried out with stakeholders from different countries and presents a governance analysis of public hospitals in Benin, Côte d'Ivoire, and Senegal. Prepared in close collaboration with health authorities and other stakeholders, the study provides an overview of hospital governance in Benin, Côte d'Ivoire, and Senegal. For each country, it presents an overview of the hospital sector followed by an analysis of five dimensions of governance.[2] Conclusions addressing governance challenges and potential reform measures close the analysis. The first part of this publication, which presents the trends in the countries of the study and in the subregion, is followed by the three country diagnostics using the same analytical structure.

The study is based on the Organisation for Economic Co-operation and Development (OECD) *Guidelines on Corporate Governance of State-Owned Enterprises* and on the World Bank's *Corporate Governance of State-Owned Enterprises: A Toolkit*. The analysis was carried out using the methodology of the OECD's *Guidelines* (OECD 2015a[3]) and follows

2 These dimensions have been adapted from the World Bank SOE Toolkit (World Bank 2014a) and include the legal and regulatory framework, state oversight function, performance monitoring, boards of directors and executive management, and transparency and disclosure.

3 The report was initially based on the previous version of the OECD *Guidelines* (2005) and *Principles* (2004) which were updated in 2015 (see bibliography).

the structure of the World Bank *Toolkit* (World Bank 2014a). A questionnaire, developed on the basis of an adaptation of the methodology to the health sector, allowed data collection in central directorates and in hospitals. The analysis of the governance framework includes a review of the legal and regulatory framework, oversight arrangements, performance planning and monitoring, boards of directors and other hospital bodies, and transparency and disclosure.

The analysis illuminates how governance arrangements interact with public hospital performance. Experience shows that governance arrangements can leverage the performance of hospitals, both financially and in terms of public service delivery. First, regular monitoring of hospitals through consolidation of information at the oversight level improves transparency in the sector and allows for the evaluation of trends in real time. Second, effective internal and external control bodies contribute to the sound management of public finances and the financial performance of hospitals. Third, the implementation of accountability mechanisms between hospitals and the state helps to clarify the reciprocal commitments of stakeholders in the hospital sector and to increase the transparency of hospitals vis-à-vis the state and citizens. Finally, equipping oversight entities with the skills and personnel they need promotes more effective management of the sector.

Since 2000, maternal mortality has declined and skilled birth attendance has increased in the subregion. Health and hospital statistics reflect the growing role of public hospitals in the delivery of health care in West Africa. Since 2000, women's life expectancy at birth has increased by eight years in Sub-Saharan Africa and by six years, on average, in the three countries studied. The maternal mortality rate has decreased by 26 percent in the subregion.[4] In the three case countries, the percentage of births attended by skilled personnel increased by 10 percent, on average, between 2000/01 and 2011/12.[5] Skilled birth attendance has made particular progress in Benin, increasing by 24 percent during the time period. It increased by 13 percent in Senegal but remains more difficult to assess in Côte d'Ivoire given the political crisis that destabilized the country's health care system over that period.

The hospital sector represents a significant financial burden in the case countries and could pose a budgetary risk. Although the share of

4 Data includes Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, and Togo.

5 World Development Indicators, World Bank. Available at: http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators.

hospitals in health ministries' budgets is difficult to assess accurately, it remains one of the largest health cost items, accounting for more than 30 percent of the budget in the case countries.[6] Given the financial burden they represent, hospitals may pose a budgetary risk—particularly in the context of limited sharing and consolidation of information.

Governance Framework for the Hospital Sector in the Countries Studied

Legal and Regulatory Framework

The law defines the status of hospitals, oversight mechanisms, relations between the state and hospitals, the mandate of the boards of directors, and the rules on control. In the three case countries, key laws outline the governance arrangements for the hospital sector. While Senegal adopted a comprehensive hospital reform law, the hospital sectors in Benin and Côte d'Ivoire are defined in several legal texts.

Management autonomy is widespread among hospitals in Senegal and partial in Côte d'Ivoire and Benin. Hospital reforms since the late 1980s have marked a transition toward greater hospital autonomy. A consensus has gradually emerged on the advantages of autonomy. In the context of health care facilities, autonomy offers more flexibility in day-to-day management and allows them to better meet patients' needs. In 1998, Senegal implemented hospital reforms that included adopting a harmonized status for hospitals, which have become public institutions with autonomous management. In Benin and Côte d'Ivoire, some hospitals have management autonomy, while others depend on the Ministry of Health.[7] These two countries have begun to contemplate hospital reform measures.

The State's Oversight Function

Oversight entities face challenges such as fragmentation and capacity limitations. These challenges are explained in part by the country context and by the way in which oversight mechanisms are organized. In Benin, oversight of hospitals is "decentralized"[8] in that it is the responsibility of the

6 This is a low estimate, based on available data.

7 The term "Ministry of Health" has been used consistently throughout the study to refer to the "Ministry of Health" of Benin, the "Ministry of Health and Fight against HIV/AIDS" of Côte d'Ivoire, and the "Ministry of Health and Social Action" of Senegal.

8 In a decentralized model, supervision is the responsibility of the sector ministry.

Ministry of Health, through the National Directorate of Health and Care Facilities (DNEHS). This recently created directorate does not appear to have the resources to steer the sector; as a result, several other central directorates are responsible for decision making, which creates a fragmentation in oversight. Côte d'Ivoire and Senegal have dual oversight, in that oversight responsibilities are shared between the Ministry of Health (technical oversight) and the Ministry of Finance (financial oversight).[9] In Côte d'Ivoire, without a single directorate in charge of the sector, oversight responsibilities are divided across different central directorates, generating overlapping mandates. In Senegal, although the directorate of health facilities is tasked with sector oversight, its limited capacity prevents it from effectively monitoring the sector.

Planning and Performance Monitoring

Planning is incomplete, as only a few institutions develop medium-term hospital strategies. While national sectoral policies exist,[10] hospitals do not generally develop hospital strategies ("*projets d'établissement*"). A few hospital strategies have been carried out in practice, but have not been renewed or did not succeed. Although hospitals do prepare an annual work plan, this short-term planning instrument is not considered a hospital strategy.

Implementation of Multiyear Contracts for Objectives and Resources (CPOM) and results-based financing (RBF) has created a favorable context for monitoring the sector, but performance monitoring remains variable. In Benin and Senegal, although not generalized, the implementation of measures such as RBF or CPOMs includes regular monitoring of predefined indicators. Nevertheless, while the RBF is strictly monitored, evaluation of CPOMs is constrained by data collection challenges. Côte d'Ivoire, which at the time of data collection was still in the aftermath of the crisis, faces even more significant challenges in sector monitoring.

Boards of Directors

Boards of directors have not achieved the objectives set out in the legislation. Although boards of directors[11] are by law the deliberative bodies of

9 There is a third "centralized" model in which a single central ministry, usually the Ministry of Finance or the Treasury, is responsible for overseeing the sector. The centralized model is increasingly considered to be good practice for the oversight of state-owned enterprises (SOEs).

10 National Health Policy (PNS) and National Health Development Plan (PNDS).

11 These may also be called management boards or management committees depending on the country and type of hospital.

hospitals, they are limited in their ability to fulfill their mandates. In Benin and Côte d'Ivoire, decision-making power appears to be concentrated at the oversight level, leaving little room for autonomy and community outreach, especially in peripheral hospitals. In Senegal, the boards of directors are sometimes perceived as real management bodies; in some instances, however, they are considered to be "rubber stamping" the decisions of hospital management without deliberation.

Transparency and Disclosure

The hospital sector is weakened by limited transparency, which is exacerbated by the lack of a hospital information system. First, information sharing between hospitals and their oversight entities is limited. There are often significant delays in transmitting data to oversight bodies, and in some cases, this information is not transmitted at all. Second, limited data sharing hinders sector monitoring at the central level, where the consolidation of information on a regular basis is not systematic. Third, internal and external control systems are unevenly implemented. Fourth, the reliability of information systems is weakened by the absence of computerization. Apart from some pilot experiments, hospitals do not have a hospital information system, and data processing is done manually—particularly in peripheral facilities. The collection of information raises reliability issues, and the lack of data standardization makes consolidation difficult.

Key Challenges

Benin

Apart from the National University Hospital (CNHU), which has real management autonomy, hospitals in Benin depend on the Ministry of Health. Hospitals, which are endowed in principle with a legal personality and financial autonomy, have different degrees of autonomy in practice, and the Ministry of Health exercises strong authority. With the exception of the CNHU, hospital authority remains concentrated largely at the national level. Human resources, budgeting, definition of activities, investments, and equipment are the responsibility of the central administration. This situation limits incentives for performance, thus dampening staff motivation and limiting hospitals' operational management.

The directorate in charge of hospital oversight has limited decision-making power and does not appear to be in a position to steer the hospital sector. Despite the existence of the DNEHS, the oversight function

appears to be fragmented between several central directorates, and decisions concerning the sector are not usually made by the DNEHS. These other central directorates, which are more established and have greater capacity and resources, manage oversight in their own area.

While a data repository exists, the reliability of information is sometimes questionable, especially at the peripheral level. Although there is currently no hospital information system in Benin, there is a repository of activity data. Data collection is carried out by the Directorate of Programming and Forecast, through the National System of Information and Health Management, with the annual publication of health statistics. While the publication of this directory is of interest in analyzing the health status of the population and the health system, data are unreliable given the preponderance of handwritten data transfers.

Côte d'Ivoire

The hospital legal framework in Côte d'Ivoire does not give all hospitals autonomy, which limits the capacity of certain entities to act. Some hospitals are National Public Agencies (*établissements publics nationaux,* or EPNs in French) structured in the form of Industrial and Commercial Public Agencies (*établissements publics à caractère industriel et commercial,* EPIC) with financial autonomy; others are services under state control without a separate legal status. In practice, these legal structures are not always adapted to health care facilities. For example, the lack of autonomy, which implies the oversight entity's presence in the day-to-day management of hospitals, can reduce the effectiveness of care provision.

In the absence of a hospital directorate, oversight is fragmented. The absence of a specific directorate in charge of the hospital sector, together with the involvement of various departments and central directorates of the Ministry of Health and the Ministry of Finance, creates overlapping mandates and reduces the effectiveness of oversight.

The hospital sector is undermined by a limited application of rules on transparency and disclosure. Although there is some feedback from hospitals to central departments, data transfer mechanisms vary from facility to facility. Moreover, the absence of an integrated medical information system limits the sharing and standardization of data. Finally, the lack of harmonization and consolidation of financial and medical information at the central level hinders the analysis of sector performance in providing public services and could pose fiscal risks for the state.

Senegal

Senegal's hospital sector has a comprehensive legal framework, but the limited application of the legislation has placed public health facilities (*Établissement Public de Santé*, EPS) in an uncertain legal situation. Laws are not applied consistently. For example, some reform measures provided for in the legislation, such as the introduction of management tools, have not been implemented.

Oversight effectiveness is hampered by fragmentation and capacity limitations. Hospital reform has established an oversight mechanism involving the Ministry of Health and the Ministry of Finance, but there are few incentives for regular communication between these two authorities. In practice, these limited interactions reduce overall oversight effectiveness and lead to the automatic renewal of grants. Moreover, the technical supervision exercised by the Directorate of Health Facilities (DES) does not constitute full monitoring of the sector. Finally, this situation is exacerbated by the institutional positioning of the DES, which does not seem to have the authority and visibility required to steer the sector effectively.

The hospital sector is in limited compliance with expectations for transparency and disclosure. EPSs do not systematically transmit financial and nonfinancial information to the DES in a timely manner. The inadequacy of the medical information system further limits data transfers. Existing databases established by the DES reveal gaps in information. Consequently, the publication of consolidated reports on sector trends by the DES is irregular.

Introduction

Rationale for the Study

In accordance with their mandate, public hospitals pursue public service objectives and must provide the population with access to health services. First, through the public hospital service, the state ensures the treatment of patients and the provision of the best possible care. Second, it ensures equality in access to basic services. Third, it ensures the continuity of care by maintaining a link between different health facilities and health professionals, taking into account areas of specialization and available resources.

The performance of public hospitals is essential to widespread and effective delivery of public health care. The hospital sector is essential to a country's economic and social development, as it represents a key entry point to health services, especially for vulnerable populations, and plays an important role in staff training. The optimal functioning of this complex sector, which includes different types of hospitals (national facilities, departmental and regional facilities, and local facilities), is critical to ensure the delivery of public health care.

Given their importance, health and hospital-related expenditures could pose a fiscal risk. In the countries of the West Africa subregion,[12] total health expenditures (public and private) averaged 6 percent of gross domestic product (GDP) in 2013 (WHO 2013). More specifically, the share of the health ministries' budgets dedicated to hospitals remains among the largest health expenditure items. Meanwhile, the financing of public hospitals remains heavily dependent on state subsidies. Consequently, in the absence of a strong governance framework, the financial magnitude of the hospital sector could pose a potential fiscal risk.

Reestablishing a framework that is conducive to the performance of hospitals is critical to the achievement of effective public service and patient satisfaction. Improved performance in the management of public hospitals would increase patient satisfaction while ensuring the legitimacy of the state through the provision of essential services to all categories of the population.

The establishment of an effective governance[13] framework is considered to be a key element in improving the performance of the sector. Given the importance of public hospitals, there is a consensus among stakeholders on the need to improve the performance of hospitals through their governance arrangements. A strong governance framework can contribute to better delivery of health services, quantitatively and qualitatively, and to the effective monitoring of hospitals' finances. This framework includes the following dimensions: the legal framework and implementation of autonomy, the organization of the state's oversight functions, fiscal and performance monitoring, the role of boards of directors and other bodies, and transparency and disclosure.

Conceptual Framework: Hospital Sector Governance

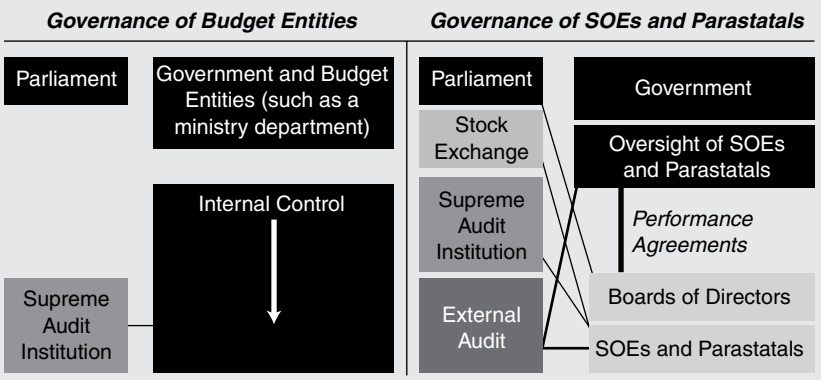
State-owned enterprises (SOEs) and parastatal entities, like some public hospitals, have a different governance framework than budget entities. On the one hand, budget entities—units that are vertically integrated

12 Data includes Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, and Togo (WHO 2013).

13 Governance can be defined as "the set of measures, rules, decision-making bodies, information, and surveillance that allow the proper functioning and the control of a state, an institution, or an organization—whether public or private, regional, national or international." Institut de Recherche sur la Gouvernance et l'Economie des Institutions (http://www.irgei.org/).

BOX 1

Governance of Budget Entities and of SOEs and Parastatal Entities



Source: World Bank compilation.

into a ministry—are subject to hierarchical subordination rules and do not have management autonomy. Control of these entities is exercised through the internal control of the government and the supreme audit institution. On the other hand, SOEs and parastatal entities operate on a principle of management autonomy, which gives them decision-making authority, like a private company. A board of directors represents the entity's ultimate authority, and its executive management oversees daily operations. This autonomy is accompanied by mechanisms for accountability between the government and SOEs/parastatal entities through, for example, performance agreements. Finally, the rules for control are more complex, less direct, and may include independent external audits (Box 1).

Hospital governance is based either on a budget unit model attached to the Ministry of Health or on an autonomous model. Historically, and in many countries, hospitals are organized according to a vertically integrated model of governance (attached to the Ministry of Health). In this model, which is maintained by some countries for all or some of their hospitals, facilities do not have any autonomy and implement central directives. The alternative model grants managerial autonomy, under which hospitals are administered by a board of directors and run by executive management, which ensures day-to-day operations under the strategic supervision of an oversight entity that monitors and controls hospitals.

Hospital reforms implemented in many countries over the last thirty years have shown a trend toward autonomous hospitals. Hospital reforms undertaken since the late 1980s, in the Africa region and elsewhere, have marked a transition, sometimes generalized, toward autonomous hospitals. A consensus has gradually emerged on the benefits of hospital autonomy, which gives hospitals greater flexibility in their daily management and thus enables them to better meet the needs of patients.

The governance of autonomous public hospitals is similar to the governance of SOEs, given their legal status and functioning. Public hospital reforms have set up a governance structure similar to that of SOEs, including oversight entities, accountability and performance monitoring mechanisms, specific external control and audit systems, and decision-making organs such as boards of directors.

Similar to those faced by SOEs, the performance challenges of autonomous hospitals are often associated with governance issues. These challenges often relate to the underlying rules that govern relations between managers and the government as owner, rather than to exogenous or sector-specific factors. These governance challenges include the existence of conflicting mandates, lack of clearly identifiable owners, inadequate performance monitoring and accountability systems, the risk of politicization of boards of directors and management, hospitals' lack of operational decision-making power, and limited transparency and disclosure practices.

Methodology: OECD *Guidelines* and World Bank *Toolkit* on Corporate Governance of SOEs

Given the similar challenges they face, this study applies and adapts a methodology for analyzing the corporate governance of SOEs to the hospital sector. Governance arrangements and practices in the hospital sector can be analyzed according to an established methodology for analyzing the corporate governance of SOEs: the Organisation for Economic Co-operation and Development (OECD) *Guidelines* (Box 2, OECD 2015a) and the World Bank's *Toolkit* (World Bank 2014a).

Experience shows that an effective governance system for SOEs and parastatal entities is associated with good sector performance. In response to the governance challenges presented above, many countries have taken concrete steps to improve the operations and activities of SOEs

BOX 2

OECD Standards on SOE Governance

Ensuring an Effective Legal and Regulatory Framework for SOEs. The legal and regulatory framework for SOEs should ensure a level playing field in markets where SOEs and private sector companies compete in order to avoid market distortions. The framework should build on, and be fully compatible with, the OECD Principles of Corporate Governance.

The State Acting as an Owner (ownership function). The state should act as an informed and active owner and establish a clear and consistent ownership policy, ensuring that the governance of SOEs is carried out in a transparent and accountable manner, with the necessary degree of professionalism and effectiveness.

Equitable Treatment of Shareholders. The state and SOEs should recognize the rights of all shareholders and, in accordance with the OECD Principles of Corporate Governance, ensure their equitable treatment and equal access to corporate information.

Relations with Stakeholders. The state ownership policy should fully recognize SOEs' responsibilities toward stakeholders and request that they report on their relations with stakeholders.

Transparency and Disclosure. SOEs should observe high standards of transparency in accordance with the OECD Principles of Corporate Governance. These include, in particular, publication of an annual aggregate report on SOEs by ownership entity, development of internal audit functions in SOEs monitored by a board and audit committee or equivalent, annual independent external audits based on international standards, high-quality accounting and auditing standards for both SOEs and listed companies, and disclosure of material information described in the OECD Principles of Corporate Governance.

The Responsibilities of SOE Boards. The boards of SOEs should have the necessary authority, competencies, and objectivity to carry out their function of strategic guidance and monitoring of management. They should act with integrity and be held accountable for their actions.

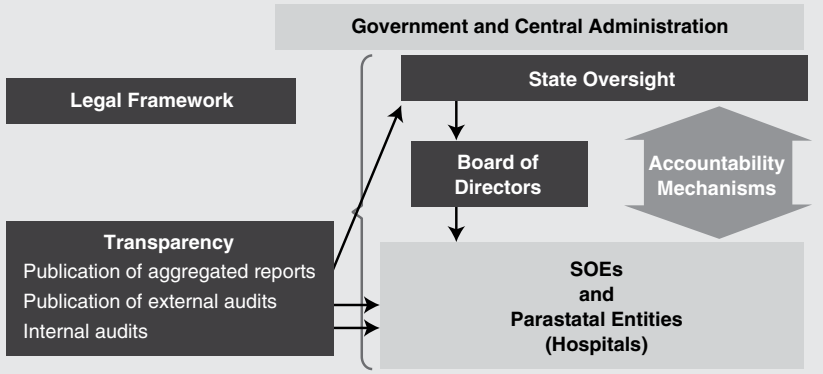
Source: OECD (2015a).

and parastatal organizations. These measures include adjusting the legal framework; strengthening state oversight entities by giving them the skills and staff they need to monitor the sector efficiently; improving sector monitoring, including by developing accountability mechanisms (such as performance agreements); improving recruitment processes and the functioning of boards of directors; and increasing transparency (for example, through improved information sharing between hospitals and the oversight entity).

Several "good practices" in the governance of SOEs and parastatal entities can be transferred to public hospitals, particularly to autonomous hospitals. As mentioned above, this study focuses on the following governance dimensions: legal and regulatory frameworks, state oversight, performance and activity monitoring, the role of boards of directors, and transparency and disclosure. These governance dimensions are applied to the hospital sector (Box 3)[14] and are at the heart of the analysis proposed in the following sections (Box 4).

BOX 3

Dimensions of Hospital Sector Governance



Sources: Adapted from OECD (2015a); World Bank (2014a).

14 The study does not include the dimensions associated with the fair treatment of shareholders and the relations with stakeholders, as they are less applicable to the hospital sector.

BOX 4

Governance Dimensions of OECD Guidelines and World Bank Toolkit Adapted to the Hospital Sector

Governance Dimension	Application to the Hospital Sector
Effective legal and regulatory framework	• Which status is suitable for hospitals? (autonomous facility, service under state control) • Do hospitals have management autonomy?
Organization of the state's shareholder function	• What is the organization model of the oversight entity? • Is there a directorate in charge of the hospital sector?
Performance and fiscal risk monitoring	• How is the monitoring of the sector organized? • Is there any form of contract between hospitals and the oversight entity?
Efficient boards of directors	• How are the members selected? What are their profiles? • What is the mandate of the boards of directors? • What are the links with the management?
Transparency and disclosure	• Does information flow effectively from hospitals to the oversight body? • Does the oversight entity produce consolidated reports on the sector? • Are there internal and external control systems in place and how often are they carried out?

Source: World Bank (2014a).

Objectives of the Study

The objective of this study is to analyze the governance of the hospital sector in Benin, Côte d'Ivoire, and Senegal based on the methodology for assessing the corporate governance of SOEs, in order to identify opportunities for improvement. Based on the OECD *Guidelines* and the World Bank *Toolkit* on Corporate Governance of SOEs, this study aims to conduct an analysis of the governance practices of hospitals in Benin, Côte d'Ivoire, and Senegal. It aims to identify regional trends and main challenges and to highlight options for strengthening governance to leverage performance improvements.

Audience

The study's main audience is the governments of the countries concerned, although other stakeholders could benefit from its conclusions. The study focuses primarily on providing a knowledge base to case country governments on hospital sector governance and how it links to public hospital performance. The study could benefit a wider audience as well, including sectoral ministries, directorates in charge of hospitals and boards of directors, the supreme audit institution, and the parliament.

Sampling and Data

Three countries in West Africa were selected for this study: Benin, Côte d'Ivoire, and Senegal. The three countries were selected on the basis of existing World Bank engagement in the hospital sector. For the sake of comparison, experiences from other countries in the subregion and "good practices" elsewhere have been highlighted as examples of regional trends. In addition, this study could inform the development of new World Bank activities in this area.

The hospitals in the study sample were selected in consultation with the directorates in charge of hospitals in each of the three case countries. Owing to time constraints and the large number of facilities, a sample of hospitals was selected for each country. The selection of hospitals was carried out in consultation with the central directorates within each country's health ministry (Annex 1).

Information was gathered through desk research and field missions conducted in collaboration with the case country governments. Sources include ministries of health, ministries of finance, hospitals, control and audit bodies, and supreme audit institutions in the relevant countries. More specifically, this study is based on: (i) available health statistics; (ii) interviews with professionals from hospitals, directorates, and central services of the health and finance ministries, as well as decentralized services; and (iii) hospital visits, including different types of facilities.[15]

Data collection was carried out using open questionnaires at the oversight level and at the hospital level. The questionnaire was developed on the basis of the OECD and World Bank methodologies for assessing SOE governance, adapted to the hospital sector. The questionnaire was completed through interviews with stakeholders in central services, hospitals

15 The samples include at least one private facility for comparison.

(including hospital management, commissions, and boards of directors), and control bodies. These interviews helped to develop a landscape of the hospital sector and understand the specific challenges facing the sector. In addition, they helped to capture the governance models of hospitals across the five dimensions of governance under review.

Structure of the Report

This study is presented in four parts: a consolidated review of regional trends and three country-specific diagnostic reviews of hospital governance in the case countries. The main results are summarized and discussed in the first part, which also describes practices in the subregion. This part aims to present, through points of convergence and divergence, the main trends in the hospital sectors of Benin, Côte d'Ivoire, and Senegal, as well as in the subregion more broadly. Subsequently, three comprehensive diagnostics describing and analyzing hospital governance in Benin, Côte d'Ivoire, and Senegal are presented (Parts 2, 3, and 4). The study concludes with key references and annexes with more detailed material.

To facilitate reading and comparisons, the four parts of the report follow the same structure in accordance with the five governance dimensions under review. This structure includes an analysis of:

- The organization, the size, and the performance of the hospital sector, along with the main challenges it faces ("landscape").
- The legal and regulatory framework.
- The role of the state's oversight function.
- Sectoral planning and the mechanisms in place to ensure performance and fiscal monitoring.
- Boards of directors, executive management, and other hospital bodies such as advisory boards and control bodies.
- Practices regarding transparency and disclosure.

PART 1

REGIONAL TRENDS

CHAPTER 1.1

Landscape of the Hospital Sector

Background and Evolution of the Hospital Sector

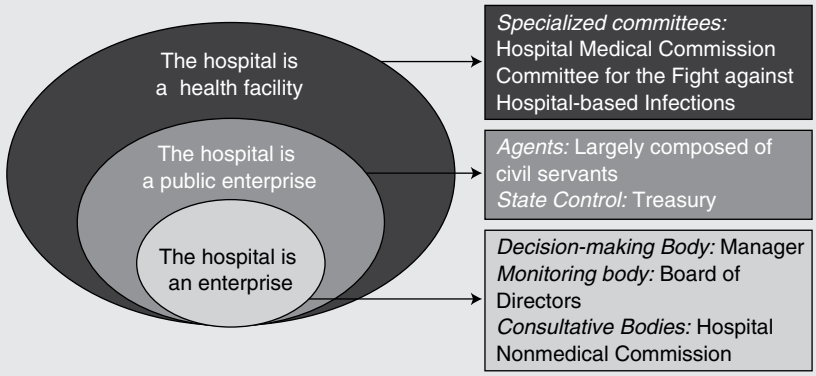
In response to the performance challenges faced by hospitals, a trend toward hospital reforms has developed in Africa and elsewhere since the 1980s. These reforms, which continue today, took root in an effort to confront observed limitations in hospital performance, including inefficiency, limited quality of care, wastage, losses, difficulties in attracting patients, and limited access to health care, especially for the poorest. Questioning the traditional model of hospital governance has sparked reflections on sector reorganization and facility management with a view to improving hospitals' ability to achieve their public service mission.

Previous reforms have generally favored hospital autonomy, making the hospital similar to an enterprise. In many countries, hospital reform has increased the independence of hospitals by introducing operational and financial management autonomy. This autonomy has resulted in an institutional organization that brings hospitals closer to a corporate structure (Box 5). As such, they are administered by a board of directors, led by an executive management team, and equipped with advisory bodies such as a

Hospital Nonmedical Commission (CTE). As in SOEs, hospital staff are composed partly of civil servants, and the treasury generally controls the entity's activities. The specific nature of the health sector is reflected in the introduction of specialized advisory committees such as the Hospital Medical Commission (*commission médicale d'établissement*, CME) or the Committee for the Fight against Hospital-based Infections (CLIN).

BOX 5

Hospital Reforms and the New Institutional Organization of the Hospital



Sources: De Kervasdoué (2015); World Bank adaptation.

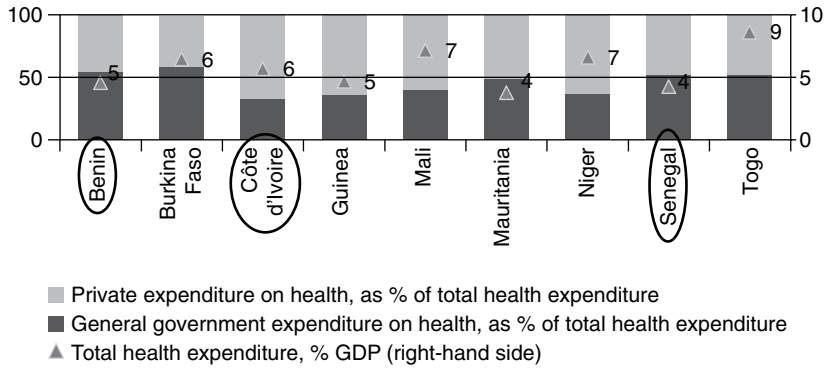
Financial, Material, and Human Resources

Financial Resources

Although states are actively involved in health financing, African households on average remain the primary funders of health services. According to the World Health Organization (WHO), total health expenditures in 2013 represented, on average, 6 percent of GDP in the Sub-Saharan West African subregion (Figure 1). These health expenses are supported both by public spending and by the private sphere. Private spending includes health insurance (6 percent) and spending by individual households (over 90 percent).

In the countries covered by the study, state participation in the health sector represents 5 percent of the national budget, on average.

FIGURE 1: Health Spending in the Countries of the Subregion, 2013



Distribution of Private Health Spending, 2013

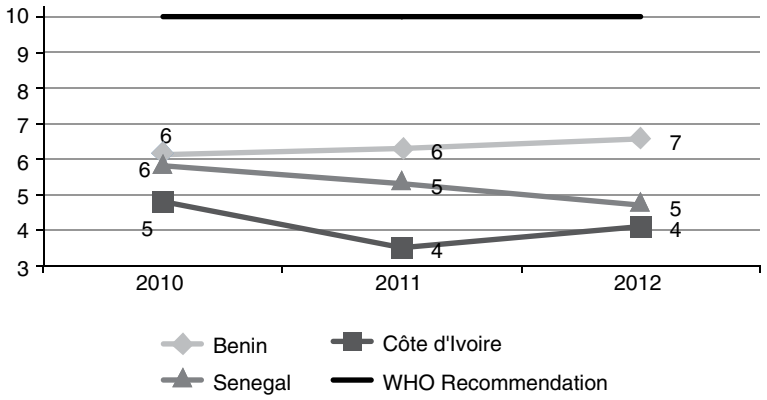
	Benin	Burkina Faso	Côte d'Ivoire	Guinea	Mali	Mauritania	Niger	Senegal	Togo
Out-of-pocket expenditure as % of private expenditure on health	*89*	*83*	*77*	*88*	*100*	*91*	*84*	*77*	*85*
Private insurance as % of private expenditure on health	*11*	*3*	*5*	*1*	—	*5*	*1*	*21*	*4*

Source: WHO (2013).

The share of health financing supported by the state varies across countries. In terms of fiscal effort, Benin spends the greatest share of its budget on health, at about 6 percent (Figure 2). Health spending decreased slightly in Senegal between 2010 and 2012, and Côte d'Ivoire saw a recovery in health spending in 2012. It is important to note that these figures remain below the WHO recommendation that states allocate 10 percent of GDP to health spending.

The autonomous nature of certain hospitals allows them to manage their own resources. In Benin, the National University Hospital (CNHU) is the only hospital with this level of autonomy. In Côte d'Ivoire, only hospitals with the status of national public agency (EPN) can generate their own resources. For other hospitals, the country has a system close to Benin's centralized organization, but with aspirations to reform this system. Public health facilities (EPS) in Senegal are autonomous. They can charge for health care treatments and directly collect the resulting benefits. Moreover,

FIGURE 2: Evolution of Budget Allocated to Health in Benin, Côte d'Ivoire, and Senegal



Source: World Bank compilation of national finance laws.

they can decide the conditions relating to the use of these resources and have the opportunity to invest given their financial capacity.

Infrastructure and Equipment

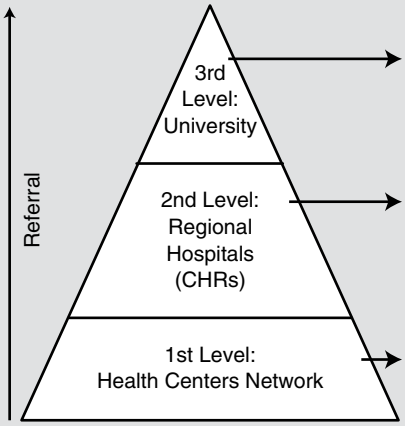
Hospitals are organized according to a pyramidal structure with three degrees of specialization based on the level and type of medical equipment. In the three case countries, the health system structure consists of: (i) the peripheral level, with at least one health center and one health center network, and first-level hospitals; (ii) the regional level, with one regional hospital and a regional referral structure; and (iii) the central level, where highly specialized referral hospitals are located (Box 6).[16] These levels form the referral/counterreferral system and continuity of care. Based on connections between facilities according to their degree of technical expertise, this organization ensures appropriate management from one level of care to another. This organization generally corresponds to the administrative division of the territory, but coverage is not always complete in all countries (Box 7).

Implementation of the health system raises challenges in all three case countries. Some overlaps exist in practice between the different levels. Several explanations were given in interviews for this situation: (i) third-level hospitals are saturated by first- or second-level care requests from patients living nearby, especially in cities such as Abidjan and Dakar; (ii) second- and third-level hospitals are constrained by inadequate technical

16 Most central-level facilities are university hospitals and in the capitals, except in Côte d'Ivoire where they are in Abidjan and Bouaké, not in the political capital Yamoussoukro.

BOX 6

Organization of the Health System



Central level: ***Central referral hospitals.*** This level refers to high specialization. Most of these hospitals are university hospitals, and located in capitals.

Regional level: ***Regional referral hospitals*** (CHR). This level usually corresponds to the administrative and political region, led by a public health doctor, but depending on the country, the prerogatives of these doctors are highly differentiated.

Peripheral level: ***Health centers and network of health centers, peripheral hospitals.*** This level usually corresponds to the health district (whole department or part of a department), managed by a head doctor.

Source: World Bank compilation of national health development plans.

BOX 7

Number of Hospitals in the Countries of the Subregion

	Benin	Côte d'Ivoire	Guinea	Niger	Senegal	Togo
Administrative division	6 departments, 34 health zones	12 districts, 30 regions	7 regions, 33 prefectures	8 regions, 42 districts	14 regions, 50 districts	6 regions, 35 districts
Number of hospitals	**36**	**89**	**40**	**42**	**31**	**44**
Tertiary: central	4	4	2	3	10	3
Secondary: regional	5	85	4	6	11	6
Primary: peripheral	27	—	34	33	10	35

Source: World Bank compilation of national health development plans.

facilities; and (iii) patient referrals are made in the absence of adequate and affordable means of transport.

While infrastructure and equipment are operational in some hospitals, in many they are obsolete. Some hospitals do have well-maintained infrastructure. Examples include the HOMEL maternity hospital in Cotonou,

Benin, which—despite relatively unsophisticated technical facilities—engages in a rigorous quality policy; the Heart Institute in Abidjan, Côte d'Ivoire; the Principal Hospital in Dakar, which offers more diversified services; the Grand Yoff Hospital in Senegal; and several private and nonprofit health facilities in the subregion. In contrast, many facilities are in a state of advanced dilapidation, operating with obsolete equipment.

Maintenance of equipment and infrastructure remains limited in the three case countries. This is a general problem, for which many explanations were given in interviews: (i) disparate and nonstandard facilities; (ii) small numbers of biomedical engineers among hospital staff; (iii) the geographical remoteness of firms producing the devices; (iv) technical shortcomings among local equipment brand representatives; and (v) failure to finance preventive maintenance. Moreover, in Benin and Côte d'Ivoire, the centralized management of facilities in a directorate of the ministry does not allow for the implementation of appropriate maintenance service, which leads to frequent equipment inadequacies.

Human Resources

There is a lack of skilled health sector staff at the subregional level. With an average of 0.1 doctor and 0.56 nurse and nursing aide for 1,000 people, caregiver ratios in the case countries fall below the regional average of 0.2 and 1.1, respectively, and well below comparators in the Middle East and North Africa region and the OECD (Box 8).

This deficit is significant in the hospital sector and can dampen motivation among personnel. Accurately assessing this deficit is difficult,

BOX 8

Regional Comparison of Caregiver Ratios, 2010/2011

Per 1,000 persons	Benin	Côte d'Ivoire	Senegal	Burkina Faso	Guinea	Mali	Mauritania	Sub-Saharan Africa	OECD	Middle East and North Africa
Nurses and nursing aides	0.8	0.5	0.4	0.6	0.0	0.4	0.7	1.1	8.8	2.5
Doctors	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.2	2.9	1.6

Source: World Development Indicators, World Bank.

however, given shifting functions as medical tasks are performed by nurses or less-skilled staff. Moreover, some heath care services (such as washing patients, distributing drugs, and monitoring activities) are provided by those who accompany the patients rather than by professional caregivers. Though it is not always true that skilled staff are lacking, the perception of this overall deficit is present in all countries and leads to a strong loss of motivation among health sector staff.

The political and economic context partly explains staff deficits. In Benin, a recruitment freeze implemented as part of the country's structural adjustment program had constrained the sector's hiring capacity until 2008, when a wave of unskilled workers was integrated into the civil service. This had the effect of widening the deficit of skilled staff, which was filled by the recruitment of contract workers. The decade of political turmoil experienced by Côte d'Ivoire has created a crisis of confidence in public hospitals. In an effort to remedy this situation, the government implemented recruitment measures and salary increases in 2014. In Senegal, hospital reform has significantly increased staff tenure, but often among under-skilled workers, thereby creating a shortfall in skilled medical and paramedical staff.

Some hospitals have put in place incentive mechanisms to address dual public/private employment and absenteeism challenges. Hospitals face major challenges in motivating staff, for which low remuneration is often cited as a principal cause. Some countries have responded by setting up financial incentive mechanisms, including Guinea (Box 9) and Senegal, but in Senegal these bonuses have proved unsustainable and significantly destabilized hospital finances. Owing to the limited attractiveness of the public sector, physicians have increasingly entered into dual public/private practice, raising concerns regarding hospital ethics and effective presence at work. Absenteeism is a major challenge for the credibility of the hospital system, especially in Côte d'Ivoire.

Health Care Delivery Performance

Health status has improved in the region as a whole over the last decade. In particular, women's life expectancy at birth increased by eight years, and maternal mortality statistics have progressed across the subregion. Despite this upward regional trend, however, some countries show slower progress. Côte d'Ivoire, which has experienced a decade of crisis and a loss of confidence in the public hospital service, shows an inverse trend as compared to other countries in the subregion (Box 10), despite starting off in a more advantageous position on some indicators.

BOX 9

Financial Incentives in Guinea

Guinea's Ministry of Health has developed a system of financial incentives linked to the amount of own revenues generated by the hospital. To keep these costs from outweighing other priority sectors financed by a hospital's own revenues (such as paying contract workers and purchasing drugs), the amount of bonuses may not exceed 30 percent of revenues. The allocation of bonuses is not automatic, but is instead based on a monthly evaluation of attendance, punctuality, and execution of instructions in services. This bonus is based on activity indicators rather than on service quality. In 2003, motivational incentives—which mobilized 17.6 percent of revenues generated by hospitals—represented 3.6 percent of total expenses. Staff salaries accounted for 34 percent of hospital resources.

Source: WBI (2005).

Indicators on skilled birth attendance and cesarean sections reflect increased rates of utilization. Evolution of health indicators such as the growth in the number of births attended by skilled staff or the (sometimes excessive) increase in the rate of cesarean sections show improvements in hospital performance, especially in Benin and Senegal (Box 10). A list of additional indicators is presented in Annex 2.

Measures aimed at providing free health care have played a role in this evolution. These measures typically concern vulnerable people who are easily identifiable: pregnant women, children aged 0 to 5 years, the elderly (through the SESAME plan in Senegal), or people suffering from renal failure. These measures also target socially vulnerable people, although there remain difficulties in assessing vulnerability. Côte d'Ivoire tried for a short time after its postelection crisis to implement a system of free universal hospital care, then introduced a revised policy aimed at targeted free access.

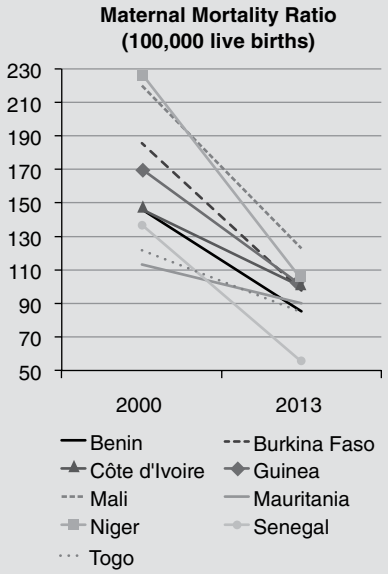
Hospital capacity, as measured by the number of beds per 10,000 inhabitants, is uneven among case countries—three in Senegal, four in Côte d'Ivoire, and five in Benin.[17] This indicator represents only one element of the supply of hospital care; however, an accurate inventory of technical facilities would give an interesting complementary image.[18] It appears

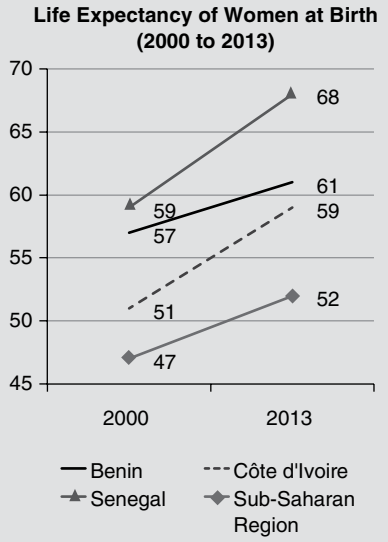
17 Ministries of Health of Benin, Côte d'Ivoire, Senegal.

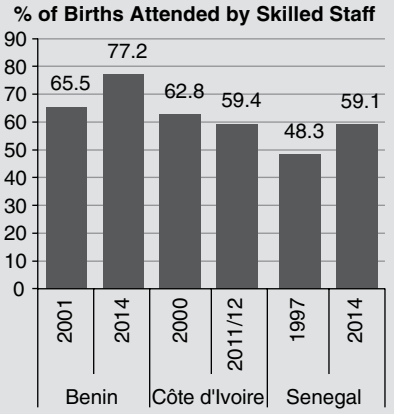
18 This inventory could not be obtained due to time constraints, but would be a useful area for further study.

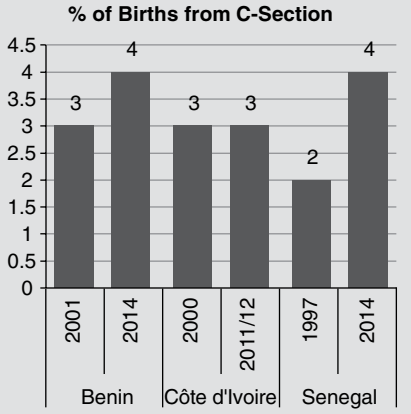
BOX 10

Health and Hospital Statistics









Sources: World Development Indicators, World Bank; Ministries of Health; WHO.

from field visits that, in contrast to bed capacity figures, facilities in Senegal and Côte d'Ivoire have generally more developed technical facilities than those in Benin. This is the case for equipment such as resuscitation beds or operating rooms.

Measures initiated with regard to quality should also be taken into account in assessing hospital performance, but indicators are limited. Certification initiatives have been launched in several hospitals. In addition, Committees for the Fight Against Hospital-based Infections (CLIN) have been created and are operating effectively in many facilities. Nonetheless, there are few clearly identifiable quality policies and accreditation approaches in the hospitals visited, apart from the 5S[19] approach to continuously improving service quality through clearing, storing, cleaning, order, and rigor—an approach that has been applied in some facilities with highly positive results. Results-based financing (RBF), through target indicators, takes into account the quality concept, but although quality approaches have been initiated in facilities, there are generally few indicators to measure their progress.

Financial Performance and Fiscal Risk

Generally, the consolidated financial information that is available is limited which could present a risk. The consolidation of financial information at the oversight level is limited. Hospitals do not systematically transmit their financial statements to the oversight entity, or if they do so, it is with long delays. This lack of monitoring and control at the central level limits the review of global trends and could pose fiscal risks and threaten the financial viability of hospitals.

Autonomous hospitals are not always able to generate sufficient resources for their operations, and many rely on state subsidies. Autonomous hospitals have two sources of financing: (i) own resources generated by the facility (through billing activities and resale of drugs), and (ii) state subsidies. For different reasons (such as free universal health care policies, pressure on payroll, and so on), these hospitals are not always able to generate a sufficient level of resources for their operations, and thus remain dependent on state subsidies, which opens the door to fiscal risk.

In Benin and Côte d'Ivoire, hospitals have little financial flexibility due to the centralization of decision making. Although hospitals should develop an annual work plan and a draft budget, the budget allocated by the

19 5S is a workplace organization method based on five Japanese words: *seiri, seiton, seiso, seiketsu, and shitsuke* ("sort," "set in order," "shine," "standardize," and "sustain").

ministry is not necessarily in line with requests. The budget may include funding for equipment and infrastructure, but these allocations do not fall within the framework of expression of needs.

The widespread financial imbalance of public hospitals contrasts with the situation of private nonprofit facilities. Unlike private clinics, nonprofit facilities charge prices that are identical or nearly identical to those of public facilities. While they are able to support wage bills, these facilities (within the study sample) manage to maintain fiscal balance. Their full financial management autonomy, and perhaps more crucially the actual authority of their executive management in decisions related to human resources, helps explain their effectiveness.

In Senegal, fiscal risk stems from the hospitals' debt and the volatility of the wage bill. The debt held by EPS facilities is significant, and there is pressure on the wage bill because of the tenure offered to low-skilled workers as part of recent hospital reforms. Most of the resources generated are used to pay salaries and bonuses, which represents a risk for facilities and prevents them from creating self-financing capacities for investment projects.

Free health care policies create fiscal risks in Côte d'Ivoire and Senegal. Senegal has introduced a set of free health care measures, for which advances made by EPSs are subject to reimbursement by the government. Delays in government payments have led to outstanding arrears, which have a negative impact on hospital funds. In Côte d'Ivoire, the implementation of such measures has destabilized hospital financing systems, including the buying and selling of drugs, and the loss of revenue linked to their resale has reduced hospital resources.

Hospital sectors are characterized by limited planning, especially for investment projects. Overall, hospitals do not develop hospital strategies, called "*projets d'établissement*." Hospital planning is limited primarily to annual work plans, and does not include medium-term strategic planning. Only in Senegal was an initial series of hospital strategies developed, but they were considered unrealistic and were not renewed. One of the main consequences of the absence of a hospital strategy is low hospital investment, which contributes to a situation in which technical facilities are not kept up to date or developed over time.

CHAPTER 1.2

Legal and Regulatory Framework

Heterogeneous Legal Frameworks

Hospitals have different legal forms across the three case study countries, and they do not all have legal personality or financial independence. In Benin, some hospitals take the form of social, cultural, and scientific offices, legal entities benefiting in principle from managerial autonomy; others are semiautonomous. In Côte d'Ivoire, some hospitals are EPNs, which are legal entities with financial autonomy structured in the form of Industrial and Commercial Public Agencies (*établissements publics à caractère industriel et commercial,* EPIC). Public health units, on the other hand, are considered to be services under direct state control without managerial autonomy. In Senegal, hospital reform has granted all hospitals EPS status, which implies legal autonomy. Annex 3 summarizes the applicable laws.

Autonomy is effective in all hospitals in Senegal and to some extent in Benin and Côte d'Ivoire. In Benin, hospitals are closer to deconcentrated services of the state than autonomous facilities. The National University

Hospital seems to be the only structure with real financial autonomy; it receives a subsidy that represents only 12 percent of its resources and pays 90 percent of staff directly. Other hospitals have limited autonomy, and employment and investment decisions remain the responsibility of oversight authorities. In Côte d'Ivoire, there is autonomy through the EPIC structure, but this seems inappropriate, because hospitals cannot generate the needed resources (60 percent). In contrast, regional hospitals and general hospitals, which are under state control without autonomy, seem to be limited in their operational management. In Senegal, hospital autonomy is effective at all levels (Box 11).[20]

BOX 11

Legal Status and Managerial Autonomy in Benin, Côte d'Ivoire, and Senegal

	Legal Status of Hospitals	Degree of Managerial Autonomy*
Benin	• University hospital and local hospitals: social, cultural, and scientific offices • Departmental hospitals: public health facilities	• ***Degree 1:*** only the national university hospital enjoys real autonomy • ***Degree 1:*** semiautonomy provided for by law, but decisions are mainly ministry's responsibility
Côte d'Ivoire	• National public agencies (EPN): Industrial and Commercial Public Agency (EPIC) • Zone hospitals and departmental hospitals: services under state control	• ***Degree 1:*** EPN of university hospitals are autonomous, but in practice depend on the state • ***Degree 0:*** depend on the ministry services
Senegal	Public health facility (EPS)	***Degree 2:*** widespread autonomy

Source: Legal texts and interviews. *Degrees ranked from 0 to 2, where 0 = no autonomy; 1 = weak autonomy; and 2 = strong autonomy.

20 The levels of autonomy are differentiated according to an arbitrary three-level scale. See note to Box 11.

BOX 12

Legal Status and Managerial Autonomy in the Countries of the Subregion

	Legal Status of Hospitals	Managerial Autonomy
Guinea	• Initially all public hospitals: public health agencies • Afterward, local hospitals reattached to the ministry	• Yes, except for local hospitals; autonomy was withdrawn
Burkina Faso	• All public hospitals: public health agencies (EPA)	• Yes
Mali	• All public hospitals: public hospital agencies	• Yes
Mauritania	• National public hospitals: public health agencies (EPA) • 2 regional hospitals: public health agencies (EPA)	• Yes
Chad	• All public hospitals: public hospital agencies (EPA)	• Yes

Source: WBI (2005); World Bank compilation of hospital reform acts.

Like Senegal, several countries of the subregion have granted hospitals autonomy by creating a public hospital or health facility status. As in Senegal, some countries mentioned have initiated hospital reforms and created a new category of public hospital agency (Box 12), in some cases linked to the French Administrative Public Agency status (*établissement public à caractère administratif*, EPA).

Challenges Related to the Legal Framework of Hospitals

Despite existing regulatory provisions, difficulties in applying laws lead to a situation in which hospital governance is not always consistent with the established legal framework. In Benin, the proliferation of laws makes implementation and monitoring difficult. In Côte d'Ivoire, certain provisions cannot be applied due to the absence of related implementing decrees, as illustrated by the law on decentralization or the difficulty in establishing some principles related to advisory commissions. Finally, in

Senegal, the lack of effective enforcement of laws hampers reform implementation. As a result, the legal autonomy achieved on paper has still not been applied effectively in practice or is subject to heavy external constraints.

Experiences with autonomy in practice have raised questions about the effectiveness of extending it to all structures, including local facilities. While the principle of autonomy has not been questioned, some assessments of Senegal's hospital reform have concluded that, while autonomy was beneficial to central and regional facilities, it was not clear that the same degree of autonomy would be as useful when applied to local-level entities. In Guinea, for example, this concern prompted the authorities to renounce the autonomy given to local hospitals.

CHAPTER 1.3

The State's Oversight Function

Conceptual Framework

The oversight function of the state refers to the organizational model delineating the state's role vis-à-vis hospitals. In the West Africa subregion, state oversight in the health sector operates through two models: "dual," in which the oversight function is shared between the finance ministry (financial supervision) and the health ministry (technical supervision); or "decentralized," in which the oversight function is entirely the responsibility of the line ministry (Box 13).

Organization of the State's Oversight Function

In Benin, the oversight function is "decentralized" and carried out by the Ministry of Health via the National Directorate for Hospital and Health Care Facilities (DNEHS). According to the laws, it is the linchpin of the hospital oversight function. With a staff of 18, it is in charge of coordinating hospital activity in relation to other directorates. At the subnational level, it is supplemented by the departmental directorates of health.

BOX 13

Models of State Oversight Functions

	Responsibility	Advantages	Limitations	Examples
Centralized Model	Centralized supervision: unique institution (finance ministry, specific agency)	Clear definition of objectives, priorities, and responsibilities of government Focus on efficiency and effectiveness	Risk of excessive concentration on financial aspects	—
Dual Model	Shared supervision: sector ministry and "central" institution	Appropriate balance between financial considerations, regulation, and public policies	Limited responsibility, shared authority	**Senegal, Côte d'Ivoire, Burkina Faso, Guinea**
Decentralized Model	Supervision by the sector ministry	Specific knowledge of the sector	Budgetary risk and lack of aggregate information	**Benin, Mali, Mauritania, Chad**

Sources: OECD (2015a); World Bank (2014a); WBI (2005).

In Côte d'Ivoire and Senegal, the oversight function is dual and therefore shared between the Ministry of Finance and the Ministry of Health. In Côte d'Ivoire, it involves: (i) the Budget Directorate-General of the Ministry of Finance (economic and financial supervision); and (ii) various central directorates of the Ministry of Health (technical supervision). At the subnational level, the departmental and regional directorates of health supplement them. In Senegal, the oversight function is shared between: (i) the Budget Directorate and the Economic and Financial Cooperation Directorate of the Ministry of Finance (financial supervision); and (ii) the Directorate of Health Facilities (DES) of the Ministry of Health (technical supervision), which is the main interlocutor and the supervisor of hospitals.

Only Benin and Senegal have a directorate responsible for the supervision of hospitals. In Benin, it has been subject to several revisions over the last few years; its last modification created the National Directorate for Hospital and Health Care Facilities, with a staff of 18. In Senegal, the directorate was created during the hospital reform of 1998, which specified the oversight of the sector by a DES composed of 20 people, of which three are specifically assigned to the monitoring of public hospitals (Box 14).

BOX 14

Oversight Functions in Benin, Côte d'Ivoire, and Senegal

	Model of Supervision	Directorate of Hospitals	Staff	Responsibilities
Benin	**Decentralized:** Ministry of Health	**YES:** National Directorate for Hospital and Health Care Facilities (DNEHS/MS)	DNEHS: 18	• Define and design the national policy of hospitals • Define norms and standards for curative care • Coordinate, monitor, and evaluate the implementation of the national policy for hospital and health care facilities • Collaborate with hospitals and health care facilities • Collaborate with the infrastructure, technical equipment, and hospital maintenance directorate
Côte d'Ivoire	**Dual:** • Ministry of Health • Ministry of Finance	**NO:** Planned in the upcoming reform	—	In the absence of a directorate responsible for hospitals, oversight is shared between various central directorates from the Ministry of Health
Senegal	**Dual:** • Ministry of Health • Ministry of Finance	**YES:** Directorate of Health Facilities (DES/MS(AS))	DES: 20 Public hospitals (EPSs) division: 3	• Develop, monitor, and evaluate hospital policy • Ensure the fulfillment of EPS missions • Responsible for regulating, supporting, and controlling private clinics and surgeries and ensures promotion of their contribution to the public health service

Source: World Bank compilation. Annex 4 details the name of each of the directorates involved in the supervision of hospitals.

Challenges Related to the Oversight Function

In Benin, given the limited capacities and authority of the DNEHS, most of the decisions related to the hospital sector do not emanate from it. The DNEHS does not have the authority it needs to exercise its oversight mission. As a result, the oversight function is fragmented among other central directorates, which play that role to the detriment of the

DNEHS. In practice, sector decisions are made by the directorates involved in oversight: the Directorate of Programming and Planning; the Directorate of Financial Resources and Material; the Directorate of Infrastructure, Equipment, and Maintenance; and the Directorate of Human Resources.

The Directorate of Health Facilities in Senegal operates with limited capacities. Among a staff of 20 people, three are dedicated to the subdivision of public hospitals (EPSs). Budget resources are limited, and the DES is not in a position to steer hospital policy. Under these conditions, exacerbated by its secondary position in the organization chart of the Ministry of Health, the DES is limited in its oversight function.

In the absence of a directorate responsible for hospitals in Côte d'Ivoire, oversight is spread across the Ministry of Health. It appears, therefore, to be highly concentrated in the Ministry of Health and fairly hierarchical. The establishment of a hospital directorate is under consideration as part of a planned hospital reform.

CHAPTER 1.4

Planning and Performance Monitoring

Planning Framework

Strategic planning and decision making include the development of a health map implemented through a variety of legal tools such as contracting and authorization schemes. Benin has developed a health map based on criteria that aims to respond to the population's health needs. Although its development was slowed down by financial capacity limitations, implementation of the health map has led to the construction and establishment of new facilities.[21] In Senegal, an initial health map project was developed in 2002; an update has been carried out, but has not yet been approved or implemented.

Hospital strategies and other planning instruments are rudimentary. A multiyear hospital strategy (*projet d'établissement*) is organized for a five-year period. In Senegal, strategic planning was a key element of hospital

21 This is the case with the new hospital center of Djidja–Agbanizou in the region of Zou. Construction has been completed, but its entry into service is not assured owing to a lack of human resources.

BOX 15

Lessons Learned from Hospital Strategies in the Subregion

	Objectives and Components	Lessons Learned
Burkina Faso	The *projet d'établissement* defines, based on medical directions, the facility's general objectives in the fields of medicine, nursing and midwifery, teaching and research, social policy, training plans, management, and information systems. It includes the following: a medical strategy, a nursing and midwifery strategy, a social strategy, and a management strategy.	• Most hospitals in Burkina Faso have initiated strategic approaches. • Only a few of them have managed to finalize their *projet d'établissement,* and most of them remain at the stage of action plans.
Guinea	Objectives include strengthening the medical rationale; greater openness to context to situate the facility within the broader health care delivery environment and to better understand health care demand and service needs; redirecting hospital financial resources away from implementing routine activities and toward the achievement of clearly defined objectives; creating a participatory dynamic; developing service projects to make unit chiefs more accountable; and integrating and disaggregating the different strategies.	• Importance of delineating the choices of facilities by providing documentation relating to the national program (investment). • Need for external support. • Need for adequate development time to ensure that the strategy is accepted by all key stakeholders. • Importance of providing the means of implementation. • *Projets d'établissement* should be funded as part of an investment fund that could be allocated based on specific criteria.
Mali	The *projet d'établissement* defines the facility's objectives in the fields of medicine, nursing and midwifery, the reception of patients and their families, social policy, management, information systems, hygiene and safety, training, and research. It must be compatible with the national health and social development plan, and it determines the material and financial means as well as the human resources needed by the facility to meet its objectives.	• Financial problems hinder the rapid modernization and maintenance of hospital infrastructure (such as bringing buildings and equipment into compliance with the legitimate demands of patients, availability of medical consumables, improving management methods, and profit sharing among hospital teams). • Implementation of *projets d'établissement* was identified as a major challenge in 2004.

Source: WBI (2005).

reform and initiated in all EPSs. While there is consensus on the positive contribution made by these hospital strategies, due to variations in quality and a lack of associated funding, they have not been renewed. The experiences of neighboring countries show that Senegal is not alone in encountering these challenges (Box 15). In Benin and Côte d'Ivoire, only a few hospitals have developed such strategies.

To compensate for the nonrenewal of hospital strategies, Senegal has implemented Multiyear Contracts Specifying Objectives and Resources (CPOMs), with support from donors. Established in recent years, CPOMs have enabled beneficiary hospitals to make targeted investments. These investments have improved the availability of health care as well as revenues, as investing in imaging and laboratory equipment generates resources. The CPOMs have also permitted Senegalese hospitals to reinvest in technical facilities according to a more consistent planning framework than in the context of bilateral cooperation or support from nongovernmental organizations. Even if several facilities benefit from this cooperation, they rarely fall within a coherent and coordinated hospital development plan.

Performance Monitoring: Multiyear Contracts and Results-Based Financing

The establishment of CPOMs or RBF has allowed for the integration of accountability mechanisms. These measures have strengthened accountability through agreements between hospitals and the state. Although they cover only a portion of hospitals, they set up communication routines that encourage regular monitoring, both financial and in terms of activities. These mechanisms, which provide performance incentives, are developed in other countries that have implemented hospital autonomy for example, Mali (Box 16).

In Senegal, hospital reforms envisioned the development of results-based management. A National Contracting Policy was established in 2006. Initially, this policy was not renewed, but when EPSs' debt grew significantly, the government restarted contracting through the CPOMs. A second series of contracts was introduced in 2011, including typical areas to be assessed, evaluation criteria, and accompanying results indicators (Box 17). The initiative has been successful and is positively perceived by both the EPSs and the oversight entity. There are practical challenges, however, in monitoring progress toward results indicators.

While RBF was introduced in Benin in 2010, it has yet to be implemented in Côte d'Ivoire. In Benin, given the weaknesses of input-based funding, the government's commitment to establishing results-based management was reflected in the introduction of the RBF in 2010 (Box 17). Performance is evaluated through a series of quantitative and qualitative indicators. In addition, the contracts provide for regular reporting and independent audits. The RBF approach is under review as part of planned

BOX 16

Performance Contract in Mali

- Include a set of incentives linked to performance, with the aim of changing behaviors and practices.
- Include a specific budget line to cover specific subsidies granted to hospitals.
- The extra budgetary subsidy cannot substitute for either the regular budget or the investment budget.
- The extra budgetary subsidy is allocated on the basis of performance, as measured indicators such as:
  - Number of days of drug stockouts
  - Level of user satisfaction
  - Level of compliance with standards on medical records.
- Each hospital is awarded points on the basis of the selected indicators.
- These points determine the hospital's eligibility for and the amount of the subsidy (with more points allowing for a larger subsidy).

Source: WHO (2008).

BOX 17

Performance Monitoring in Benin, Côte d'Ivoire, and Senegal

	Benin	Côte d'Ivoire	Senegal
Tools	**RBF:** Since 2010	**RBF:** Planned	**CPOM:** Second wave
Coverage	Initially in 5 sanitary zones, extended to 8 others	Pilot expected in 4 health districts	1st wave: 2006, 15 EPSs 2nd wave: 2011, 6 additional EPSs
Duration			**5 years**
Indicators	**YES:** Quantitative and qualitative indicators		**YES**: Evaluation criteria and performance indicators
Monitoring and Reporting	**YES:** Dissemination of quantitative reports; independent control; close monitoring of indicators		**YES:** Dissemination of financial and medical information (standardized format)
Challenges			Monitoring of CPOM indicators remains limited

Source: World Bank compilation.

hospital reforms in Côte d'Ivoire, with the aim of improving accountability mechanisms within the hospital system and in the context of a broader reform of the public financial management system.

Information Systems

In all three countries, hospital information systems are still essentially nonexistent. Only one example of an integrated information system has been found in a zone hospital in Benin, from locally adapted software. In the other facilities, although there seems to be relatively sufficient information technology equipment, there is neither an information system nor computerized medical records. This deficiency makes it impossible to obtain an objective and comprehensive understanding of facilities' activities to facilitate decision making.

CHAPTER 1.5

Boards of Directors and Executive Management

In the three case countries, hospital organization involves decision-making, executive, advisory, and control actors. Hospitals are governed by a board of directors, the deliberating organ. The executive management is responsible for administration and general management, assisted by the heads of medical and technical services as well as consulting bodies (such as a hospital medical commission,[22] a hospital nonmedical commission, or units addressing hygiene or quality matters). Finally, hospitals are subject to control by accounting officers or budget controllers, who are subsidiary staff of the Ministry of Finance (Box 18).

22 The hospital medical commission (*Commission Médicale d'Etablissement,* or CME, in French) can also be called an advisory medical commission. The hospital nonmedical commission (*Comité Technique d'Etablissement*, or CTE, in French) is also known as a hospital council, depending on the country and the facility level in question.

BOX 18

Hospitals Management Bodies

Decision-Making Body	Implementation and Monitoring Body	Advisory Bodies	Control Bodies
• Board of directors, management board, or management committee	• Executive management • Administrative services	• Hospital medical commission or advisory medical commission • Hospital nonmedical commission or hospital council • Others may include executive committee, hygiene and security commission, quality units (CLIN)	• Management control • Financial control

Source: World Bank compilation.

Board of Directors

The legal framework sets out the profiles for members of the board of directors,[23] the duration of their mandate, and the frequency of meetings. Hospitals, regardless of their size, have a board of directors (also called a management board or management committee). Laws regulate and provide for their organization and function. They are composed of representatives of oversight ministries (such as health, finance, and/or education) in direct or deconcentrated representation, staff representatives, and elected members of local government. In Benin, membership can also include traditional practitioners or stakeholders of a zonal hospital. In Côte d'Ivoire, board membership also includes the director of the Civil Servants Mutual Insurance Company (*Mutuelle Générale des Fonctionnaires*), a private insurance sector representative, and a representative of the universal health insurance program.

The authority of the board of directors varies among countries. Although the laws specify that the boards of directors are the deliberative body, in practice their effectiveness is limited by several factors, including the reduced frequency of meetings and/or stakeholders' perception of the boards—whether they are considered rubber stampers or real decision makers. Their composition is sometimes criticized as well; at the central level,

23 The board of directors may also be called the board or the management board depending on the country and the facility.

BOX 19

Responsibilities of the Boards of Directors

- Reviewing and guiding corporate strategy, major action plans, risk policy, annual budgets, and business plans; setting performance objectives; monitoring implementation and corporate performance; and overseeing major capital expenditures, acquisitions, and divestitures
- Monitoring the effectiveness of the company's governance practices and making changes as needed
- Selecting, compensating, monitoring, and—when necessary—replacing key executives and overseeing succession planning
- Aligning key executive and board remuneration with the longer term interests of the company and its shareholders
- Ensuring a formal and transparent board nomination and election process
- Monitoring and managing potential conflicts of interest of management, board members, and shareholders, including misuse of corporate assets and abuse in related party transactions
- Ensuring the integrity of accounting and financial reporting systems, including independent audit, and that appropriate systems of control are in place, particularly systems for risk management, financial and operational control, and compliance with the law and relevant standards
- Overseeing the process of disclosure and communications

Source: OECD (2015b).

they are composed of related institutions and ministries and sometimes appear to be distant from operational realities. This phenomenon appears less noticeable at the peripheral level, however, where users are better represented on the boards. Box 19 reviews OECD "good practices" on the operation of the boards.

The decentralization process, reflected in the composition of the boards of directors, yields mixed results. In Benin, members of the local population serve on the board of directors of district hospitals. In Senegal, the chairmanship of the board of directors in regional hospitals is held, outside of Dakar, by the elected president of the Regional Council. While Benin's experience is viewed positively, the presence of local elected officials on Senegal's regional hospital boards is not well received by management. This

setup may indeed create conflicts of interest by defending specific interests without sufficiently taking into account either health needs or the need for fiscal balance.

Executive Management

The actual authority of executive managers appears to be limited. In Benin and Côte d'Ivoire, investment decisions, human resources management, and especially strategic planning are outside the purview of executive management. Their ability to intervene in the case of misconduct is highly limited given the protective status awarded to permanent hospital staff. In Senegal, by contrast, executive management has the autonomy to fully exercise its authority, subject to the approval of the board of directors. Management's flexibility is still limited, however, by: (i) political and union pressures; (ii) the heavy debt burden on facilities; and (iii) the absence of a sufficient fiscal margin to make investments and ensure proper equipment maintenance.

The competencies of hospital managers are a subject of debate, with some hospitals requiring a degree in hospital management while others prefer initial medical training. In Côte d'Ivoire, the management of university hospitals is regulated by a physician who is a university professor. In other facilities in Côte d'Ivoire, as in Benin and Senegal, management positions—though often held by administrators—may be covered by physicians who have received public health training. The issue of hospital managers' competencies, analyzed in WHO (2009), is outlined in Box 20.

Advisory Commissions

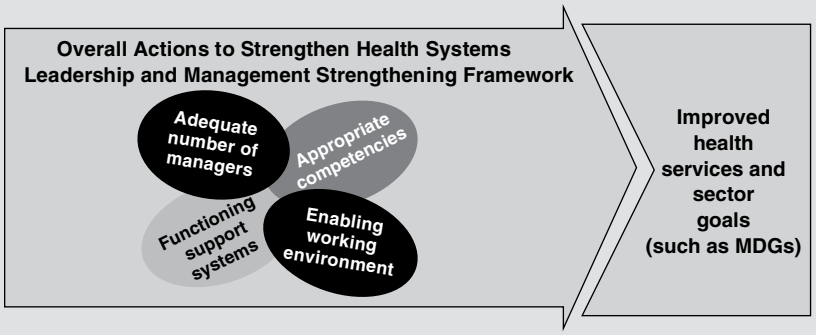
Hospital medical commissions (*commissions médicales d'établissement*, or CMEs in French) exist in the case countries and are consulted on medical organization, planning, and the promotion and evaluation of the quality of care. CMEs develop and implement the hospital's medical policy, in collaboration with management, and are responsible for the quality of health care. In particular, they are consulted on the development and distribution of technical services, maintenance costs, and the procurement and distribution of technical equipment, drugs, reagents, and medical consumables. Their membership includes all physicians, surgeons, dentists, and pharmacists practicing in the facility.

BOX 20

Leadership and Hospital Management

This framework examines the conditions for good leadership and management and shows that good governance and management require a balance among four factors:

- An adequate number of managers available at all levels of the health system;
- Managers with appropriate competencies;
- Functioning and effective support systems; and
- An enabling working environment.



Regarding the profile and tasks of health managers, a study conducted using a sample of facilities in Ethiopia, Ghana, and Tanzania revealed that:

- Managers in developing countries are often health professionals who have also assumed managerial roles.
- Managers come from diverse backgrounds, including physicians, nurses, medical assistants, health managers, pharmacists, and health officers.
- Physicians usually make up the majority of managers at the national and provincial levels, although significant gaps remain between countries.
- Many health managers are not full-time managers, but instead play a dual role in performing both their usual clinical tasks (as physicians, nurses, or pharmacists) and management tasks. The extent and the share of time spent on each role is not well defined, but this dual role appears to be fairly common in the case studies examined.

Source: WHO (2009).

The introduction of CMEs has not achieved expected outcomes. In Benin, the role of these commissions varies widely among hospitals; while limited in some facilities, they seem to enjoy more authority in others. In Côte d'Ivoire, interviews conducted with CME chairpersons show that these appear to work, but often minimally. In Senegal, CMEs are intended to support health care decision making, but they are weakly involved in EPS strategic planning and are often limited to the expression of categorical grievances.

CHAPTER 1.6

Transparency and Disclosure

Publication of Reports

Overall, the publication of activity reports and financial statements by hospitals is limited. Despite a number of legal obligations, few facilities seem to have effective and transparent reporting systems. Annual activity reports and financial statements are often submitted with heavy delays or not at all. Box 21 presents the OECD *Guidelines* on transparency and disclosure.

Hospital information is consolidated at the Ministry of Health, but the reliability of collected data is not guaranteed. Financial and nonfinancial information is consolidated at the Ministry of Health in each country. Nevertheless, the relevance, regularity, completeness, and reliability of collected data are often unsatisfactory. First, information is not always compiled on the basis of a standard template, which can undermine data consolidation at the oversight level. Moreover, most hospitals process information manually. Given the type of information that is collected, it is difficult to conduct analytical follow-up by disease or to arrive at an accurate cost for each activity.

BOX 21

OECD Guidelines on Transparency and Disclosure

OECD Principles of Corporate Governance

The corporate governance framework should ensure timely and accurate disclosure on all material matters regarding the corporation, including the financial situation, performance, ownership, and governance of the company. Disclosure should include, but not be limited to:

1. The financial and operating results of the company
2. Company objectives
3. Major share ownership and voting rights
4. The remuneration policy for members of the board and key executives, and information about board members, including their qualifications, the selection process, other company directorships, and whether they are regarded as independent by the board
5. Related party transactions
6. Foreseeable risk factors
7. Issues regarding employees and other stakeholders
8. Governance structures and policies, particularly the content of any corporate governance code or policy drafted by the company and the process by which it is implemented

OECD Guidelines on Corporate Governance of State-Owned Enterprises

State-owned enterprises should observe high standards of transparency in accordance with the OECD Principles of Corporate Governance. SOEs should disclose material information on all matters described in the OECD Principles of Corporate Governance and in addition focus on the following areas of significant concern for the state, as owner, and the general public.

1. A clear statement of the company objectives and a report on their fulfillment
2. The ownership and voting structure of each company
3. Any material risk factors and measures taken to manage such risks
4. Any financial assistance, including guarantees, received from the state and commitments made on behalf of the SOE
5. Any material transactions with related entities

Sources: OECD (2015a, b).

The consistency of consolidated reporting varies among the three case countries. In Benin, the oversight entity releases a comprehensive health statistics report annually. In Côte d'Ivoire, the consolidation of information is constrained given the postcrisis context. In Senegal, the latest consolidated report of the DES on the EPS dates from 2009.

Internal Control

In all three countries, hospitals are subject to state control.[24] Control mechanisms include: (i) the General Inspectorate of Health (Côte d'Ivoire, Benin), which, under the health minister's authority, carries out administrative, financial, and technical control of hospitals; (ii) the General Inspectorate of State (Senegal),[25] which deals with specific requests under the authority of the President of the Republic; and (iii) the General Inspectorate of Finance (Côte d'Ivoire), which monitors the budgeting of appropriations by the Directorate of Financial Affairs of the Ministry of Health. These different arrangements are unevenly implemented across the three countries.

External Control

External control of hospitals is included in the mandate of the Court of Auditors in all three countries. Supervision by the Court of Auditors[26] comprises jurisdictional control of accounts and institutional management control. In Benin, control is extended to include a performance audit of the Ministry of Health, which prepares an annual performance report. In Senegal, the Court of Auditors has recently produced a report on the emergency ward.

Some facilities are subject to audits by statutory auditors. In Benin and Senegal, hospitals are subject to audit by statutory auditors who, through annual audits, carry out a thorough verification of accounts. Box 22 presents the summary of procedures on administrative and financial transparency in the three case countries.

24 Enforcement of control systems could not be verified in detail during the missions.

25 The Senegalese hospital sector was audited in 2013.

26 The Court of Auditors is called the *Chambre des Comptes* in Benin and Côte d'Ivoire and the *Cour des Comptes* in Senegal.

BOX 22

Administrative and Financial Transparency in Benin, Côte d'Ivoire, and Senegal

	Accounting Standards	Production of Financial and Activity Reports (Hospitals)	Consolidated Reports (Oversight Entity)	Medical Information System	External Audit
Benin	SYSCOHADA	• Transmission of information is nonsystematic • Delays	• Annual report on health statistics (including hospitals)	• Paper-based information • Except for one pilot experience in Savalou	• Court of Auditors • Statutory auditors
Côte d'Ivoire	Public sector accounting	• Transmission of information is nonsystematic • Delays	—	• Paper-based information	Court of Auditors
Senegal	SYSCOHADA	• Transmission of information is nonsystematic • Delays	• Consolidated report on the hospital sector, but irregular	• Paper-based information (information system planned, but not yet implemented)	• Court of Auditors • Statutory auditors

Source: World Bank compilation.

CHAPTER 1.7

Conclusion and Opportunities for Further Strengthening

This review of the governance frameworks of public hospitals in Benin, Côte d'Ivoire, and Senegal analyzed existing arrangements in relation to "good practices" in the corporate governance of SOEs and parastatal entities. Box 23 summarizes these good practices for the five main governance dimensions reviewed in this study.

The main challenges to effective hospital governance in the three case countries relate to the legal framework for hospital autonomy, the organization of the oversight entity, and accountability mechanisms. Challenges in the legal framework refer to enforcement and difficulties in implementing hospital autonomy. With regard to sector oversight, key issues include the structure, fragmentation, institutional position, and capacity of the oversight entity. Finally, the challenges faced in the area of transparency include the limited transfer of information from hospitals to the oversight entity and the limited consolidation of data on sector trends (Box 24).

BOX 23

Good Practices in Governance of SOEs and Parastatal Entities

Governance Dimensions	Good Practices
Legal Framework	• Clear legal framework covering the entire SOE and parastatal "sector" • Definition of the legal status of entities
State Oversight Function	• Appointment of a specialized entity at the state level to ensure effective and regular monitoring of financial and nonfinancial sector performance • International trend toward centralization of oversight functions in a single structure to ensure comprehensive and coherent monitoring of all entities (centralized model)
Planning and Performance Monitoring	• Definition of mandates and objectives • Development of financial and nonfinancial performance indicators • Development of performance agreements between the state (oversight) and entities • Performance monitoring and evaluation of SOEs and parastatal entities
Boards of Directors	• Transparent and meritocratic selection of board members • Professional specialization and independence of board members • Focus on the main role of the board of directors as an autonomous body responsible for strategic decisions at the entity level and for monitoring executive management • Autonomy of the board of directors, ensuring both strong accountability toward the state as owner (oversight) and day-to-day management autonomy by the executive management of the SOE or parastatal entity
Transparency and Disclosure	• Clear rules and criteria with regard to financial and nonfinancial information • Publication of consolidated annual reports on the sector by oversight body • Regular publication of independent external audit reports • Effective internal control

Sources: OECD (2015a); World Bank (2014a); World Bank compilation.

The study identified key potential opportunities to leverage improved hospital performance. While the country cases outlined in Parts 2–4 provide more details on these opportunities for strengthening the governance framework within each country's specific context, this section on *Regional Trends* aims to present the high priority dimensions that are common to all three countries. These common opportunities converge toward three governance dimensions—the legal and regulatory framework, state oversight, and transparency—and could have an important impact on hospital performance.

BOX 24

Common Challenges in Benin, Côte d'Ivoire, and Senegal

	Benin	Côte d'Ivoire	Senegal
Legal Framework	• Fragmented legal framework; several laws apply, making implementation and monitoring difficult • Semiautonomy and autonomy for regional and peripheral hospitals, respectively, is theoretical	• Difficulties in implementing the legal framework • EPIC structure unsuitable to autonomous hospitals (EPNs) • Regional and general hospitals sometimes disadvantaged by the lack of autonomy	• Laws on reform implementation have not been fully adopted
State Oversight Function	• DNEHS lacks decision-making capacity • Several directorates of the Ministry of Health are involved in hospital oversight, leading to fragmentation	• Absence of a directorate dedicated to hospitals • Fragmented oversight among different central directorates • Existence of overlapping mandates	• Limited interactions between the two oversight ministries (health and finance) • Limited capacity in the Hospital Directorate (DES) in terms of human resources, staff training, and financial resources • Limited coordination between the DES and other stakeholders within the Ministry of Health
Administrative and Financial Transparency and Disclosure	• Variable quality of information	• No control by statutory auditors • Limited capacity for control in a postcrisis context • Limited transfer of information from hospitals to the oversight entity • Lack of annual publication on the sector • Limited publication and consolidation of information	• Nonsystematic preparation of activity reports and financial statements • Limited consolidation at the oversight level

Source: World Bank compilation.

Legal and Regulatory Framework

Defining the roles and responsibilities of stakeholders in a clear and effective legal framework would optimize health sector operation. The effective enforcement of a clearly defined legal framework through a detailed presentation of the various bodies involved in the governance of hospitals (including oversight entities, boards of directors, executive management, advisory bodies, and internal and external control bodies), together with their respective mandates, could be a useful first step toward improving governance. This step is recognized as an essential prerequisite for the optimal functioning of the sector. In assigning responsibilities, the framework could consider various parameters related to the hospital governance system, including authorization schemes, strategy, human and financial resource management, information processing, quality, and control.

The autonomy model might help hospitals overcome empowerment and accountability challenges. Empowering hospitals by giving them autonomous status—together with strong state oversight, and monitoring and control mechanisms—seems to have positive effects on performance. Maintaining the public nature of hospitals while building their capacity for initiatives could provide favorable conditions for improving the allocation of resources and for making hospitals more dynamic by encouraging them to adapt to the specific characteristics of demand in their area. In this sense, Senegal seems to have successfully empowered hospitals through an approach in which the oversight entity focuses on strategic monitoring and control of the sector, with operational management objectives defined in performance contracts, thereby ensuring the accountability of hospitals vis-à-vis the state and the public.

Oversight of the Hospital Sector

Strengthening the human and financial resources available to oversight entities would enable them to more effectively carry out their supervision and monitoring function. This is of particular relevance in the context of hospital autonomy, which in turn requires strong oversight to ensure the overall coherence of the hospital system, its integration into the overall health system, and respect for the fundamental mission of the public health service. Senegal's experience has emphasized the importance of sufficiently strong and legitimate oversight at the central administration level. Autonomy, which has significantly altered the system and the relationship

between the state and hospitals, has increased the importance of the state's oversight role, which requires adequate financial and human resources to steer hospital policy and ensure effective monitoring of facilities. Strengthening the capacity of oversight entities, which remain understaffed and operate with limited budgets, would help to reinforce their authority and credibility.

Improved communication and coordination among central supervisory services would strengthen the oversight function. Limited interaction among stakeholders (such as ministries, directorates, and central services) can contribute to fragmented supervision. This situation may contribute to a lack of coordination in decision making among oversight authorities and to overlapping roles and responsibilities. Increased coordination and more frequent communication between directorates would strengthen the effectiveness of sector monitoring and would have a positive effect on the performance of oversight entities.[27]

Transparency

Restoring regular communication between hospitals and the government would enhance the information available at the oversight level and could therefore reduce the fiscal risk associated with the sector. To date, there is little information on the hospital sector, and the information that is available is not systematically analyzed or consolidated by oversight entities. To enhance transparency in the health sector, it would be appropriate to restore a framework that enables the dissemination of information on hospitals through the implementation of communication routines and the development of appropriate tools for consistent and reliable data collection. Furthermore, regularly updating information at the oversight level would assist in the effective monitoring of the sector and in reducing related fiscal risk. This information could include financial and budgetary data as well as activity data for each hospital, published at the oversight level. Finally, data collection could be strengthened through the gradual introduction of hospital information systems, which would facilitate information management in a more standardized context. This information would be monitored through regular independent audits.

27 In Côte d'Ivoire, the proposed creation of a directorate in charge of hospitals might reduce oversight fragmentation and overlapping mandates, thereby facilitating optimal monitoring of the sector. This point is developed in more detail in Part 3 of this report.

The implementation of contracts between hospitals and oversight entities would enhance accountability and maintain strong central control. Improving hospital utilization requires qualitative improvements and stronger accountability on the part of managers and physicians working in the facilities. To that end, setting up contracts between the oversight entity and hospitals could accompany measures (discussed above) to improve the legal framework and oversight functions and thereby contribute to their enhancement. This could be achieved through the establishment of performance contracts with performance targets monitored through the regular provision of key data on hospitals, including financial and activity indicators.

PART 2

THE CASE OF BENIN

CHAPTER 2.1

Landscape of the Hospital Sector in Benin

Context and History of the Hospital Sector

Like many other African countries in the 1970s and 1980s, Benin participated in several international health initiatives. First, it adopted the Primary Health Care strategy included in the Alma Ata Declaration (1978), which was reaffirmed at the 2008 Ouagadougou conference and whose main pillars focused on equity, community participation, and intersectoral collaboration. The country also joined the Bamako Initiative in 1987, which emphasized community participation and health cost recovery, supporting implementation of the Expanded Program for Immunization integrated into the Primary Health Care strategy.

Hospital organization as it is known today emerged in the 1990s. A new constitution was adopted in the 1990s, and the legal framework for hospitals took shape. The legal status of hospitals is defined in a set of legal texts, and the territorial division into health zones was implemented in 1995.

In order to address hospital financing issues, the government launched Results-Based Financing (RBF) in 2010. RBF tracks the evolution of financial management and hospital activity using indicators and

performance monitoring targets, while providing associated financing. As such, it can help to strengthen overall health sector performance.

In response to the lack of resources for hospitals, the government launched the "120 days to equip the hospitals and health centers of Benin" program in 2012. The Minister of Health championed this program on the basis of findings indicating that the hospital sector was affected, among others, by inadequate and obsolete medical equipment and limited motivation of medical personnel.

Reforms Envisaged by the Government

The government is considering several reform measures that focus mainly on health system accessibility and planning for hospital service provision. These initiatives, which may affect both the demand for care and the supply of hospital services, include:

- ***Strengthening financial accessibility*** through the implementation of the Universal Health Insurance Scheme, following a commitment made by the President and ongoing pilot initiatives
- ***Expanding the university hospital system*** (*espace hospitalier universitaire*) to include the hospitals of Porto-Novo and Abomey-Calavi and by extending preferential employment conditions to university hospital staff in this area
- ***Implementing profit sharing*** as part of the Health System Strengthening Program (*Programme de Renforcement du Système de Santé, PRSS*), which has obtained support from the Global Fund to enable its expansion to the majority of Benin's health zones in the years ahead
- ***Enhancing strategic planning,*** including a project to develop a hospital map according to a central design, as a supplement to the health map
- ***Creating a regional referral hospital*** dedicated primarily to medical needs that justify medical transfers, through a public-private partnership whose private component has not yet been identified
- ***Seeking private management for newly constructed hospitals***, such as the Djidja zone hospital in Zou, although no private partner has applied thus far.

Financial, Material, and Human Resources

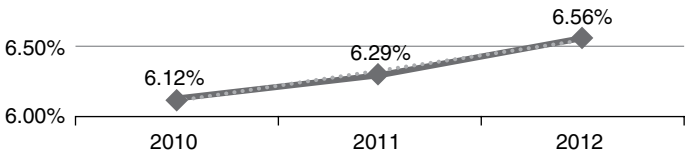
Financial Resources

The health sector's share of the government budget grew slightly between 2010 and 2012, from 6.12 percent to 6.56 percent. At CFAF 58 billion, the amount committed in 2012 is the highest so far (Figure 3). Still, as a percentage of the national budget, this amount remains below the 2000 Abuja commitment of 15 percent and the World Health Organization (WHO) recommendation of 10 percent.

According to the latest National Health Development Plan (PNDS), hospitals consume about 30 percent of the resources allocated to the health sector in Benin. Health centers consume 55 percent of resources and general administration 14 percent (Republic of Benin 2009).

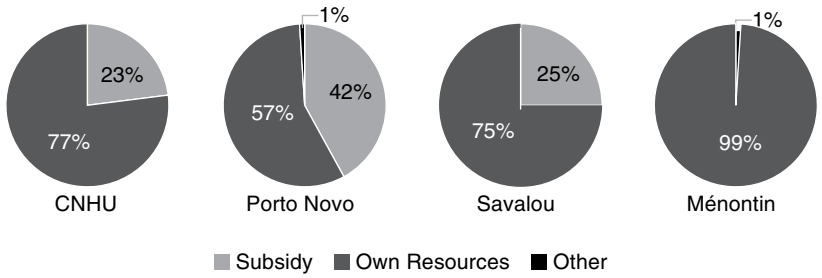
Hospital financing follows a hybrid model that combines a government subsidy with own resources. Benin's hospitals have three main sources of financing: (i) an operating subsidy from the state; (ii) revenues from care delivery; and (iii) profits from the resale of drugs. The relative share of these resources varies among hospitals. For example, own resources make up 57 percent of the budget of the Porto Novo department hospital (care delivery and drug sales), 75 percent of the Savalou zone hospital's budget, and 77 percent of the budget of the National University Hospital (CNHU) (Figure 4). In contrast, the Ménontin private hospital operates practically without state support and covers personnel costs and other expenses such as water and electricity.

FIGURE 3: Health Budget Share in Benin's Budget



Source: Republic of Benin, Ministry of Health.

FIGURE 4: Distribution of Hospitals' Financial Resources in Benin, 2012



Source: Activity reports of hospitals, World Bank compilation.

Most health financing in Benin remains the responsibility of households, and only a small percentage of the population benefits from social protection measures. According to the national health accounts (Republic of Benin 2013), households paid for 40 percent of health expenditures in 2013. Moreover, according to the number of beneficiaries, less than 20 percent of the population benefitted from social protection schemes. Beneficiaries include civil servants who are covered by the state and whose reimbursement to hospitals is deferred, as well as employees of private companies who contribute to mutual health insurance plans.[28] Yet the financial burden on citizens is not significantly reduced by such schemes, as the majority of social protection measures cover only minor risks (such as primary curative care, pre/postnatal consultation, normal delivery, and essential medicines) that are supported by free clinics and district and communal health centers.

Patients must pay out of pocket for a variety of other services. These include: (i) medicines and consumables; (ii) supplementary services for the patient and those who accompany them; (iii) official fee surpluses such as the surcharge imposed by nonprofit private facilities to cover free cesarean sections, which is justified by the insufficient compensation received for this procedure;[29] and (iv) hidden payments such as gratuities and bribes, which could be particularly frequent and significant in the public service.

Infrastructure and Equipment

Hospitals are organized according to a pyramidal structure with three levels of specialization and equipment. The tiers adhere to a referral and

28 Such plans have been in place since the 1990s. In 2010, there were approximately 201, compared to 11 in 1997.

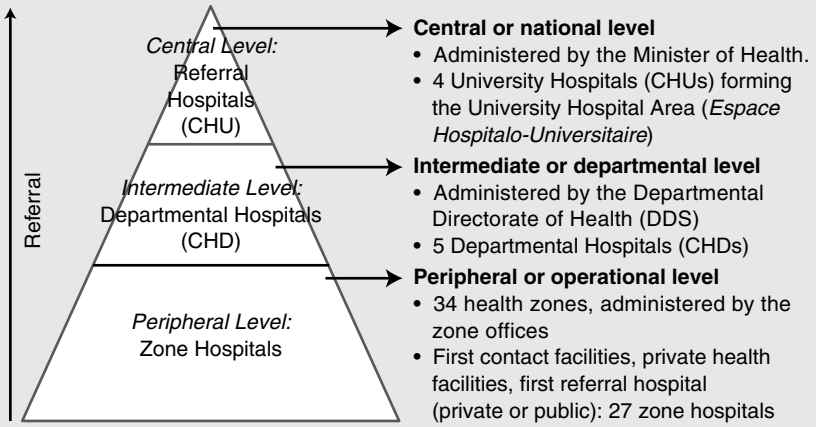
29 The actual cost of a cesarean section would be CFAF 135,000, but the government's reimbursement rate is only CFAF 100,000.

counterreferral system in order to ensure continuity of care between the levels given the available technical facilities and resources (Box 25):

- ***Central level:*** composed of facilities with efficient equipment and qualified human resources such as university hospitals (CHUs), coordinated by the Ministry of Health
- ***Intermediate level:*** composed of departmental hospitals (CHDs), coordinated by the Departmental Directorates of Health (*Directions Départementales de la Santé*, DDS)
- ***Peripheral level:*** composed of first contact facilities, coordinated by zone offices.

BOX 25

Health Pyramid in Benin



Source: World Bank compilation from national health policies.

These levels follow the territorial division of the hospital system, which is organized into health zones. There are 34 health zones (Annex 5) outlined on the basis of five criteria: population, geographical accessibility, sociocultural affinities among the population, availability of health facilities, and alignment with administrative divisions. In 2013, 27 of the 34 health zones had a hospital that was endowed, in theory, with the necessary resources. In practice, however, not all of them are functional, as some zone hospitals and CHDs lack adequate human resources or sufficient equipment.

Benin has a total of 36 hospitals. They include 27 zone hospitals at the peripheral level, five CHDs at the intermediate level, and four CHUs, forming the university hospital area at the central level (Annex 6).

Traditional medicine also plays a role in health care delivery. As part of the promotion of traditional medicine, the Ministry of Health works to develop local therapeutic resources, and traditional healers can be represented on boards of directors. The Pharmacopoeia and traditional medicine play important roles in health care delivery.

Projects are envisaged to address the technological deficiencies that lead to the transfer of patients abroad. Some patients with conditions that cannot be treated due to a lack of technical facilities and/or specialized medical skills are often transferred to foreign health facilities. As a response, the idea of a national referral hospital was born. It is envisaged that this facility, which is currently at the project stage, will be run as a public-private partnership.

Existing infrastructure and equipment are not highly developed technologically. To take a few examples, to date, the country has no magnetic resonance imagining (MRI), no coronary angiography equipment, and no neonatal resuscitation. Some specialties, such as nuclear medicine, have no equipment, even though specialists have been trained abroad.

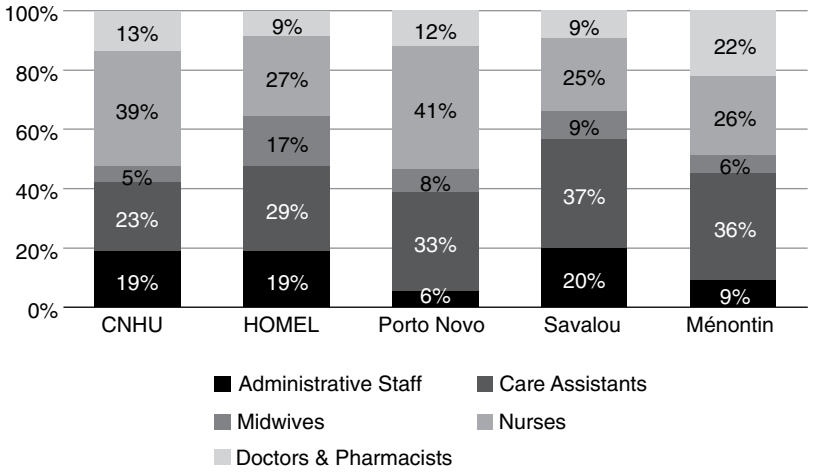
Human Resources

Hospital staff includes medical, paramedical, and administrative staff. Administrative staff make up around 20 percent of the total, except in the private hospital of Ménontin and, more surprisingly, at the Porto Novo departmental hospital, where their share is much lower. Conversely, while medical staff comprise a particularly high share (22 percent) of hospital employees in Ménontin, they remain below 14 percent in the public sector, including at the CNHU (Figure 5).

The state is the largest employer of hospital staff. Although the statutory distribution varies among hospitals, most staff are state employees (Figure 6) with the exception of the private hospital of Ménontin and at the HOMEL maternity hospital, which apply a quality delivery policy and recruit qualified staff using own resources.

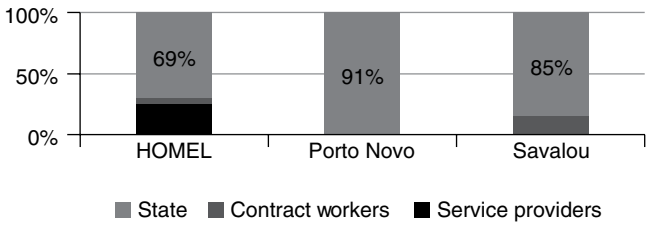
Overall, hospitals report a shortage of staff, especially skilled personnel. The ratio of staff to the number of beds ranges between 1 and 1.7. The HOMEL maternity hospital is an exception, given the additional capacity required to care for mothers and newborns. At 8.6 workers per 1,000 inhabitants, the number of qualified health care workers in the health system is below the WHO recommendation of 25. The geographical distribution of workers is highly uneven.

FIGURE 5: Staff Distribution in Hospitals in Benin, 2012/2013



Source: Activity reports of hospitals, World Bank compilation.

FIGURE 6: Distribution of Staff at HOMEL, Porto Novo, and Savalou Hospitals, 2012/2013



Source: Activity reports of hospitals, World Bank compilation.

Beyond this quantitative deficit, there are issues with managing and mobilizing human resources. Challenges include: (i) unattractive employment conditions; (ii) unsatisfactory conditions for the integration of contract workers into the public service; (iii) obstacles to penalizing staff who fail to perform their duties properly (some staff do not take up their posts when assigned to peripheral areas); and (iv) the effect of "moonlighting" in private practice at the expense of the public hospital service. Extending profit-sharing incentive measures to the majority of zone hospitals and CHDs could help to address these dysfunctions.

Service Delivery Performance

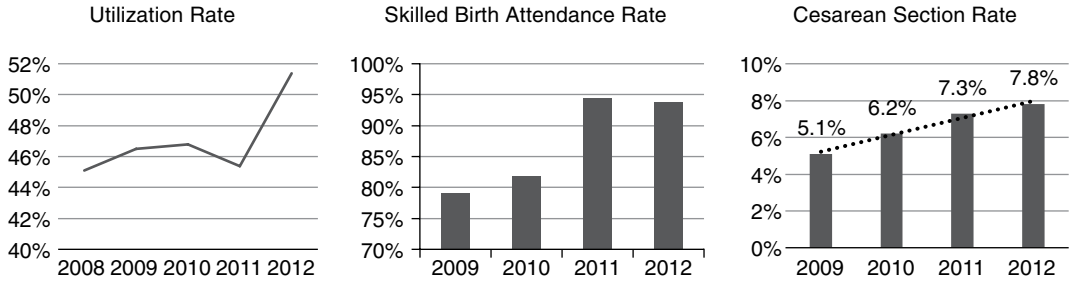
Health statistics[30] show an increase in health care delivery between 2008 and 2012. The rate of utilization of health services (as measured by the ratio of patients to total population) increased by 13 percent between 2008 and 2012. In addition, the growth in rates of assisted deliveries and cesarean sections reflects improved user confidence in the health system (Figure 7). Annex 7 provides a detailed analysis of these indicators.

Hospital activity indicators show a growth in bed occupancy from 30 percent to 57 percent between 2010 and 2012. This trend was observed in most of the facilities visited, including the HOMEL maternity hospital, the CHDs, and the zone hospitals except for Ouidah, which may be at a disadvantage given its relative distance from its population pool.

While the overall increase in activity is incontestable, it appears to be differentiated between private and public hospitals. Private hospitals, like Ménontin, appear to be fully occupied, whereas public facilities seem to have greater capacity than their occupancy rates. This is the case at the CNHU, where available beds and equipment are not fully utilized. For example, the recently installed 16-bar scanner could easily perform three to four times more examinations than it does.[31]

Efforts to strengthen the accessibility of health care through free cesarean sections or the Universal Health Insurance Scheme partly explain the growth in health service utilization. While free cesarean sections are practically universal, the Universal Health Insurance Scheme remains at the pilot stage. The latter aims to regulate, control, and

FIGURE 7: Utilization, Skilled Birth Attendance, and Cesarean Section* Rates in Benin



Source: Republic of Benin, Ministry of Health. *National Data.

30 The statistics presented refer to annual health statistics prepared by the Ministry of Health and relate to the health system as a whole.

31 This scanner performs 2,000 annual examinations at the CNHU, whereas the average activity for this type of device would exceed 8,000 examinations. ANAP (2010).

coordinate coverage mechanisms for health risks at the national level. It should be expanded to allow for free treatment in public facilities, provided that membership and regular payment of contributions are guaranteed. It is envisaged that vulnerable people would not have to pay contributions.

Financial Performance

Procedures for budget preparation and expenditure validation seem to be well followed. The process includes the following steps: department budget requests, arbitration, financial translation of requests, and submission to the board of directors for validation. It is described in detail and in accordance with the law. The executive management plays a key role in the preparation of the budget, in collaboration with the head of the administrative and economic affairs department and the head of the financial affairs department, and in consultation with the chair of the medical commission and the general nurse. The composition of the board of directors enables the Ministry of Health representative to ensure that the hospital complies with the national health policy. Moreover, in the zone hospitals, the presence of community representatives makes it possible to defend adjustments to the budget.

Budget execution is not always in line with budgeted amounts, especially in zone hospitals. In the central and departmental hospitals, executed budgets are close to budgeted amounts. This is the case at the Porto Novo departmental hospital, where operating income amounted to CFAF 1,123 million in 2012 as compared to the budget projection of CFAF 1,200 million. Larger gaps are observed in some zone hospitals, however, due to social movements that have disrupted hospital utilization.[32]

Drug procurement represents the largest expenditure item. Purchases constitute the main operating expenditure, of which the pharmacy forms a major part (58 percent in Savalou). However, drug procurement can generate proportional income if distribution and stock are well managed.

RBF has strengthened financial performance monitoring in hospitals. This mechanism, which links financial incentives and outcomes, empowers and motivates the facilities and their staff. Expected results include increased health service provision and improved service quality, as measured through defined monitoring indicators and targets. Zone

32 The gap may be explained in part by projecting "desired" rather than "achievable" amounts. This is the case for the Ouidah hospital, whose 2014 amount was set at CFAF 750 million (compared to CFAF 500 million in 2013), including an investment forecast of CFAF 250 million (compared to CFAF 50 million in 2013) without specifying additional funding sources.

hospitals have been subject to monthly verification of reported performance and assessment of the quality of care and services since 2012.

Investments remain limited. Investment projects account for only about 8 percent of budget resources for the CNHU and the Porto Novo departmental hospital. The government's contribution to large investments is also limited.

The limited focus on investment provides a partial explanation for the deficiencies in infrastructure and equipment. In the hospitals visited, the technological development of infrastructure and equipment was low, and many facilities did not have the basic equipment needed to ensure satisfactory care.

CHAPTER 2.2

Legal and Regulatory Framework

Health Sector Legal Framework and Decentralization

The state guarantees the protection of the health of the population. Article 8 of the Constitution provides that the state shall ensure equal access to health care for all its citizens, through the development of a government-run public hospital sector designed to provide low-cost public health care.

The 1999 reform of Benin's territorial administration deconcentrated the department's authority and transferred health sector mandates to municipalities. Law No. 97-028 of January 15, 1999, reorganized territorial administration into three areas: territorial division, administrative deconcentration, and decentralization. The territorial division increased the number of departments from six to twelve. Administrative deconcentration allowed the transfer of responsibilities and powers to the departments, and decentralization led to the devolution of responsibility to the municipalities. In the health sector, municipalities were granted power over the construction, equipping, repair, and maintenance of public health facilities

in the district or neighborhood, but no power was transferred regarding their management.

This reform was accompanied by a reorganization of the health sector into three levels. The three levels apply to both the health care side and the administrative side (Box 26; Part 2.1; Annex 6).

BOX 26

Pyramidal Organization of the Sector of Health in Benin

	Peripheral	Intermediate	Central
Administrative	• Health zone office (34 health zones)	• 6 Departmental Directorates of Health (DDS)	• Ministry of Health • Central directorates
Health Care	• Zone hospitals • First-level health facilities (Commune and District Health Center, private health facilities, Village Health Units)	• 5 departmental hospitals (CHD)	• University hospital

Source: Legal texts.

Management and decision making are driven by the respective central or deconcentrated oversight entities:

- At the health zone level, the management board, the health committee, and the health zone management team administer the hospital and health zone. The health zone management team is led by a coordinating physician and includes several health, administrative, financial, and technical executives. The zone office reports to the DDS.
- At the intermediate level, coordination is carried out by the DDS, which is responsible for adapting national strategic approaches to the regional context, monitoring standards, and providing technical support to zone hospital management teams. The relevance of this intermediate level is not evident to the hospitals, since the DDS directors are often general public health doctors who are not always aware of hospital problems.

- At the central level, which is responsible for health development policy design and decision making, overall coordination is provided by the minister's office, the general secretariat, and the central directorates.

Legal Structure of Hospitals

Status of Hospitals

Departmental hospitals (CHDs) have the status of a semiautonomous facility. According to Decree No. 90-347 of November 14, 1990, the CHD, whose decision-making body is the board of directors, is chaired by a representative of the Minister of Health and has only limited autonomy with regard to investments and employment.

Other hospitals are structured as social, cultural, and scientific offices (*offices à caractère social, culturel et scientifique*). They were created through Law No. 94-009 of July 28, 1994, and are endowed with legal personality and financial autonomy.

The zone hospital has a legal personality and, in principle, enjoys management autonomy. According to Decree No. 2002-0113 approving their status, zone hospitals are intended to have management autonomy under the administrative and technical oversight of the Ministry of Health. The zone hospitals are administered by a deliberative institution known as the management board, the members of which are appointed by order of the Minister of Health. In practice, however, public zone hospitals enjoy little management autonomy, because employment and investment decisions are made mostly by oversight authorities.

The National University Hospital (CNHU) and some other health facilities are organized according to a specific status. The CNHU has undergone several changes in status since 1962, most recently in 2012 (Annex 8). The CNHU is the only health facility in Benin with real management autonomy, as reflected in the composition of its budget and staff. The government subsidy makes up only 12 percent of its financial resources, and nearly 90 percent of staff are contracted and paid directly by the hospital.

In practice, the legal status of hospitals is closer to a deconcentrated service of the state than to an autonomous agency. Apart from the CNHU, the management of health facilities depends directly on the Ministry of Health or the administrative subdivision that represents it, the DDS. The manager of the hospital and the majority of staff are appointed directly by the central level. Boards of directors at the central and intermediate levels are chaired by representatives of the Ministry of Health. Investment is

managed by a central directorate within the Ministry of Health and its deconcentrated representatives, and public finance rules apply.

Employment Regime

Most hospital staff are public employees. Public hospitals employ four categories of personnel who are recruited at the central and local levels. The first two categories, composed of public servants, are the most prevalent. The latter two categories are being progressively integrated into the civil service and are thus becoming less common.

- ***Permanent state agents (APEs):*** These staff are governed by statutes specific to their department, and assessment of their productivity can be conducted only according to the standards and procedures of the civil service. APEs include teachers in the Faculty of Health Sciences, who are responsible both for teaching and for providing health care, but are under the management of the Ministry of Higher Education and Scientific Research. This dual reporting line poses a problem for the Ministry of Health's authority over their health care activities.
- ***Contractual state agents (ACEs):*** These workers are recruited by the Ministry of Civil Service (MFP) on two-year renewable contracts that are managed by the MFP. ACEs may become permanent staff after a four-year service period.
- ***Contractual agents hired as part of a special program called "Social Measure":*** These are government-funded positions financed through resource allocations under the social measures taken by the government in 2000. Their administrative situation is precarious, as the renewal of their contracts for the following year depends on the availability of appropriations made for this purpose.
- ***Contractual agents hired with community funds:*** These workers are recruited by health facilities, using resources obtained through the cost recovery policy, to fill gaps in the number of APEs. Contractually, they are under the direct authority of the management committee of the health center or the head doctor.

Accounting

Accounting and budget rules are outlined in Decree No. 90-347 on the management and financing of health facilities. This decree remains in force despite significant reforms undertaken since its publication. The decree establishes a budgetary and accounting nomenclature referring to

the national accounting plan. In addition, it entrusts to the manager of the facility, who is the chief authorizing officer of the budget, the responsibility of establishing an accounting of expenditures incurred, ignoring the distinction between authorizing officer and accounting officer.

Accounting is the responsibility of an accounting officer, under the authority of executive management. Law No. 94-009, together with subsequent decrees regulating the status of various health facilities, foresees the appointment of an accountant by the Ministry of Finance on the basis of a proposal made by the oversight ministry. However, the accounting officer is placed under the authority of the executive management of the health facility.

The accounting system applied is SYSCOHADA. The accounts of the zone hospitals and the departmental hospitals are managed by an accounting officer in accordance with the international principles and standards incorporated into SYSCOHADA. The hospital is required to follow an accrual accounting system rather than cash accounting, entries must be based on valid supporting documents, records must be kept chronologically in approved accounts included in the chart of accounts, and statements of accounts are prepared on a monthly basis. The accounting process is handled by the head of the administrative and financial affairs department, who performs the accounting entries, records them in the manual books, enters the accounting inputs into the system, and prints the data. He or she publishes the monthly general balance and analyzes the accounts month by month.

At the CNHU, accounting treatment is provided by a public accountant attached to the executive manager. Appointed by the Minister of Finance at the request of the Minister of Health, the accounting officer has the status of a public accounting officer and is required to take an oath before the competent court and to secure a surety bond. The accounting officer is attached directly to the executive manager, not to the Ministry of Finance.

There is no harmonization of accounting rules and practices, and hospitals do not have an integrated accounting and administrative management system. Notwithstanding the SYSCOHADA chart of accounts, which defines the nomenclature of key accounts, the accounting treatment is not harmonized in the sub-accounts, causing accounting to vary considerably between hospitals. In addition, there are no standardized financial and human resource management systems. Accounting systems differ significantly from one facility to another, ranging from simple manual processing to more or less fragmented computerized processing. Only two zone hospitals, including that of Savalou, use an integrated computerized management system.

Legal and Regulatory Challenges

The legal framework is scattered in different texts, making it difficult to monitor its implementation. Although comprehensive laws, regulations, policies, and strategic plans have been adopted in some areas, the overall legal framework is fragmented and comprises a multiplicity of regimes, undermining the legal certainty of hospital governance and making interventions less predictable.

Shortcomings identified in previous diagnoses regarding the application of laws and regulations remain. Stakeholders mention an incomplete application of laws and regulations due to limited political will, capacity constraints, and insufficient material and human resources, in particular within control bodies such as the ministry's general inspectorate. Difficulties in applying the texts are illustrated in the evaluation report of the management of the Comé zone hospital (Box 27).

BOX 27

Issues with Implementation of the Law—The Case of Comé Hospital in Benin

- Failure to set up certain entities
- Noncompliance of administrative acts with legal texts
- Unsustainable implementation of directives with regard to exemptions and fee waivers
- Lack of upgrading of professional standards and absence of management tools
- Absence of counterreferral systems
- Underdevelopment of the health information system due to inadequate production, dissemination, and use of information
- Ineffective approach to ensuring the quality of care
- Lack of plans for staff training and continuous improvements in service quality

Source: Ahanhanzo, Ouédraogo, and Saizonou (2014).

CHAPTER 2.3

The State's Oversight Function

Organization of Hospital Oversight

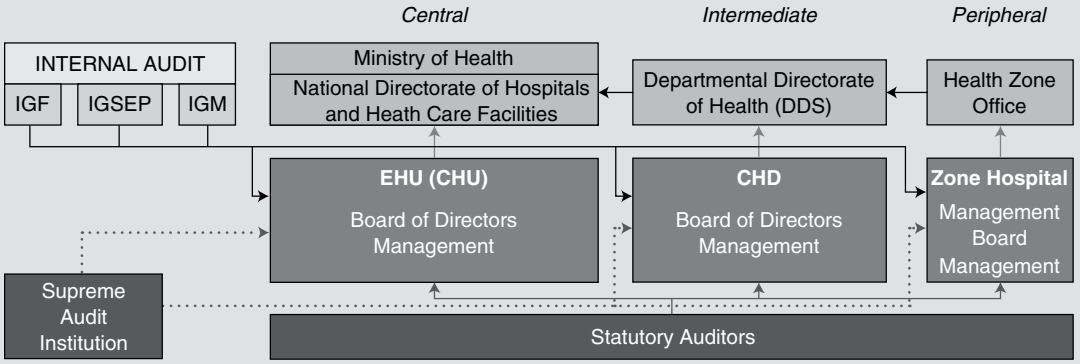
Oversight of hospitals is carried out by the Ministry of Health.[33] Law No. 94-009 stipulates that offices are subject to the supervision of the oversight minister (Box 28). Supervision is exercised primarily to check whether the objectives set for the offices are in line with government guidelines and to ensure the quality of management of the office. It initiates health activities and plans, coordinates, and monitors the implementation of activities. Article 3 of Decree No. 90-347 approving the statutes of the CHDs places them under the supervision of the Minister of Health.

Oversight at the central level is divided among different ministerial departments, and at the local level between the DDS and the health zones. At the central level, technical oversight is exercised through several technical and central departments of the Ministry of Health, while financial supervision is exercised mainly by the Directorate of Financial Resources and Materials (DRFM). At the departmental and health zone level, oversight is provided by the DDS and the zone offices (Box 29).

33 In terms of SOE corporate governance, this would be considered a "decentralized model" of oversight, since it is led by a line ministry.

BOX 28

Oversight System of Hospitals in Benin



Source: World Bank compilation. Note: IGF = General Inspectorate of Finance; IGSEP = General State Inspectorate of Service and Public Employment; IGM = General inspectorate of Ministry; EHU = University Hospital Area.

The Ministry of Health's oversight is exercised by transmitting the minutes of board of directors' meetings to oversight authorities. Legal texts provide for the preparation of a detailed report on the deliberations of central and intermediate hospitals' boards of directors, upon receipt of which the Minister of Health has 15 days to decide on the approval, suspension, or cancellation of the report. After this point, the deliberations become enforceable. In the case of zone hospitals, only the preparation of a report is required, with no power of suspension, cancellation, or approval.

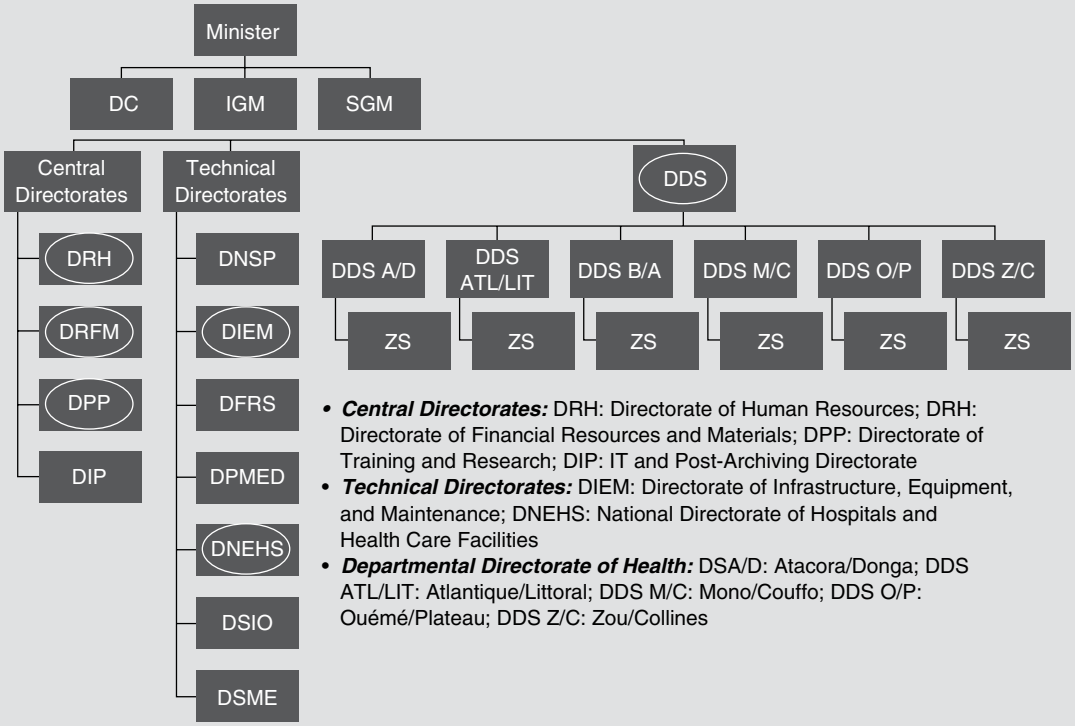
National Directorate of Hospitals and Health Care Facilities (DNEHS)

The National Directorate of Hospitals and Health Care Facilities (DNEHS) coordinates hospital activity with the help of other directorates. Created in 2005 under the name of Hospital Directorate, the DNEHS is, according to the legal texts, the pivot point for hospital oversight. It is responsible for:

- defining and designing the national policy on hospital and health care facilities;
- defining standards for curative care;
- coordinating, monitoring, and evaluating implementation of the national policy;
- working with hospitals and health care facilities;

BOX 29

Organizational Chart of Benin's Ministry of Health



Source: Ministry of Health website, http://beninmoh.eu5.org/index1.html.

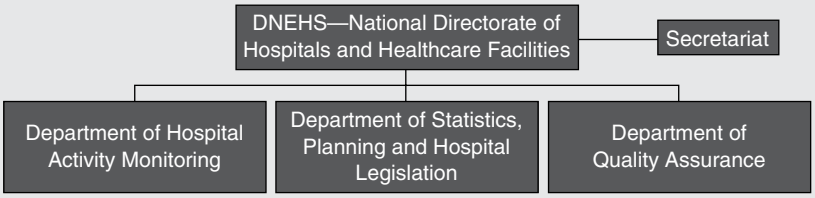
- collaborating with the Directorate of Infrastructure, Equipment, and Maintenance (DIEM) on all aspects of infrastructure, medical and technical equipment, and hospital maintenance; and
- collaborating with the Ministry of Higher Education and Scientific Research and the Ministry of Secondary Education, Vocational Education, and Technical Training on the core training of health personnel.

The DNEHS is divided into several services. Following an organizational chart redefined by the decree of December 9, 2013, only slightly over a year after the reorganization of the ministry as a whole, the DNEHS consists of:

- a secretariat;
- a Department of Hospital Activity Monitoring;

BOX 30

Composition of the DNEHS



Source: Legal texts and interviews.

- a Department of Statistics, Planning, and Hospital Legislation, including the Department of Hospital Facilities and the Department of Hospital Legislation and Care, which continue to operate according to the rules established prior to the reorganization; and
- a Department of Quality Assurance (Box 30).

The Department of Statistics, Planning, and Hospital Legislation is responsible for planning and statistical monitoring, as well as the organization, supervision, and control of hospital activities. This department, which is the reflection of the Directorate of Programming and Planning (DPP) within the DNEHS, is expected to coordinate the development of hospital projects and carry out most oversight functions. In particular, it is responsible for implementation of the national hospital policy, organization of the public hospital civil service, supervision of hospital management, institutionalization of new therapeutic services, monitoring of compliance with standards and legislation, contracting with the private sector, and monitoring and enforcing activities defined in the hospital health map.

The DNEHS has neither the institutional visibility nor the capacity to fulfill the role described in the legal framework. The DNEHS, with only 18 out of the 500 staff in the Ministry of Health, has limited institutional capacity to fulfill its mission. In practice, the coordinating role described in legal texts is reduced to a supporting role vis-à-vis directorates with greater decision-making power. Most hospitals are not familiar with the DNEHS. They do not transmit to DNEHS their budgets after adoption by the boards or their activity reports. Coordination with DIEM is essentially nonreciprocal. In addition, technical oversight of nursing and obstetrics care is provided not by the DNEHS but by the Directorate of Nursing and Obstetrics. Similarly, human resources fall under the leadership of the Directorate of Human Resources (DRH).

Role of Other Central and Technical Directorates

Technical oversight is carried out in practice by the Directorate of Programming and Planning. The DPP (a central directorate) is responsible for managing the ministry's planning process[34] and is, together with the DRFM, the heart of the oversight function. It is responsible, *inter alia*, for the: (i) collection, processing, and dissemination of information needed to define and monitor health policy; (ii) development of strategic and operational plans for the sector; (iii) monitoring and evaluation of the program budget; and (iv) mobilization of financial resources. The DPP is the *de facto* driver of technical oversight for the sector as a whole, including hospitals. It receives statistical data from hospitals and consolidates them into the health statistics yearbook. In collaboration with the DRFM, the DPP prepares the annual performance report for the Ministry of Health, including a summary of activities that have been implemented in the sector.

The DPP manages the National Health Information and Management System (*Système National d'Information et de Gestion Sanitaire*, SNIGS). A critical tool for sector planning, the SNIGS was established in 1990 and is attached to the DPP. The system collects information on:

- health system management, including information on human resources, equipment and materials, pharmaceuticals, and financial data;
- health care services such as the number and type of consultations performed (including diagnosis and associated prescribed treatments), hospitalizations, surgeries performed, diagnostic activities (including biological services, medical imaging, and transfusion), and monitoring data, particularly those associated with major communicable diseases; and
- child and maternal care, family planning, and nutrition services provided by the health system.

Financial oversight is carried out by the Directorate of Financial Resources and Materials. As the Ministry of Health's authorizing body, the DRFM is responsible for designing, implementing, and monitoring regulations, standards, and procedures with regard to the Ministry of Health's budgetary, financial, and material resources. Its duties include:

- establishing and enforcing rules, standards, and procedures regarding the management of budgetary, financial, and material resources applicable to all central and decentralized structures of the Ministry of Health;

34 According to the decree on responsibilities, structure, and functioning of the Ministry of Health.

- ensuring the accounting and financial administration of all credits and financing made available to the Ministry of Health, maintaining the related cost accounting, and controlling the management of deconcentrated units;
- mobilizing and monitoring the optimal use of financial resources in collaboration with the DPP and with other directorates of the Ministry of Health;
- centralizing resource needs and the acquisition and allocation of supplies;
- coordinating the preparation of the minister's budget proposals in collaboration with the DPP and the central, technical, and department directorates;
- assisting the minister in budget conferences and participating alongside central, technical, and department directorates in all meetings or work dealing with budgetary, financial, and material resource-related matters of the Ministry of Health; and
- tracking the financial execution of public procurement contracts.

The Directorate of Human Resources is responsible for the strategic and administrative management of state personnel assigned to the Ministry of Health. The DRH is in charge of managing and monitoring careers, forecasting and recruitment, litigation, and disciplinary cases. In the absence of a human resources department within the DNEHS, the DRH of the Ministry of Health oversees human resources policy for the entire hospital sector. The incentive and advancement policy is decided at the central level.

The Department of Infrastructure, Equipment, and Maintenance implements the health ministry's investment policy in public hospitals. The DIEM is responsible for designing, monitoring, and evaluating civil engineering activities such as construction, rehabilitation, and maintenance. It is also responsible for the management and maintenance of the Ministry of Health's medical and technical equipment and plays a critical role with regard to investment. The DIEM operates with a staff of nearly 50, including those in the Infrastructure, Equipment and Maintenance Departments of the DDSs as well as maintenance correspondents in the zone offices.

Challenges Related to the Oversight of Hospitals

Hospital oversight is weakened by fragmentation. The Ministry of Health and its local representatives are expected to ensure oversight of the public hospital sector. However, the central directorates involved in

oversight operate as full ministries, at least with respect to the DNEHS. The result is fragmentation in the definition and implementation of hospital policy in the context of limited exchange of information between the decision-making bodies in hospitals and in the Ministry of Health.

The DNEHS is not well known and does not play a leading role in hospital oversight. The DNEHS was established recently and does not yet have the visibility to steer the sector, further accentuating the fragmentation in the oversight function.

CHAPTER 2.4

Planning and Performance Monitoring

Planning Framework

Health Sector Planning Framework

The general objective of the Ministry of Health is contained in the National Health Development Plan (PNDS), which envisages an effective health system by 2025. To achieve this goal, five objectives have been identified: (i) reducing maternal and infant mortality, preventing and controlling disease, and improving the quality of care; (ii) enhancing human resources; (iii) strengthening partnerships in the sector and promoting ethics and medical deontology; (iv) improving sector financing mechanisms; and (v) strengthening management of the sector (Republic of Benin 2009).

The PNDS underscores the intention to put in place a results-based management governance system. The improvement of governance and resource management in the health sector is targeted through two objectives: the improvement of financing mechanisms and the strengthening of sector management. To this end, the plan envisages the implementation of "a management system based on a culture of performance, accountability, and results orientation."

Hospital development is a key aspect of the PNDS. To improve the quality of the services provided, the PNDS foresees:

- the establishment of specialized centers;
- the strengthening of hospital communications;
- the development of a partnership between hospitals and external collaborators;
- the implementation of an effective system to manage hospital information and monitor and evaluate client satisfaction;
- the efficient management of resources;
- the development and implementation of a national plan for the development of hospital technical facilities;
- the revision and completion of tools for equipment management;
- the establishment of a system for the redeployment of equipment in hospitals;
- the development, implementation, and evaluation of new norms and standards for the infrastructure and equipment of public and private hospitals;
- the development of appropriate maintenance strategies;
- the implementation of a preventive maintenance program in hospitals; and
- the efficient management of obstetric emergencies.

This hospital development is intended to be undertaken through a program of "hospital reform." The reform envisages the following activities: (i) a regulatory review, including the formulation or updating of legal texts (although no guidelines have been adopted yet); (ii) the implementation of a system of vertical and horizontal complementarity between public and private health facilities at all levels; and (iii) the construction of centers of excellence in the hospital subsector.

The PNDS stresses the importance of human resources development. The PNDS is accompanied by a 2009–2018 Strategic Plan for the Development of Human Resources in the Health Sector, which aims to improve planning, to strengthen staff and personnel skills, and to strengthen the partnership between internal and external actors with regard to health human resources and the development of human resources research.

Performance-based financing is a central aspect of the Health System Strengthening Project (PRSS). It aims to increase the accountability and motivation of hospitals and their staff and to contribute to the achievement of the Sustainable Development Goals. It covers 29 health zones. The project combines performance bonuses with investment and technical assistance through a contract linking financial incentives and results.

Hospital Planning at the Hospital Level

Hospitals formulate a short-term planning document called Annual Work Plan. It is centered on the current year and does not include multiyear planning. With the exception of an initiative supported by Belgian Technical Cooperation and carried out in a few facilities, hospitals do not develop medical strategies, hospital strategies ("*projets d'établissement*"), or master plans. This is due in particular to their limited control over their own development and financing capacities.

Multiyear planning is hampered by hospitals' limited decision-making power over investments and human resources. Hospital management teams face difficulties in planning the evolution of their care offerings and technical facilities, because a significant part of their investment budget is out of their control. Forward planning of jobs and skills is limited, as recruitment and assignments are decided mainly at the central level. Hospitals only have flexibility in the mobilization of community financing.

Performance Monitoring: Results-Based Financing

An evaluation of the health system in 2006 identified the weaknesses of the input-based financing system, which did not do enough to motivate health personnel to use available resources to achieve expected results. In response, the evaluation recommended the implementation of measures to initiate a transition toward results-based management (Box 31).

Benin, in collaboration with donors, has made a commitment to experiment with RBF. In 2010, the government and its donors signed a compact agreement to harmonize procedures, budgeting, and monitoring and evaluation, based on the main national plans.[35] This agreement, implemented under the PRSS, aims to implement RBF in all 34 health zones with support from various partners: Belgian Technical Cooperation (5 zones), the World Bank (8 zones), the Global Alliance for Vaccines and Immunization (Gavi, 4 zones), and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (17 zones).

RBF was launched in Comé in 2010 and gradually extended. A pilot of "performance bonuses" was implemented in the Comé health zone in 2010 with the support of Belgian Technical Cooperation. It was subsequently

35 These include the PNDS 2009–2018, Triennial Development Plan 2010-2012, and the Medium-Term Expenditure Framework for 2010–2012. EEZS: Management team of health zone. UCP: Communal union of producers. DDS: Departmental Directorate of Health.

BOX 31

Recommendations of the Health System Rapid Assessment in Benin

- **Establish a contractual system for transferring resources, including performance requirements that correspond to health system objectives.** These resource transfers may take the form of "internal contracts" between the Ministry of Health and the public health facilities in the relevant health zones, or "external contracts" with private entities. At this level, performance-based financing promotes motivation for achieving results, not at the individual level, but at the team or institution level.
- **Define incentives for motivation and deterrence to adopt appropriate behaviors.** In addition to contracting mechanisms, other incentives can be developed to encourage personnel to accept positions in the periphery as well as disincentives in case of refusal. This also entails the implementation of sanctions in the event of inappropriate behavior of health workers, ensuring the systematic application of sanctions, decentralizing sanctioning authority, and strengthening audit and monitoring systems.
- **Clarify the definition of the organization of services delivery.** The creation of motivational and deterrent measures to encourage good behavior and performance requires a more explicit definition of what constitutes a "good organization of services" and the specification of norms determining what needs to be done in a health facility and with what type of staff. This requires a clear vision of what is happening at the service delivery point so that local-level priorities match the real needs of the local population.

Source: Adeya et al. (2007).

extended as part of the Mono-Couffo and Atacora-Donga Health Zones Strengthening Support Project (PARZS) in 2012. Subsequently, RBF was officially launched in January 2014 in the five health zones supported under PARZS (Box 32).

The World Bank's PRSS spends US$ 18 million on the RBF component. RBF covers a total of eight health zones, comprising 189 health facilities.

The RBF governance framework distinguishes among the program's various functions. The implementation framework (Box 33) separates the

BOX 32

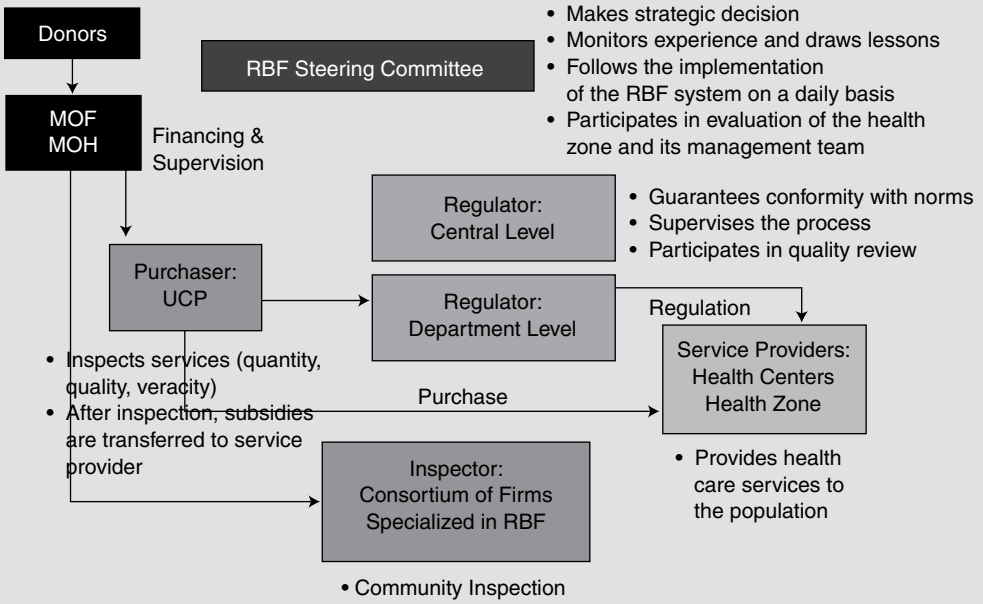
Objectives of the PARZS in Benin

- To contribute to the implementation of the PNDS through the implementation of an effective local health system in the five health zones and two DDSs
- To provide strategic and technical support to health zones and ensure effective communication between the central level and the peripheral level; and at the level of the Departmental Directorates of Health

Source: PARZS.

BOX 33

RBF Implementation Framework in Benin



Source: Republic of Benin, Ministry of Health (2014). EEZS: Health Zone Management Team; UCP: Program Coordination Unit.

functions of regulation, delivery, contracting and verification, funds payment, and strengthening voice among members of the community.

Performance is assessed on the basis of quantitative and qualitative performance indicators. The former aim to reward health facilities according to their workload, while the latter aim to avoid a "race to production" to the detriment of the quality of care. The list of selected indicators for hospitals is presented in Annex 9.

The financing contract provides for the submission of monthly reports by hospitals and controls carried out by independent teams. Quantitative indicators are checked for consistency between the results reported and the facility's registers, including verification that the activity recorded in a register has been carried out through visits to a random sample of patients' homes. For qualitative indicators, the Ministry of Health ensures that they are measured on a quarterly basis by independent teams based on a checklist, and that they are subject to cross-verification on a semiannual basis (through outgoing patient surveys and stock and registry controls, for example) at a random sample of facilities, based on surprise visits.

Challenges Related to Result-Based Financing

Several challenges have arisen in the implementation of the RBF program. These challenges include, but are not limited to:

- the need to adjust indicators;
- the sharing of good practices;
- the need to review the framework's provisions regarding new regulatory structures; and
- the need to involve other sectoral ministries in an effort to promote sustainability.

There are questions as to the sustainability of the system for allocating RBF credits once donors withdraw. RBF credits can be allocated to two broad expenditure categories: (i) a maximum of 50 percent of RBF funds can be directed toward premiums for health workers; and (ii) a minimum of 50 percent of the credit must be allocated to operating and capital costs. With regard to staff costs, it is expected that RBF funds will be used as a bonus for collective rather than individual performance, and distributed among staff on the basis of their professional category, base salary, and level of responsibility. If donors withdraw or reduce their engagement, the lack of sustainability regarding wage incentives could lead to social tensions.

CHAPTER 2.5

Boards of Directors and Executive Management

Boards of Directors/Management Boards

For the CNHU, CHUs, and CHDs, the decision-making body is the board of directors. The relevant ministries are represented, either directly or through their representatives at the department level. The Ministry of Health representative serves as board chair. Representatives of the local government and the community sit on the board. Traditional practitioners are also included in health sector planning through participation on the board. It is worth noting that the manager of the department hospital or the HOMEL hospital participates in board deliberations, positioning him or her as both participant in and judge of board proposals.

Zone hospitals are administered by a management board. The management board is composed of representatives of local authorities, structures, and stakeholders contributing to the development and operations of the health zone (Box 34). They are appointed by order of the Minister of Health on the recommendation of the institutions they represent. The term of office is three years and can be renewed once. A representative of the community, via an association, is elected chair of the management board.

BOX 34

Composition of Boards of Directors/Management Boards in Benin

CHU-CNHU Board of Directors	CHD Board of Directors	Zone Hospitals Management Board
• representative of the MOH (Chair) • representative of the Minister of Higher Education (Vice Chair) • representative of the Minister for Finance • representative of the Minister of Labor • representative of the traditional practitioners, elected by his/her peers • Chair of the Hospital Medical Commission • two elected staff representatives • mayor of the town where the CHU head office is located or his/her representative	• representative of the MOH (Chair) • representative of the Minister for Enterprise (Vice Chair) • Departmental Director of Health • manager of the department hospital • tax collector • representative of the Department Prefect • departmental director of labor and social affairs • departmental director of planning and statistics • citizen representative • representative of the Minister of Justice • President of the Advisory Medical Commission • two representatives of CHD staff, including one administrative • representative of development partners • representative of traditional healers	• representative of the departmental director of public health • chair of a management committee of a health district of a commune • current subprefect or a mayor of the municipality • elected donor representative • representative of a nongovernmental organization active in the field of health • elected representative of the private sector • elected representative of the private sector • two staff representatives elected at a general meeting

Sources: Republic of Benin, legal texts.

The boards of directors and management boards have the power to act on behalf of the facility. Their mandate includes, among others: (i) definition of the facility's general policy; (ii) control of financial management; (iii) review of estimated budgets and accounts, and balances from past financial years; and (iv) authorization to take any legal action. For CHUs, this mandate is extended to the examination and adoption of the creation or suppression of university hospitals and nonuniversity hospital posts. For zone hospitals, a strategic plan must be developed in accordance with the development plan of the health zone.

Decision-making power appears to be concentrated at the oversight level, leaving little room for community feedback. Management boards

of zone hospitals, where the communities are represented, have limited autonomy in practice. Moreover, the lack of medium-term prospects or projections limits strategic planning. Hospitals therefore tend to prioritize their activities according to short-term operational constraints.

Executive Management

The executive manager coordinates activities and directs the development of the hospital. Appointed by order of the Minister of Health, the executive manager is responsible for: (i) executing the decisions taken by the board to whom he or she reports; (ii) implementing the decisions of the board; (iii) serving as authorizing officer for the hospital budget and ensuring the execution of revenues and expenses; (iv) exercising authority over personnel employed by the hospital; (v) representing the hospital vis-à-vis third parties; and (vi) attending board meetings in an advisory capacity. The manager is responsible for developing the hospital within the framework of the board's policies and programs. Each year, the manager prepares and submits to the board a proposed program of activities and implementation timetable.

The manager relies on a team whose composition varies with the category of hospital. In a CHD, the management team is composed of the head of the administrative and economic affairs department, the head of the financial affairs department, and the head of medical and technical services. In zone hospitals, this team also includes the head nurse, and in CHUs and the CNHU the head of human resources.

The executive manager is vulnerable to influence. As a hospital administrator, the manager is required to have at least five years of experience in public health and is appointed by ministerial order for an official term of five years. However, subject to the relational and political context, the manager may be transferred to another post without recourse.

Other Bodies: Advice and Control

Executive Committee

The management committee (CODIR) brings together medical, managerial, and management personnel and is consulted on a wide range of issues. Chaired by the manager, it is composed of the management team and two elected staff representatives (in the case of the CHDs). The chair of the

medical commission is also present. According to the legal framework, the CODIR examines all matters relating to the "general organization of work, number of staff, statutes, quality of care, hygiene, safety and the cleanliness of services [. . .], and is consulted on [. . .] budget preparation and the general policy of the institution." The CODIR meets once a month in ordinary session, but can be convened in extraordinary session at the request of the executive manager or a majority of its members. In addition, the CODIR meets every three months in an expanded session that includes the heads of hospital services and the heads of medical and technical services.

Hospital Medical Commission (CHU-CNHU) or Advisory Medical Commission (CHD and Zone Hospitals)

The hospital medical commission or advisory medical commission is responsible for the management of health activities and the functioning of medical and technical services. The commission must be consulted on the organization and distribution of technical services, major maintenance expenses, and procurement and distribution of technical equipment, drugs, reagents, and medical consumables. It is composed of all doctors, surgeons, dentists, and pharmacists, or their peer-elected representatives (CNHU), working in the facility. The chair, usually the head of medical and technical services, is elected by its members (department and zonal hospitals), or by all university hospital members among heads of departments (CNHU). The executive manager attends the deliberations of the medical commission in an advisory capacity. The commission meets in ordinary session at least quarterly and in extraordinary session at the request of its chair or a majority of its members.

In practice, medical commissions appear to have a modest impact. At the CNHU, the medical commission is not operational. At Ménontin, there is no medical commission as it is perceived as a duplication of staff meetings. HOMEL's commission seems to have greater sway, as it provides an opinion on the appointment of technical service managers/chiefs/heads and on medical and technical recruitments. It also establishes the fees for services to be submitted to the board and examines contracts as part of the private practice of doctors.

Commission on Hygiene and Safety

The commission on hygiene and safety, a nonmandatory advisory body, appears to be supplanted by the CODIR. The commission on hygiene and safety is a technical body focused on control, treatment, and promotion of all

matters relating to hygiene and sanitation, waste disposal, safety of persons and goods, and improvement of the work environment. The commission is composed of the heads of medical and paramedical staff, the head of the administrative and economic affairs department, an elected staff representative, and, in the case of CHDs, of the department head of hygiene and sanitation. The commission is often supplanted by the CODIR in most of the areas in which it operates.

By ministerial directive, there is a Committee for the Fight Against Hospital-based Infections in all hospitals. This committee's activity is uneven among hospitals, some of which highlight its role in improving the quality of care while others barely mention it. Few facilities have developed other initiatives, such as the 5S method (HOMEL).

Quality Units

Quality units have been set up in some hospitals on their own initiative. This is the case for the Abomey and Porto Novo department hospitals, as well as HOMEL, which has been a leader in this field: the hospital has been implementing a quality management system since 2003 (Box 35). It is the

BOX 35

Implementation of a Quality Approach at HOMEL Hospital in Benin

- Sensitization of HOMEL senior managers and staff to quality culture
- Training and sensitization of all managers in the Quality Management System
- Designation of a Quality Manager
- Designation of the steering and quality committee by the Quality Manager (10 members)
- Reexamination of the organization chart with the introduction of the "Quality Committee"
- Training of the steering committee in the development of quality documents
- Progressive development of quality documents and validation by the steering committee

(box continues on next page)

BOX 35 *continued*

- Training of the project management team on quality internal audit, and other managers
- Preparation of the terms of reference of the steering committee
- Implementation, follow-up, and validation by the steering committee of the procedures developed in each sector of the HOMEL
- Development and regular monitoring of quality indicators for each identified process, including efficiency indicators and drive indicators
- Development, implementation, and monitoring of a staff training plan
- Weekly meeting of the steering committee
- Implementation of internal audits
- Participation in external audits, proposals, and follow-up of corrective and preventive actions
- Implementation of management reviews (twice per year)

Source: Excerpts from Dossouvi and Vodounon (year not available).

first hospital of the West African Economic and Monetary Union (WAEMU) to be ISO 9001 certified.[36]

Control Bodies of the Facility

A management control unit is present in the CHDs and in HOMEL. The unit provides the hospital's management with the information needed to analyze and monitor the evolution of each department and the facility as a whole. For example, it can carry out unannounced controls of cash registers. It does not, however, take on the role of global financial control.

36 ISO 9001 refers to quality management criteria set out by the International Organization for Standardization. See https://www.iso.org/iso-9001-quality-management.html.

CHAPTER 2.6

Transparency and Disclosure

Publication of Reports

Decree No. 90-347 of November 14, 1990, determines the reporting obligations for public health facilities. This decree obliges hospitals to establish a provisional budget to be submitted to the board of directors/ management board, based on a proposal from the facility manager. The budget must be approved by the oversight authority before January 1 of the related financial year. In addition, at the end of the financial year, the authorizing officer must establish an administrative account detailing the expenditure and revenue operations of the chief authorizing officer, including expenditure authorizations and revenue estimates in the budget.

Decree No. 90-347 of November 14, 1990, clarifies the reporting system of CHDs. It calls for the establishment of a management control unit that provides management and managers with the internal information needed for forward-looking management and sound budgetary management. It provides economic, financial, and statistical information to help assess the evolution of a service or to evaluate its results, and helps the departments establish their budgets. In addition, the decree requires management to compile, within two months of the end of the financial year, the

hospital's inventory, income statement, balance sheet, and activity report, and send it to the auditor, who has one month to examine them.

Law No. 94-009 provides for a number of reporting obligations for the social, cultural, and scientific offices, accompanied by criminal sanctions for noncompliance. For example, the manager should prepare an inventory of balance sheet items at the end of the financial year, draw up the profit and loss accounts, and prepare a written report describing the situation of the office and its activities during the financial year. The manager must then provide the board with the income statements and balance sheet for the previous financial year. Once the board approves the inventory, profit and loss accounts, balance sheet, forward-looking operating accounts, and estimated capital budget, these items must be submitted to the government for approval. Failure to execute these reporting obligations on the part of the operational and strategic management bodies is punishable by fines and imprisonment.

Recent decrees require the executive management to prepare the activity report and the financial statements within three months of the end of the financial year. Whether for the zone hospitals (Decree No. 2002-0113 of March 12, 2002) or the CHUs (Decree No. 2012-300 of August 28, 2012), the manager is obliged to submit, within three months of the end of the fiscal year, the inventory, income statement, balance sheet, and activity report. These documents must be sent to the auditor and approved by the board before the end of the fourth month after the end of the financial year. Surprisingly, the accounting officer (Decree No. 2012-300) is also responsible for the inventory, income statement, and balance sheet, but the board has until the end of the sixth month to approve the accounts approved by the accounting officer.

Health facilities are linked to the national Integrated Public Financial Management System (*Système Intégré de Gestion des Finances Publiques,* SIGFIP). This linkage allows for real-time information on the status of expenditure commitments.

Health data are communicated through the National Health Information and Management System (SNIGS), which is managed by the DPP. Annex 9 outlines the data transfer system, specifying the format used (paper or computerized). Since data computerization is limited in hospitals, particularly at the periphery, there are concerns regarding the reliability of data.

Promising initiatives are being deployed with regard to hospital information systems. The Savalou pilot project envisages an integrated solution comprising both a computerized medical file with integrated drug prescriptions and computerized billing, and computerized pharmaceutical management.

Monthly activity reports are transmitted by the zone office to the DDS. Each month, the zone office, whose representative is a member of the DDS management committee, transmits to the committee a report on zone activities (Annex 11).

Reporting obligations are not uniformly respected, and reporting accuracy is questionable. Interviews conducted for this study demonstrated that the enforcement of hospital reporting obligations is variable. Several facilities submit their annual activity reports either irregularly or not at all.

The lack of harmonization of available data limits peer comparisons. While the CNHU and CHDs have efficient financial and administrative services, these services are more fragile in area hospitals. Limited standardization of reporting formats makes it difficult to obtain systematic indicators for the sector.

Given the irregular submission of activity reports, the reliability of consolidated information at the level of the DPP is not assured. Each year, the DPP prepares consolidated reports covering the sector as a whole. It publishes a statistical yearbook and a performance report, which is sent to the Court of Auditors. Owing to the irregularity of information provided from the field, however, the reliability and truthfulness of the information used by the DPP in preparing its reports may be questionable.

Internal Control

The internal control framework is the same in all public hospitals. The hospitals are subject to the control of the oversight minister, who verifies whether the objectives set are in line with the guidelines laid down by the government. The Minister of Finance exercises control over the quality of public hospital management and, in this context, carries out inspections and audits. Internal inspection bodies such as the General Inspectorate of Finance, the General Inspectorate of Public Services and Employment, and the General Inspectorate of the Ministry of Health (IGM) perform inspections. Moreover, in each sectoral ministry, there is a financial control delegate from the General Directorate of the Treasury and Public Accounting, who performs upstream management control by verifying the expenses incurred.

The IGM carries out inspections in accordance with the General Inspectorate of State's mission plan and upon the request of the Ministry of Health. Under the direct authority of the Minister of Health, the IGM is responsible for verification and control of the administrative, financial,

and technical management of all central and decentralized services and organizations under the oversight of the ministry. The IGM is tasked either with execution of the mission plan, which is harmonized with the General Inspectorate of State and plans the inspections for the year, or with conducting inspections upon the ministry's request. In the latter case, the IGM may decide, as the case may be, that there is no need for inspection.

External Control

The Court of Auditors exercises external control of hospitals. It carries out:

- *A performance audit of the Ministry of Health:* Each year, the Ministry prepares a performance report and sends it to the Court of Auditors, which compiles a performance and monitoring report on the basis of inspection missions conducted by auditors in the Ministry of Health and reporting structures (such as the DDS and zone offices).
- *Judicial control of the state budget:* The Court of Auditors carries out an annual budget execution audit program, which includes a schedule of audits to be conducted in institutions that have received public funds.
- *Management control:* The Court of Auditors issues a general declaration on the compliance of accounts and all other certificates of compliance.

Hospitals are subject to audits of independent auditors. Treasury accounts are reviewed thoroughly twice a year, and an in-depth audit of all of the facility's accounts is conducted once a year.

CHAPTER 2.7

Conclusion and Opportunities for Further Strengthening

This study of Benin's hospital governance framework has highlighted its strengths as well as opportunities for further strengthening. This analysis has allowed for links to be drawn between the governance framework of hospitals and the "good practices" presented in the methodology for analyzing the corporate governance of SOEs and parastatal entities (Box 36).

BOX 36

Good Governance Practices of SOEs and Parastatal Entities

Governance Dimensions	Good Practices
Legal Framework	• Clear legal framework covering the entire parastatal "sector" • Definition of the legal status of entities

(box continues on next page)

BOX 36 *continued*

Governance Dimensions	Good Practices
State Oversight Function	• Appointment of a specialized entity at the level of the state/government to ensure effective and regular monitoring of financial and nonfinancial performance of the sector • International trend toward centralization of oversight function in a single entity to ensure comprehensive and coherent monitoring of all entities ("centralized model")
Planning and Performance Monitoring	• Definition of mandates and objectives • Development of financial and nonfinancial performance indicators • Development of performance agreements between the state (oversight entity) and the parastatal entities • Performance monitoring and evaluation of public enterprises
Boards of Directors	• Transparent and meritocratic selection of board members • Professional specialization and independence of board members • Clear definition of the respective roles of oversight bodies, boards of directors (autonomous bodies responsible for strategic decisions and monitoring of executive management), and executive management • Principle of autonomy of the board of directors, ensuring both strong accountability toward the state shareholder (oversight entity) and day-to-day management autonomy on the part of the parastatal entity
Transparency and Disclosure	• Clear rules and criteria for financial and nonfinancial reporting • Publication of consolidated annual reports on the sector by the oversight entity • Regular publication of independent external audit reports • Effective internal control

Sources: OECD (2015a); World Bank (2014a); World Bank compilation.

Hospital Governance under the Ministry of Health

The management of hospitals by the central services of the Ministry of Health is the model favored by the Government of Benin. Although the legal framework provides that hospitals have (partial) management autonomy, in practice Benin's hospitals have limited room for decision making. In general, the central administration retains the majority of decisions in terms of strategy, investments, or human resources. Even though the government envisages a certain degree of "hospital reform" under the PNDS, the authorities appear to favor maintaining a governance framework that is steered from the ministry level (Box 37).

BOX 37

Hospital Governance Framework in Benin

Legal Framework	• Different statutes, depending on the type of hospital • Different degrees of autonomy for hospitals
State Oversight Function	• Oversight by the Ministry of Health • Existence of a directorate in charge of hospitals since 2005 (DNEHS)
Planning and Performance Monitoring	• Sector health planning: National Health Policy, National Health Development Plan • Health System Strengthening Program (PRSS) • Short-term hospital policy: annual work plans • Increased performance monitoring with RBF
Boards of Directors	• Existence of boards of directors or management boards at all levels of the health pyramid • Legal provisions for board member profiles, terms of reference, frequency of meetings
Transparency and Disclosure	• Annual health statistics reports; centralized data at the level of the DPP of the Ministry of Health • Health information system • Hospital information system in a limited number of hospitals • Internal and external controls are in place

Source: World Bank compilation.

Challenges in Hospital Governance

The main challenges that might hamper hospitals' performance relate to their empowerment, oversight coordination, and accountability mechanisms. Hospitals have limited autonomy, restricted generally to day-to-day management. This situation dampens the motivation of hospital personnel. In addition, oversight is fragmented among different central directorates and hindered by insufficient coordination; key stakeholders, including, in theory, the DNEHS, do not seem to interact according to an established schedule or objectives. As a result, the DNEHS does not systematically have information on the sector and is weakened in exercising its tasks. Finally, systematic transmission of information on a regular basis is not widespread, and the quality of information is sometimes questionable (Box 38).

BOX 38

Challenges to Hospital Governance in Benin

Legal Framework	• Legal framework fragmented across several laws, making implementation and monitoring difficult • Limited autonomy for regional and peripheral hospitals
State Oversight Function	• DNEHS has no decision-making capacity • Several directorates of the Ministry of Health are involved in hospital oversight, resulting in a fragmentation of functions
Planning and Performance Monitoring	• Limited multiyear hospital strategy ("*projet d'établissement*")
Boards of Directors	• Boards of directors and management boards are limited in pursuing their missions • Decisions are essentially the responsibility of the central administration, limiting the autonomy and decision making of hospitals
Transparency and Disclosure	• Transfer of information from hospitals to oversight entities is not systematic • Variable quality of information (paper-based treatment in hospitals)

Source: World Bank compilation.

Increased hospital empowerment, combined with strong oversight and performance contract mechanisms, could improve hospital performance. Maintaining the public nature of hospitals, while increasing their responsibility, could make it possible to better allocate resources and provide hospitals with incentives to adapt to specific health care demands in their territory. Hospitals with operational management autonomy could develop their capacity for initiative and improve their performance, while strategic decisions could be made at the central level. Under such a scheme, the oversight entity would focus on monitoring and control of objectives defined in performance contracts, while hospitals would be empowered by and accountable to both the state and the public.

Improved communication and coordination between the directorates of the Ministry of Health could strengthen oversight, in particular by the DNEHS. The existence of several central directorates involved in the oversight of the hospital sector raises coordination issues. Limited interactions between stakeholders contribute to uncoordinated decisions that do not align systematically with hospitals' actual needs. These communication constraints restrict the availability of information at the DNEHS, which in turn reduces its ability to act. Greater coordination between the directorates could make overall sector monitoring more effective and could have a positive effect on the performance of the recently established DNEHS. In addition, increased institutional recognition of the DNEHS would strengthen it as the oversight entity and reinforce its role in steering the hospital sector.

Implementation of accountability mechanisms could strengthen communication between the state and hospitals, thus maintaining strong oversight. Accountability mechanisms such as performance contracts between the oversight entity, represented by the DNEHS, and the hospitals would be an essential accompaniment to the first two measures. These mechanisms could include regular transfer of information from hospitals to the DNEHS, so as to enable the latter to monitor operational management effectively.

PART 3

THE CASE OF CÔTE D'IVOIRE

CHAPTER 3.1

Landscape of the Hospital Sector in Côte d'Ivoire

Context and History of the Hospital Sector

Given the health situation in the country, modern and tropical medicine has developed in parallel with traditional medicine. A centralized health system was developed at the beginning of the 19th century. At that time, the degraded health situation (characterized by high infant mortality, malnutrition, malaria, and yellow fever) facilitated the development of tropical medicine. Access to this modern approach to medicine was confined to the wealthy, however, and a significant part of the population remains close to traditional medicine.

The first free health care policies in Côte d'Ivoire gave way to the Primary Health Care approach. The "fully free" policies of the 1960s quickly proved unsustainable in a fragile and highly dependent economic environment. A Health Consultation in 1984 launched initial institutional and organizational adjustments, but these were not accompanied by an actual care policy. As a result, the government developed the Primary Health

Care approach beginning in 1992–93,[37] together with a policy statement and an action plan, including an essential drugs policy and community participation.

The hospital legal framework took shape at the end of the 1990s, distinguishing between autonomous and nonautonomous facilities. Regulation of Ivorian hospitals, which are not all autonomous, was undertaken in the late 1990s. Second-level referral hospitals (university hospitals, or CHUs in French) take the form of an Industrial and Commercial Public Institution (*établissement public à caractère industriel et commercial*, or EPIC in French), while first-level referral hospitals (regional hospitals, or CHRs, and general hospitals, or HGs) are departments under state control without management autonomy. The parallel establishment of health districts in 1994 initiated the decentralization of the health administration.

Reforms undertaken in the early 2000s were unsuccessful in a divided political context that affected the utilization of hospitals. Reforms such as the transfer of power to local authorities or the introduction of universal health insurance, were attempted at the beginning of the 2000s. Yet, owing to the situation in the country during this decade, these laws did not achieve the expected goals. The 2002 coup, the partitioning of the country, and the post-electoral crisis of 2011 have shaken the country and impeded the use of health services. These factors contributed to the decline of the health system, as evidenced by the looting of many hospitals, the fact that nearly half of health sector staff abandoned their posts, the embargo on medicines and medical equipment, and the nonfunctionality of the medical and epidemiologic monitoring systems. These events, in turn, led to the underutilization of health services by the population.

Reform Perspectives Envisaged by the Government

The government is considering a program of hospital reforms to revitalize the sector. According to the reform document, the overall objective is to revitalize the public hospital sector to contribute to the improvement of the population's health status and well-being. This overall goal is complemented by three specific objectives: (i) improving hospital governance and oversight; (ii) improving motivation among hospital health workers; (iii) and improving the quality of health care provision in hospitals. These reforms

37 The Primary Health Care Strategy, a precursor to the Bamako Initiative (1987), was formulated in 1978 at the Alma Ata Conference, which identified primary health care as the key to reducing health inequalities. This strategy fell within the objective of "health for all in 2000."

BOX 39

Objectives and Strategic Priorities of the Reform Project in Côte d'Ivoire

The overall objective of the hospital reform in Côte d'Ivoire consists of revitalizing the public hospital sector in order to contribute to the improvement of the population's health status and well-being.

- ***Improving hospital governance and oversight:***
  - Tertiary level: developing a new status for national public agencies (EPNs), evolving toward a greater degree of management autonomy
  - Secondary level: defining a new status for non-EPN health facilities, conferring management autonomy and legal personality
  - Infrastructure/technical facilities: upgrading health facilities
- ***Improving motivation among hospital health workers***
  - Developing the job directory
  - Developing the competency framework
  - Developing a performance assessment system
  - Proposing text on the special status of health workers
- ***Improving the quality of health care provision in hospitals***
  - Reorganizing services
  - Computerizing medical services
  - Improving medical care for patients

Source: Republic of Côte d'Ivoire, Ministry of Health (2014a).

would reorganize the governance system of hospitals, make public hospitals more attractive, and motivate health professionals to provide better-quality care (Box 39).

The reform project aims to increase hospital autonomy and develop human resources. While there were several versions of the reform plans, there seemed to be two areas of agreement: (i) autonomy, which would be extended to all hospitals through changes in the legal framework; and (ii) staff empowerment. Implementation modalities and their prioritization are still under discussion. Some stakeholders have proposed changes in the status of public health workers, with a distinction made between the civil service and the hospital public service. Others envisage to revise the EPIC status currently enjoyed by the EPNs, and to confer a legal personality to other facilities, as a priority.

With respect to human resources, two reform measures were decided and budgeted in 2014. The first measure is a salary increase for health workers, by as much as 60 percent for some categories. The second measure concerns the recruitment of over 4,000 staff, which would increase the number of health professionals by nearly 20 percent.

Financial, Material, and Human Resources

Financial Resources

Between 2010 and 2012, approximately 4 percent of the national budget was dedicated to the health sector. This percentage remains well below the West African Economic and Monetary Union (WAEMU) standard of 15 percent.

In 2012, 27 percent of the Ministry of Health's budget was dedicated to the operation of health facilities and 18 percent to buildings and equipment. The figures presented in Box 40 relate to all health facilities and not exclusively hospitals. They do not take into account "central administration" expenses, which include the salaries of all ministry staff as well as centrally administered costs such as the ministry's water, electricity, and telephone subscriptions.[38]

In principle, up to 40 percent of autonomous hospitals' funding comes from a government subsidy. EPNs have two sources of financing: (i) an operating subsidy from the state (40 percent); and (ii) own resources related to health care delivery and resale of drugs (60 percent, including 15 percent for staff incentives). Own resources include: medical, paramedical, and medical-technical activities,[39] the sale of health booklets (*carnets de santé*), and recoveries made under agreements with public or private bodies.

Infrastructure and Equipment

Hospitals are organized according to a pyramidal structure with three tiers of operational specialization. These levels correspond to different degrees of equipment, technical facilities, and care. This organizational structure relates essentially to the territorial administrative division, with

38 Available data do not allow for estimations of the effective share of hospital expenditures in these totals.

39 Consultations, hospitalizations, deeds, clinical and paraclinical examinations.

BOX 40

Health Sector Share of Côte d'Ivoire's National Budget

In CFAF Million	2010 Supplementary Budget	2011 Supplementary Budget	2012 Draft Budget
National budget	2,481,000	3,050,000	3,160,000
Health expenditures	118,644	105,592	128,929
Health expenditures in the national budget	**4.8%**	**3.5%**	**4.1%**
Current expenditure	92,697	91,252	105,184
Central administration	66,227	58,716	70,314
Health facilities (excluding staff expenses)	**26,471**	**32,536**	**34,870**
Health facilities as a share of health expenditures	**22%**	**31%**	**27%**
Capital expenditure	**25,947**	**14,340**	**23,744**
Administration	1,266	578	564
Building and equipment	24,681	13,762	23,181

Source: Republic of Côte d'Ivoire, Ministry of Economy and Finance, Draft Budget (2012).

highly specialized hospitals at the central level (capital city). A referral and counterreferral system allows continuity of care between the levels, given the technical sophistication and means of care.

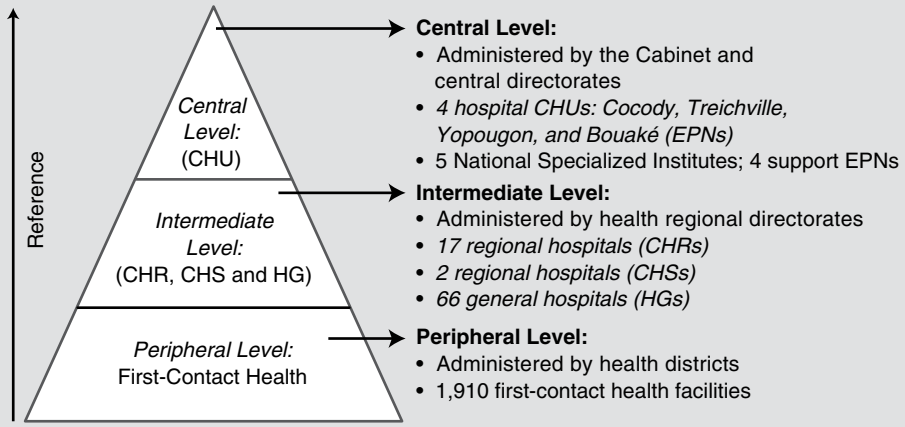
Côte d'Ivoire's three-tiered structure includes the central level, the intermediate level, and the peripheral level. The central level is composed of second-level referral hospitals and comprises four university hospitals: Cocody, Treichville, Yopougon, and Bouaké. It also includes five national specialized institutes,[40] and four supporting EPNs.[41] The intermediate level corresponds to first-level referral hospitals and comprises 17 regional hospitals, two specialized regional hospitals, and 66 general hospitals. Finally, the peripheral level contains first-contact health facilities such as rural health centers, specialized urban and urban health centers, and urban health facilities (Box 41).

40 These are the National Institute of Public Health, National Institute of Public Hygiene, Raoul Follereau Institute, Pierre Richet Institute, and Abidjan Heart Institute.

41 These include the National Blood Transfusion Center, National Laboratory of Public Health, Public Health Pharmacy, and Emergency Medical Service.

BOX 41

Operational Organization of the Hospital System in Côte d'Ivoire



Source: Republic of Côte d'Ivoire, Ministry of Health, World Bank compilation.

The pyramidal organization appears to be inefficient in Abidjan, where CHUs are obliged to cover any type of care in the context of an unscheduled activity. In the absence of upstream regulation, and given free access to referral hospitals, emergency rooms receive requests for care of unequal degrees of severity.

Public health care provision is complemented by the private for-profit sector, the faith-based sector, and community-based associations and organizations. The private sector is made up of polyclinics, clinics, medical centers and physicians' offices, pharmacies, and private nursing stations—comprising over 2,000 private health facilities for which compliance authorizations are in progress. The faith-based sector and community-based associations/organizations also participate in health care provision, with 50 facilities in total. Some private facilities even serve as referral institutions for local public services and achieve remarkable results in terms of both quality of care[42] and financial performance.[43]

The state of infrastructure and equipment, together with limited maintenance, do not permit optimal care. Hospitals, which were developed

42 For example, the Don Orione clinic in Anyama had a maternal mortality rate of 0 over 500 deliveries in 1993.

43 Two facilities visited for this study achieved a balanced budget by charging rates that were close to those of the public service outside the free system.

in the 1980s and 1990s, seem to be in poor condition, and some of their infrastructure is obsolete. The Treichville University Hospital, for example, is based on a pavilion design on a large site without functional connection between the units. By contrast, the Yamoussoukro regional hospital was built on a small site and opportunities for evolution are limited. Moreover, hospitals do not have the equipment required for effective management: the technical facilities are either poorly developed or nonexistent, and are rarely maintained.

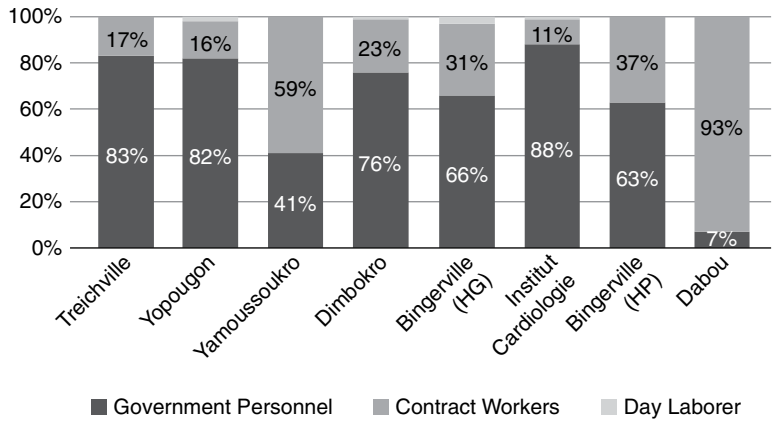
Human Resources

Hospital human resources are composed of medical, paramedical, technical, and administrative staff. According to the Yopougon CHU activity report, for example, the distribution of staff in the hospital is as follows:

- Medical staff: doctors, pharmacists, dental surgeons
- Paramedical staff: nurses, midwives, laboratory and biomedical technicians
- Technical staff: drivers, medical assistants, litter holders, firefighters
- Administrative staff: directors, office staff, administrative assistants, secretaries, social workers, educators.

Except in private facilities, most health sector staff are government personnel. This figure is 83 percent in the Treichville and Yopougon CHUs, and slightly lower for the CHRs or HGs (such as those in Dimbokro and Bingerville), which appear to have higher numbers of contract workers (Figure 8).

FIGURE 8: Composition of Hospital Staff in Côte d'Ivoire



Source: Activity reports of hospitals, World Bank compilation.

The 2012–2015 national health development plan (PNDS) provides for the establishment of a hospital public service. The PNDS highlights the need to implement an adequate institutional framework for the efficient management of health sector human resources, in particular through the establishment of a hospital public service.

Bed capacity, which is higher in CHUs, reflects the geographical concentration of health personnel in Abidjan. While bed capacity is 3–4 in the Treichville and Yopougon CHUs, this figure reaches only 1–2 at the CHR and HG levels (Box 42). This significant imbalance in the geographical distribution of staff was identified in 2011 in the National Health Policy (PNS), which highlighted the significant proportion of staff in the southern regions and in Abidjan.

In general, hospitals report staff shortages, especially among specialists and nurses. The needs expressed mainly include: gynecologists, pediatricians, surgeons, and anesthetist resuscitators (Bingerville Hospital); specialized personnel for units such as ear, nose, and throat, resuscitation, and ophthalmology (Yopougon CHU); and state-registered nurses.

The work ethic among health workers, especially physicians, is severely criticized by the population. The sector is experiencing a real moral crisis among public hospital staff. The existence of unofficial payments or misappropriations of patients for the benefit of private structures (double public/private treatment is common in Abidjan) is not unusual, but meets with significant public disapproval.

BOX 42

Hospital Bed Capacities and Human Resources in Côte d'Ivoire, 2013

Hospitals	Treichville CHU	CHU Yopougon	CHR Yamoussoukro	Dimbokro CHR	HG Bingerville (2012)	Bingerville Psychiatric Hospital	Dabou Assimilated HG
Number of active beds	394	354	128	80	15	130	96
Capacity	1,245	1,416	254	107	125	117	177
Capacity/ bed	3	4	2	1	8	1	2

Source: Activity reports hospitals, World Bank compilation.

Service Delivery Performance

The loss of public confidence in the public health system appears to be significant. Interviews revealed a variety of potential causes, including the poor quality of reception and care, hidden payments even in the case of targeted free access, inadequate technical facilities, demotivation of staff, and the lack of availability of medicines and consumables.

In response to the poor utilization of the health system, cost-free measures have been introduced temporarily. To revitalize the sector, a payment exemption for the medical costs of health facility users was introduced in 2011, on an exceptional basis and for a period of 45 days.[44] In response to the lack of financial resources that led to the failure of this "fully free" program, the government opted instead for targeted free health care as a transition toward universal health coverage. Beneficiary populations include those who are not subject to taxes as well as disadvantaged populations, especially mothers and children. These targeted services include childbirth and cesarean sections, common pathologies among children aged 0 to 5 years, malaria treatment, and the first 48 hours of medical and surgical emergencies (Box 43).

BOX 43

Transition from Full Free Access to Targeted Free Access in Côte d'Ivoire

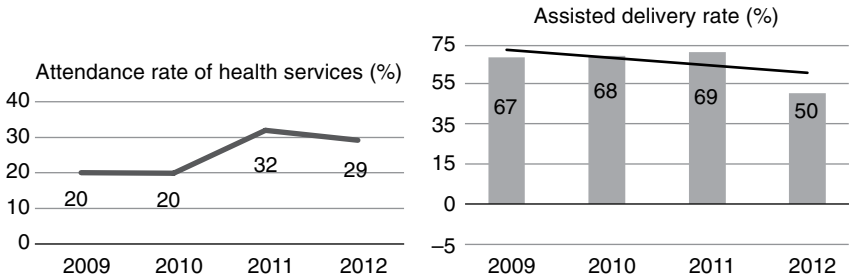
Although it produced beneficial effects, difficulties were experienced during the implementation of exceptional payment exemptions (April to October 2011). Pending the establishment of universal health coverage aimed at providing optimal health care, the Council of Ministers decided to implement transitional measures:

- Introduction of *targeted selective free access* for nontaxable persons and poor populations, in particular mothers and their children
- Continuation of free childbirth and cesarean section, as well as the most frequent pathologies among children aged 0–5 years
- Introduction of free surgical emergencies and certain pathologies (malaria), and a 30 percent deduction applied to all medical procedures costing more than CFAF 1,000

Source: Republic of Côte d'Ivoire, Communiqué of the Council of Ministers, January 18, 2012.

44 In public, parapublic, and community contractual hospitals.

FIGURE 9: Rates of Health Services Utilization and Assisted Deliveries in Côte d'Ivoire



Source: Republic of Côte d'Ivoire, Ministry of Health.

Although universal free health care temporarily boosted hospital activity through a high demand for care, this approach quickly showed its limits. As hospitals became unable to provide the drugs and consumables needed for free access to be effective, the increase in utilization has not been sustained over time. Inadequate services, missing drugs, nonfunctioning technical facilities, and lack of care partially explain the decline in hospital utilization as of 2012 (Figure 9).

The number of assisted deliveries and the overall rate of cesarean sections are low in Côte d'Ivoire. The drop in the latter during 2012 is difficult to explain, since it occurred after the political situation had stabilized and free access measures were effective. The development of private provision and the competitive advantage it presented may be partly responsible for this shift.

Financial Performance

Procedures for budget preparation and expenditure validation seem to be followed properly across the three tiers of the hospital system. The process includes the following steps: department requests, arbitration, financial translation of budget proposals, and submission to the board or management committee for validation. The process is described in a scrupulous manner and in accordance with the legal framework. The importance of management is undeniable in the budget, which is prepared in collaboration with the Financial Affairs Department and in consultation with the Chairman of the Hospital Medical Commission (*commission médicale d'établissement*, or CME) and the general nurse. The composition of the management committee allows the ministry's representative to ensure that the facility

observes the country's health policies. In regional hospitals, the draft budget is submitted to the prefect and discussed and validated within the management committee before being transmitted to the Ministry of Health.

Drugs comprise the main expenditure item. Procurement of drugs and medical devices represents a significant financial burden for the facilities. Such purchases can lead to proportionate income, however, if delivery and storage are well managed. The mechanism is based on a medical supply store at the hospital, the income from which is transferred directly to the Public Health Pharmacy (*pharmacie de santé publique*, or PSP). In theory, the facility retains 10 percent.

The PSP has suffered the consequences of free health care measures. Having already faced delays and gaps in deliveries, the PSP has been weakened further by the free health care policy. The latter created a situation in which hospitals were unable to honor the PSP, and the PSP was unable to deliver all requested products. Elevating the PSP to a nonprofit association would allow it to be more effective (Box 44).

Hospitals' reliance on state subsidies may pose a fiscal risk. The main reason lies in the introduction of free health care, which prompted an influx of patients while depriving hospitals of income related to the resale of drugs and inputs. As facilities lacked own revenues, they no longer had the ability to manage inputs within the logic of cost recovery. In addition, the 30 percent reduction in health facility fees further reduced financial inflows (Box 45).

BOX 44

The Public Health Pharmacy in Côte d'Ivoire—Challenges

Currently, the PSP holds the status of EPN. It went bankrupt, owing in part to the establishment of free health care measures. The hospital pharmacies, which were intended to be supplied by the PSP, experienced drug shortages with frequent and extended disruptions in supply. Reconverting the PSP into a nonprofit association could give it greater operational autonomy, if combined with a reorganization of hospital pharmacies, differentiated according to facility type. In some cases, this could involve the PSP's medical supply store, divesting the facilities of this service and a part of the related revenue.

Source: Interviews.

BOX 45

Composition of Hospital Financial Resources in Côte d'Ivoire, 2013

Hospitals CFAF Million	CHU Treichville	CHR Yamoussoukro	CHR Dimbokro	Bingerville HG (2012)	Abidjan Heart Institute	Bingerville Psychiatric Hospital
Own income	334	76	7	37	973	11
Operating subsidy	5,290	248	154	36.5	2,041	167

Source: Activity reports of hospitals, World Bank compilation.

Compensation was made available by the state, but it does not cover the shortfall. In addition, the poor attractiveness of public hospitals and the population's limited utilization of them has made it impossible to foresee significant income. Finally, the supply of health care services has declined, as buildings have become dilapidated and poorly maintained equipment has become inoperative.

The recovery management system of hospitals under state control limits their flexibility. All receipts are paid to the Treasury, which provides for the following:

- 65 percent for the facility: operation (50 percent) and employee incentives (15 percent);
- 35 percent for the state: Treasury (20 percent) and the Health Action Fund (15 percent).

The Treasury is to pay the hospital's benefits and expenses in accordance with the budget. There is no imprest fund for contingencies, which leaves hospitals with little room for maneuvering.

Limited investment in the public hospital sector helps boost the attractiveness of private clinics. Investment projects remain modest, as is the government's contribution to large investments (Box 46). In comparison, private hospitals benefit from renewed investments, better maintenance organization, and a regular supply of consumables. This more efficient functioning contributes to the private sector's attractiveness for health professionals (particularly physicians) who, while continuing to be officially employed on a full-time basis in public hospitals, devote much of their time to activities in private structures.

BOX 46

Investment and Operating Budget in EPNs in Côte d'Ivoire

EPN CFAF Million	Treichville CHU 2013	Yopougon CHU 2011	Abidjan Heart Institute 2013
Operation	6,413	4,164	2,962
Investment	942	1,921	812

Source: Activity reports of hospitals, World Bank compilation.

CHAPTER 3.2

Legal and Regulatory Framework

Legal Framework for the Health Sector

In Côte d'Ivoire, the protection of health is a right guaranteed primarily by the state. Article 7 of the Constitution provides that the state shall ensure equal access to health for all its citizens. This provision is reflected particularly in the development of a hospital sector run by public authorities, which aims to ensure the provision of low-cost public health care.

A reform of the territorial administration transferred health competencies to territorial communities, but the implementing decrees have not been passed. Law No. 2003-208 of July 7, 2003, transferring and distributing the state's powers to territorial communities, provided for the transfer to regions, departments, districts, and communes of:

- the development and implementation of regional, departmental, district, and city plans in health, public hygiene, and quality control;
- the expression of views on the prospective development of the national health map;

- the construction, management, and maintenance of regional hospitals (at the regional level) and general hospitals (in departments and districts); and
- the adoption of preventative measures related to hygiene.

However, the implementation of decentralization in the health sector is not effective due to the failure to adopt the implementing decrees. In fact, the organization of the public hospital sector remains under the authority of the government.

The sector's pyramidal structure has an operational component and an administrative component.[45] The operational component is defined in Decree No. 96-876 of November 25, 1996, supplemented by Order No. 028 of February 8, 2002, which structures the health care system. The administrative component, on the other hand, is composed of:

- ***the central level***, which is assigned the function of developing health care policy and determining the strategic directions of each level of the health system;
- ***the deconcentrated level***, which relates to the coordination of national strategies in the regions by the 20 Regional Directorates of Health (intermediate level), overseeing the activities of the 82 health districts (peripheral level) led by the district teams, themselves supervised by a district head doctor or department head; and
- ***the decentralized level***, which consists of EPNs carrying out support, training, and research tasks.[46]

Legal Structure of Hospitals

Status of Hospitals

University hospitals (CHUs) are EPNs with an EPIC structure, including legal personality and financial autonomy. Law No. 98-388 of July 2, 1998, lays down the general rules of EPNs and creates the category of public hospitals. The EPNs have a legal personality under public law and financial autonomy, but may not perform any act that contravenes their purpose. Operating under the financial oversight of the Ministry of Economy and Finance and the technical oversight of the Ministry of Health, according to

45 As described in Chapter 3.1.

46 These include the Public Health Pharmacy, National Laboratory of Public Health, National Institute of Public Health, and National Blood Transfusion Center.

Decree No. 2001-650 of October 19, 2001, on the organization and functioning of CHUs, the hospital EPNs are the four CHUs: Cocody, Treichville, Yopougon, and Bouaké. Managed by a deliberative body known as the management board, which is composed essentially of government officials and chaired by the Minister of Health, hospital EPNs are EPICs that must generate 60 percent of their operating budget.[47]

Regional hospitals (CHRs) and general hospitals (HGs) are services under state control without legal personality or financial autonomy. They are regulated by Decree No. 98-379 of June 30, 1998, on the organization and functioning of urban public health facilities without EPN status. CHRs and HGs are administrative units of the state under the administrative oversight of the Ministry of Health. Without their own legal personality, they have neither management autonomy nor the ability to use the financial resources they generate to cover their operational costs or carry out investments.

Employment Scheme

Public hospitals employ mainly civil servants, although they also call on contract workers. Only administrative staff are contract workers, and they are recruited from among service providers approved by the Ministry of Finance (which is in charge of organizing recruitment), either through public health programs or use of own resources (in the case of EPNs). The recruitment of contract workers makes it possible to compensate for broader staffing inadequacies. The distribution of civil servants and contract staff varies according to the type of structure.

Accounting and Management Standards

Accounting management is carried out on the basis of public accounting rules.

- ***EPN:*** The financial and accounting management of hospital EPNs involves the manager as chief authorizing officer and two levels of control (budget execution and accounting). The manager incurs the expenditure under the supervision of the budget controller, who is an official of the Ministry of Finance. As a representative of the finance minister, he or she

47 The other form of EPN provided for by the law of 1998 is the administrative public agency, whose resources are derived mainly from allocations and grants from the state budget and grants from public and private organizations.

monitors the propriety of expenditure incurred by the authorizing officer. Financial transactions are to be carried out by a public accounting officer who is seconded to the EPN, but who does not belong to the organizational structures of the EPN and has a dual role as payer and cashier. Hospital EPN funds are public funds managed according to the rules of public accounting.

- ***CHR and HG:*** Funds recovered as part of the pricing policy of health care acts are managed by an income administrator and an imprest administrator, who are appointed by the Minister of the Economy and Finance and placed under the control of the public accounting officer of the district. Control of hospital financial transactions is exercised by the relevant departments of the Ministry of Health and the Ministry of the Economy and Finance.

There is no cost accounting or stock record system. Governed by general public accounting regulations, the accounting system has not enabled the implementation of a hospital chart of accounts. Without cost accounting and stock records to track the specificities of supply in public hospitals, it is difficult to forecast prices that align the fees charged with real costs.

Legal and Regulatory Challenges

Implementation of the legal framework encounters a few difficulties. Some directions defined in law may not be implemented owing to the lack of an implementing decree, as illustrated by the case of the decentralization law of 2001, which transferred health skills to regions, departments, districts, and communes but has not yet been backed up by an implementing decree. Sometimes, the laws themselves are not implemented. The guidelines for Côte d'Ivoire's hospital reform point out that the failure to implement legal texts could lead to "aggravated corruption" and "impunity for the frequent deviant behaviors observed (including diversion of patients, private consultations with patients, and parallel sales of drugs and consumables)."

The lack of a legal personality for regional and general hospitals reduces hospital flexibility. These hospitals are under the control of the Ministry of Health. They are managed directly by the ministry or the administrative subdivision representing it: hospital managers and staff are appointed directly by the central level, and the public financial rules of the state apply. This model implies that the central level ensures the management and control of hospital practices and the allocation of public funds.

Given the specificities of these hospital facilities, this type of model may create inefficiencies in the supply of hospital services.

The EPIC structure seems to be unsuitable to EPNs. The requirement that EPNs generate 60 percent of their operating budget—which no EPIC hospital can achieve—reduces their autonomy in practice and seems to contradict the socially oriented public service mission of hospital EPNs, especially as they sometimes encounter cumbersome financial management procedures. The World Bank has noted that EPN autonomy "remains low, or even nonexistent, in the management of human and financial resources. This is because the majority of qualified staff is composed of civil servants. This implies that their careers are entirely managed at the central level. Even for contract staff, the hiring has to be controlled by the Ministry of Economy and Finance" (World Bank 2010).

The link between the public and private sectors is not set out in a clear framework. In the absence of a contractual framework with clear and precise objectives, there is no collaboration or partnership between the public and private sectors.

The proposed hospital reform aims to revise the legal and regulatory framework. The reform document provides in particular that hospitals will now have legal personality and financial autonomy, while the state will take on the role of defining the objectives and directions of health policy.

CHAPTER 3.3

The State's Oversight Function

Organization of the Oversight Function

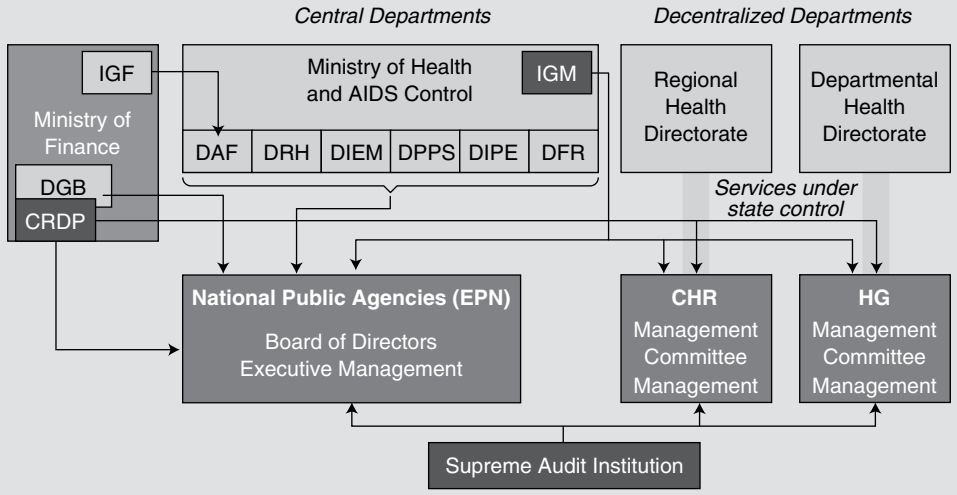
The oversight function varies by hospital type. For hospitals with EPN status, the oversight function is shared between the Ministry of Finance (financial oversight) and the Ministry of Health (technical oversight). Regional and general hospitals are services under the control of the Ministry of Health, and they report to the ministry through the Regional Directorates of Health and the Departmental Directorates of Health (Box 47).

National Public Agencies

Technical oversight over EPNs is exercised at the central level by the Ministry of Health and financial oversight by the Ministry of Economy and Finance. This setup is laid out in Article 6 of Law No. 98-388 of July 2, 1998, establishing the general rules for EPNs. Article 8 provides that the coordination of all actions needed for both technical oversight and economic and financial oversight shall be carried out by the minister responsible for the economic and financial oversight. Under this coordination mechanism,

BOX 47

Oversight Arrangements in Côte d'Ivoire



Source: World Bank compilation.

the finance minister ensures effective oversight over the hospital in strict compliance with its autonomy.

Economic and financial oversight is supported by a commission in charge of monitoring the coordination of the oversight function. Law No. 98-388, Article 9, provides for the establishment of a monitoring commission to assist the minister responsible for economic and financial oversight in coordinating the oversight function. The commission acts as a regulatory body for the economic and legal sector consisting of EPNs, and is intended to enable the efficient and effective exercise of their missions, in accordance with public finance rules and constraints. The commission's activities include:

- the creation, transformation, division, or merger of EPNs;
- the dissolution and liquidation of EPNs; and
- analysis and development of proposals to resolve challenges posed by the implementation of applicable regulations.

Economic and financial oversight is the exclusive responsibility of the General Directorate of Budget (DGB) and its divisions. The DGB

establishes the distribution of budget allocations for the EPNs and the Ministry of Health. Assisted by the Public Expenditure Review Unit, which carries out EPNs' organizational and financial audits, the DGB is responsible for most of the economic and financial oversight of EPNs.

Regional and General Hospitals

CHRs and HGs are services under state control, placed hierarchically under the supervision of the regional and departmental directorates of health.

- ***Regional Health Directorates (DRS):*** The central level accounts for 20 regional health directorates responsible for coordinating and supporting health regions and districts in connection with the Directorate of Health and the Department of External Services and Decentralization Support (SASED). This level ensures the implementation of national health policy at the regional level; the coordination of activities carried out in health districts; and the technical, administrative, and logistical supervision of the districts in collaboration with territorial communities.
- ***Departmental Health Directorates (DDS):*** The district directorate, led by a district team, is the operational unit of the health system that groups together all health facilities in its geographical area. It is responsible for planning and organizing the activities necessary to meet the needs of the population.

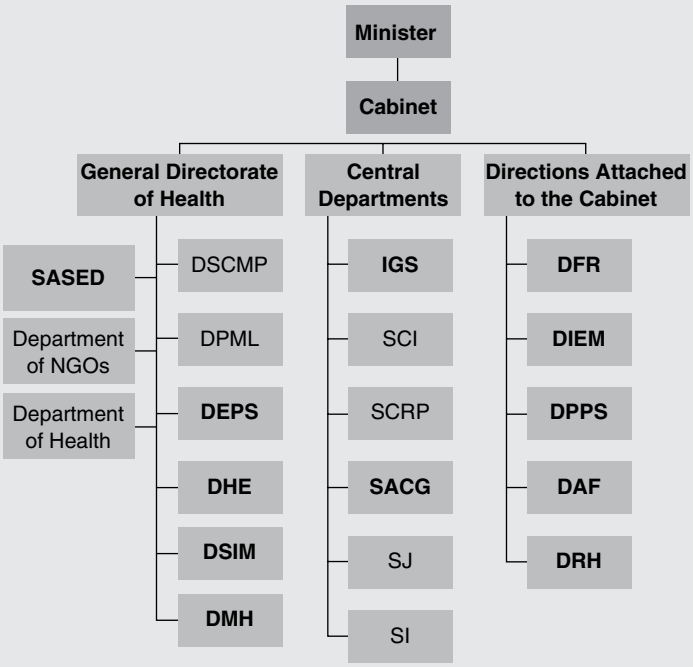
Fragmented Oversight in the Absence of a Directorate in Charge of Hospitals

The proposed hospital reform provides for the establishment of a directorate responsible for the oversight of hospitals, which does not currently exist. There is uncertainty in the health ministry around the organization of hospitals, in particular with regard to the EPN directorate. The establishment of a directorate of (public) hospital medicine is under consideration as part of the hospital reform.

Within the Ministry of Health, a number of central directorates and departments are involved in oversight. Technical oversight is carried out through several technical and central departments and services identified in bold type in the ministry's organization chart (Box 48).

BOX 48

Organizational Chart of the Ministry of Health Côte d'Ivoire



Source: Ministry of Health website, http://www.sante.gouv.ci/.

The Directorate of Financial Affairs (DAF) plays an important role in fiscal matters and resource mobilization. Responsible for preparing the ministry's annual budget, the DAF makes decisions on the distribution of all hospital allocations, whether to EPNs, CHRs, or HGs. Furthermore, it is responsible for monitoring procurement contracts initiated by entities within the Ministry of Health.

The Directorate of Human Resources (DRH) is responsible for programming and controlling the workforce and managing careers. In particular, the DRH decides on hospital staffing. It determines human resource allocations for all hospitals, which are relayed to CHRs and HGs by the Regional and Departmental Directorates of Health.

The Directorate of Infrastructure, Equipment, and Maintenance (DIEM) is responsible for standardization, planning, and maintenance

of infrastructure and equipment. The DIEM is responsible for developing norms and standards related to buildings and equipment, including safety standards; investment programming; monitoring and controlling infrastructure construction and maintenance programs; and maintaining infrastructure and equipment. With a staff of 70 at the central level, the DIEM is represented in four of the twenty regions through Regional Infrastructure and Equipment Maintenance Centers. The DIEM occasionally purchases equipment for hospitals, but these acquisitions constitute only a small part of the sector's equipment. The national health development plan (PNDS) for 2013–2015 foresees the creation of three Regional Infrastructure and Equipment Maintenance Centers in Abidjan, Bouaké, and Korhogo, together with a reform of the DIEM "to enable it to provide leadership in the realization, management, and maintenance of health infrastructure and equipment."

The Directorate of Forecasting, Planning, and Strategies (DPPS) plans reforms and coordinates strategy development. With a staff of four, the DPPS ensures sector strategic planning and forecasting. It develops the PNDS and the PNS in collaboration with the Department of Information, Planning, and Evaluation. The DPPS establishes EPNs' strategic planning as well.

The Department of Information, Planning, and Evaluation (DIPE) is responsible for collecting and processing statistics for the entire sector and is entrusted with the development of the health map. As the central manager of the management information system, the DIPE collects and processes health statistics and compiles and disseminates them in an annual report on the national health situation. It is also responsible for preparing the health map and the directory of health facilities. It assists the DPPS in preparing the PNDS and the PNS.

The Directorate of Training and Research (DFR) is responsible for planning and identifying training needs. With a total of 23 employees, it is charged with programming the training opportunities offered by external service providers. Although the legal framework organizing the Ministry of Health stipulates that its mandate includes initial training, in practice it only intervenes in continuing education activities.

The General Inspectorate of Health (IGS) has the dual role of controlling and supporting the sector. The IGS, which is assigned this dual mission by the decree organizing the Ministry of Health, is responsible for the administrative, financial, and health control of hospitals and ensures the dissemination and enforcement of legislation, regulations, and directives. Its staff includes 25 inspectors and seven support staff, with an annual budget of CFAF 75 billion, as of 2013.

The Department of Audit and Management Control (SACG) is responsible for audit and management control in hospitals. Comprising three directors and an attaché, the SACG is responsible for day-to-day management monitoring and steers a number of boards that meet on a quarterly basis (management review in the first quarter, review of the upcoming budget in the second quarter, midterm management review in the third quarter, and specific issues in the fourth quarter). The SACG collects administrative, financial, asset, and personnel information by means of a detailed questionnaire, compiling the results in an assessment report and supplementing this information, where appropriate, with on-site inspections on a sample basis.

The General Directorate of Health (DGS) ensures compliance with regulations on the organization of health facilities. The DGS performs its duties through central directorates acting under its authority. The Directorate of Health Facilities and Professions (DEPS) thus monitors the regulation of health professions. It defines, monitors, and controls standards for public and private health facilities. The DEPS also plays an important role in quality control.

The Department of External Service and Decentralization Support (SASED) assists local authorities and deconcentrated units. Attached to the DGS, the SASED assists the Regional and Departmental Directorates of Health in planning and organizing the monitoring and evaluation of health activities. It is tasked with promoting quality, preparing management tools (such as manuals and guidelines for the supervision of the national public health system), and training staff to ensure that services function properly. As a supplement to the DPPS, which supports the strategic planning of EPNs, the SASED carries out planning activities at the deconcentrated level through planning meetings that aim to adapt hospital policies to national planning requirements as expressed in the PNDS and PNS.

Challenges Related to the Oversight Function

Hospital oversight is fragmented across central directorates and services with overlapping mandates. The existence of two directorates and one support service in charge of planning, or of inspection and control bodies with overlapping duties, illustrates this challenge. Moreover, the oversight function is both omnipresent and out of touch with operational realities; it remains central and hierarchical, with limited feedback from external services and EPNs with little decision-making autonomy.

The establishment of a hospital directorate is under consideration as part of proposed reforms. The ministry is considering the creation of a

Directorate of Hospital Medicine and a Directorate of Nursing and Maternal Care. Combined with hospital autonomy, and provided that the new directorate has adequate institutional visibility and resources, its establishment could refocus oversight on national strategy considerations rather than on operational management and thus give hospitals the flexibility they need to implement an investment policy.

CHAPTER 3.4

Planning and Performance Monitoring

Planning Framework

Health Sector Planning

As part of the reconstruction of Côte d'Ivoire, a national health policy was developed and operationalized in the PNDS for 2012–2015. In 2011, the government renewed the PNS, taking into account the country's evolving socioeconomic environment and the sector's political orientation. The current PNS defines priority objectives and strategic directions for the health sector, and its implementation is carried out through the PNDS.

The PNDS for 2012–2015 aimed to "guarantee all citizens optimal health status to sustain the growth and the development of the country." In line with the preceding PNDS, which had little impact given the political situation of the country at the time, the new PNDS has five objectives: (i) strengthening health sector governance and the leadership of the Ministry of Health; (ii) improving health care provision and utilization of good quality health services; (iii) improving maternal and child health services; (iv) strengthening the control of diseases and hospital-based

infections; and (v) strengthening prevention, health promotion, and local medicine (Republic of Côte d'Ivoire 2012).

These overarching objectives are reflected in four more focused, specific strategic aims. These include: (i) developing the institutional and management regulatory framework to improve sector efficiency, coordination, governance, and decision making through better quality health information; (ii) improving health care service provision by rehabilitating existing facilities, upgrading technical facilities, and building new facilities in underserved areas; (iii) expanding the availability and accessibility of drugs, vaccines, and blood products; and (iv) improving the availability of specialized skills.

The government has proposed a program of hospital reforms and has highlighted in the reform document the key factors blocking the full operation of hospitals. The document mentions the lack of technical facilities, the lack of continuity of care, insufficient financial resources, lack of equipment maintenance, drug shortages, and insufficiently motivated staff as factors behind the unattractiveness of hospital services. This document even mentions a "near-failure of the hospital system" due to "poor governance . . . , inadequate organization of care, poor living conditions in hospitals, degraded infrastructure and medical equipment, and frequent drug stockouts" (Republic of Côte d'Ivoire 2014a).

Hospital-Level Planning

Hospital strategies are not widely used. Hospitals do not have a formalized medical project or a master plan, except in targeted cases that form part of a rehabilitation project and in the absence of control over their development and funding capacity. Nevertheless, the "*projet d'établissement*," which represents the hospital's multiyear policy, is listed as a subject for deliberation by the CHU Management Board. The Treichville University Hospital formalized a *projet d'établissement* for 2011–2015, which includes several components (including medical, care, equipment, quality, hygiene, and social components), but its implementation appears to have been limited by both postelection disruptions and financial constraints.

With little management autonomy, hospital management is more likely to focus on day-to-day management than on medium-term planning. Managers cannot foresee developments in their care provision or technical facilities because they are not in control of a significant part of their investment budget. It is also difficult to plan training and future job and skills needs, as recruitment and postings are decided at the central level. Hospitals' management autonomy rests exclusively on the mobilization of community financing within a framework set by oversight entities.

Performance Monitoring: Transition to Results-Based Management

In preparing to pilot results-based financing (RBF) in Côte d'Ivoire's health sector, situational analyses of the health system were carried out to identify the main weaknesses in the sector. These include:

- Weak regulatory authority of the state due to "insufficient activities of verification, monitoring, and evaluation of the system"
- Lack of effective community participation in management committees
- Inefficient allocation of resources within the sector
- Low level of managerial accountability to both the state and the population, as a result of input-based funding
- Concentration of human resources in large urban areas due to a lack of incentives for health workers to reside elsewhere
- Uneven distribution of infrastructure across the country and poor maintenance
- A poorly functioning referral system
- Lack of continuity in pharmaceutical stocks
- Non-application of guidelines by health workers
- Low availability of information to enable decision making.

Monitoring of public hospital performance is affected by the weak capacity of oversight authorities. Given the fragmentation of oversight, the Ministry of Health does not have adequate monitoring and evaluation capacity to effectively monitor performance. As it stands, performance monitoring is apportioned between the DIPE, which has a planning and data collection role, and the SACG. This dimension has been minimized, however, as evidenced by the successive downgrading of the SACG within the ministry's organizational chart—moving from a general directorate to a central directorate, then autonomous service, and finally to a central service.

The quasi-systematic annual renewal of allocations and the lack of reference to performance further reduces incentives. Allocations in the form of subsidies are decided by the Directorate of Financial Affairs and are not indexed to performance or to cost recovery, which provides negative incentives for hospital performance.

The PNDS, which is based on a results-based management approach, identifies key bottlenecks in the health sector. The PNDS was developed using modeling tools, such as the Country Health Policy Process, which enabled the identification of obstacles in terms of both supply of and demand for health services. To complete this analysis, the Ministry of Health commissioned a survey carried out by the Regional and Departmental Directorates of Health,

which identified the "bottlenecks related to the availability of essential inputs, human resources, geographical accessibility, use, and adequate coverage (continuity)."

The PNDS also provides for concrete actions to improve the accountability of the hospital system. Within the integrated management system, the PNDS provides for the collection of routine data and epidemiological surveillance data. It plans to strengthen the supervision and monitoring system at each level of the health pyramid by means of a regular plan to monitor health activities at each level. However, the monitoring tools provided for by the PNDS (action plans) remain largely theoretical.

A pilot of RBF is planned with donor support in four districts. This pilot project will be financed jointly by the government and the World Bank, as set out in a national performance-based financing strategy document.

Initiatives that aim to move toward results-based management could reinforce ongoing efforts to reform the public finance management system. The government has embarked on a public financial management reform process with the eventual goal of introducing results-based management. This reform focus is reflected in the introduction of a Medium-Term Expenditure Framework as a central element of budget elaboration, thus changing the roles assigned to stakeholders at the central, intermediate, and peripheral levels of the health pyramid. In addition, the Minister of Health has been designated as the chief authorizing officer for the budget and the appointment of delegated authorizing officers.

CHAPTER 3.5

Boards of Directors and Executive Management

Management Boards/Committees

EPNs are placed under the control and authority of a management board, which ensures the proper execution of tasks entrusted to the hospital. The EPN management board comprises at least eight members. Duties include monitoring, preparing, and implementing the budget and reviewing the financial accounts. It meets four times per year and may include a scientific committee that assists the board chair with certain decisions. University hospitals report directly to the office of the Minister of Health.

CHRs and HGs are administered by a management committee. The committee's mandate includes: approving the hospital's annual action plan; approving the rules of procedure; issuing opinions on the proper functioning of the hospital and on the draft state-financed budget; monitoring budget execution; approving the hospital's own resources budget and monitoring its execution; and reviewing and approving the hospital's annual activity report.

The composition of management boards and management committees differs among hospitals. The main relevant ministries have direct

representatives on the management board. Civil society is strongly represented on management committees, including representatives of the municipal council, heads of district, women's associations, and youth associations. The oversight entity is represented in a deconcentrated form by the prefect and the regional director of public health. The manager (or the head doctor) and the chair of each hospital medical commission attend meetings in an advisory capacity (Box 49).

BOX 49

Composition of Management Boards/ Committees in Côte d'Ivoire

CHU: Management Board	CHR, HG: Management Committee
• Minister of Public Health (Chair) • Minister of Higher Education • Minister of Defense • Minister of Economy and Finance • Minister of Civil Service • Minister of Social Affairs • Mayor of the city where the head office is located • Director of Civil Servants General Corporation • Private insurance company representative • Universal health insurance representative	• Prefect (Chair) • Two representatives appointed by the municipal council from among its members • Regional Director of Public Health • Departmental Treasurer • Two staff representatives (one from medical profession and one from nonmedical staff) • Two female representatives • Two youth representatives • Two representatives of heads of districts

Source: Legal texts and interviews.

The duties assigned to hospital boards leave little room for initiative on the part of hospitals themselves. The regulatory framework clearly defines the mandate of EPNs' management boards; for example, any new project must be presented, discussed, and validated by the board

before it can be implemented. In CHUs, the board can, according to the legislation, deliberate on service fees, allocation of own resources, service changes, jobs, association and cooperation agreements, property acquisitions, and loans. In practice, however, board members seem to have limited power to act. As in the case of CHRs and HGs, they perform their duties under the authority of the departmental or regional director of public health. Overall, decision-making power is highly concentrated at the oversight level.

Executive Management

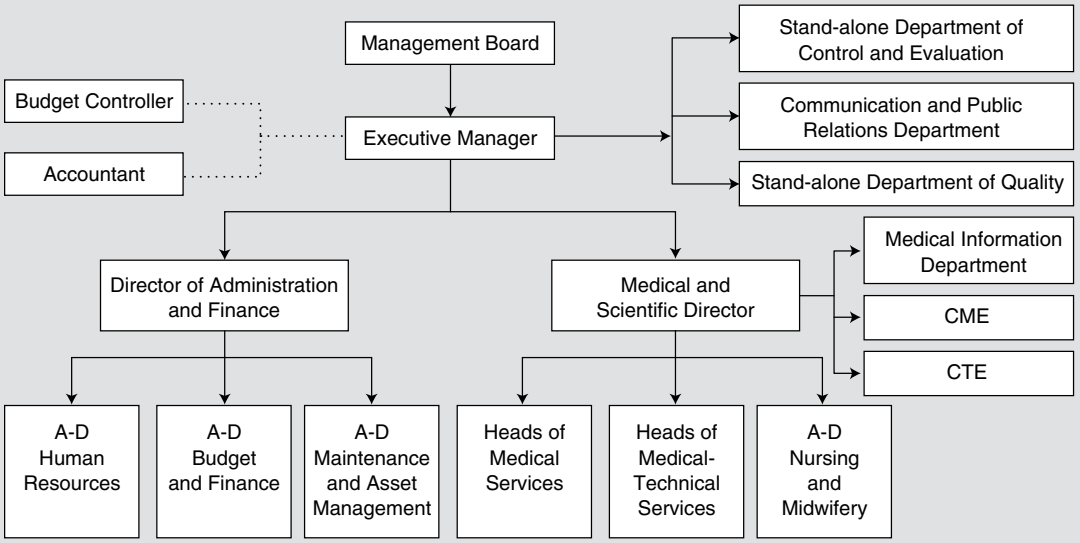
The EPN's manager is responsible for the administration and general management of the hospital, under the supervision of the management board. Appointed by decree on the recommendation of the Minister of Health, the manager is the chief authorizing officer for the hospital. The executive management team leads hospital services under the supervision of the management board. For CHUs, the role of chief executive officer must be assumed by a professor of medicine.

In CHRs and HGs, the manager is responsible for the administration and general management of the hospital under the hierarchical authority of the DDS. The manager is appointed by order of the Minister of Health. According to the legislation, the hospital management's mandate includes: (i) preparation of the hospital's annual plan and master plan; (ii) establishment of rules of procedure; (iii) monitoring the propriety of activity implementation; (iv) management of human resources made available to the institution; and (v) budget preparation.

The manager is supported by a management team, under the supervision of the management board/committee. For CHUs, the team consists of the director of medicine and science and the director of administration and finance. It should be noted that the function of head of human resources is provided by the manager and the administrative and financial officer, particularly with regard to the recruitment and management of contractors. In some EPNs, managers also rely on the heads of various other hospital departments (Box 50).

BOX 50

Organization Chart for Yopougon University Hospital



Source: CHU of Yopougon. Note: A-D = Assistant Director; Dept. = Department.

Other Bodies: Advice and Control

CHU Commissions

CHUs have two advisory commissions: the Hospital Medical Commission (CME) and the Hospital Nonmedical Commission (CTE). The commissions focus on the overall organization of the hospital, its funding, its services, service quality, staffing and human resource capacity, cleanliness, and security. It is chaired by a doctor who is elected from among the hospital's department heads and then appointed director of medicine and science. The CTE brings together the supervisors of the health units and the representatives of the various staff categories, and elects its officers from among its members.

While the CME meets regularly, the CTE does not seem to meet according to the periodicity stipulated in the regulations. These bodies are supposed to meet every quarter. In practice, monthly department

meetings often replace CME meetings. The CTE meets only under special circumstances.

The CME and CTE are supported by technical committees based on the hospital's expertise requirements, but these meet rarely. The committees are in charge of the operational aspects of a particular area: medicines, medical equipment, emergencies, hygiene, and the fight against hospital-based infections. They meet infrequently, with the exception of the Committee for the Fight against Hospital-based Infections (CLIN).[48] If a committee or working group is to be set up, it must be presented and justified to the management committee for approval.

Advisory Medical Commission and Hospital Council (CHRs and HGs)

For CHRs and HGs, the advisory medical commission (*commission médicale consultative* in French) is responsible for issuing recommendations on the functioning of the hospital. The medical commission meets at least four times per year and is composed of the head doctor, the general supervisor, and the heads of medical-technical services. The commission must be consulted on: (i) the master plan for investment programs; (ii) the program of activities; (iii) the organization and operation of services; (iv) the rules of procedure; (v) application of the drug policy; (vi) the institution's budget and accounts; and (vii) issues related to ethics and the quality of care.

The hospital council examines issues related to staff development and advises on health and safety. It is responsible for informing staff about the organization and operation of the facility, as well as health and safety issues, and is supposed to meet once a year. It is composed of the manager, members of the medical commission, and a representative from each of the hospital's professional categories.

48 While there were few identifiable quality policies or accreditation procedures in the hospitals visited, many institutions had an infection control committee (CLIN) and certification procedures had been initiated.

Control Bodies

In EPNs, control is carried out by staff seconded from the Ministry of Economy and Finance. These seconded officers monitor compliance with the legal framework. For EPNs, the budget controller exercises control over execution of the hospital's budget, and the accountant carries out financial transactions in accordance with legal provisions.

University hospitals are provided with an autonomous Service for Control and Evaluation. Established by Decree No. 2001-650 of October 19, 2001, the service liaises with the manager and is responsible for monitoring and controlling the proper application of procedures and the proper use of resources.

CHAPTER 3.6

Transparency and Disclosure

Publication of Reports

Transparency and publication of reports are limited within the hospital sector. Despite a number of legal obligations, few hospitals have truly transparent disclosure systems. The rules and practices of the Organisation for Economic Co-operation and Development (OECD) on transparency and information are reported in Annex 10.

The tax, budgetary, and accounting systems of public hospitals borrow from the general legal environment of the state. CHRs and HGs apply the same accounting rules as the deconcentrated services under state control, and EPNs are subject to the budgetary and accounting rules of the state's administrative departments. The rules of annuality, legality, specialization, unity, and balance are in force. The same applies to compliance with procedures for revenue collection and expenditure execution, which are dominated by the principle that the Ministry of Economy and Finance is the sole authorizing officer for the budget.

Law No. 98-388 of July 2, 1998, sets out the main fiscal and accounting rules to be followed by EPNs. The law obliges EPNs to draw up a provisional budget before the end of the third month of the current fiscal year.

The provisional budget is to be submitted to the management board for approval before the end of the fourth month and transmitted to the Minister of Economy and Finance thereafter. In addition, within three months of the end of the financial year, the accountant must produce a financial statement that is submitted to the manager for approval and to the budget controller for reference. During the same time frame, the hospital manager is required to draw up an annual activity report, and the budget controller must prepare a special report on budget execution. No later than eight days after the end of the third month of the current fiscal year, the manager is required to submit to the management board the financial statement, the activity report, and the special budget execution report for verification and compliance. Within eight days of the management board meeting, the accountant submits the financial statement to the Directorate of Treasury and Public Accounting, along with the activity report and the special report on budget execution. The directorate is required to submit all these documents to the Court of Auditors before the end of the sixth month of the fiscal year.

Decree No. 98-379 of June 30, 1998, clarifies the rules governing hospitals under state control. This decree on the organization and functioning of urban public health facilities that do not have EPN status stipulates that the provisional budget prepared by the hospital manager must be submitted to the management committee after consultation with the medical commission, and subsequently transmitted through hierarchical channels to the Minister of Health. Regarding budget execution, the manager acts as the delegated credit administrator for CHRs and HGs. Budget execution is to be monitored by the management committee, which reviews the regularity and level of revenues and of expenditure execution on a quarterly basis. Funds recovered as part of the health care pricing policy are managed by an income administrator and an imprest administrator, who are appointed by the Minister of Economy and Finance and placed under the control of the public accountant of the related departmental directorate of health.

Compliance with accounting and fiscal rules is facilitated by integrated management systems. The Integrated Public Finance Management System currently in place in hospitals under state control and the integrated accounting computer network in EPNs allow for monitoring of compliance with rules and principles. Expenditure transactions are carried out according to the phases of commitment, liquidation, scheduling, and payment, with the exception of regularization procedures for unplanned government expenses. In the payment phase, payment items are issued by the authorizing officer.

Monthly, quarterly, and annual activity reports for CHRs and HGs are transmitted through hierarchical channels. Each month, the

management of HGs sends its activity report to the departmental directorate of health, which compiles the statistical data and submits them to the regional directorate of health—in principle no later than the tenth day of the month. For CHRs, the report is sent directly to the regional directorate of health. The latter, which is not equipped with data compilation software, transmits the raw data to the ministry's DIPE.

Data availability and reliability are uneven across hospitals, and the nonstandardized nature of the information limits data consolidation. Hospitals do not provide their statistics in a systematic and regular manner, and the manual processing of data raises questions about the reliability of information. Moreover, because financial and activity reports are not harmonized, there is no systematic identification of critical indicators, which hinders data consolidation.

Internal Control

The General Inspectorate of Health (IGSLS) is responsible for hospital inspections and for ensuring that regulations are disseminated and applied. Under the direct authority of the minister, the IGSLS carries out all administrative, financial, and health supervision of the health facilities and services under the Ministry of Health and ensures the dissemination and application of laws, regulations, and directives. The IGSLS conducts unannounced field inspections upon the request of the minister's office. It also fields complaints from users of public hospitals. The IGSLS serves on the management board. Recently, 15 IGSLS inspectors were trained in risk-based auditing. During 2013, the IGSLS carried out 66 out of 75 planned health facility inspections.

The General Inspectorate of Finance (IGF) is charged with controlling the budgeting of appropriations by the Ministry of Health's Directorate of Financial Affairs. Responsible for monitoring the proper use of public resources in ministries and institutions under state control, the IGF performs—on instruction from the Ministry of Economy and Finance—any inspections deemed necessary. In the hospital sector, IGF control is concentrated on the Ministry of Health's Directorate of Financial Affairs, and the IGF acts as an authorizing officer delegated by the Ministry of Economy and Finance. The IGF has the authority to inspect EPNs and has recently completed a survey at the Yopougon CHU.

The mission of the Public Spending Review Unit (CRDP) is to conduct *ex post* reviews of public spending. The CRDP is staffed with inspector-auditors with the rank of director of central administration. The unit is

placed within the General Directorate of Budget and Finance and is responsible for evaluating *a posteriori* expenditure execution by state services, including hospitals under state control and EPNs. It conducts general, sectoral, or crosscutting reviews of public expenditures to allow for the *ex post* evaluation of state spending. In addition, the CRDP may be asked to carry out an audit by the Minister of Economy and Finance or by the general director of budget and finance. These audits aim to analyze and evaluate public expenditure to assess its management, ensure that it is properly executed, and gauge its impact. Following an audit, the CRDP is tasked with preparing a report and briefing note. When the evaluation reveals dysfunctions, the audit report makes recommendations to the oversight authorities for addressing the dysfunctions within an operational action plan. The CRDP has audited most hospital EPNs. The audits consist of both financial and organizational audits.

External Control

The Court of Auditors (*Chambre des Comptes*) exercises both judicial and management control over public bodies. Its mandate includes judicial review of the accounts of public accountants and management control of public and semipublic bodies. Until recently, the chamber has focused more on regional councils and town halls, and control of the public hospital sector has concerned only peripheral issues such as medical waste management. It is expected, however, that the Court of Auditors will increase its focus on the public hospital sector.

CHAPTER 3.7

Conclusion and Opportunities for Further Strengthening

This study of Côte d'Ivoire's hospital governance framework has highlighted its strengths as well as opportunities for further strengthening. This analysis has helped put the hospital governance framework into perspective vis-à-vis the "good practices" presented in the methodology for analyzing the corporate governance of SOEs (Box 51).

BOX 51

Good Practices in the Corporate Governance of SOEs and Parastatal Entities

Governance Dimensions	Good Practices
Legal Framework	• Clear legal framework covering the entire parastatal "sector" • Definition of the legal status of entities

(box continues on next page)

BOX 51 *continued*

Governance Dimensions	Good Practices
State Oversight Function	• Appointment of a specialized entity at the state level to ensure effective and regular monitoring of financial and nonfinancial performance of the sector • International trend toward centralization of oversight function in a single entity to ensure comprehensive and coherent monitoring of all entities ("centralized model")
Planning and Performance Monitoring	• Definition of mandates and objectives • Development of financial and nonfinancial performance indicators • Development of performance agreements between the state (oversight entity) and the parastatal entities • Performance monitoring and evaluation of public enterprises
Boards of Directors	• Transparent and meritocratic selection of board members • Professional specialization and independence of board members • Clear definition of the respective roles of the oversight bodies, boards of directors (autonomous bodies responsible for strategic decisions and monitoring of executive management), and executive management • Principle of autonomy of the board of directors, ensuring both strong accountability toward the state shareholder (oversight entity) and day-to-day management autonomy on the part of the parastatal entity
Transparency and Disclosure	• Clear rules and criteria for financial and nonfinancial reporting • Publication of consolidated annual reports on the sector by the oversight entity • Regular publication of independent external audit reports • Effective internal control

Sources: OECD (2015a); World Bank (2014a); World Bank compilation.

A Sector Marked by the Crisis

The hospital governance model that has been in place since the late 1990s has been affected by political unrest and is experiencing major

performance challenges. This model provides that hospitals are structured either in the form of the French EPIC or as services under state control. Not all of them have financial autonomy. The model also defines the oversight of autonomous facilities without mentioning the existence of a directorate in charge of hospitals. In addition, the regulatory framework provides for the transmission and dissemination of information. Despite the existing governance framework (Box 52), in practice Côte d'Ivoire's public hospital sector faces significant performance challenges. In particular, hospitals suffer the effects of political unrest, which has had a significant impact on the overall public health system and has led to a loss of consumer confidence.

BOX 52

Hospital Sector Governance Framework in Côte d'Ivoire

Legal Framework	• Industrial and commercial public agency (EPIC) for national public agencies (EPNs) • Lack of legal personality for regional hospitals (CHRs) and general hospitals (HGs), which are structured as services under state control
State Oversight Function	• Dual oversight of EPNs: Ministry of Health (technical oversight) and Ministry of Finance (financial oversight) • Technical oversight of EPNs carried out through different directorates
Planning and Performance Monitoring	• Sector planning: National Health Policy, Health Development National Plan • Strategic planning largely centralized • Short-term hospital planning: annual work plan • Transition to results-based management
Boards of Directors	• Presence of boards/management committees in the hospitals, at all levels of the health pyramid • Regulations define membership profiles, terms of reference, frequency of meetings
Transparency and Disclosure	• Controls provided internally and by the Court of Auditors, according to the legal framework

Source: World Bank compilation.

Challenges in Hospital Governance

The main challenges identified by the study relate to the implementation of autonomy, the organization of the state oversight function, and transparency and disclosure. The diagnosis has helped to identify opportunities to strengthen the sector, which are in line with the reform options proposed by the government. The legal framework is the primary area of focus, with the potential extension of autonomy beyond the EPNs and establishment of a directorate dedicated to hospitals in order to compensate for fragmented oversight. On the other hand, the political crisis, which has destabilized the sector, has reduced the ability of hospitals and authorities to share information. As a result, the hospital sector is characterized by a significant deficit in available information and little analysis of sector trends (Box 53).

The creation of a directorate in charge of hospitals would limit the fragmentation of oversight and the duplication of mandates and would facilitate optimal monitoring of the sector. The creation of a directorate with sufficient institutional visibility and adequate resources could refocus sector oversight, which is currently scattered among different central directorates. This fragmentation, which opens the door to overlapping mandates, does not allow effective monitoring of the sector. Implementation of a hospital directorate would make it possible to centralize national strategy considerations, as well as monitoring and control, while limiting its involvement in the operational management of hospitals. Moreover, increased hospital autonomy could help create the space needed by hospitals to develop a credible investment policy.

Reviewing international good practices in hospital autonomy could be a first step toward progressively expanding autonomy in Côte d'Ivoire. Initiating a policy discussion on hospital autonomy with all stakeholders could help extend autonomy to CHRs and HGs. Evaluating best practices in the hospital field and the experiences of other countries in the subregion would assist in evaluating the potential benefits of autonomy, particularly for hospitals in more remote areas. This review of the hospital legal structure could empower hospitals to collect more own resources. If necessary, the expansion of autonomy could be carried out gradually, beginning with the regional hospitals. Under this approach, the revision of the statutory framework would need to be accompanied by clear mechanisms for accountability between hospitals and the state.

Restoring regular communication between hospitals and the state is an essential step toward improving performance. To date, there is little information on the hospital sector, and the information that is available has

BOX 53

Challenges in Hospital Governance in Côte d'Ivoire

Legal Framework	• The legal framework faces some enforcement challenges. • The EPIC infrastructure does not seem well suited to EPNs. • Regional and general hospitals (CHRs and HGs) are sometimes disadvantaged by their lack of autonomy.
State Oversight Function	• There is no directorate that is dedicated specifically to hospitals. • Oversight of EPNs is fragmented across several central-level entities. • Several mandates overlap.
Planning and Performance Monitoring	• Hospital strategy development is limited (to a few "*projets d'établissement*"). • Performance monitoring is limited.
Boards of Directors	• Boards and/or management committees are in place, but their capacity to carry out the tasks entrusted to them is limited.
Transparency and Disclosure	• There is no control by statutory auditors. • Côte d'Ivoire faces a postcrisis context with still limited control. • Transmission of information from hospitals to oversight entities is limited. • There is no annual publication on the hospital sector. • There is limited publication and consolidation of information.

Source: World Bank compilation.

not been consolidated or analyzed at the oversight level. The crisis context in Côte d'Ivoire has exacerbated this situation and raised questions about the reliability of data. Restoring a framework for facilitating the sharing of information on hospitals would strengthen overall sector monitoring and reduce fiscal risks. As a first step, introducing a culture of performance by setting up communication routines would enhance transparency in the sector. This communication framework could then be extended to the development of monitoring tools such as a hospital information system, which would support a more systematic and standardized transfer of information.

PART 4

THE CASE OF SENEGAL

CHAPTER 4.1

Landscape of the Hospital Sector in Senegal

Context and History of the Hospital Sector

Until 1998, hospitals in Senegal were under central management and showed poor performance. Hospitals had no management autonomy and were required to apply central directives. There was an absence of clear health sector objectives, management procedures were overly formalized, infrastructure had degraded, and biomedical equipment became obsolete. This context resulted in poor performance, in terms of both hospital utilization and quality of care.

To restore performance, the government undertook hospital reforms in 1998 with the clear goal of strengthening autonomy. The reform targeted all hospitals, from the largest and most significant (university hospitals in Dakar) to the most modest hospitals in rural areas. They became public health facilities (*établissements publics de santé*, or EPSs, in French), specialized legal entities with their own assets, under the dual oversight of the Ministry of Finance and the Ministry of Health. Financial autonomy allows them to charge service users directly. The reform, in both

its objectives and its implementation, has resulted in a transfer of hospital governance to the EPSs, which operate according to principles of corporate governance. A decentralization dimension is also present, as the chair of the board of directors is drawn from outside Dakar: the elected president of the regional council.

Initially, there was strong resistance to reform among hospitals and staff, and compliance was uneven. Some department heads of hospitals located mainly in Dakar have long resisted reform implementation. Social partners, on the other hand, have lobbied to secure the tenure of often underqualified staff, which had a considerable impact on the wage bill without meeting the need for skilled personnel.

Implementation issues hampered the reform process. Obstacles included: (i) insufficient preparation of and support for reform; (ii) the inability of technical oversight services (Ministry of Health) to ensure adequate monitoring and control of EPSs; (iii) a lack of coordination among oversight ministries; and (iv) a lack of capacity among advisory bodies, such as the board of directors or the hospital medical commission, to perform their functions effectively.

In spite of these challenges, reform consensus is building in some areas, particularly with regard to the organizational level and the principle of autonomy. Although the relevance of EPS status to hospitals in rural areas is not evident to the technical oversight services, the key point of the reform—EPS autonomy—is not in question. Many positive trends are emerging, including: (i) improved synergy between medical and administrative services; (ii) participatory management; (iii) a certain degree of beneficial competition among EPSs, which has provided incentives for performance; and (iv) more operationally focused management of EPSs, given that the Treasury is represented in each EPS hospital by an accounting officer (ACP). In addition, management tools such as procedural manuals have facilitated reform implementation.

Government Reform Plans

Without calling into question the key focus of the 1998 reform, the Ministry of Health is considering adjustments to the status of rural EPSs, to the EPS Directorate, and to hospital planning. Legal amendments would include the following:

- EPSs in the periphery would move to a communal regime (even if the utility of EPS autonomy is not in question, the relevance of the EPS status to hospitals in rural areas is not clear to technical oversight entities).

- The mayor of the town in which a rural EPS is located would become the chair of the board of directors for that EPS.
- A deputy manager would be appointed in all EPSs.
- A hospital map for each EPS would become a component of the overall health map.

Financial, Material, and Human Resources

Financial Resources

Since 2009, the government has allocated 5 percent of its health budget, on average, to the health sector (Box 54). This figure, which has declined slightly since 2009, is below the World Health Organization (WHO) recommendation of 10 percent.

In 2011 and 2012, more than 30 percent of the Ministry of Health's budget was spent on hospitals and their operating budgets. Although the overall share of the Ministry of Health budget allocated to hospitals is difficult to assess, available data can help estimate the proportion of the subsidy, which amounted to approximately 10 percent of the ministry's budget (2011 and 2012), and the amount allocated to EPS operation, which averaged 20 percent over the 2009–2013 period (Box 54).

BOX 54

Budget Allocated to EPSs in Senegal, 2009–2015

	2009	2010	2011	2012	2013	2014	2015
Ministry of Health (MH) budget as a share of the state budget (%)	5.6	5.8	5.3	4.7	4.9	4.7	4.7
Subsidy to EPS as a share of MH budget[49] (%)	—	—	10	10	—	—	—
EPS operating budget as a share of total MH budget[50] (%)	20	20	22	21	21	—	—

Source: Republic of Senegal, Ministry of Economy and Finance, Ministry of Health, Budget Laws 2009 to 2014.

49 Data available for only 2011 and 2012.

50 Including budget lines for staff salaries; staff incentives; and operations (DAGE).

Hospital financing follows a hybrid model, which includes—in addition to the state subsidy—receipts from the delivery of health care and the sale of medicines. Subsidies include: a state subsidy, paid directly to EPSs by the Ministry of Health in quarterly installments; a regional subsidy, determined each year by the regional council for regional hospitals; and a municipal subsidy whose envelope is defined by the municipal council and for which the amount is determined by the mayor. In addition, given the autonomous status of EPSs, they receive direct payments for health care delivery, examinations, and hospitalization services in accordance with the hospital's pricing policy.

It is recognized that the current arrangements for allocating the state subsidy are unsatisfactory. EPSs do not receive justification regarding the allocation of the state subsidy across facilities, and they do not find that allocations take into account their needs, activities, or changes in the supply of care. A workshop was held to discuss this issue and to establish objective criteria for allocating subsidies. Given that the activity criterion is not currently in use,[51] the grant was renewed this year.

Infrastructure and Equipment

Hospitals are organized according to a pyramid with three tiers of care that correspond to levels of technical competence. The health pyramid is based on the division of the territory into medical regions and health districts (Annex 12). The tiers correspond to different levels of equipment, technical facilities, and specialties. The referral/counterreferral principle establishes links between the tiers to allow for adaptation and continuity of care from one level to another. These tiers also correspond to the administrative side: the central administration (the Cabinet and related services), the intermediate level (medical regions), and the peripheral level (health districts).

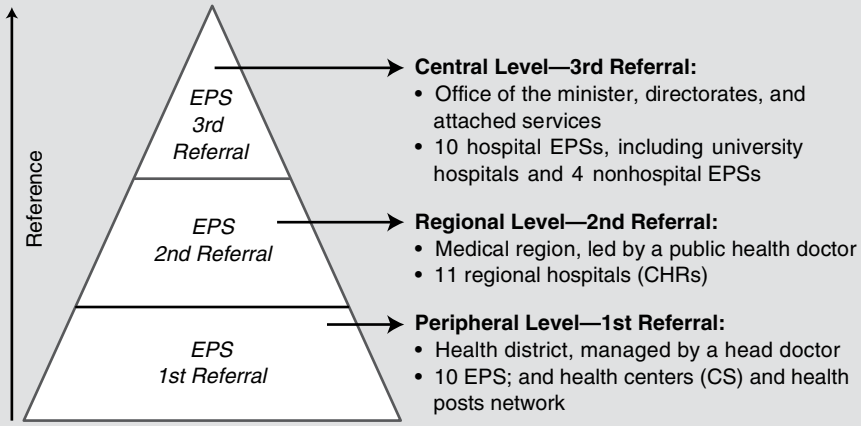
Senegal's 31 EPSs are spread across all three levels of specialization:

- ***Central level:*** There are ten hospital EPSs and four nonhospital EPSs. Their vocation extends throughout the national territory, due to their high specialization in medicine, surgery, obstetrics, and psychiatry. This is the third referral level.

51 While awaiting the establishment of criteria based on the results of an accounting analysis and the Medical Information System, the criterion based on days of hospitalization was chosen.

BOX 55

Organization of Senegal's Health System

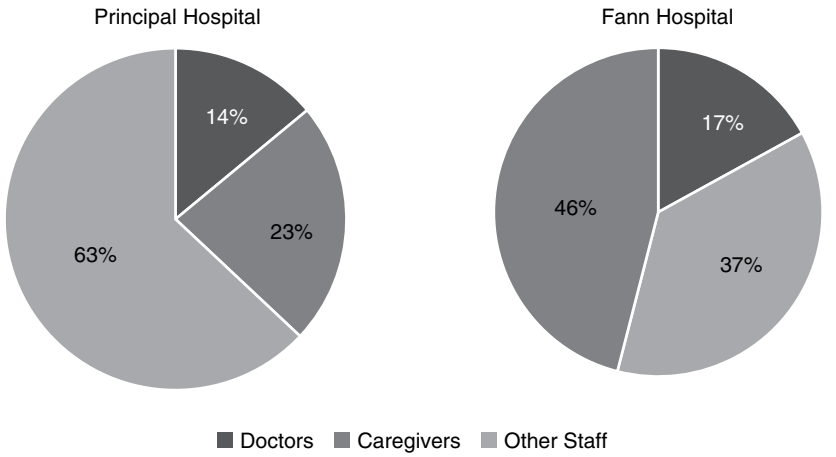


Source: Republic of Senegal, Ministry of Health, World Bank compilation.

- ***Regional level:*** There are 11 regional hospitals (CHRs) that provide medical, general surgery, obstetric, and emergency care, as well as specialized medical, surgical, or psychiatric care services. They represent the second referral level for health facilities in their coverage area.
- ***Peripheral level:*** There are ten EPSs at the peripheral level, which represents the first referral level for health facilities. Located at the bottom of the health pyramid, they provide general medicine, general surgery and obstetric care, and emergency care (Box 55 and Annex 13).

The state of hospital infrastructure is uneven, and equipment maintenance is often lacking. Many hospital buildings appear to be dilapidated or obsolete, including in Dakar. For example, Le Dantec University Hospital is housed in a degraded unit-based structure with narrow buildings, which makes it impossible to foresee a move toward a modern hospital design. The lack of follow-up and equipment maintenance appears quite widespread. Hospitals rarely have biomaintenance services ready to intervene on equipment that is heterogeneous due to various acquisition conditions (including donations, secondhand purchases, and allocations from the Directorate of Infrastructure, Equipment, and Maintenance, or DIEM) and for which maintenance contracts are rarely valid.

FIGURE 10: Structure of Jobs in Senegal's Hospitals, Fann and Principal, 2013



Source: Republic of Senegal, Ministry of Health, World Bank compilation.

Human Resources

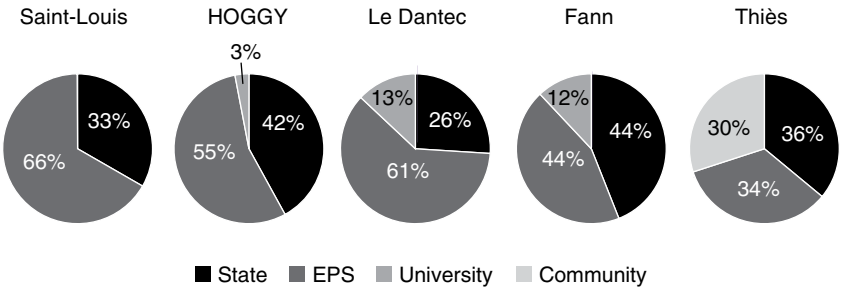
In 2012, there were 6,764 EPS employees in Senegal,[52] divided into medical, paramedical, and administrative categories. Doctors comprised 11 percent of staff, paramedical 48 percent of staff, and "other staff," including administrative and technical staff, 41 percent.

The relative balance between medical and administrative staff varies widely across hospitals. This disparity is illustrated among EPSs of comparable capacity, such as Fann and Principal. First, among medical staff, there are 98 physicians at Fann and 156 at Principal. Administrative and technical employees seem to be overrepresented in relation to the health care workforce, with the proportion of "other staff" (including administrative and technical staff) ranging from 37 percent at Fann to 63 percent at Principal (Figure 10). Finally, interviews conducted for this study revealed inadequacies in the number of registered nurses receiving state certification (*infirmiers diplômés d'état*) and in the number of qualified executives.

Significant disparities were also observed in the number of medical staff per bed. This statistic ranges from 3.3 staff per bed at Principal Hospi-

52 This figure refers to the following EPSs: Abass Ndao, FANN, HALD, HEAR, HOGGY Diourbel, Kaolack, Kolda, Louga, Ndioum, Ourossogui, Principal, Saint-Louis, Tamba, Thiès, Ziguinchor, Touba, and Thiaroye.

FIGURE 11: Distribution of Staff in Some of Senegal's EPSs, 2011



Source: Republic of Senegal, Ministry of Health, World Bank compilation.

tal to 1.5 for Thiès and St-Louis (Level 2 regional hospitals) and Fann (a university hospital in Dakar).

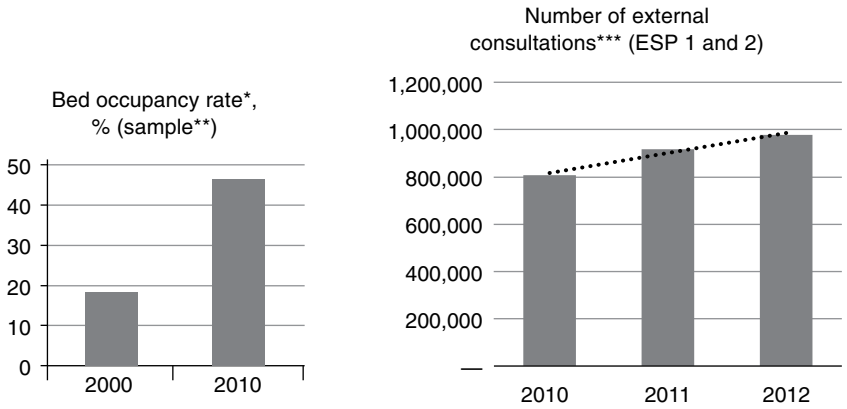
The relative share of civil servants, contract workers, and staff made available by universities or local authorities varies according to the type of EPS. Available statistics show that the proportion of staff recruited by the EPSs themselves varies from 34 percent at Thiès to 66 percent at Saint-Louis. The proportion of teaching staff is slightly over 10 percent at university hospitals (CHUs), and the proportion of community workers in Thiès hospital accounts for almost one-third of its staff (Figure 11).

Service Delivery Performance

The increase in the utilization of hospital services since the 2000s demonstrates the population's renewed confidence in the sector. Whether it is measured in terms of bed occupancy, number of visits, or hospitalization rates, utilization of hospital services has increased in Senegal following reforms (Figure 12). The EPSs in the study sample have doubled their bed occupancy rate since 2000 (moving from 21 percent in 2000 to 49 percent in 2010, for example). In addition, data on wait times, occupancy of hospitalization and emergency services, and activity levels in delivery and surgery units reflect the increase in hospital activities. Annex 14 presents a detailed set of indicators.

Policies to encourage access to health services among vulnerable populations, which have become more prevalent in recent years, partly explain the increase in hospital activity. Currently, these policies offer free access to: (i) patients over the age of 60, as part of the "SESAME" program (Box 56); (ii) women who require cesarean sections; (iii) patients with

FIGURE 12: Bed Occupancy and Number of External Consultations in Senegal's Hospitals



Source: Republic of Senegal, Ministry of Health, World Bank compilation. ** The bed occupancy rate indicates the extent to which available hospital beds are utilized during the year. ** The sample contains the following institutions: Hôpital Principal de Dakar, HOGGY, Le Dantec, Fann, Abass Ndao, Saint-Louis, Thiès. *** External consultations refer to outpatient consultations.*

BOX 56

SESAME Program in Senegal

- SESAME is a system of assistance for people of Senegalese nationality aged 60 years and over.
- It provides access to free or reduced medical costs throughout the country, upon presentation of the national identity card.
- A committee is established to promote, monitor, and evaluate this system.

Source: Decree No. 2008-381 establishing a system of "sesame" assistance. Official newspaper.

renal insufficiency; and (iv) indigent people, identified under conditions set by the EPSs themselves. The fee waivers relate only to the costs of hospitalization, however. Pharmaceutical costs are generally paid by patients, except in Principal Hospital—the one hospital where these costs are included in the rates charged. Implementation of these policies is uneven and imposes significant costs on EPSs. New schemes for free access are under consideration, including for health care for children under the age of five or under universal health coverage.

The development of quality policies plays a role in improving the health service. The most advanced method in EPSs is the 5S method, which

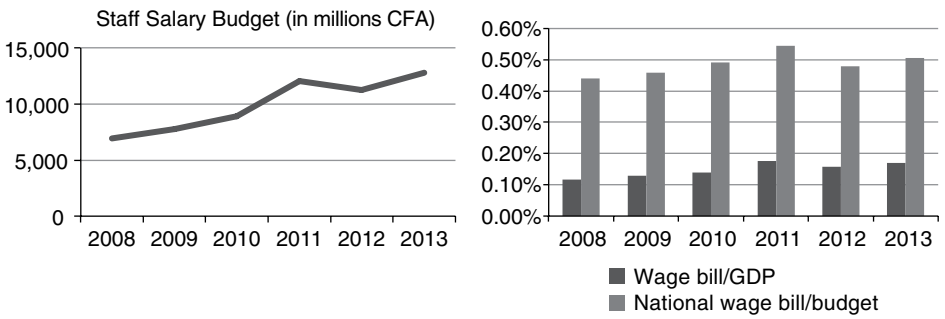
aims to continuously improve tasks through clearing, storing, cleaning, order, and rigor. It is a popular and successful program. In addition, Committees for the Fight against Hospital-based Infections (CLINs) are effective in numerous hospitals, and a national CLIN committee has been set up. On the other hand, hemovigilance and material vigilance approaches seem to have been limited to date. In terms of certification, two key examples include the laboratory of the Abass Ndao hospital and Principal Hospital, which is seeking ISO certification[53] for the facility as a whole.

Financial Performance and Fiscal Risk

According to the budget, the wage bill for Ministry of Health employees increased by 83 percent between 2008 and 2013. The wage bill/GDP ratio rose from 0.12 percent to 0.17 percent and the national wage bill/budget ratio increased from 0.44 percent to 0.50 percent during the same period (Figure 13).

EPSs need to use the state subsidies they receive in order to pay salaries, which creates a fiscal risk. In most EPSs, the wage bill represents a significant part of the total operating budget; it falls generally in the range from 60 percent to 80 percent, with the exception of Le Dantec Hospital (40 percent) and Principal Hospital (52 percent). As a result, EPSs draw resources from the subsidy to meet their wage burden, which creates a reliance on the state. This source of fiscal risk was identified in a 2013 report of the General Inspectorate of State (IGE), which stated that "no EPS can pay wages with its own resources" (Box 57).

FIGURE 13: Evolution of the Ministry of Health's Budget for Salary Expenses



Sources: Republic of Senegal, Ministry of Health, World Bank compilation; GDP figures from: World Economic Outlook, IMF.

53 https://www.iso.org/iso-9001-quality-management.html

BOX 57

Financial Resources of EPSs in Senegal

EPS	Collected Own Resources (OR)	Total Resources (OR+Subsidy)	Total Payroll	Salaries/ OR	Salaries/Total Resources
	CFAF	CFAF	CFAF	%	%
Fann	138,339,889	2,441,202,838	1,060,747,920	674.42	43.45
Abass Ndao	404,082,590	1,874,885,619	937,779,940	232.07	50.01
Saint-Louis	695,492,105	1,528,976,566	750,393,702	107.89	49.07
Thiès	653,725,422	1,722,119,369	758,229,063	115.98	44.02
Le Dantec	2,332,991,787	4,896,991,179	1,909,547,635	81.76	38.95

Source: Republic of Senegal (2013).

The significant increase in the wage bill can be explained in part by the effect of reforms on staff tenure. Hospital reform has forced the EPSs to recruit previously unpaid volunteers or task-based paid workers with an automatic increase in remuneration.

Incentive schemes also contribute to the weight of the wage bill. The monthly incentive bonus envelope is 25 percent of expected revenue, and the special quarterly incentive amounts to CFAF 150,000 per worker. Other incentives also exist, depending on the EPS, including an incentive bonus, medal award, retirement party, or employee of the month program (Le Dantec hospital). Implementation of these incentives, at the expense of financial sustainability (Box 58), has reduced EPS resources and, in turn, hampered management of ongoing operations.

Delays in reimbursements for services offered free of charge by the state affects the financial balance of EPSs. As part of the national social policy, hospitals are responsible for providing care for the elderly, the poor, and deliveries by cesarean section. According to an IGE report (Republic of Senegal 2013), the debt to be recovered for these elements amounted in 2009 to CFAF 1,883 million for the SESAME plan, CFAF 755 million for the care of indigent patients, and CFAF 113 million for cesarean sections. Adding in the government's debt with regard to budgetary allocations (CFAF 1,335 million in 2009), these programs have impinged considerably on EPS budget margins. The total debt owed to EPSs by the national government amounted to CFAF 4.2 billion in 2013.

BOX 58

The Problem of EPS Bonuses in Senegal

To attract or retain staff, hospitals have created a variety of bonuses, but several problems have arisen.

- More than 67 percent of staff costs correspond to bonuses and allowances, the largest category of which was incentive payments (amounting to about 37 percent of staff costs).
- Profit sharing should theoretically be based on hospital revenues. In practice, however, it is paid to staff in a fixed manner, without a clear link to actual revenues.
- Each hospital had the option of setting the percentage of own revenues to be offered in the form of employee incentives within the range of 0 to 25 percent. Most institutions chose the maximum rate of 25 percent, without studying its practicality beforehand.
- Hospitals have often created bonuses that overlap with those of the state.

Source: Lemière et al. (2012).

Notwithstanding the state's commitment to pay what it owes on a regular basis, EPSs continue to bear the weight. At the interministerial council of May 5, 2008, the state committed to making regular payments on amounts due to the hospitals for fiscal allocations or other services (such as the SESAME plan and cesarean sections), the prerequisite being that EPSs would improve their billing and revenue collection systems. In practice, however, the state continues to pay irregularly, posing challenges for hospital fund management and creating fiscal risks.

Fee waiver policies also pose specific implementation challenges. According to the SESAME program, the government is responsible for covering the costs of health care for the elderly. There is no distinction between those over the age of 60 who have medical coverage and those who do not. In many cases, the health care costs of elderly patients are fully paid by the state under the SESAME plan, regardless of whether the patient has partial or full medical coverage. On the other hand, not all EPSs systematically charge free cesarean sections to the state, as some of them consider these procedures to be covered by operating subsidies.

EPSs face a heavy tax liability. According to the IGE, the tax burden of EPSs amounted to CFAF 3 billion in 2009; therefore, cross-compensation between the EPSs and the state based on the year 2009 would generate only

CFAF 917 million in favor of the EPSs. The current debt held by EPSs is out of all proportion to this amount, however. The debt of the *Hôpital Général de Grand Yoff* (HOGGY) alone is evaluated at CFAF 7 billion.

EPSs initiated a medium-term strategic planning framework in the early 2000s, but this effort did not succeed and no investments were made as a result. In the absence of dedicated funding, these strategies—called "*projets d'établissement*" were considered disproportionate and thus not implemented or renewed. Envisaged by the reform, they included a medical project, a care project, a social project, and even an information system project. Given the management difficulties encountered by EPSs, they were not able to generate the financing capacity needed to implement the *projets d'établissement*. Moreover, owing to their uncertain creditworthiness, EPSs were not able to access the banking system.

Investments were relaunched, however, through the establishment of Multiyear Contracts Specifying Objectives and Resources (CPOM) and with financing from partners. Some renovations, and even the creation of new services, could be carried out through budgets dedicated to a specific reform, within the framework of a CPOM or the targeted financing of a bilateral or decentralized partner.

CHAPTER 4.2

Legal and Regulatory Framework

Pre-Reform Context

Prior to the 1998 reforms, hospitals were deconcentrated services under the authority of the state, and thus managed directly by the state. Management of hospitals depended directly on the Ministry of Health: the hospital director and staff were appointed directly by the central administration, and the state's public finance procedures were in force.

To introduce a dimension of community participation in the management of hospitals, Senegal experimented with health committees. As part of a pilot initiative launched in 1976 on the outskirts of Dakar and expanded in 1983, community participation had been established through health promotion associations and health committees. Translating the twofold desire to involve people in care by paying for their medical consultations and to involve them in the management of health care, the health committees allowed the hospital sector to benefit from new resources and to introduce a dimension of cost control at the hospital level.

The health committees showed their limits, however, and this led to the implementation of a thorough reform process. Beginning in 1992,

health committees have been subject to regulations governing associations and have been given a standard status, but they continue to have limited autonomy and have been open to abuse in the management of recruitment and funds. In response, the government initiated a consultation process in 1996, which led to the 1998 reforms.

The Emergence of Public Health Facilities: The 1998 Reform

Status of Hospitals and Public Service Mission

The 1998 reform marked a clear choice in favor of hospital autonomy by creating the status of public health facilities (EPSs). Two laws—No. 98-08 of March 2, 1998, on hospital reform and No. 98-12 relating to the creation, organization, and functioning of the public health facilities, a status inspired by French law (Box 59)—have made major changes in favor of public hospital autonomy. Supplemented by Decree No. 98-701 of August 26, 1998, on the organization of public health services, and Decree No. 98-702 of August 26, 1998, on the administrative and financial organization of EPSs, the 1998 laws are characterized by four major areas of focus:

- Hospitals are EPSs, specialized legal entities, with their own assets.
- EPSs are placed under the financial supervision of the Ministry of Finance and under the technical oversight of the Ministry of Health.
- EPSs are managed by a board of directors, which defines the hospital's policy and its guidelines, and by the hospital management team, which guarantees day-to-day management and executes the decisions of the board of directors.
- EPSs benefit from financial autonomy, enabling them to invoice directly for health care services provided.

In addition to EPSs, the Hospital Reform Act of 1998 created two other statutes for the establishment of military and private hospitals. In parallel to EPSs, the law provides for military hospital facilities (EHMs) participating in the public service as well as for private nonprofit and for-profit hospitals.

The hospital reform law classifies EPSs according to their specializations and areas of intervention. Pursuant to section 2.1 of the hospital reform law No. 98-08, there are three levels of EPS (Chapter 4.1), as defined in article 3. Depending on its location and its technical or administrative characteristics, an EPS can be called a national hospital center, a regional hospital center, or a communal hospital.

BOX 59

Public Health Facilities in France

The creation of a public health facility reduces the administrative burden, increases management flexibility, and promotes greater responsibility and involvement of staff.

Its management bodies are composed of:

- **a deliberative body:** the board of directors, comprising representatives of local and regional authorities, staff, experts in relevant fields, patient representatives, and representatives from funding entities. The board defines the general policy of the institution and votes on the budget.
- **an executive body:** the hospital management team takes responsibility for technical management and can play a lead role in providing strategic guidance for the facility. It is headed by a director (from the hospital's management) who is appointed by the Minister of Health following consultation with the chairman of the board of directors.

Its operation rests on three main principles:

- **autonomy:** allows the EPS to control management bodies, assets, and legal, material, and financial resources. Financial autonomy is essential for the EPS to have the resources it needs without having to depend on the oversight authority.
- **specialization:** entrusts the EPS with a mission specifying the nature of the activities to be carried out (statutes). It cannot operate in other areas.
- **linkage (*rattachement*):** allows the body creating the hospital to exercise oversight control over the EPS (including approving the budget and making important decisions). This linkage may be more or less heavily emphasized.

Public health services are subject to the oversight of public authorities:

- The EPS accountants are accountants of the Treasury (with a separation between the authorizing officer and the accounting officer).
- The budget must be submitted to the regional hospital agency, which can request the modifications it considers necessary.
- EPSs are subject to the public procurement code.
- The decisions of the board of directors must be approved by the oversight authority.

Source: Perrot and de Roodenbeke, eds. (2005).

The law defines the public hospital service that comprises EPSs, EHMs, and the private hospitals that have chosen to participate. The hospital reform law states that the public service mission includes not only the provision of care, but also prevention, training, and research. The public service mission is ensured by EPSs and EHMs, but the law provides that private hospitals may participate by request. Defined in articles 8 and 9 of Law No. 98-08 (Box 60), the public service mission is based on three fundamental principles:

- continuity of service;
- equality in access to essential care; and
- provision of the best possible care.

BOX 60

Mission of the Public Service Hospitals in Senegal

The public hospital service provides for:

- equal access to care for all;
- admittance day and night, including on an emergency basis;
- patient care or transfer to another suitable facility;
- establishment of a diagnosis and the provision of preventive, curative, and rehabilitative care; and
- continuity of care, in connection with other health care facilities.

The public hospital service also participates in:

- university and postgraduate education;
- continuing education for practitioners;
- medical, odontostomatological, pharmaceutical, and psychological research;
- initial and in-service training for paramedical staff and on nursing and obstetric research;
- preventive medicine and health education activities, and their coordination;
- organization of emergency medical aid in conjunction with relevant persons and services;
- implementation of any activity falling within the framework of the public health priorities defined by the Ministry of Health; and
- care of the prison population under conditions set by regulation.

Source: Law No. 98-08 on hospital reform.

Employment System

EPS staff are subject to varying employment systems. These include:

- Public servants, including EPS managers of hierarchy A, appointed by decree after consultation with the board of directors;
- University teaching staff;
- Contractors hired by the hospital under the Labor Code;
- Contractors made available to the EPS by the state and paid by the state;
- Staff made available to the hospital by local authorities; and
- Staff made available to the hospital under the cooperation agreements.

Law No. 98-12 on the creation, organization, and functioning of EPSs provides that the statutes existing at the time of the reform were intended to apply on a transitional basis until the adoption of a statute for EPS staff. The reform of the statutes was not achieved, however.

Public Procurement Regulations

EPSs must comply with public procurement rules. Article 12 of Law No. 98-12 provides that the procurement rules followed by EPSs shall be determined in accordance with the regulations in force. According to article 2 of the public procurement code, all public agencies fall within the scope of the code.

Accounting Regime

EPS accounting is to be conducted by a public accounting officer in accordance with the rules of public accounting. Although they are specialized facilities, at the financial and accounting level EPSs operate as public administrative agencies. As such, the goods and services they provide are made available to the public, in principle, at cost, like a service under state control (*régie financière*). The revenue and expenditure chain involves two main actors:

- the executive manager, who serves as credit administrator and initiates expenses, settles them, and issues payment orders; and
- the accounting officer (ACP), who collects revenue, settles expenses, and prepares financial statements for each EPS. The ACP transmits financial statements to the State Council within eight months of the end of the fiscal year, after submitting them for approval to the board of directors. The ACP is under the authority of the General Treasurer but must respect the internal rules of organization and operation of the EPS.

The chart of accounts does not reflect the specific nature of financial flows to a health care institution. The chart of accounts used is the SYSCOHADA accounting plan that applies to all public agencies. Each EPS has the same main accounts, but the title and nature of the subaccounts are the responsibility of the EPS, with no harmonization from one EPS to another. The general presentation by type of expenditure does not allow a more specifically hospital-oriented view of the nature of spending. At the interministerial council of EPSs in May 2008, the lack of a financial regime for EPSs was pointed out, and it was requested that the Ministry of Health, in conjunction with the Ministry of Economy and Finance, trigger the procedure for drawing up a financial scheme for EPSs.

With the exception of the Principal Hospital, EPSs do not keep cost accounting and do not have an integrated accounting management system. There is no standardized financial management system; EPSs' accounting systems differ significantly from one hospital to another, ranging from simple manual processing to more or less fragmented computerized treatment. Only the Principal Hospital uses an integrated computerized management system.

Challenges Related to the Effectiveness of the Legal Framework

Despite a well-defined and comprehensive legal framework, limited application of laws has placed hospitals in an uncertain legal position. The 1998 hospital reform has initiated significant changes of hospitals' legal framework by granting them a new status and autonomy. However, not all provisions accompanying the reform have been adopted fully, which has introduced legal uncertainty. For example, tools foreseen by the reform, such as the information system or revised EPS personnel statute, have not been created. Without these tools to strengthen hospital autonomy, EPSs face significant management challenges.

CHAPTER 4.3

The State's Oversight Function

A Dual Organization Model

Oversight of EPSs is exercised jointly by the Minister of Finance and the Minister of Health. Technical oversight of EPSs is exercised by the Directorate of Health Facilities (DES) of the Ministry of Health, and financial oversight by the Ministry of Finance (Box 61).

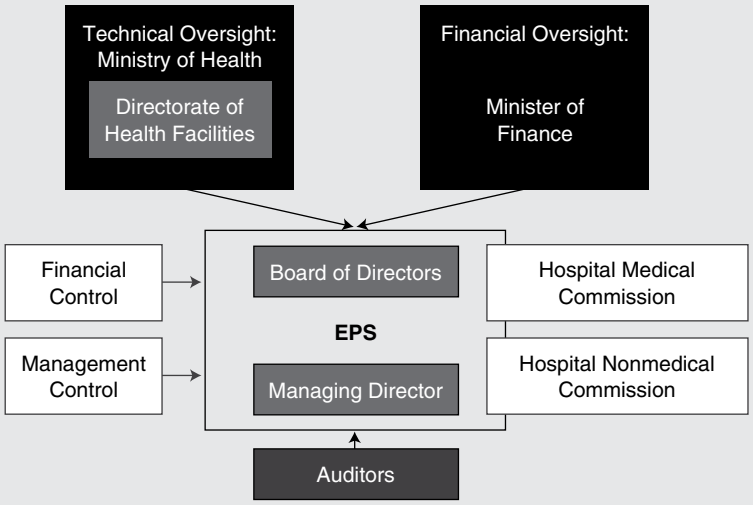
Oversight of regional and peripheral EPSs is the responsibility of the governor of the region where it is located. The governor is a deconcentrated authority of the state. Technical and financial oversight is the responsibility of the regional head doctor and the regional financial controller, respectively, under the authority of the regional governor. The accounting officer, however, reports directly to the Treasury of the Ministry of Finance.

Financial Oversight: Ministry of Finance

Financial oversight of EPSs is shared between the Directorate of Economic and Financial Cooperation (DCEF) and the Budget Directorate (DB) of the Ministry of Finance, with the principal aim of determining allocations in the sector. These units prepare entries in the state budget for

BOX 61

EPS Oversight Regime in Senegal



Source: World Bank compilation.

the purpose of allocating funds for investments and operation, respectively. For this purpose, they rely on the financial statements communicated by the ACP and on the information communicated by technical oversight bodies. The DCEF and the DB participate in validating the CPOMs.

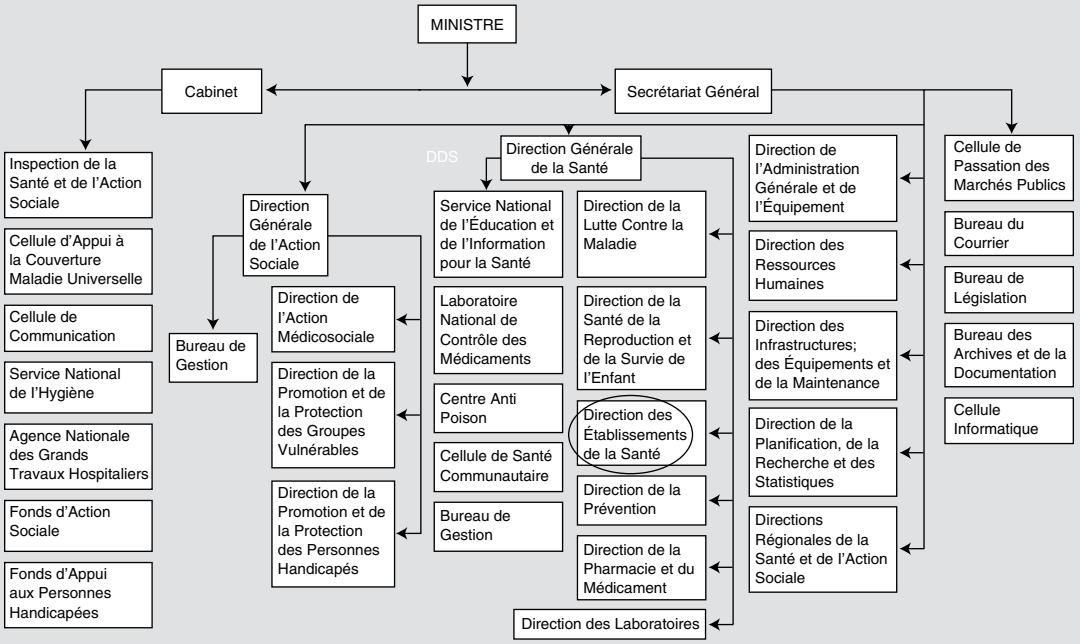
Approval procedures for EPS budgets differ according to the level of the EPS. Level 3 EPS (central level) budgets are forwarded directly to the Ministry of Finance, while level 1 and 2 EPSs (peripheral and intermediate level) send their budget to the regional governor for approval.

Technical Oversight: Directorate of Health Facilities

Technical oversight is exercised by the Ministry of Health through the DES. Located within the General Directorate of Health (Box 62), the DES is responsible for developing and monitoring the implementation of state policy on hospitals and health care facilities. The DES ensures the fulfillment of the missions of EPSs and specialized health facilities. It is also responsible for regulating, supporting, and controlling private clinics and practices and promoting their participation in the public health service. DES consists of:

BOX 62

Organizational Chart of the Ministry of Health in Senegal



Source: Ministry of Health website, http://www.sante.gouv.sn/ (in French).

(i) the Division of EPSs; (ii) the Division of Private Health Facilities; (iii) the Regulatory and Litigation Division; (iv) the Monitoring and Evaluation Division; and (v) the Management Office.

The DES is in charge of allocating subsidies to EPSs and monitoring their performance. The DES plays a key role in steering national hospital policy because it distributes health sector budget allocations among EPSs. In addition, it determines EPSs' eligibility for entering into CPOMs and assesses their implementation.

The DES operates with modest human and financial resources. In 2013, the DES operated with a budget of CFAF 100 million and a staff of about 20 people.

Within the DES, the Division of EPSs is the focal point for technical oversight. This division has a staff of three and a budget of CFAF 8 million (2013). In order to ensure comprehensive and continuous care of the

population and to improve complementarities among public health actors, various missions are entrusted to this division, including:

- ensuring proper functioning of EPSs;
- assisting EPSs in the preparation of multiyear hospital strategies (*projets d'établissement*), forward-looking budgets, and financial statements;
- identifying equipment needs that correspond to public hospital service offerings; and
- designing action plans for delivering health care services.

Role of Ministry of Health Crosscutting Departments in EPS Oversight

The Directorate of General Administration and Equipment (DAGE) also plays a role in preparing the EPS budget. The DAGE is a crosscutting directorate located at the same hierarchical level as the two general directorates of the Ministry of Health. Responsible for coordinating budget preparation, the DAGE serves as the Ministry of Finance's focal point for overall health sector budget allocations and defines, along with the DES, the criteria for allocating annual EPS grants.

The Directorate of Infrastructure, Equipment, and Maintenance (DIEM) is responsible for ensuring the development and maintenance of hospital infrastructure. The DIEM is at the same level as the DAGE and is tasked with implementing the Ministry of Health's acquisition policy with regard to designing infrastructure, monitoring its operation, choosing equipment, and controlling its installation. The DIEM acts as a delegated project owner in public sector real estate projects and purchases large equipment (such as scanners, MRI machines, and mammography equipment) for EPSs. Managing an investment budget of CFAF 30 billion, according to the forecast budget for 2014, the DIEM has allocated about CFAF 1.5 billion to the purchase of medical equipment for EPSs in recent years and has thus contributed to the modernization of their technical facilities. The DIEM is also responsible for implementing the national maintenance policy for the health sector (Box 63).

The Directorate of Human Resources (DRH) is responsible for the training, management, and promotion of Ministry of Health staff. The DRH ensures effective coordination in the recruitment and management of health and social work staff by the state, local authorities, health facilities, and health committees, as well as the enforcement of regulations governing public and private facilities in charge of professional training in health and

BOX 63

National Maintenance Policy in Senegal

Overall objective: The overall objective of maintenance is to ensure the sustainability, operation, and safety of investments at all levels of the health pyramid.

Specific objective: Meeting this overall objective will be achieved through the following specific objectives:

- developing procurement standards and procedures (for infrastructure, equipment, and donations);
- setting up procurement standards and procedures (for infrastructure, equipment, and donations);
- strengthening the technical and managerial skills of professionals and those of stakeholders relevant to the implementation of these standards and procedures;
- ensuring the extension and application of these standards and procedures to all relevant stakeholders;
- maintaining a database on infrastructure and equipment related to the sector's assets;
- implementing decentralized maintenance services at all levels of the health pyramid; and
- ensuring implementation and monitoring of the maintenance policy.

Strategies: The strategies to be developed concern:

- establishment of a regulatory framework for coordination/consultation at all levels of the health pyramid;
- creation of a database of national assets (including health equipment and infrastructure);
- compliance with procurement standards and procedures (for infrastructure, equipment, and donations);
- implementation of a continuing education policy for maintenance technicians and users; and
- implementation of a plan for the oversight and evaluation of maintenance projects.

Source: Republic of Senegal, Policy for the Maintenance of Infrastructure, Facilities, and Equipment of Health Services in Senegal.

social work. It sets up policies for promotion and dialogue with partners. It is responsible for:

- developing policies for the forward planning of jobs and skills;
- drawing up and monitoring the execution of management actions on the part of Ministry of Health staff, in accordance with regulations; and
- developing and implementing training plans.

Challenges in Organizing Oversight

The lack of integration between financial and technical oversight results from limited communication between the oversight ministries. Although the Ministry of Health and Ministry of Finance both play a role in allocating resources to EPSs, they do not appear to meet on a regular basis, which leads to automatic renewal of endowments as previously specified.

The method by which financial oversight is exercised does not allow for financial arbitrage according to health needs. Although central and deconcentrated financial control bodies sit on the board of directors, financial oversight is essentially exercised by central services. Apart from water, electricity, and gas expenditures, there are no regulations that provide a framework for exercising financial oversight to better determine the financial resources involved in steering a national hospital policy. This contributes to the annual renewal of budgets, disconnected from real, local needs for health care service provision.

Technical oversight is weakened by a lack of resources and disadvantageous institutional positioning. With low staffing and budget, and a secondary position within the Ministry of Health organization chart, the DES is not in a position to process the information needed to implement a public hospital sector strategy.

In the absence of the strategic management tools provided for in the reform, the DES focuses more on EPS establishment and organization than on their operation. Without: (i) an information system enabling a real-time understanding of health care activities and costs of service provision; (ii) the authority to enforce the health map; or (iii) real multiyear hospital strategies (*projets d'établissements*), the DES does not have the tools it needs to adequately manage the sector. Moreover, the DES faces challenges in attracting qualified staff, as managers prefer to be assigned to EPS positions rather than to those at the oversight level.

Given its structural weaknesses, the DES is constrained in distributing the funding envelope allocated to EPSs. A workshop was held in 2012

with the aim of defining and proposing criteria for budgetary allocations to EPSs. The conclusion of the meeting summarized five criteria for determining funding allocations: EPS level (70 percent), poverty in the hospital area (10 percent), performance of the EPS (5 percent), remoteness of the EPS location (5 percent), and size of the care population (10 percent). Still defined as provisional, these criteria are not operational and, in view of the lack of information provided to DES, they maintain the *status quo ante,* which consists of annually renewing the previous financial year's budgets.

CHAPTER 4.4

Planning and Performance Monitoring

Planning Framework

Planning in the Health Sector

The national health development plan (PNDS) is the reference document for health planning in Senegal. The PNDS projects the ministry's 10-year strategic orientations, which are implemented through two operational tools: the medium-term expenditure framework, which sets a multiyear programming and budget execution framework over three years, and the annual work plan (PTA).

The latest PNDS for 2009–2018 responds to the sector issues highlighted by the poverty reduction strategy paper (PRSP).[54] The second pillar of the latter is devoted to accelerating the promotion of access to basic social services. The PNDS is divided into four objectives and 11 strategic pillars (Box 64).

54 Republic of Senegal (2009).

BOX 64

Objectives and Strategic Orientations of the PNDS in Senegal

Objectives of the PNDS	Strategic Pillars
Reduce the burden of maternal and infant/child morbidity and mortality	• Accelerating the fight against maternal, infant, and child mortality and morbidity
Increase health sector performance in preventing and controlling disease	• Improving health promotion • Strengthening case management • Strengthening integrated disease surveillance and response
Sustainable strengthening of the health system	• Developing human resources • Strengthening infrastructure, equipment, and maintenance • Improving the availability of medicines and medico-surgical products • Strengthening the information and research system
Improve governance of the health sector	• Promoting results-based management • Improving the sector's capacity for planning and administrative and financial management • Strengthening health risk coverage by focusing on vulnerable groups

Source: Republic of Senegal (2009).

Following initial evaluations of the 1998 reform, the PNDS provides for further strengthening of hospital reform plans. While early results of the 1998 hospital reform appear to be mixed, the PNDS reports a situation "of concern to users, health staff, and health and political authorities" (Republic of Senegal 2009). The PNDS thus foresees certain reinforcements to the hospital reforms through the establishment of a hospital policy. The strategic directions announced by the PNDS are: (i) strengthening the control and regulation of the oversight entity; (ii) improving administrative, financial, and accounting management; (iii) strengthening the provision of hospital care and services; (iv) improving the quality of services and performance; and (v) strengthening communication.

A health map was drawn up in 2008. According to Law No. 98-08, the purpose of the health map is "to anticipate and bring about necessary changes in the provision of care in order to optimally satisfy the demand for health." In addition, it is intended to be "based on a measure of the needs of the population and their evolution, taking into account demographic and epidemiological data and advances in medical technology, following a quantitative and qualitative analysis of the provision of care." A first health map project was developed in 2002 after many hospitals adopted their hospital strategies. A new health map was prepared in 2008.

The national health information system provided for in the law has not yet been established. Law No. 98-08 provides that "hospital EPSs implement a policy for evaluating their activities and service costs, as part of the national health information system." This system has not been implemented, however.

Hospital Planning at the EPS Level

Hospital policy is reflected in a multiyear planning document. The "*projet d'établissement*" represents the hospital's medium-term strategy. According to Law No. 98-08, hospital strategies cover a maximum period of five years. They must define, on the basis of medical guidelines proposed by the hospital medical commission, the general objectives of the facility and its planned activities in research, social policy, training, management, and application of an information system. As they should be consistent with the health map, hospital strategies must determine the hospitalization, staff, and equipment capacities it needs in each area of care in order to achieve its objectives.

Following the 1998 hospital reform, a first generation of hospital strategies emerged in all EPSs in 2000. The hospitals undertook the development of these strategies in collaboration with consulting firms. Designed for a five-year period, they addressed medical needs, care needs, social needs, and information systems.

Despite some recognized contributions to EPS management, these hospital strategies were deemed unrealistic and have not been renewed. Despite strong initial resistance to their elaboration, the strategies often helped to build a shared vision, involve staff in the strategy development process, and develop a participatory approach as a new management and governance tool. Some shortcomings were also identified, however, namely: (i) disproportionately ambitious investment plans; (ii) inadequate preparation and insufficient accompanying information; (iii) simultaneous start-up

of all hospitals without spreading over time; and (iv) failure on the part of the government and donors to finance the projects called for in the hospital strategies. As a result, the strategies were not renewed.

Each EPS develops an annual work plan (PTA). Implemented on the initiative of the Ministry of Health, PTAs are a tool for short-term monitoring and planning of EPS activities. They align with PNDS guidelines while responding to local problems.

PTAs do not seem to be as highly regarded, either at the oversight level or at the EPS level. While the DES seems to pay particular attention to the PTAs, the EPS are somewhat skeptical about this exercise and thus make little use of it. Furthermore, PTAs are integrated broadly at the level of the ministry's department of planning, research, and statistics, whereas it might be appropriate to do so specifically for the hospital sector at the DES level.

Performance Monitoring

The government's reform initiative concluded with the adoption of a national contracting policy with a results-based management approach. Since the accompanying measures to alter the image of public hospitals have proved insufficient, the authorities have decided to introduce more incentive measures to link a portion of the state subsidy to the achievement of a set of objectives defined by mutual agreement with hospital officials. This approach was reflected in the national health sector contracting policy of 2004. Based on the hospital strategy, the contracting policy aims to make a transition to results-based management. Performance contracts are among the tools favored by the national contracting policy document, as they would set objectives to be achieved in return for additional resources allocated by the state in light of the results achieved.

First-generation performance contracts were concluded, but were not pursued after the first evaluation. Initially, in consultation with reform stakeholders, the DES drew up a standard model contract defining the areas to be contracted, results criteria and indicators, and the respective commitments of hospitals and the state (Box 65). In 2006, so-called first-generation contracts were signed with 15 EPSs following approval by their respective boards of directors. An initial evaluation was carried out in 2007 using an on-site audit method, based on a standard form for data collection and an evaluation grid to translate the results obtained. At the end of this evaluation, the EPSs that were considered to be meeting performance

BOX 65

Hospital Performance Contracts in Senegal

The preparatory work undertaken for the formulation of performance contracts—in particular, the choice of subjects, criteria, and indicators—has been the subject of broad consultations with the hospital community. The results of the evaluation were used as a basis for calculating the performance subsidy to be paid in 2008 to hospitals that met eligibility conditions. Despite shortcomings in the content of the contracts and in their implementation, they have had a positive impact:

- In operational terms, they have in some cases been a powerful lever to encourage teams to work together more effectively, and where results have been less convincing, they have led to further probing of challenges.
- At the institutional level, they have laid the ground for a new organization of the oversight relationship between the ministry and public hospitals.

Source: Extracted from Gueye and Kopp (2009).

criteria received supplementary budget resources of CFAF 37 to 75 million in 2008. Since the commensurate funding could not be provided, the first attempt to manage results through performance contracts came to an end prematurely.

Given the structural debt of EPSs, the government ordered the re-establishment of performance contracts. Following the evaluation of hospital reform in 2008, which had pointed to chronic deficits in EPS management, the government approved a series of directives regarding EPSs during an interministerial council in 2008 (Box 66). One of these directives concerned the implementation of plans for the discharge of hospital debts and another called for arbitration of investment subsidies, taking into account national health priorities and public service missions assigned to EPSs. Performance contracts were among the tools favored by the latter directive.

Second-generation contracts, CPOMs, have been signed with a number of hospitals beginning in 2011. Within the framework of the national contracting policy, the Ministry of Health concluded CPOMs with a series of hospitals (including Fann, Albert Royer, Touba, Thiès, and Saint Louis) in 2011, 2012, and 2013.

BOX 66

Extract from the Conclusions of the Interministerial Council on EPSs

- Disproportionate operating costs, in particular those relating to staff costs
- Inadequate medical and nursing staff alongside unqualified staff
- Very high debts to suppliers
- Compromised financial sustainability
- Continuing deterioration in the quality of care
- Chronic payment collection difficulties
- Absence of oversight control mechanisms
- Dissatisfaction among users, health professionals, and state authorities

Sources: Republic of Senegal, Interministerial Council of EPSs (2008).

The DES provided for performance evaluation in a number of areas, including performance criteria and indicators. In a guidance document, the DES set out a number of areas to be covered by the CPOMs, accompanied by evaluation criteria to be assessed through results indicators (Annex 15). Taking into account the lessons learned from first-generation performance contracts, the DES introduced trigger criteria to overcome the difficulties encountered by oversight authorities in obtaining quarterly activity reports.

However, the CPOMs suffer from the same deficits in the reliability of information and in oversight capacity. By providing additional resources for hospitals, CPOMs can contribute to improved efficiency in hospitals that meet performance criteria. However, given capacity constraints and a lack of effective transmission of reliable information, oversight bodies are unable to verify the accuracy of the information provided by the EPSs. As a result, they lack the performance information they need to make additional resources available for strengthening EPS efficiency.

Challenges in Planning and Performance Monitoring

Hospital strategies have not been the strategic and operational planning tool that they were expected to be at the time of the reform. Although first-generation hospital strategies were prepared between 2000

and 2002, owing to the lack of coherence, they have not met expected planning objectives for oversight bodies or for the EPSs themselves. In the Le Dantec hospital, no hospital strategy was adopted due to opposition from medical professionals to the reform.

The lack of consolidated financial information and an effective information system hinders the financial monitoring. Beyond the institutional and capacity challenges, financial monitoring is complicated by the inadequate availability of reliable data, insufficient communication of financial information, and the limited capacity of the DES to process information. Furthermore, owing to the lack of an integrated computerized information system, there is no system in place to consistently identify and monitor missing information.

Performance monitoring is affected by the limited interaction between the DES and the EPSs under its control. It appears that a number of EPSs do not disclose their financial statements and budget forecasts on a regular and timely basis. Information from the boards of directors and financial reports reach the DES only after long delays and, in some cases, not at all. Since the DES does not have the means to coerce production of this information, it finds itself unable to exercise effective control.

The limited data that are available are not used to analyze the financial performance of hospital sector entities. The DES performs little analysis of EPS financial and budget performance. The only consolidated annual report for EPSs dates back to 2009. In the absence of an analysis of the existing risks and their potential evolution under different scenarios, the DES cannot reasonably quantify EPS results.

CHAPTER 4.5

Boards of Directors and Executive Management

Boards of Directors

Boards of directors are the main innovation of the reform and represent the hospital's highest level of authority. The autonomy of EPSs has led to a situation in which the boards of directors act as the principal decision-making body for the hospital. The hospital reform provided the modalities for organization of the board of directors: member profiles, conditions of appointment, terms of office, frequency of meetings, quorum, and matters under its authority. Hospital management and staff are accountable to the board of directors.

The board of directors is made up of various health sector stakeholders from different levels of the health pyramid:

- staff representative, elected by peers;
- management advisory bodies, such as the hospital medical commission;
- users of health services, through consumer associations;
- representatives of oversight bodies such as the Ministries of Finance, Health, and the Armed Forces (in the case of the military hospital);

- representative of the regional oversight body (regional council) as part of decentralization;
- representative of the hospital's local community; and
- representative of the university, for university-based hospitals.

The manager and the ACP participate in the work of the board of directors in an advisory capacity.

In practice, the relative weight among board members seems to diverge from the reform's original intention to empower the users and staff of EPSs. The share reserved for representatives of the administration and local communities, as well as qualified experts, appears to dominate in comparison to that of users and staff.

The board of directors approves the decisions made by EPSs concerning hospital resources and services. The board validates the decisions of the EPS, which has broad authority in determining the prices of services (fees within a range established by the ministry), allocating operating resources (in the budget according to operating results), and managing investments and human resources (recruitment, remuneration, and assignments, with the exception of state staff). It also decides on the projects and the functioning (rules of procedure) of the hospital.

For strategic decisions, the board's deliberations require approval from the oversight entity. Certain strategic decisions[55] become enforceable only after approval of the oversight authorities and within a period of 30 days. In practice, however, these decisions are not subjected to in-depth review, since the approval of the oversight authority is generally perceived to be automatic.

Boards of directors have varying power and autonomy. The power of the board rests on the ability of each member to fulfill its role well, whether by understanding the issues and technical subjects, or by ensuring its functional integrity. In some hospitals, the board of directors is regarded as a real management actor, associated with decisions concerning the follow-up of business plans, budget execution, and projects, and meeting on a quarterly basis. For others, it functions as a rubber stamp and meets only twice a year.

Executive Management

The executive manager represents the EPS and ensures the general management of the facility. Appointed by decree, following advice from

55 These include strategic directions and hospital strategies, multiyear action plans and investment programs, budgets and estimated accounts, service fees, loans, and cooperation and partnership agreements between institutions. See Decree No. 98-702 on the administrative and financial organization of EPS.

the board of directors, the manager represents the hospital in court and is obliged to carry out the results of board deliberations and decisions on the part of oversight authorities. It organizes EPS management and rules of procedure.

The executive manager is responsible for the proper functioning of the hospital and the quality of its services. To this end, he or she develops a managerial policy and administers and manages the staff. As the budget authorizing officer, he or she prepares the estimated annual accounts and ensures that they are executed.

EPS managers have varying professional backgrounds. Some are health practitioners, while others have a management background, for example, graduates of the African Center for Advanced Studies in Management. These differences in qualifications imply that managers do not systematically have training in administration or experience in hospital management. To overcome this disparity, a proposal has been made to institutionalize a "learning path" based on taking successive administrative and staff positions over time.

The head of administrative and financial services and the heads of technical services support the hospital manager. Administrative and accounting management is ensured by: (i) the head of the administrative and financial service; (ii) the management controller; and (iii) the financial controller. A director of human resources manages staff. At the technical level, the hospital has a nursing service under the responsibility of a senior health technician or a nurse who is appointed by the director and part of the management team.

The proliferation of positions tends to add to the administrative burden. Even if the existence of these functions makes sense, the fact that they each require a separate staff member increases the administrative burden. While the separation of positions may be justified for the larger level 2 and 3 EPSs (intermediate and central levels), the same level of specialization may not be necessary for small hospitals at level 1 (peripheral level).

Other Bodies

Hospital Medical Commission

Regulated by Decree No. 98-701, the hospital medical commission (CME) is the decision-making body with regard to care. It is composed of the heads of medical, pharmaceutical, and odontology services, and three representatives of physicians, pharmacists, and dental surgeons elected by their peers. The CME is consulted on medical organization and planning,

BOX 67

Responsibilities of the Hospital Medical Commission in Senegal

Preparing with the Manager	Issuing Opinions on
• Hospital medical strategy • Organization of medical and medico-technical activities • Guidelines/measures relating to the policy of continuous improvement of the quality of care and safety • Continuing training plans for medical, dental, and pharmaceutical staff and their implementation	• Hospital strategy • Draft budget, service fees, accounts, works/equipment programs, creations/deletions/transformations of facilities, technical and financial aspects of medical/odontology/pharmaceutical activities • Rules of procedure • The plan of job positions for medical staff, and for permanent and contractual workers; training plans, for paramedics in particular; and the terms of incentive policies • Conventions concerning medical and academic activities • Appointment of department heads

Source: Decree No. 98-701 of August 26, 1998, on the organization of hospital EPS.

promotion of quality of care, and its evaluation within the EPS (Box 67). The president shall be elected from among the heads of departments by members of the commission.

The current functioning of the CME does not reflect the mission assigned to it. The CME sometimes seems to more closely resemble a lobbying body than an actual partner in the management and functioning of the hospital and in the quantitative and qualitative development of care activities. CME meetings do not always include the participation of the hospital manager.

The Hospital Nonmedical Commission

The hospital nonmedical commission (CTE) is a forum for information and consultation of staff. The CTE, composed of one peer-elected representative of each category of staff, is chaired by the hospital manager and consulted on issues such as hygiene, safety, hospital strategies, work- and equipment-related programs, work conditions and organization in the hospital, control of hospital-acquired infections, general staff training policies, and incentive policies. It meets at least twice a year.

The mandate of the CTE seems to be in question, as its meetings are perceived by management to be redundant with those of staff, service, and health and safety committees. The CTE does not appear to meet according to the frequency provided for in the legal framework. Staff would prefer for the CTE to be represented on the board of directors on the same basis as the CME and chaired by a peer-elected member rather than automatically by the manager, as is currently the case.

Control Bodies within the Hospital

A regular control system is in place that is specific to the EPS, including a management controller and a financial controller. The management supervisor is responsible for regularly reviewing budget execution and the cash position, reporting to the hospital manager. In addition, the ACP is responsible for monitoring activities and for the permanent control of financial management. As an agent of the Treasury, the ACP is responsible for enforcing proper application of regulations and procedures. Hierarchically, the ACP depends on the hospital manager but reports to the Treasury (Box 68).

BOX 68

Control Mechanisms within Senegal's EPSs

The management control unit is responsible for, on behalf of the manager:

- regularly reviewing budget execution and the cash position;
- submitting a quarterly report on hospital management;
- continuously monitoring the evolution of the workforce and payroll; and
- providing, through fiscal control and specific investigations, the financial information necessary for management to make decisions.

The financial controller is responsible for monitoring activities and the permanent monitoring of financial management by:

- ensuring control, either individually or through an authorized state controller;
- ensuring compliance with applicable regulations;

(box continues on next page)

BOX 68 *continued*

- advising on the hospital's investment programs and draft budgets, prior to their presentation to the board of directors; and
- sending periodic reports on the hospital's activities and financial situation to the president of the republic, oversight ministers, the IGE, the president of the board of directors, and the manager of the hospital.

Source: Decree 98-702 Administrative and financial organization of EPS (Articles 23 and 24).

The positioning of the ACP is sometimes a source of conflict. The separation between authorization and accounting, through the installation of the ACP as an accounting officer, is relevant but raises some obstacles. Although the functional proximity of the accountant is helpful in that it allows for greater ease of transmission of information, the accounting officer's authority and hierarchical relationship with the manager may be a source of conflict.

CHAPTER 4.6

Transparency and Disclosure

Publication of Reports

Transparency and publication of institutional reports from the EPS to the oversight authority are limited. Despite a number of legal obligations, few EPSs have truly transparent publishing systems. The OECD standards on transparency and information are reported in Annex 10.

Law No. 98-702 provides for a number of reporting obligations to be borne by management control. Article 23 requires that the management unit be responsible for:

- reviewing budget execution and the cash position;
- submitting quarterly reports on the management of the hospital;
- continuously monitoring the evolution of the workforce and payroll; and
- providing, through fiscal control and specific investigations, the financial information necessary for the executive management to make decisions.

Law No. 98-08 provides that the EPSs implement a policy for the evaluation of their activities and their service costs, as part of the national health information system.

The reporting obligations to be fulfilled by the authorizing officer are regulated in a 2011 decree. Decree No. 002980 of April 7, 2011, regulates the fiscal principles applicable in all public agencies. The result is this timetable:

- ***October:*** The competent departments of the authorizing officer (the management unit) draw up the first budget outlines, including estimates of own revenue, new expenses arising from decisions made, or the application of laws or regulations.
- ***On November 20th of year N-1:*** The final draft budget or estimated accounts are to be submitted to the board of directors.
- ***By December 10th of the year N-1:*** The budgets or provisional accounts are to be adopted by the decision-making body and become binding only after approval.

The authorizing officer must also draw up quarterly activity reports, an annual management report, and financial statements. They must be submitted to executive management by March 31st. In addition, the financial statements must be prepared and forwarded to the ACP and to the DES no later than June 30th.

These reporting obligations are not uniformly respected, and the accuracy of reports is questionable. Several EPSs submit their quarterly activity reports and annual management reports irregularly, if at all. This has been addressed in part by the CPOMs, under which it is expected that activity reports will serve as trigger criteria for the implementation of the contract, but only 11 EPSs currently have a CPOM. Furthermore, owing to the lack of sufficient oversight capacity and the resulting lack of on-site inspections, the accuracy of information remains questionable. The lack of reliability was confirmed in an interview with the Court of Auditors.

The EPSs do not engage in inventory management. With the exception of Principal Hospital, EPSs do not maintain an inventory of available equipment or maintenance follow-up. There is no procedure for recording equipment incidents and accidents (hardware vigilance), or dashboards of small hardware (such as syringes, compresses, cotton, and rubbing alcohol) which, in turn, are not available in sufficient quantities. Emergency services do not have a stock of consumables for medical equipment to avoid supply disruptions.

Finally, there is no consolidated information on EPSs. Neither the DES, nor the financial oversight authority, periodically produce a consolidated report to the public or the parliament on the EPSs. The only consolidated annual report published by the DES dates back to 2009.

Internal Control

The sector's internal control framework consists of the current internal systems within hospitals and the interventions of state control bodies. The EPSs are included in the respective mandates of the IGE[56] and the General Inspectorate of Finance (IGF).[57] These inspections work on annual programs and respond to specific inspection requests from their respective supervisory authorities. In addition, EPSs need to develop their own internal control system.

In its public report on the state of governance and accountability, the IGE points to a number of dysfunctions in EPSs. The IGE made a severe assessment of EPS management in a 2013 report (Box 69).

BOX 69

Report of the General Inspectorate of State in Senegal

The hospital reform undertaken in 1998 promoted some hospitals and health facilities to the status of Public Health Facilities (EPS) with legal personality and financial autonomy. The objective was to enable these entities to provide sufficient resources to cover all of their operating costs and to finance a portion of their investment programs.

[. . .] the exponential evolution of the problems and their increasing complexity created, among other consequences, the rapid maladjustment of the initial legal framework of these entities:

- Some programs did not fully meet beneficiary expectations, including the Sesame Plan, which was designed to ensure free delivery by cesarean section.

(box continues on next page)

56 The General Inspectorate of State is under the responsibility of the President of the Republic and responsible for the general inspection of the administration.

57 The General Inspectorate of Finance, under the authority of a coordinator, is responsible for controlling public bodies, parastatals, and private legal entities financed by public authorities, irrespective of their field of activity and location, with regard to the enforcement of the laws and regulations governing their financial and accounting functions.

BOX 69 *continued*

- The so-called "service" function, which was to enable EPS to generate own resources that could relieve their budget, was transformed into "private services," which should lead the political authorities to undertake institutional readjustments of EPSs and clearly redefine and reorient their missions.
- Other management shortcomings include noncompliance with rules on inventory management and difficulties in implementing cost accounting.

Source: Republic of Senegal (2013).

Internal control of the regularity of EPS financial transactions is carried out by the ACP. Charged with settling expenses, collecting revenues, and preparing financial statements, the ACP is a member of the treasury staff and submits financial statements to the treasury for approval within eight months of the end of the financial year, subject to the approval of the hospital's board of directors. The ACP is obligated to observe the internal operating rules of the EPS and is personally and financially responsible for the operations to which he or she is entrusted, having provided guarantees and taken an oath upon taking office. Accountable to the Court of Auditors, the ACP reviews the regularity of financial transactions conducted by authorizing officers, excluding any assessment of their appropriateness.

Internal monitoring is carried out in accordance with the principles laid down by the general accounting regulations and the SYSCOHADA chart of accounts. The accounting system is that of public accounting, regulated by Decree No. 2011-1880 of 2011. Accounting entries are drawn up according to the nomenclature of the West African accounting system (SYSCOA), which implements the uniform act on accounting law provided for in the OHADA Treaty (Box 70).

External Control

The Court of Auditors exercises external control over EPSs. It conducts a judicial review of the accounts and administrative control of EPS management. This control is based on an annual calendar, which provides for a sample of entities to be monitored.

BOX 70

West African Accounting Framework

The accounting and auditing obligations of companies and financial sector entities (such as banks and insurance companies) are contained in WAEMU laws and regulations and in the texts of the Organization for the Harmonization of Business Law in Africa (OHADA, which comprises 17 countries, most of them French-speaking). Audit standards are the only elements governed by national laws. The accounting standards applicable to all companies in Senegal are contained in the West African Accounting System (SYSCOA), developed in the mid-1990s at the instigation of the Central Bank of West African States (BCEAO). Even before its implementation, SYSCOA has been integrated into the OHADA Accounting System (SYSCOHADA), which is identical.

Source: World Bank Institute (2005).

The Court of Auditors audited the emergency services in 2013. Subsequently, the Court of Auditors issued its first thematic report on the management of emergencies.

EPSs are subject to audits of statutory auditors defined by the OHADA legislation, and in accordance with national standards governing financial audits. The statutory auditor is appointed by the board of directors for a term of three financial years.

CHAPTER 4.7

Conclusion and Opportunities for Further Strengthening

This study of Senegal's hospital governance framework has highlighted its strengths as well as opportunities for further strengthening. This analysis has helped put the governance framework of hospitals into perspective vis-à-vis the "good practices" presented in the methodology for analyzing the corporate governance of SOEs and parastatal entities (Box 71).

BOX 71

Good Practices in the Corporate Governance of SOEs and Parastatal Entities

Governance Dimensions	Good Practices
Legal Framework	• Clear legal framework covering the entire parastatal "sector" • Definition of the legal status of entities

(box continues on next page)

BOX 71 *continued*

Governance Dimensions	Good Practices
State Oversight Function	• Appointment of a specialized entity at the state level to ensure effective and regular monitoring of financial and nonfinancial performance of the sector • International trend toward centralization of oversight function in a single entity to ensure comprehensive and coherent monitoring of all entities ("centralized model")
Planning and Performance Monitoring	• Definition of mandates and objectives • Development of financial and nonfinancial performance indicators • Development of performance agreements between the state (oversight entity) and the parastatal entities • Performance monitoring and evaluation of public enterprises
Boards of Directors	• Transparent and meritocratic selection of board members • Professional specialization and independence of board members • Clear definition of the respective roles of the oversight bodies, boards of directors (autonomous bodies responsible for strategic decisions and monitoring of executive management), and executive management • Principle of autonomy of the board of directors, ensuring both strong accountability toward the state shareholder (oversight entity) and day-to-day management autonomy on the part of the parastatal entity
Transparency and Disclosure	• Clear rules and criteria for financial and nonfinancial reporting • Publication of consolidated annual reports on the sector by the oversight entity • Regular publication of independent external audit reports • Effective internal control

Sources: OECD (2015a); World Bank (2014a); World Bank compilation.

Governance Framework Based on EPS Autonomy

The autonomy of hospitals, resulting from the hospital reform of 1998, has set the basis for a governance framework adapted to hospitals. Hospital autonomy was intended to give hospitals the decision-making power necessary for their effective management. Implementation of this

management autonomy was accompanied by a set of measures that reorganized the sector and strengthened the hospital governance framework (Box 72):

- redefining the legal framework governing the hospital sector, including elevating the status of hospitals to that of public health facilities (EPSs) with legal personality;
- organizing the oversight of EPSs under a dual model shared by the Ministry of Health and the Ministry of Finance;
- defining the roles and responsibilities of each stakeholder (oversight entities, EPSs, boards of directors, executive management, advisory bodies, and control bodies);
- setting up strategic bodies (boards of directors) and advisory bodies;
- developing and implementing accountability mechanisms, such as CPOMs.

BOX 72

Governance Framework of EPS Following the Hospital Reform in Senegal

Legal Framework	• General application of the principle of hospital autonomy • Status of hospitals upgraded to public health facility (EPS) • Comprehensive legal framework
State Oversight Function	• Dual oversight implemented by Ministry of Health (technical supervision) and Ministry of Finance (financial oversight) • Creation of a Directorate of Health Facilities (DES), in charge of the sector
Planning and Performance Monitoring	• Sector planning: National Health Development Plan, Medium-Term Sectoral Expenditure Framework • First wave of hospital strategies (*projets d'établissement*) • Annual work plans and budget preparation • Multiyear contracts specifying objectives and resources (CPOMs) (in some EPSs)
Boards of Directors	• Existence of boards of directors in EPSs • Diversified composition and decentralization taken into account • Regulatory texts provide terms and conditions related to board members, board mandate, and frequency of meetings

(box continues on next page)

BOX 72 *continued*

Transparency and Disclosure	• Sectoral publication by DES on hospital sector performance (2009) • (Partial) transmission of information to the DES • EPSs subject to internal controls (Ministry of Finance) and external auditors (auditors, Court of Auditors)

Source: World Bank compilation.

Challenges in Hospital Governance

Full implementation of the 1998 reform plan, together with stronger oversight and increased transparency, would improve the performance of the hospital sector in Senegal. While the hospital reform laid the foundations for a governance framework driven by the principle of hospital autonomy, the limitations of this governance framework (Box 73) have

BOX 73

Challenges in Hospital Governance in Senegal

Legal Framework	• Incomplete adoption of implementing regulations for reform
State Oversight Function	• Limited interaction between the two oversight ministries • Limited capacity within the DES in terms of human resources, staff training, and budgetary resources • Limited coordination between the DES and the other actors within the Ministry of Health
Planning and Performance Monitoring	• Integrated EPS information system planned by the reform but not implemented • Hospital strategies (*projets d'établissement*) not renewed
Boards of Directors	• Representation of users and staff in boards of directors does not reflect initial intention to give these groups more weight in decision making
Transparency and Disclosure	• Limited compliance of EPSs with regard to the regularity and completeness of financial statements and activity reports transmitted to the DES • Limited consolidation of information at the oversight level

Source: World Bank compilation.

affected the overall reform process. The most important challenges include incomplete enforcement of reform tenets, limited oversight capacity, and insufficient availability and sharing of information. Adopting measures to address these challenges would improve accountability and performance in the sector.

A more comprehensive application of the 1998 reforms would complete their implementation. Although the hospital reform made hospitals autonomous, reform implementation has not been systematic. Full adoption and enforcement of the associated legal and regulatory framework would enable the various stakeholders to have access to all of the monitoring and management tools envisaged by the reform.

Increased interaction among oversight authorities would help to strengthen oversight and improve accountability. The fragmentation of oversight resulting from uncoordinated decisions between technical and financial entities reduces its effectiveness. Restoring regular communication among the relevant stakeholders would optimize decision making, particularly in terms of distributing subsidies allocated to the health sector.

The DES, which is responsible for technical oversight, would benefit from capacity building. With adequate capacity and clear accountability mechanisms, the DES—and particularly its EPS Division—would be better able to ensure specific monitoring of EPSs, and in particular sector trends and risks.

Finally, improved provision of financial and nonfinancial information by EPSs to the DES would enhance performance monitoring in the sector and thereby reduce fiscal risks. In the current context of irregular and incomplete transfers of information, oversight entities are not in a position to produce regular annual reports analyzing sector trends. Strengthening EPSs' accountability and control mechanisms could have a beneficial effect on the hospital sector. Improving information flows through a clear framework defined jointly by the EPSs and oversight entities would make it possible, for example, to closely follow procedures for reimbursement of fee waivers from the government to EPSs, as well as other sources of risk for the government, such as the wage bill, which is volatile and subject to increases year after year. Implementing a performance culture by encouraging EPSs to provide financial (audited) and nonfinancial information would reduce this risk, and could be expanded gradually through the implementation of a hospital information system shared among EPSs and driven by the DES.

Bibliography and Reference Texts

Adeya, Grace, Alphonse Bigirimana, Karen Cavanaugh, and Lynne Miller Franco. 2007. "Rapid Assessment of the Health System in Benin, April 2006." Submitted to the United States Agency for International Development. Available at: http://www.urc-chs.com/sites/default/files/Benin_Pilot_Test_Assessment_Report.pdf (accessed August 25, 2017).

Agence Nationale d'Appui à la Performance (ANAP). 2010. "Imagerie—Scanner/IRM: rapport de benchmark." Paris: ANAP.

Ahanhanzo, Yolaine Glèlè, Landaogo Soutongonoma Lionel Ouédraogo, and Jacques Saizonou. 2014. "Performance of a health zone hospital in Bénin: an example of an evaluation model." *The Pan African Medical Journal* 18 (63).

Balique, Hubert. 1996. "*Le système hospitalier du Sénégal: analyse et perspectives.*" Ministry of Health and Social Action. Dakar: Republic of Senegal.

Barry, Ismahel Abdoul. "Effet de l'autonomie sur la performance des hôpitaux publics: cas du centre hospitalier universitaire de COCODY." Dakar: African Center for Higher Studies in Management (CESAG). Available at: http://bibliotheque.cesag.sn/gestion/documents_numeriques/M0141DSES08.pdf (accessed September 21, 2017).

De Kervasdoué, Jean. 2015. "L'Hôpital." *Que sais-je* series. Paris: Presses universitaires de France.

Dossouvi, J. Brahi, and Dr. J. A. Vodounon. No year available. "Implementation of a Quality Approach: Experience from the Hospital of the Mother and Child Lagoon (HOMEL) of Cotonou." Power Point Presentation accessed at: http://slideplayer.fr/slide/504421/.

Embassy of France in Senegal. "Compétences transférées par ordre de la collectivité locale–Région, Commune, Communauté Rurale." Available at: http://www.resacoop.org/sites/default/files/documents/zoompays/ZoomSenegal_ComptencesTransfresCollect.pdf (accessed September 26, 2017).

Gueye, Mame Abdoulaye, and Jacques Edouard Kopp. 2009. "Le contrat de performance hospitalière: l'expérience sénégalaise." *Santé Publique* 2009/1 (21): 77–87. DOI 10.3917/spub.091.0077.

Harding, April, and Alexander S. Preker. 2000. *Understanding Organizational Reforms: The Corporatization of Public Hospitals.* Health, Nutrition, and Population. Washington, DC: World Bank.

Institut de Recherche sur la Gouvernance et l'Economie des Institutions Website: http://www.irgei.org/ (accessed September 20, 2017).

Islamic Republic of Mauritania. n.d. "National Hospital Policy" (*Politique Nationale Hospitalier*). Ministry of Health and Social Affairs.

Lemière, Christophe, Vincent Turbat, and Juliette Puret. 2012. *A Tale of Excessive Hospital Autonomy: An Evaluation of the Hospital Reform in Senegal.* HNP Discussion Paper. Washington, DC: World Bank. Available at: https://openknowledge.worldbank.org/bitstream/handle/10986/13665/728380WP0Seneg09021020120Box371927B.pdf?sequence=1&isAllowed=y (accessed September 18, 2017).

Organisation for Economic Co-operation and Development (OECD). 2005. *Corporate Governance of State-Owned Enterprises: A Survey of OECD Countries.* Paris: OECD. Available at: http://www.oecd.org/daf/ca/corporategovernanceofstate-ownedenterprises/corporategovernanceofstate-ownedenterprisesasurveyofoecdcountries.htm (accessed September 18, 2017).

———. 2010a. *Accountability and Transparency: A Guide for State Ownership.* Paris: OECD. Available at: http://dx.doi.org/10.1787/9789264056640-en (accessed September 18, 2017).

———. 2010b. "Réforme de la gouvernance des entreprises publiques: Panorama de l'évolution récente. " Paris: OECD. Available at: http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DAF/CA/SOPP(2010)1/FINAL&docLanguage=Fr (accessed September 21, 2017).

———. 2015a. *Guidelines on Corporate Governance of State-Owned Enterprises.* Paris: OECD. Available at: http://www.oecd.org/corporate/guidelines-corporate-governance-SOEs.htm (accessed August 22, 2017).

———. 2015b. *Principles of Corporate Governance.* Paris: OECD. Available at: http://dx.doi.org/10.1787/9789264236882-en (accessed August 22, 2017).

Perrot, Jean, and Eric de Roodenbeke, eds. 2005. *La contractualisation dans les systèmes de santé: Pour une utilisation efficace et appropriée.* Paris: Karthala.

Republic of Benin. 2006. "*Analyse de la situation actuelle de la gestion des hôpitaux au Bénin.*" Hospital Directorate, Ministry of Health. Cotonou: Republic of Benin.

———. 2006. "*Mission hospitalière sur le système de contrôle de gestion dans les hôpitaux de huit départements du sud du Bénin.*" Hospital Directorate, Ministry of Health. Cotonou: Republic of Benin.

———. 2009. "National Health Development Plan 2009–2018" (*Plan National de Développement Sanitaire 2009–2018*). Cotonou: Republic of Benin. Available at: http://www.sante.gouv.bj/documents/PNDS.pdf (accessed September 18, 2017).

———. 2011, 2012, 2013. "Health Statistics Yearbooks" (*Annuaires des Statistiques Sanitaires*). Directorate of Forecasting, Planning, and Strategies (DPP), Ministry of Health. Cotonou: Republic of Benin.

———. 2013. "Distribution of Health Expenses by Health Care Provider." Directorate of Programming and Forecast, Ministry of Health. Cotonou: Republic of Benin.

———. 2014. "*Document de cadrage du financement basé sur les résultats*." Health System Strengthening Program (PRSS). Ministry of Health. Cotonou: Republic of Benin.

———. 2011. "*Plan de réforme des hôpitaux et établissements de soins du Bénin à l'horizon 2015*." National Directorate of Hospitals and Health Care Facilities (DNEHS), Ministry of Health. Cotonou: Republic of Benin.

———. n.d. "Les projets-programmes > PRSS—Projet de Renforcement du Système de Santé." Ministry of Health website. Available at: http://www.sante.gouv.bj/spip.php?article31 (accessed September 19, 2017).

———. Results-Based Financing Portal. Available at: http://beninfbr.org (accessed September 26, 2017).

Republic of Burkina Faso. 2011. "National Health Development Plan 2011–2020" (*Plan National de Développement Sanitaire 2011–2020*). Ouagadougou: Republic of Burkina Faso. Available at: https://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Burkina_Faso/Burkina_Faso_National_Health_Strategy_2011-2020_French.pdf (accessed September 18, 2017).

Republic of Côte d'Ivoire. 2011. "National Health Policy" (*Politique Nationale de Santé*). Abidjan: Côte d'Ivoire.

———. 2012. Council of Ministers Communiqué, January 18. Abidjan: Republic of Côte d'Ivoire.

———. 2012. Draft Budget 2012. Abidjan: Republic of Côte d'Ivoire.

———. 2014a. "*Document d'orientation sur la réforme hospitalière en Côte d'Ivoire*," Reform Document. Ministry of Health. Abidjan: Republic of Côte d'Ivoire.

———. 2014b. "*Stratégie nationale de financement basé sur la performance en Côte d'Ivoire*." General Health Directorate, Ministry of Health. Abidjan: Republic of Côte d'Ivoire.

———. n.d. "National Health Development Plan 2013–2015" (*Plan National de Développement Sanitaire 2013–2015*). Ministry of Health. Abidjan: Republic of Côte d'Ivoire.

———. 2013. "*Rapport annuel sur la situation sanitaire 2010-2012*." General Directorate of Health, Directorate of Information, Ministry of Health.

Republic of Guinea. 2001. "Strategic Health Development Plan" (*Plan Stratégique de Développement Sanitaire*). Ministry of Public Health, Final Draft. Available at: http://www.srp-guinee.org/download/sp-pnds-2001-plan-strategique-sante.pdf (accessed September 18, 2017).

Republic of Niger. 2011. "Health Development Plan 2011–2015" (*Plan de Développement Sanitaire, PDS 2011–2015*). Secretary General, Ministry of Public Health. Niamey: Republic of Niger. Available at: www.nationalplanningcycles.org/sites/default/files/country_docs/Niger/pds_2011-2015_final_adopte_-_cm_27_janv_2011.pdf (accessed September 19, 2017).

Republic of Senegal. 2004. "*La réforme hospitalière six ans après*." MSP/DES, September. Dakar: Republic of Senegal.

———. 2006. "Growth and Poverty Reduction Strategy Paper II, 2006–2010." (*Document Stratégique pour la Croissance et la Réduction de la Pauvreté II,*

2006-2010). Dakar: Republic of Senegal. Available at: http://siteresources.worldbank.org/INTSENEGALINFRENCH/Resources/DSRP-II.pdf (accessed September 19, 2017).

———. 2008. "*Rapport introductif au Conseil Interministériel sur le système hospitalier, Sénégal.*" Interministerial Council of EPSs, April. Dakar: Republic of Senegal.

———. 2009. "National Health Development Plan 2009–2018" (*Plan National de Développement Sanitaire, PNDS 2009–2018*). Ministry of Health and Social Action. Dakar: Republic of Senegal.

———. 2010. "*Rapport Global, Direction des Etablissements de Santé, 2009.*" Ministry of Health and Social Action. Dakar: Republic of Senegal.

———. 2011. *Politique de Maintenance des Infrastructures, des Installations et des Équipements des Structures de Santé du Sénégal*. Ministry of Health and Social Action, Directorate of Infrastructure, Equipment and Maintenance. Dakar: Republic of Senegal.

———. 2012. "Guide de gestion du Plan Annuel de Travail, destiné aux centres de responsabilité du Ministère de la Santé et de l'Action Sociale." First Edition, September. Ministry of Health and Social Action. Dakar: Republic of Senegal.

———. 2013. "Public report on the state of governance and accountability." General Inspectorate of State (IGE). Dakar: Republic of Senegal.

———. 2005. "Republic of Senegal Report on the Observance of Standards and Codes: Accounting and Auditing." Washington, DC: World Bank. Available (in French) at: http://documents.worldbank.org/curated/pt/389111468113082922/pdf/465360FRENCH0E1egal0rosc1aa1sen1fre.pdf (accessed September 18, 2017).

Republic of Togo. 2012. "National Health Development Plan of Togo: 2012–2015" (*Plan National de Développement Sanitaire du Togo (PNDS): 2012–2015*). Lomé: Togolese Republic. Available at: http://www.who.int/fctc/reporting/party_reports/togo_annex3_national_health_development_plan_2012_2015.pdf (accessed September 19, 2017).

World Bank. 2010. "*Santé, Nutrition et Population, Rapport Analytique Santé Pauvreté.*" Washington, DC: World Bank. Available at: http://documents.worldbank.org/curated/en/448331468234288071/République-de-Côte-d-Ivoire-Santé-Nutrition-et-Population-Rapport-Analytique-Santé-Pauvreté (accessed September 19, 2017).

———. 2014a. *Corporate Governance of State-Owned Enterprises: A Toolkit*. Washington, DC: World Bank. Available at: http://documents.worldbank.org/curated/en/228331468169750340/Corporate-governance-of-state-owned-enterprises-a-toolkit (accessed August 22, 2017).

———. 2014b. *Corporate Governance of State-Owned Enterprises in Latin America: Current Trends and Country Cases*. Washington, DC: World Bank. Available at: https://www.openknowledge.worldbank.org/handle/10986/19983 (accessed September 18, 2017).

———. n.d. World Development Indicators. Washington, DC: World Bank. Available at: http://data.worldbank.org/data-catalog/world-development-indicators. (accessed September 23, 2017).

World Bank Institute (WBI). 2005. "Hospital Policy and Financing in Africa." Washington, DC: WBI. Politique hospitalière et financement de l'hôpital en Afrique, World Bank Institute.

World Health Organization (WHO). 2006, 2011, 2014. *World Health Statistics.* Geneva: WHO. Available at: http://www.who.int/gho/publications/world_health_statistics/en/ (accessed September 23, 2017).

——. 2008. "Consultation on Strategic Contracting in Health Systems." Synthesis of the Meeting, Geneva, 9-11 January 2008. Geneva: WHO. Available at: http://who.int/contracting/Synthesis_EN_WEB.pdf (accessed August 22, 2017).

——. 2009. "Who Are Health Managers? Case Studies from Three African Countries." *Human Resources for Health Observer*, Issue No. 1. Geneva: WHO. Available at: http://www.who.int/hrh/resources/hrh_observer/en/ (accessed August 22, 2017).

——. 2013. National Health Accounts. Geneva: WHO. Available at: http://apps.who.int/nha/database/Select/Indicators/en.

Zongo, M., J. Capochichi, P. Gandaho, I. Takpara, and Y. Coppieters. 2009. "*Une gestion managériale des structures hospitalières du Bénin.*" *Médecine Tropicale* 69(1): 56–58.

List of Legal Reference Texts by Country

Benin

Décret N°90-347 du 14 novembre 1990 portant approbation des statuts des centres hospitaliers départementaux et des formations sanitaires assimilées

Loi N°94-009 du 28 juillet 1994 portant création, organisation et fonctionnement des offices à caractères social, culturel et scientifique

Décret N°2012-300 du 28 août 2012 portant attributions, organisation et fonctionnement centres hospitaliers universitaires du Bénin

Décret N°2012-422 06 novembre 2012 portant attributions, organisation et fonctionnement du centre national hospitalier universitaire Hubert Koutoukou maga (CNHU-HKM)

Décret N°2002-0113 du 12 mars 2002 portant approbation des statuts des hôpitaux de zone

Lois de Finances Initiales/Révisées 2009-2014, Ministère de l'Economie et des Finances.

Côte d'Ivoire

Loi N°98-388 du 2 juillet 1998 fixant les règles générales relatives aux EPN et portant création de catégories d'établissements publics et abrogeant la loi N°80-1070 du 13 septembre 1980

Décret N°2001-650 du 19 octobre 2001 portant organisation et fonctionnement des CHU de Cocody, Treichville, Yopougon et Bouake

Décret N°98-379 du 30 juin 1998 portant organisation et fonctionnement des établissements sanitaires publics urbains n'ayant pas le statut d'Etablissement Public National

Lois de Finances Initiales/Révisées 2009–2014, Ministère de l'Economie et des Finances.

Senegal

Loi N°98-08 du 2 mars 1998 portant réforme hospitalière

Loi N°98-12 du 2 mars 1998 relative à la création, à l'organisation et au fonctionnement des Etablissements Publics de Santé (« EPS »)

Décret d'application N°98-701 du 26 Août 1998 relatif à l'organisation des établissements publics de Santé Hospitaliers

Décret d'application N°98-702 du 26 Août 1998 portant organisation administrative et financière des Etablissements Publics de Santé

Décret N°2008-381 du 7 avril 2008 instituant un système d'assistance « SESAME » en faveur des personnes âgées de 60 ans et plus

Lois de Finances Initiales/Révisées 2009–2014, Ministère de l'Economie et des Finances.

ANNEXES

ANNEXE 1

Échantillons: Bénin, Côte d'Ivoire et Sénégal

	EPS	Niveau	Tutelle — Échelon Administratif de Supervision	Localisation
Bénin	**CNHU Hubert K. Maga**	Référence nationale	DNHES	Cotonou
	HOMEL — Hôpital de la mère et de l'enfant	Hôpital spécialisé	DNHES/DDS Atlantique-Littoral	Cotonou
	CHD de l'Ouémé	Centre Hospitalier Départemental	DDS Ouémé-Plateau	Porto Novo
	CHH du Zou	DDS Zou-Collines CHD	DDS ZOU-Collines	Abomey
	Hôpital Menontin	Hôpital privé de zone	DDS Atlantique-Littoral	Cotonou 5
	Hôpital de Savalou	Hôpital de zone	DDS Zou-Collines	Savalou
	Hôpital de Ouidah	Hôpital de zone	DDS Atlantique-Littoral	Ouidah

(continues on next page)

	EPS	Niveau	Tutelle — Échelon Administratif de Supervision	Localisation
Côte d'Ivoire	**CHU de Yopougon**	EPN	Ministère	Abidjan
	Hôpital de Yamoussoukro	CHR	DRS	Yamoussoukro
	CHU de Treichville	EPN	Ministère	Abidjan
	Hôpital de Dimbokro	CHR	DRS	Dimbokro
	Hôpital de Dabou	Hôpital privé	DDS	Dabou
	Centre médical don Orione	Hôpital privé	DRS Abidjan 2	Anyama
	Institut de Cardiologie (ICA)	EPN	Ministère	Abidjan
	Hôpital psychiatrique	CH	DRS Abidjan	Bingerville
	CHG de Bingerville	CHG	DRS Abidjan	Bingerville
Sénégal	**Hôpital Principal de Dakar**	3	Ministère des Forces Armées	Dakar
	Hoggy	3	Ancien établissement privé-MSAS	Dakar
	Le Dantec	3	MSAS-MF	Dakar
	Fann	3	MSAS-MF	Dakar
	Abass Ndao	3	Hôpital municipal	Dakar
	Saint-Louis	2	Service déconcentré du MSAS	Régional
	Thiès	2	Service déconcentré du MSAS	Régional

Source : Consolidation Banque mondiale.

ANNEXE 2

Indicáteurs Hospitaliers et Mesure de la Performance — Bénin, Côte d'Ivoire et Sénégal

La fréquentation des hôpitaux publics est en croissance, particulièrement au Sénégal et au Bénin sur les 10 dernières années. Les hôpitaux ne sont pas pour autant saturés avec des taux d'occupation qui dépassent rarement les 60 % des capacités disponibles. Historiquement plus faible en Côte d'Ivoire, très réduite pendant les années 2000, la fréquentation des hôpitaux publics a été transitoirement augmentée par les mesures de gratuité totale. Elle a connu depuis une baisse sensible.

L'augmentation du taux d'occupation a été retrouvée dans les hôpitaux visités, alors que la durée moyenne de séjour aurait dans le même temps diminuée. Dans cette analyse, un biais est néanmoins à signaler. Il concerne la comptabilité des patients en attente de prise en charge : certains établissements conditionnent toute prise en charge hospitalière, en particulier chirurgicale à la garantie d'une avance du paiement des soins par le patient, lequel attend dans les services une aide familiale pour assumer cette prise en charge.

Les indicateurs de performance du secteur hospitalier concordent avec les indicateurs de santé publique comme la mortalité maternelle et infantile et l'espérance de vie, en particulier au Bénin et au Sénégal.

Les deux pays qui ont les taux les plus élevés de fréquentation du système hospitalier, d'accouchements assistés ou encore de césarienne, à savoir le Sénégal et le Bénin ont aussi les mortalités maternelles et infantiles les plus basses et les espérances de vie les plus élevées. En ce qui concerne la Côte d'Ivoire, la situation de crise qu'elle a traversée explique en partie les résultats plus défavorables.

Le contexte général a un impact sur la performance hospitalière mais n'est pas le seul élément d'explication aux performances limitées du système de santé en Côte d'Ivoire. Le concept de performance hospitalière est multidimensionnel. Les indicateurs de résultats tels que les taux de mortalité, défavorables pour la Côte d'Ivoire ne sont pas dû qu'au fonctionnement hospitalier. En dépit de la crise majeure qu'elle a connue, la Côte d'Ivoire dispose d'une offre de soins très développée. Ses performances hospitalières sont néanmoins moins favorables que celles du Sénégal et du Bénin.

Des biais dans l'analyse de la performance hospitalière sont à prendre en compte. En l'absence de système d'information sur la mortalité et la morbidité de décès par tranches d'âge et par pathologie, et en dehors de la fréquentation du système de santé, les indicateurs de performance disponibles portent sur la santé de la mère et de l'enfant, ne prenant pas compte la prise en charge des maladies dégénératives. Ceci étant précisé, il apparait clairement que pour un investissement moindre, les systèmes de santé sénégalais et béninois obtiennent des résultats sanitaires plus favorables que le système ivoirien. Tout élément de contexte mise à part, il existe incontestablement une différence de performance des systèmes hospitaliers entre les trois pays.

ANNEXE 3

Cadre Juridique : Bénin, Côte d'Ivoire et Sénégal

Pays	Textes de Référence
Bénin	• Loi N°94-009 du 28 juillet 1994 portant création, organisation et fonctionnement des offices à caractères social, culturel et scientifique • Décret N°2012-300 du 28 aout 2012 portant attributions, organisation et fonctionnement centres hospitaliers universitaires du Bénin • Décret N°2012-422 06 novembre 2012 portant attributions, organisation et fonctionnement du centre national hospitalier universitaire Hubert Koutoukou maga (CNHU-HKM) • Décret N°90-347 du 14 novembre 1990 portant approbation des statuts des centres hospitaliers départementaux et des formations sanitaires assimilées • Décret N°2002-0113 du 12 mars 2002 portant approbation des statuts des hôpitaux de zone
Côte d'Ivoire	• Loi N°98-388 du 2 juillet 1998 fixant les règles générales relatives aux EPN et portant création de catégories d'établissements publics et abrogeant la loi N°80-1070 du 13 septembre 1980 • Décret N°2001-650 du 19 octobre 2001 portant organisation et fonctionnement des CHU de Cocody, Treichville, Yopougon et Bouake • Décret N°98-379 du 30 juin 1998 portant organisation et fonctionnement des établissements sanitaires publics urbains n'ayant pas le statut d'Etablissement Public National
Sénégal	Loi N°98-08 du 2 mars 1998 portant réforme hospitalière Loi N°98-12 du 2 mars 1998 relative à la création, à l'organisation et au fonctionnement des Etablissements Publics de Santé (« EPS ») Décret d'application N° 98-701 du 26 Août 1998 relatif à l'organisation des établissements publics de Santé Hospitaliers Décret d'application N°98-702 du 26 Août 1998 portant organisation administrative et financière des Etablissements Publics de Santé

Source : Consolidation Banque mondiale.

ANNEXE 4

Organisation de la Tutelle: Bénin, Côte d'Ivoire et Sénégal

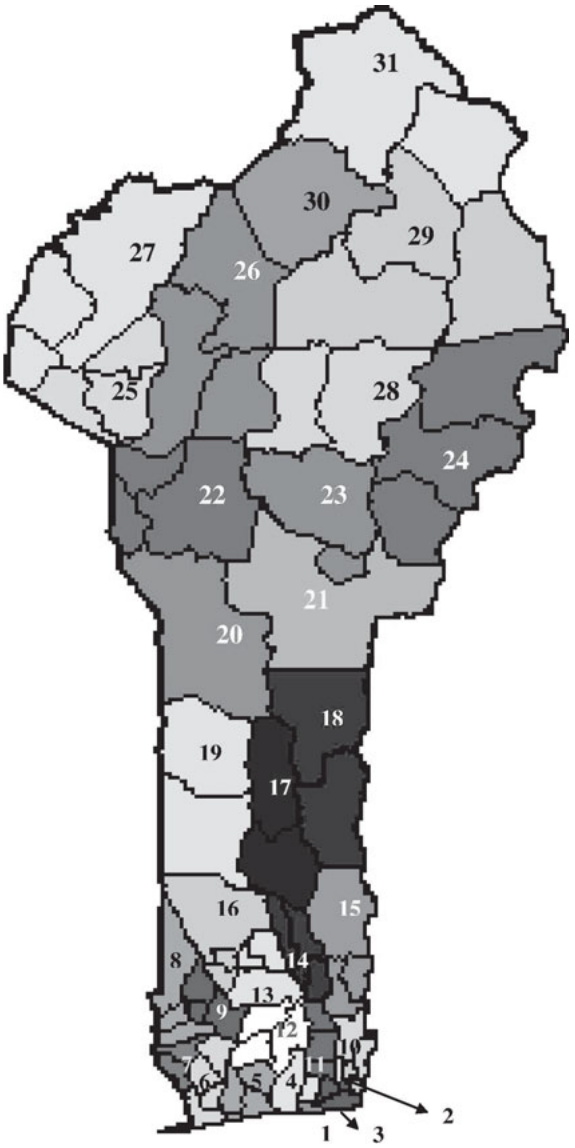
	Tutelle	Direction des Hôpitaux	Directions Impliquées dans la Tutelle
Benin	Centralisée MS	Oui : DNEHS	***Volet Technique : Ministère de la Santé*** • **Direction Nationale des Etablissements Hospitaliers et de Soins—DNEHS** • Direction de la Programmation et de la Planification—DPP • Direction des Ressources Humaines—DRH • Direction des Infrastructures, des Equipements et de la Maintenance—DIEM
			Volet Financier : Ministère de la Santé • Direction des Ressources Financières et du Matériel—DRFM.

	Tutelle	Direction des Hôpitaux	Directions Impliquées dans la Tutelle
Côte d'Ivoire	Duale MS/MF	Non, en projet	***Volet Technique : Ministère de la Santé et de la Lutte contre le SIDA*** • Direction des Affaires Financières—DAF • Direction des Ressources Humaines—DRH • Direction des Infrastructures, des Equipements et de la Maintenance—DIEM • Direction de la Prospective, de la Planification et des Stratégies—DPPS • Direction de l'Information de la Planification et de l'Evaluation—DIPE • Direction de la Formation et de la Recherche—DFR • Service d'Audit et du Contrôle de Gestion—SACG • Direction Générale de la Santé—DGS • Service d'Appui aux Services Extérieurs et à la Décentralisation—SASED
			Volet Financier : Ministère des Finances • Direction Générale du Budget—DGB
Sénégal	Duale MS/MF	Oui, DES	***Volet Technique : Ministère de la Santé et de l'Action Sociale*** • Direction des Etablissements de Santé—DES • Direction de l'Administration Générale et de l'Equipement—DAGE • Direction des Infrastructures, des Equipements et de la Maintenance—DIEM • Direction des Ressources Humaines—DRH
			Volet Financier : Ministère des Finances • Direction de la Coopération Economique et Financière—DCEF • Direction du Budget–DB

Source : Consolidation Banque mondiale.

ANNEXE 5

Zones Sanitaires au Bénin



1. Cotonou 1 & 4
2. Cotonou 2 & 3
3. Cotonou 5
4. Cotonou 6
5. Missérété/A vrankou/Adjarra
6. Porto-Novo/Sèmè-Kpodji/Aguégués
7. Abomey-Calavi/Sô-Ava
8. Ouidah/Kpomassè/Tori-Bossito
9. Comè/Bopa/Grand-Popo/Houéyogbé
10. Lokossa/Athiémé
11. Aplahoué/Dogbo/Djakotomey
12. Klouékanmè/Lalo/Toviklin
13. Sakété/Ifangni
14. Adjohoun/Dangbo/Bonou
15. Allada/Toffo/Zè
16. Bohicon/Za-Kpota/Zogbodomey
17. Covè/Ouinhi/Zagnanado
18. Pobè/Kétou/Adja-Ouèrè
19. Djidja/Abomey/Agbangnizoun
20. Dassa-Zoumè/Glazoué
21. Savè/Ouèssè
22. Savalou/Bantè
23. Bassila
24. Tchaourou
25. Djougou/Ouaké/Péhunco
26. N' dali/Parakou
27. Nikki/Pèrèrè/Kalalé
28. Natitingou/Boukoumbé/Toucountouna
29. Kouandé/Ouassa-Péhunco/Kérou
30. Tanguiéta/Cobly/Matéri
31. Bembèrèkè/Sinendé
32. Kandi/Gogounou/Ségbana
33. Banikoara
34. Malanville/Karimama

Source : République du Bénin, Ministère de la Santé.

ANNEXE 6

Organisation du Système de Santé au Bénin

Niveau	Structure	Institution Hospitalière et Socio-Sanitaire	Spécialité
Central ou National	Ministère de la Santé Publique (MSP)	• Centre National Hospitalier Universitaire (CNHU-HKM) • Centre National de Pneumo-phtisiologie • Centre National de Psychiatrie • Hôpital de la Mère et de l'Enfant des Lagunes (HOMEL)	• Médecine • Pédiatrie • Chirurgie • Gynéco obstétrique • Laboratoire • O.R.L. • Ophtalmologie • Autre spécialité
Intermédiaire ou Départemental	Direction Départementale de la Santé Publique (DDSP)	Centre Hospitalier Départemental (CHD)	• Médecine • Pédiatrie • Chirurgie • Gynéco obstétrique • Laboratoire • O.R.L. • Ophtalmologie • Autre spécialité
Périphérique	Zone Sanitaire (ZS) (Bureau de Zone)	• Hôpital de Zone (HZ) • Centre de Santé de Commune (CSC) • Centre d'Action de la Solidarité et d'Évolution de la Santé (CASES) • Formations Sanitaires Privées • Centre de Santé d'Arrondissement (CSA) • Maternité dispensaire • Unité Villageoise de Santé (UVS)	• Médecine générale • Chirurgie d'urgence • Gynéco-obstétrique • Alphabétisation • Loisirs • Radiologie • Laboratoire • Pharmacie • Dispensaire • Maternité • Pharmacie ou dépôts pharmaceutiques • Soins • Accouchements • Caisse de pharmacie

Source : République du Bénin, ministère de la Santé, SNIGS (2005).

ANNEXE 7

Indicateurs de Santé et Indicateurs Hospitaliers au Bénin

Taux de fréquentation : Les statistiques disponibles montrent que les services de santé connaissent une activité en croissance même si cette progression est un peu erratique. Cette croissance apparait dans le taux de recours aux services de santé correspondant au rapport du nombre de consultants sur la population globale. Il présente de grandes disparités selon le secteur géographique, et ce sans rapport direct avec l'urbanisation ou la sociologie puisque ce ratio atteint 116 % sur la zone sanitaire de Tchaourou, dans le Bourgou alors qu'il n'est que de 23,8 % à Klouékanmé, dans le Couffo. Ce rapport de 1 à 5 fait émettre des doutes sur la fiabilité de certaines données statistiques.

Taux d'accouchements assistés et taux de césarienne : L'évolution du taux d'accouchements assistés (par un médecin ou une sage-femme) entre 2009 et 2012 témoigne de l'augmentation de la référence au système de santé et donc de la confiance croissante de la population dans le schéma de prise en charge pouvant conduire à une prise en charge hospitalière. Le taux de césarienne est également en croissance, régulière même s'il demeure inférieur au taux cible de l'OMS. Cette évolution est certainement en rapport avec la politique de gratuité de la césarienne, dont la gestion de ce programme par une agence permet un correct et rapide remboursement aux établissements

sous réserve qu'ils n'omettent pas d'en faire les demandes, ce qui serait parfois le cas.

Prise en charge des urgences : Le développement de la prise en charge des urgences existe dans certains établissements. Il s'est traduit par la mise en place d'une sectorisation, d'un renfort de la médicalisation et du développement des protocoles de prise en charge. Il existe notamment au CNHU, à l'HOMEL ou encore au niveau du secteur pédiatrique du CHD Zou. Cette organisation des soins n'est pas encore généralisée et beaucoup d'établissements ne sont pas, sur ce chapitre, conformes aux standards en vigueur.

Taux d'occupation des lits : Les indicateurs d'activité hospitalière font état d'une croissance sur ces dernières années du taux d'occupation des lits, passant de 30 % à 57 % entre 2010 et 2012. Cette constatation globale de l'occupation des services a pu être constatée dans la plupart des établissements visités. Elle est particulièrement notable dans le seul hôpital de zone privé en contrat avec l'Etat, faisant partie de l'échantillon qui tourne à pleine capacité. Elle est également effective à l'HOMEL, dans les CHD visités et dans les hôpitaux de zone à l'exception de celui de Ouidah sans doute desservi par une situation assez excentrée par rapport à son bassin de population. Le cas du CHNU est plus difficile à analyser. Si son taux d'occupation est réputé proche de 70 %, il présente également une durée moyenne de séjour (DMS) élevée (7,5 jours) qui ne correspond pas aux standards de prise en charge. Le différé de prise en charge des patients (en attendant des garanties de prise en charge financière), qui apparaît couramment pratiqué dans cet établissement, peut expliquer ces résultats.

ANNEXE 8

CNHU-HKM au Bénin: Présentation et Modifications Statutaires

Présentation

Créé le 30 octobre 1962 pour une capacité de 350 lits, l'Hôpital "350 lits" est devenu Centre National Hospitalier et Universitaire de Cotonou depuis le 10 janvier 1973. Il a pris le statut d'Office à caractère social et scientifique le 13 mai 1991 et est doté de la personnalité juridique et de l'autonomie financière. A la mort du Premier Président de la République, son Excellence Hubert Koutoukou MAGA sous le mandat duquel l'hôpital a vu le jour, il a été baptisé CNHU Hubert K. MAGA.

Modifications Statutaires

- Loi N°62-36 du 30 octobre 1962 portant création de l'Hôpital de Cotonou et dotant cet Etablissement Public de l'Autonomie Financière ;
- Décret N°465/PR/MSPAS du 02 novembre 1962 portant Organisation de l'Hôpital de Cotonou sous forme d'Etablissement Public Autonome ;
- Décret N°490/PR/MSPAS du 21 décembre 1966 érigeant l'Hôpital de Cotonou en Centre National Hospitalier ;

- Décret N°366/PR-MSPAS du 27 novembre 1968 modifiant le décret N°465/PRIMSPAS du 02 novembre 1962 portant organisation de l'Hôpital de Cotonou sous forme d'Etablissement Public Autonome ;
- Décret N°73-8 du 10 janvier 1973 portant organisation et création du Centre National Hospitalier et Universitaire de Cotonou ;
- Décret N°91-77 du 13 mai 1991 portant approbation des statuts du Centre National Hospitalier Universitaire de Cotonou ;
- Loi N°94-009 du 28 juillet 1994 portant création, organisation et fonctionnement des offices à caractères social, culturel et scientifique ;
- Décret N°2012-300 du 28 août 2012 portant Attribution, Organisation et Fonctionnement des Centres Hospitaliers Universitaires;
- Décret N°2012-422 du 06 novembre 2012 portant attributions, organisation et fonctionnement du Centre National Hospitalier Universitaire Hubert Koutoukou MAGA (CNHU-HKM).

Source : Site Internet du CNHU, http://www.cnhu-hkm.org/.

ANNEXE 9

FBR au Bénin : Indicateurs Quantitatifs et Qualitatifs

Indicateurs de Résultat Quantitatifs

Indicateurs FBR Hôpital	• TBC* bactériologiquement confirmé ; • TBC bactériologiquement confirmé traité et guéri ; • Intervention chirurgicale en service de gynécologie-obstétrique et en chirurgie ; • Accouchement dystocique effectué chez les parturientes référées des centres de santé ; Cas de césarienne ; • Contre référence de l'hôpital arrivée au CS ; • Femme enceinte séropositive et initiée au traitement ARV** ; • Enfant éligible et initié au traitement ARV au cours du mois ; • Client sous traitement ARV suivi pendant les 6 premiers mois ; • Nombre de cas d'IST diagnostiqués et traités ; • Paludisme simple chez les enfants de 0 à 5 ans ; • Paludisme simple chez la femme enceinte ; • Paludisme grave chez les enfants de 0 à 5 ans ; • Paludisme grave chez la femme enceinte.

* TBC: Tuberculose ** Antirétroviral

Indicateurs de Résultats Qualitatifs

Ensemble des Composantes	Nombre d'Indicateurs Composites
Indicateurs généraux	10
Suivi évaluation et SNIGS	9
Hygiène, environnement et stérilisation	11
Consultation externe/urgence et mise en surveillance	13
Maternité	5
Consultation prénatale	14
Planification familiale	9
Vaccinations et suivi des nourrissons	10
Lutte contre le VIH	11
Tuberculose et lèpre	4
Laboratoire	6
Petite chirurgie/pansement	5
Gestion des médicaments	8
Gestion financière	10
TOTAL	**124**

Source : République du Bénin, ministère de la Santé, FBR, document de cadrage (2013).

ANNEXE 10

Standards de l'OCDE sur la Transparence et la Diffusion d'Informations

From OECD Principles of Corporate Governance

The corporate governance framework should ensure that timely and accurate disclosure is made on all material matters regarding the corporation, including the financial situation, performance, ownership, and governance of the company:

1. The financial and operating results of the company.
2. Company objectives.
3. Major share ownership and voting rights.
4. Remuneration policy for members of the board and key executives, and information about board members, including their qualifications, the selection process, other company directorships and whether they are regarded as independent by the board.
5. Related party transactions.
6. Foreseeable risk factors.

7. Issues regarding employees and other stakeholders.
8. Governance structures and policies, in particular, the content of any corporate governance code or policy drafted by the company and the process by which it is implemented.

From OECD Guidelines on Corporate Governance of State-Owned Enterprises

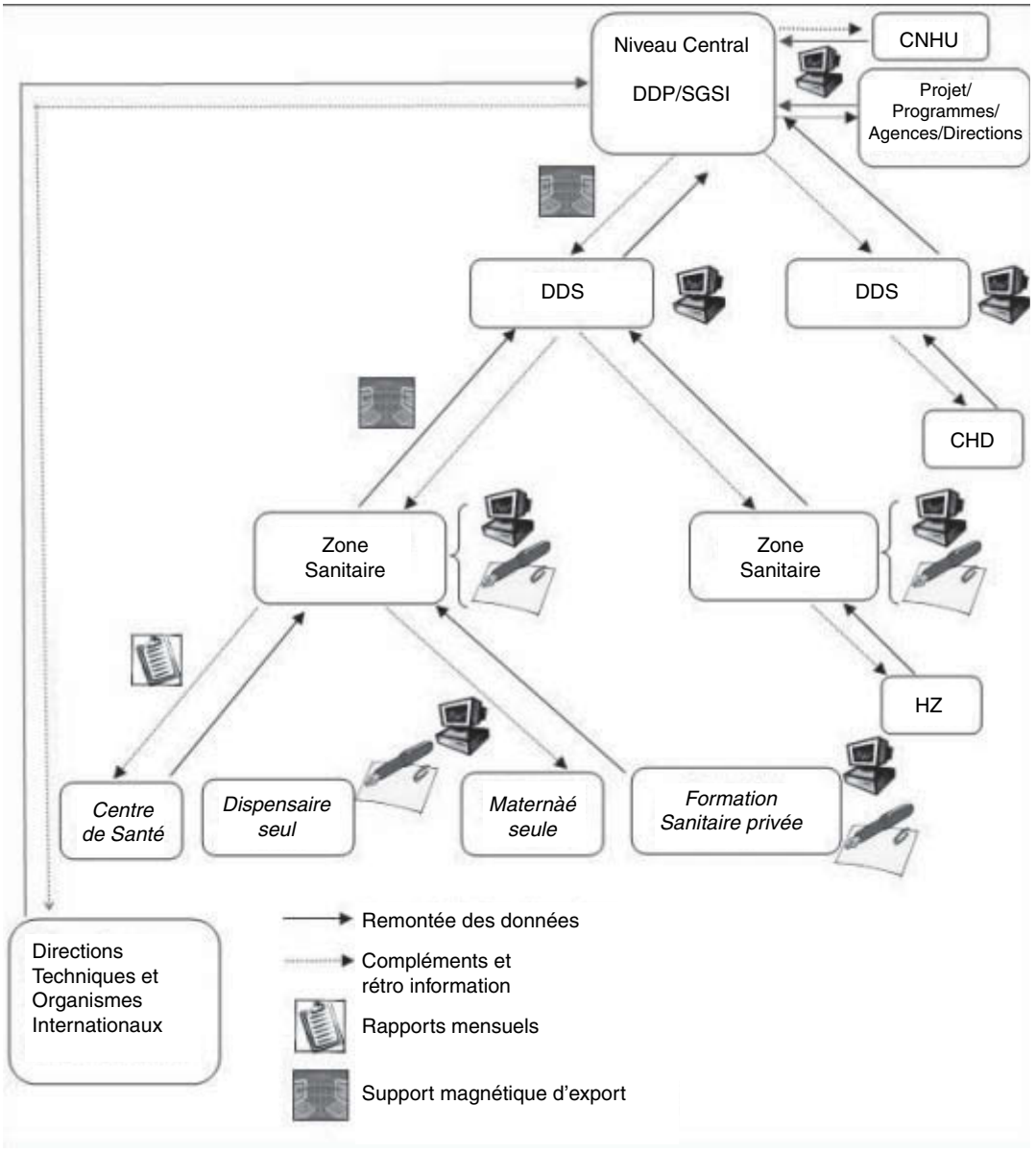
State-owned enterprises should observe high standards of transparency in accordance with the OECD Principles of Corporate Governance. SOEs should disclose material information on all matters described in the OECD Principles of Corporate Governance and in addition focus on areas of significant concern for the State, as owner, and the general public:

1. A clear statement of the company objectives and a report on their fulfillment.
2. The ownership and voting structure of each company.
3. Any material risk factors and measures taken to manage such risks.
4. Any financial assistance, including guarantees, received from the state and commitments made on behalf of the SOE.
5. Any material transactions with related entities.

Source: OECD.

ANNEXE 11

Mécanisme de Transmission d'Information au Bénin



Source : République du Bénin, ministère de la Santé, Annuaire des statistiques sanitaires.

ANNEXE 12

Régions Médicales et Districts Sanitaires au Sénégal

Source : République du Sénégal, ministère de la Santé, PNDS 2009–2018.

ANNEXE 13

Liste des Etablissements Publics de Santé au Sénégal

EPS III

Centre Hospitalier d'Enfants Albert ROYER
Hôpital Abass NDAO
Centre Hospitalier Aristide Le DANTEC
Centre Hospitalier de FANN
Hôpital Principal de Dakar
Centre Hospitalier de Pikine
Hôpital de Thiaroye
Hôpital Général de Grand Yoff
Matlaboul Fawzeini de Touba
Hopital d'Enfants de DIAMNIADIO
Dala Jamm de Guédiawaye (Ouverture Fin 2014)

EPS II

Centre Hospitalier Régional Amadou Sakhir Ndjeguene de Thiès
Centre Hospitalier Régional Amadou SakhirMBAYE de Louga

Centre Hospitalier Régional Lt Cl Mamadou DIOUF de Saint-Louis
Centre Hospitalier Régional de NDioum
Centre Hospitalier Régional de Ourossogui
Centre Hospitalier Régional Heinrich Lubkë de Diourbel
Centre Hospitalier Régional de Matam ouverture 2014
Centre Hospitalier Régional El Hadji Ibrahima NIASSE de Kaolack
Centre Hospitalier Régional de Tambacounda
Centre Hospitalier Régional de Kolda
Centre Hospitalier Régional de Ziguinchor
Hôpital de la paix de Ziguinchor (Ouverture 2014)
Centre Hospitalier Régional de Fatick (Ouverture Aout 2013)

EPS I

Institut d'Hygiène Sociale (IHS)
Roi Baudoin de Guédiawaye
Youssou Mbargane Diop de Rufisque
Touba Ndamatou
EPS 1 de Linguère
Kaffrine EPS 1
Richard Toll EPS 1
Sédhiou EPS 1
Mbour EPS 1
Tivaouane EPS 1

EPS Non Hospitaliers

Centre National de Transfusion Sanguine (CNTS)
Centre National d'Appareillage Orthopédique (CNAO)
Service d'Assistance Médicale des Urgences (SAMU)
Pharmacie Nationale d'Approvisionnement (PNA)
Centre Talibou Dabo: non encore érigé

Etablissements Privés avec Convention

Hôpital Saint Jean de DIEU
Hôpital de NINEFESHA
Hôpital BARTHIMEE de Thiès
Centre hospitalier de l'Ordre de Malte

Source : République du Sénégal, ministère de la Santé, DES.

ANNEXE 14

Indicateurs Hospitaliers, Indicateurs de Santé au Sénégal

Taux d'occupation des lits : la croissance de l'activité hospitalière, avec un taux d'occupation des lits deux fois plus élevé qu'en 2000, traduit un regain de confiance de la population dans le système hospitalier. Les taux d'occupation des lits ont plus que doublés depuis le début des années 2000 dans presque tous les EPS visités (49 % en 2012 versus 21 % en 2000). Au-delà de l'évolution de la demande de soins relative à la croissance démographique et aux capacités financières des ménages portées par une croissance économique favorable (+5 % en 2013), cette croissance de l'activité est appréciable, d'autant que dans le même temps l'offre de soins privée s'est elle aussi développée. Il est difficile d'affirmer que cette évolution est directement liée à la réforme hospitalière mais on peut néanmoins penser que celle-ci a constitué un contexte favorable à cette évolution positive.

Consultations externes : le nombre de consultations externes a augmenté d'environ 21 % entre 2010 et 2012. Une activité réelle a été constatée, dont témoignent les files d'attente, l'occupation des services d'hospitalisation visités ou encore l'activité des blocs accouchements ou opératoires. Les données d'activité agrégées des EPS 1 et 2, qu'il convient d'analyser avec

prudence dans la mesure où il y a eu une importante rétention d'informations suite à un conflit social avec les agents en charge de la transmission de ces données, confortent néanmoins cette analyse avec une croissance notable de l'activité externe (+ 21 %). Egalement, les activités de consultations au titre des urgences connaissent aussi une très forte augmentation, ce qui en fait pour la Direction Générale de la Santé (DGS) une problématique prioritaire.

Taux d'hospitalisation : les taux d'hospitalisation présentent de fortes disparités géographiques avec un taux de 61 % pour Dakar et sa banlieue, contre 36 % en milieu rural. Ce taux d'occupation est beaucoup plus conséquent sur Dakar et sa banlieue — où il atteint 61 % — que dans les CHR hors Dakar où ce taux n'est que de 36 %. Différents éléments peuvent expliquer cette différence significative. Parmi ceux-ci, sont évoqués: (i) l'attractivité des établissements hospitalo-universitaires (CHU) ; (ii) l'accessibilité des établissements en milieu urbain dense ; (iii) le plateau technique plus conséquent de certains de ces établissements ; (iv) les spécialités de référence nationale ; et (v) la solvabilité de la population. Le cadre physique des établissements de la région de Dakar et l'organisation des soins n'apparaissent en revanche pas comme des spécificités et des avantages concurrentiels déterminants au profit des établissements Dakarois, bien au contraire.

Durée Moyenne de Séjour (DMS) : l'évolution de la durée moyenne de séjour (DMS)[58] a une certaine pertinence. Le résultat global pour 2012 de 5,0 jours de DMS peut être considéré comme favorable d'autant que l'on constate une réduction par rapport à 2010 où il était de 5,7 jours. Cette DMS apparaît particulièrement faible dans les hôpitaux hors Dakar puisqu'elle est de 3,4 jours. La part dans les séjours hospitaliers de l'activité de la maternité explique sans doute ceci.

Taux de mortalité hospitalière : il est également recueilli dans les statistiques nationales et se révèle assez stable, autour de 6,5 % en 2012, contre 6,7 % en 2010.

Taux de mortalité : on retrouve un taux de mortalité plus défavorable dans les hôpitaux de Dakar (8,4 %) que dans les CHR (4,6 %), ce qui illustre le rôle de référence des hôpitaux de la capitale.

Taux d'infection nosocomiale : Le taux d'infection nosocomiale est recueilli dans certains établissements par l'intermédiaire des comités de lutte contre les infections nosocomiales (CLIN) mais les résultats agrégés de cet indicateur n'ont pu être recueillis.

58 Nombre de journées d'hospitalisation dans l'année rapporté au nombre de séjours.

Capacités litières : Les capacités litières autorisés des EPS 2 et 3 ne sont pas saturées selon les statistiques disponibles. Il convient néanmoins de noter qu'une partie des capacités litières autorisées ne sont pas installées en raison selon les cas : (i) de dégradation des locaux d'hospitalisation devenus insalubres ou dangereux (exemple de l'hôpital Le Dantec) ; (ii) de projet de réhabilitation hospitalière en cours pour l'amélioration du plateau technique (exemple du CHR de St-Louis).

ANNEXE 15

Processus d'Elaboration des CPOM au Sénégal

Domaines	Critères	Indicateurs
Qualité des soins et des services/Démarche qualité	Mise en place et évaluation d'un des cinq chantiers qualité avec une (ou des) procédure(s) écrite(s), validée(s), mise(s) en œuvre et évaluée(s)	Existence d'un chantier qualité mis en œuvre et évalué
	Ouverture d'un nouveau chantier suivant le processus standard	Nouveau chantier ouvert avec Procès-verbal de réunion
Qualité des soins et services/Méthode 5S KAIZEN TQM	Mise en place ou réactualisation du cadre institutionnel (Comité 5S, Sous-comité 5S avec composition, missions et fonctionnement)	Note de service de mise en place du comité et de nomination des responsables
	Existence d'un comité 5S (QIT) • Composition • Attribution • Fonctionnement	Note de service de création du comité

(continues on next page)

Domaines	Critères	Indicateurs
	Nomination d'un président Comité 5S et d'un adjoint (avec missions et attributions)	Note de service de nomination
	Elaboration et Mise en place d'un plan d'action global	Existence d'un plan d'actions validé
	Mise en place des procédures et protocoles	Protocoles et procédures validés
	Evaluation interne effectuée et résultats diffusés	Existence d'un rapport d'évaluation
Qualité des soins et des services/Accueil	Evaluation du fonctionnement du service ou de la structure d'accueil	Existence d'un rapport d'évaluation
Qualité des soins et des services/Hygiène et Infections nosocomiales	Existence d'un plan d'actions validé par la CME, la Direction et délibéré en Conseil d'Administration comprenant un programme de surveillance, un programme de formation des personnels	Existence d'un plan d'actions validé et délibéré
	Réunions trimestrielles du CLIN tenues régulièrement	Existence des Comptes rendus de réunions
	Mise en place d'un protocole choisi parmi les thèmes prioritaires définis par le niveau central	Existence d'un Protocole écrit, validé et mis en place
Qualité des soins et des services/Qualité des soins	Evaluation de deux protocoles thérapeutiques relatifs à la prise en charge de deux affections parmi les dix les plus courantes dans l'établissement	Existence des rapports d'évaluation
Qualité des soins et des services/Hôtellerie/Draps	Instauration d'un suivi de l'utilisation des draps par les services Vérifications régulières des dotations sur place.	Existence d'une fiche mensuelle de suivi Existence d'une fiche trimestrielle de vérification sur place des dotations de draps dans les services
	Mise en place d'un circuit du linge	Existence d'un protocole ou procédure validée

Domaines	Critères	Indicateurs
Amélioration continue de la qualité/Relation à l'usager	Réalisation d'au moins une enquête de satisfaction auprès des usagers au cours de l'année	Enquête réalisée et résultats analysés
	Réalisation d'au moins une enquête thématique et spécifique de satisfaction auprès des usagers (gestion de la file d'attente, de la restauration etc.)	Enquête réalisée et résultats analysés
	Réalisation d'une enquête de satisfaction auprès du personnel au cours de l'année	Enquête réalisée et résultats analysés
Des principes de bonne gouvernance hospitalière	Tenue de réunion de coordination régulière de la Direction	
	Tenue des conseils d'administration	Existence d'un procès-verbal de réunion
	Tenue des réunions de CME/CCE	Existence de compte rendu de réunion
	Tenue des réunions du CTE	
	Tenue d'une assemblée générale d'information et de partage avec tout le personnel	Rapport de l'assemblée élaborée et disponible
Gestion administrative, financière et comptable	Elaboration et transmission des rapports trimestriels de suivi budgétaire	Rapport trimestriel transmis selon le canevas et en respect des délais
	Réalisation et transmission du rapport annuel de gestion	Rapport annuel transmis selon le canevas et en respect des délais (au plus tard le 31 Mars de l'année en cours)
	Finalisation de la comptabilité analytique hospitalière (5 hôpitaux pilotes) **Ou** Réalisation d'une première expérimentation de la comptabilité analytique hospitalière (autres établissements)	Retraitement des résultats de l'année N-1 au plan analytique et rapport transmis au niveau central au plus tard le premier trimestre de l'année N Exercice de retraitement des résultats N-1 réalisé par l'établissement et restitué à la tutelle au plus tard le dernier trimestre de l'année N
	Elaboration et mise en œuvre d'un plan de maitrise des dépenses	Existence d'un plan de maitrise des dépenses

Domaines	Critères	Indicateurs
	Elaboration et mise en œuvre d'une politique de maitrise de la masse salariale et des effectifs	Masse salariale à maintenir à un taux de 35 à 65 % Existence d'un plan de formation, d'une GPEC et au besoin d'un plan social
Système d'information hospitalière	**Critère « déclencheur » :** **Complétude et promptitude de la transmission des rapports trimestriels d'activité**	Rapports complets et transmis dans les délais (au plus tard à la fin du mois qui suit la fin du trimestre demandé)
Système d'information médicalisée (SIM)	**Critères distinctifs selon le niveau d'engagement de l'établissement dans la démarche**	
	Taux d'exhaustivité du remplissage des RUM (90%) (établissements pilotes et établissements formés)	Indicateurs de résultats à personnaliser en fonction du taux d'exhaustivité du remplissage des RUM propre à chacun des 5 établissements
	Autres établissements : Fonctionnalité de la cellule d'information médicalisée (CIM)	Existence d'une CIM fonctionnelle (production des RUM et rétro information des services)

Source : République du Sénégal, ministère de la Santé, DES.

The public hospital sector is essential to a country's economic and social development, as it represents a key entry point to health services. Through the sector, the state fulfills its public service mission and provides access to healthcare, especially for vulnerable populations. The financial weight of the health sector is significant. In the countries of the West Africa subregion, total health spending averaged around 6 percent of GDP in recent years, and the funding of public hospitals remains among the largest health expenditure items in health ministries' budgets. An effective governance framework of the hospital sector is therefore critical for the efficient use of resources and the provision of quality healthcare. This study analyzes governance arrangements in the public hospital sector in Benin, Côte d'Ivoire, and Senegal, relying on an adapted methodology for analyzing the corporate governance of state-owned enterprises. Based on the OECD's *SOE Corporate Governance Guidelines* and the World Bank's *SOE Corporate Governance Toolkit,* the analysis covers the legal framework, the organization of the state's oversight function, fiscal and performance monitoring, the role of hospital boards of directors, and transparency and disclosure. It identifies regional trends and key challenges and highlights options for strengthening hospital governance to leverage performance and ultimately improve the delivery of public hospital services to the population.

WORLD BANK GROUP

16425