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HEALTH CARE SYSTEM AND HEALTH FINANCING STRUCTURE, THE CASE OF CAMEROON

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ABSTRACT

The purpose of this study is to identify healthcare systems and its financial components of Cameroon. As we know, Health care financing studies in Africa and cross-national levels have tended to focus on many modes of financing at a time, such as user fees, insurance,government budget, external aid, also on financing-related issues such as equity and quality of care. Relatively few attempts have been made in the literature to analyze total national health financing from all sources and to relate them to their various uses. This study also uses the broader framework of National Health Accounts (NHA) to analyze national health system and financing in Cameroon. Health care financing is one of the fastest growing areas in the field of public health economics. Health systems are defined as comprising all the organizations, institutions and resources that are devoted to producing health activities. Due to that reasons this study examined the challenges of health system and financing health care in Cameroon. It also identified various funding mechanisms available to finance health care in Cameroon.

Key Words: Healthcare System, financing, funding mechanisms and Cameroon

ÖZET

Bu çalışmanın amacı Kamerun sağlık sisteminin ve sistemin finansal bileşenlerini tanımlamaktır. Bildiğimiz gibi, Afrika ve uluslar arası düzeyde sağlık hizmet finansmanı çalışmalarında tüketici ödemeleri, sigorta, kamu bütçe kaynakları, dış yardımlar gibi çeşitli yöntem eğilimlerinin yanı sıra hizmet etkinliği ve kalitesi gibi finansmanla alakalı konular vardır. Literatürde tüm kaynaklarla toplam ulusal sağlık hizmeti finansmanını analiz etmek ve bunların farklı kullanımlara göre ilişkilendirmek için nispeten az sayıda deneme yapılmıştır. Bu çalışma aynı zamanda Kamerun'un ulusal sağlık sistemini ve finansmanını analiz etmek için Ulusal Sağlık Hesaplarını (NHA) kullanır. Sağlık hizmet finansmanı, sağlık ekonomisinde en hızlı büyüyen alanlardan birisidir. Sağlık sistemleri, sağlık aktivitesi sunmaya adanmış tüm organizasyonların, kurumların ve kaynakların kapsamı olarak tanımlanır. Bu çalışma, bu nedenlerden ötürü Kamerun'da sağlık sistemi ve finansmanının zorluklarını incelemektedir. Çalışma aynı zamanda Kamerun'da sağlık hizmet finansmanı için uygun çeşitli finansman mekanizmalarını tanımlamaktadır.

Anahtar Kelimeler: Sağlık Sistemi, finansman, Finansman Mekanizmaları ve Kamerun

INTRODUCTION

Improved health status leads to increased productivity, educational performance, life expectancy, savings and investments, and decreased debts and expenditure on health care. Ultimately this would lead to greater equity, economic return, and social and political stability. Therefore, improved health is a key factor for human development. However, many policy analysts have expressed fears that at the current rates of progress, sub-Saharan Africa (SSA) will not be able to provide satisfactory health care to its inhabitants by 2020, and will not achieve any of the United Nations millennium development goals due to increasing poverty. Health must be seen as a central element of productivity, rather than as an unproductive consumer of public budgets.

Globally, more advances in health, science, and technology have been made in the last 50 years than in the 500 years before the 20th Century (1) Health infrastructure has been expanded and education, incomes, and opportunities have improved. Public health interventions and socioeconomic development have reduced mortality and raised life expectancy. Unfortunately, these gains have by no means been universal. The health gaps within and between countries have widened, perhaps due to inequality in the absorption of new technology as well as unequal distribution of new and re-emerging health problems (2).

1. BACKGROUND

Cameroon is a Central West African map 1 and 2 Republic country headed by President Paul Biya and has a surface area of 475,442 km^2 divided into 10 regions, the regions are in turn divided in to 58 divisions with 322 subdivision. Cameroon has 2 official languages English and French (due to colonization by the French and the English) with 380 dialects. The country has 40% indigenous beliefs, 40% Christian and 20% Muslim. She has a population of 20,129,878 (3). Cameroon has inhabitants' annual growth rate of 2.082% (4-5).

Table 1:Cameroon : Economic and Social Indicators

Text Table 1. Cameroon: Economic and Social Indicators		
	Cameroon	**SSA**
Economic indicators, (average over 2007-11)		
Real per capita GDP (U.S. dollars, at 2000 prices)	680.8	680.1
Real GDP growth (percent)	3.0	5.2
Real non-oil GDP growth (percent)	3.7	6.0
Real per capita GDP growth	0.3	2.9
Total investment (percent of GDP)	16.7	22.3
Social indicators, 2010		
Employment to population ratio, ages 15+, total (percent)	62.0	65.0
Primary education completion rate, total (percent of relevant age group)	79.0	67.0
Ratio of female to male primary enrollment	86.0	92.0
Ratio of female to male secondary enrollment	83.0	79.0
Immunization, measles (percent of children ages 12-23 months)	79.0	75.0
Mortality rate, under–5 years of age (per 1,000)	136.0	121.0
Prevalence of HIV, total (percent of population ages 15-49)	5.3	5.5
Improved water source (percent of population with access)	74.0	60.0
Sources: IMF, African Department and WEO databases, 2012; and The World Bank, World Development Indicators database, 2011.		

SSA - Sub Saharan African

Because of its modest oil resources and favorable agricultural conditions, Cameroon has one of the best-endowed primary commodity economies in sub-Saharan Africa. It is one of the few lower middle income countries (GNI per capita $ 4,086 to 12,615) in sub-Saharan Africa. Still, it faces many of the serious problems confronting other underdeveloped countries, such as stagnant per capita income, a relatively inequitable distribution of income, a top-heavy civil service, endemic corruption, and a generally unfavorable climate for business enterprise (6).The country GDP stands at $50.32 billion (7-8). The currency of Cameroon is the Communaute Financiere Africaine franc (FCFA). Cameroon's main export commodities are crude oil and petroleum products, lumber, cocoa beans, aluminum, coffee and cotton. Main export destinations are Spain, Italy, France, the Netherlands, the US, and China.

Cameroon's main imports are machinery, electrical equipment, transport equipment, fuel and food. The origins of Cameroon's imports include France, Nigeria, Japan, US, China, and Germany.

1. HEALTHCARE SYSTEM.

Over the past two decades, Cameroon has achieved one of the smallest reductions in the under-five child mortality rate in the world and life expectancy has even declined. The burden of health care financing is largely born by households and risk-pooling mechanisms are quasi-inexistent. The limited public resources allocated to health do not seem to be deployed where they are the most needed. As a result, substantial disparities exist in health outcomes between rural and urban areas, as well as across socio-economic groups, hereby perpetuating poverty and vulnerability.

1.1 Health profile

Over the last two decades, there has been little change in Cameroon's health indicators (Table 2). The under-five child mortality rate has slightly improved. About 16 more children out of every 1,000 survive their first five years in Cameroon than two decades ago (9). This slight progress pales, however, compared to an average of 65 additional children surviving in Sub-Saharan Africa **(Figure 2**). Life expectancy in Cameroon has even declined since 1990 by about two years, while countries in Sub-Saharan Africa have on average gained about five years **(Figure 3)**.

Table 2: Important Health Indicators

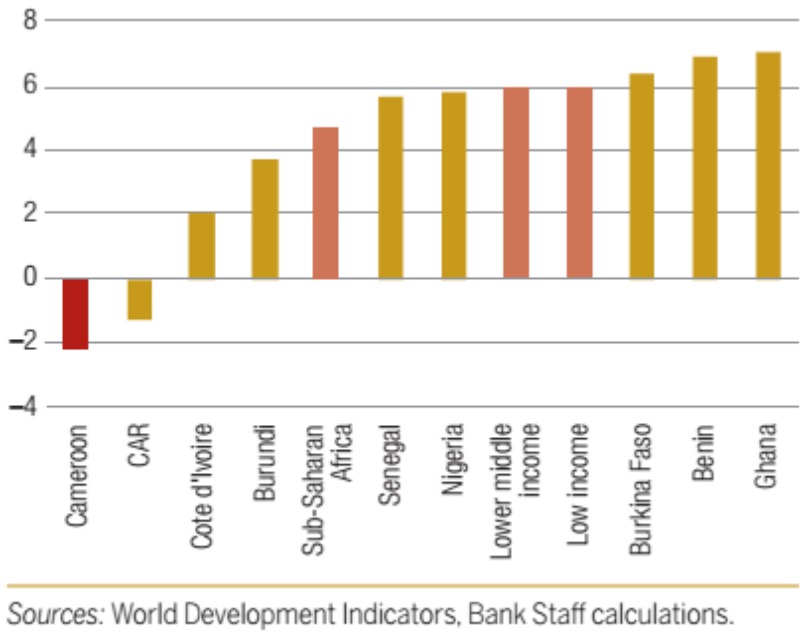
INDICATOR	**YEAR**	**AFRICA**
	2011	**Value**
Gross domestic income per capita PPP $	2,330	
Population(in thousands)	21,156	-
Population median age		
Population proportion under-15 (%)	43.24	
Population proportion over 60(%)	4.93	
Population living in urban areas (%)	52	
Population annual growth rate (%)		
Life expectancy at birth (years) for both sex	53	56
Life expectancy at age 60(years)	16	16
Adult mortality rate(probability of dying between 15[a] and 60 year of age per 1000 of population	394	340

Under-5 mortality rate(	127	107
Death due to HIV/AID(per 100 000 population)	172	107
Prevalence of HIV among adult aged 15 to 49 (%)	4.6	-
Antiretroviral therapy coverage among people with advanced HIV infection (%)	41	
Malaria number of reported deaths	3,808	
Crude birth rate(per 1000 population)	37.37	
Crude death rate(per 1000 population)		
Estimated percentage of pregnant women living with HIV who received antiretroviral to prevent mother-to-child transmission	53	
Antenatal care coverage at least one visit (%)	84.7	74
Population using improved drinking-water source(%)	74	64
Number of patient per physician	12,500	4000
Population per hospitals	111,111	111,111

Table was constructed form WHO Report of 2013,

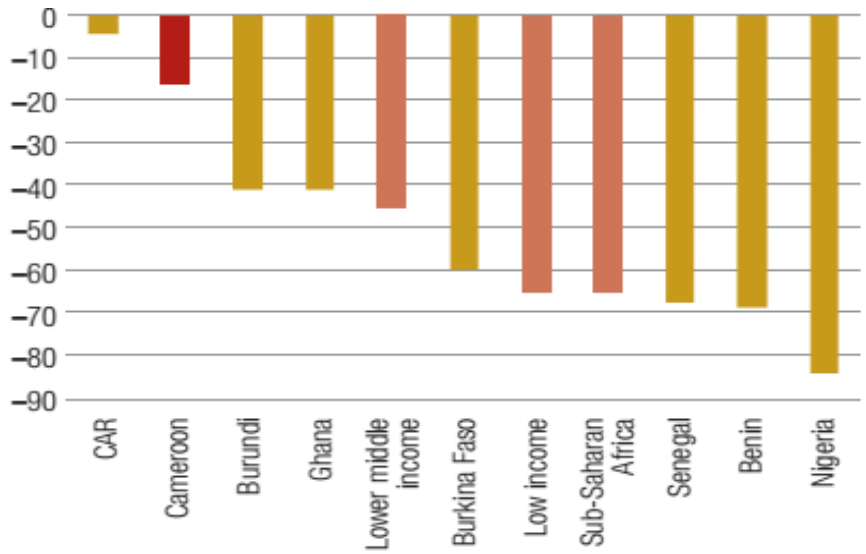
a– 1990=351 and 2011=415 (for male), 1990=296 and 2011=372(for female

Figure 2: Change in life expectancy at birth 1990 to 2010.



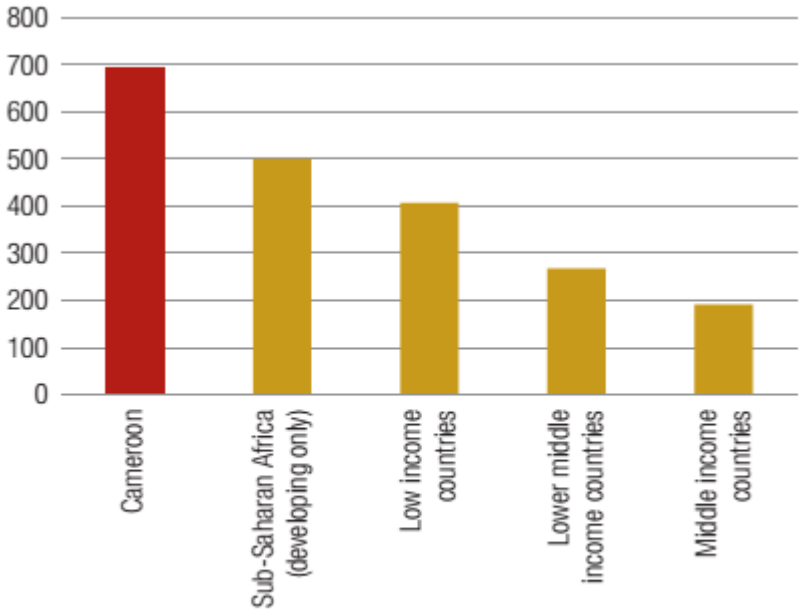
Sources: World Development Indicators, Bank Staff calculations.

Figure 3: Change in under-5 child mortality rate 1990 to 2010 (per 1000)



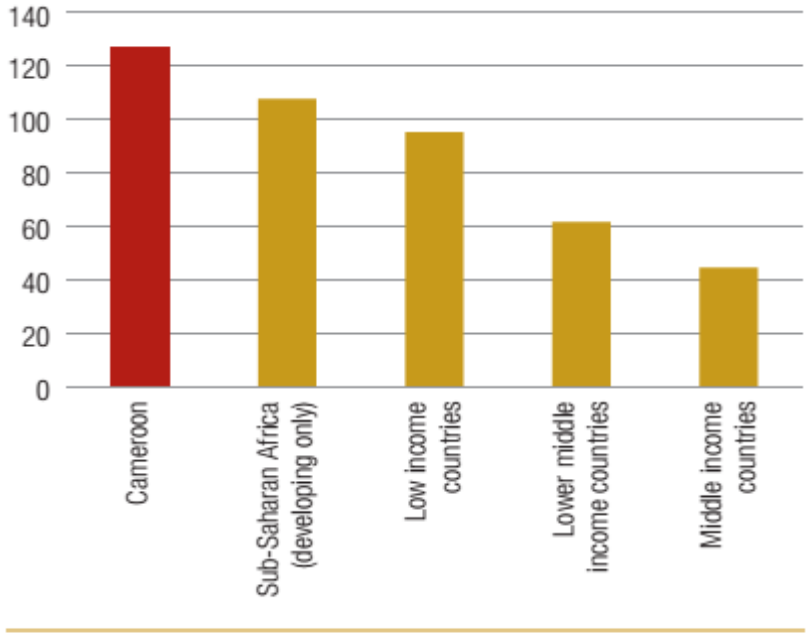
Sources: World Development Indicators, Bank Staff calculations.

Figure 4: Maternal mortality 2010(per 100000 live births)



Source: World Development Indicators.

Figure 5: Child mortality 2011(per 1000 live births)

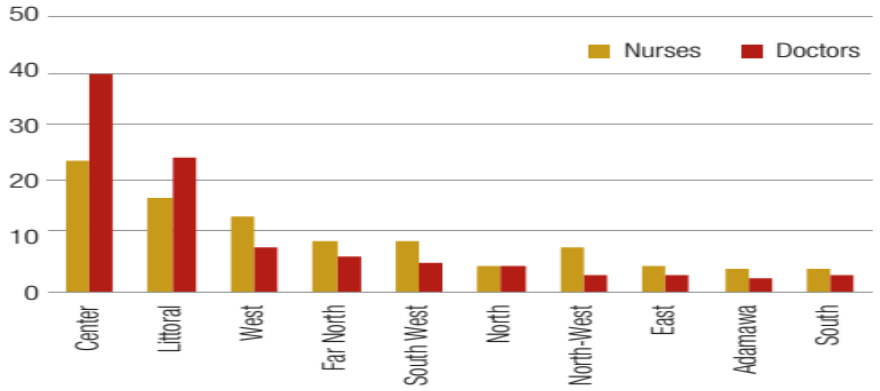


Source: World Development Indicators.

As a result, Cameroon's health indicators lag behind those of the rest of Sub-Saharan Africa and behind those observed in countries to which Cameroon is economically comparable (**Figure 4 and 5**) above. For instance, Cameroon has one of the highest under-five child mortality rates in the world (122 deaths per 1,000 live births), exceeding the average in developing Sub-Saharan Africa (108 deaths per 1,000 live births) with malaria, pneumonia and diarrhea being the main causes of death. Similarly, its maternal mortality ratio per 100 000 of live birth is also higher than the average for Sub-Saharan Africa and has increased substantially over the past decade. The ratio is higher than those observed in countries such as Ghana (230) and Zambia (440) that are also lower middle income countries and even higher than neighboring Gabon (230) and Congo (560). Pregnancy and childbirth remain significant risk factors for mortality: One woman dies every two hours from complications from pregnancy or childbirth, and one pregnancy out of 127 is fatal. The country has almost twice as many doctors as the minimum recommended by the WHO (1 doctor per 10,000 people) 1:12 500 table 2 above. (10).

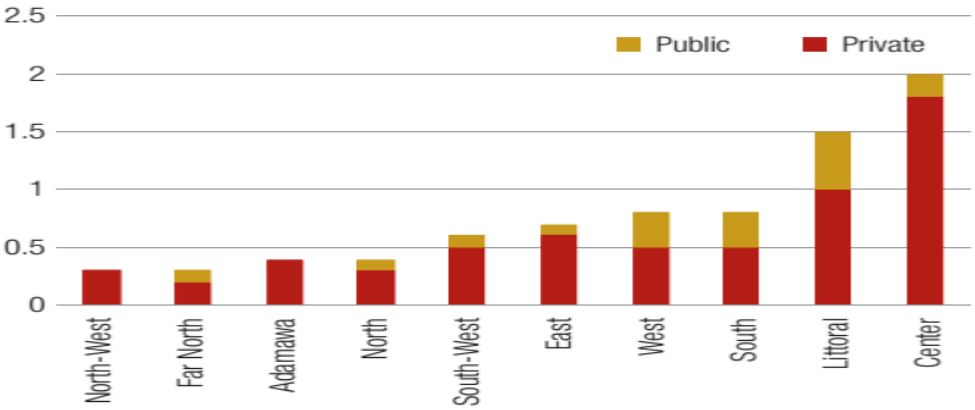
The main problem with human resources in the health sector is not just the ratio but their distribution across the country. The distribution of health professionals is highly urban-focused and varies significantly by region (**Figure 6 and 7**). In addition, absenteeism in Cameroon is a problem, especially in rural remote areas, and contributes to the migration of health personnel towards urban centers. Incentives for health staff to work in difficult environments or to perform are limited. Similarly, there are limited career options or opportunities for career development working in rural areas.

Figure 6: Health Staff Regional Distribution 2011 (in percent of total)



Source: Cameroon Health Workforce Census (2011).

Figure 7 Healthcare worker distributions by region



Sources: Cameroon Health Workforce Census (2011), Bank Staff calculations.

2.1.1. Presentation of Health System.

The organization of the Cameroon health system was defined in 1989 by the Ministry of Health Public by Decree No. 89/011. The Ministry of Public Health is the guarantor of the design and implementation of health policy. As such, it develops strategies for implementation of health policy, ensures the organization, development and technical inspection services and public and private health facilities, control the exercise of the profession of health care professionals, supervises the relevant professional associations and public health agencies, develops and implements the training plan for staff serving in the Ministry of public Health, contributes to the training and retraining of staff of the permanent body of public health manages public health institutions, contributes to the promotion of cooperation . Stakeholders in health in Cameroon working within a system structured in three levels:

central, intermediate and peripheral. Each level has specific functions and features of administrative structures, health facilities and structures for dialogue as presented on **Table 3** below. Each level is divided into three sub-sectors: Public, private and traditional medicine.

Under the public sector includes all public health institutions and quasi-public including those managed by other ministries (Defense, Employment and Labor, the Business Social, Gender and Education). It is organized according to a structure pyramid with 1st categories hospitals on the top followed by 2rd category hospitals at regional level managing the so many district hospitals. This sub-sector is inefficient of it dilapidated infrastructure, outdated equipment and inadequate human resource.

Table 3: Organisational Level of Public sector Health Services in Cameroon

Level	Administrative Structures	Competence	Care facilities
Central	central Services Ministry of Public Health	-Development of concepts, policy and strategies - Coordination - Regulation	General Hospitals reference center hospital and university, Central hospitals
Intermediary	Regional delegations	Technical support to district health	Regional hospitals and similar
Peripheries	Health service districts	Implement health programs	District Hospitals, Medical centers the District, Health centers

Source: INS/PETS2, 2010 (construit à partir du SSS 2006 – 2015)

The private sector occupies a very important place in Cameroon health care services. They complement and sometime compute with the government for patients. It includes health institutions, non-profit (religious groups, associations and NGOs) and those for profit. This subsector somewhat escapes the control of health authorities at all levels.

Traditional medicine is the third sub-sector, although it is not yet regulated. However, there are, for the promotion of this medicine, many state actions: the creation of a department in charge of traditional medicine in the Ministry of Health, creation of the Centre for Research on Medicinal Plants and traditional medicine (CRPMT / IMPM), the development of a legal framework being adopted and encouraging the organization of traditional Practitioners Association.

2.1.2. Health infrastructure and Accessibility

Health coverage through health care facilities has improved from 3039 in 2007 to 3370 in 2009. The Cameroon health system has 04 general hospitals(First category), 04 central hospitals(second category), 11 regional hospitals(third category), 164 hospitals District 155 district health centers and 1,888 health centers are integrated with 1600 functional . We must add 93 private hospitals, 193 centers private nonprofit health 289 clinics/polyclinics and 384 care practices. In addition, it takes 12 testing laboratories, 05 drug manufacturers, 14 wholesalers, pharmacies 331 (181 in Yaounde and Douala), 01 National Central of Supply Essential medicines and medical consumables, 10 supply centers regional pharmaceutical (GARP), 04 public medical school in Yaoundé, Douala and Buea and 01 private medical school (Universite des Montagnes) and 39 training institutions health personnel shows population distribution (9).

Health provider are; Government health facilities, Public enterprise health clinics, Public enterprise health clinics,Public enterprise health clinics, Health facilities of religious, Missions, non-governmental organisation (NGO), private clinics pharmacies, Drug retailers traditional doctors. A number of State-owned enterprises also operate health facilities for their staff like SONARA (cameroon oil producing company) has a health center for both it workers and the public.

The bulk of non-profit facilities are operated by the Catholic and Protestant Health Services: For example Cameroon Baptist Convention (protestant) that has been in the country now for more than 60 years, comprises 5 hospitals (2 of which are 250-bed hospitals), 23 integrated Health Centers, 43 primary Health Centers, Pharmaceutical procurement and distribution department, a Private Training School for Health Personnel (PTSHP), a Center for Clinical Pastoral Education and Social Services (CECPES), Services for People with Disabilities, among others (11).

3. HEALTHCARE FINANCE

3.1. Background

Health system is defined as the overall organization of health systems and care of the population. Care to the population is delivered by different types of providers or health care providers: hospitals, public and private institutions, liberal medical and paramedical practitioners, pharmacies and suppliers of equipment. The main sources of funding for the health sector in Cameroon are: the state budget, households (through cost recovery and other direct payments), external financing, Local authorities, NGOs and the private health insurance which provide a marginal contribution. There is a huge disproportion between these different funding sources. In 2009, for example, out of a total funding estimated at $5 752 750 000, the contribution of households stood at 94.6% against 3.8% to the State and 1.6% for external partners. Healthcare hardly gets more than 5% of the country's budget which is very inferior to the 10% standard laid by WHO **Table 4** below. Health sector in Cameroon is financed by both public and private

contributions with the later mainly playing a major role and in a decade has just improve by what decade itself is; 80.7% of the total expenditure in health in 2000 to 70.4% of total expenditure in 2010.It should be noted that out-of-pocket expenditure is still very high 94.5% of private expenditure **Table 4** below.

Table 4: Health Expenditure Indicators

INDICATOR	YEAR		LOWER MIDDLE INCOME	AFRICA REGION
	2011	2010	Value (2010)	Value (2010)
Gross domestic product(billion US %)[b]	25.2	22.4		
Per capita government expenditure on health(average exchange rate $)	21.2	18	27	42
Per capita total expenditure on health(PPP int.$)	127.9	122	152	154
Per capita government expenditure on health(ppp int.$)	39.8	36	55	73
Per capita total expenditure on health at average rate of exchange($)	68.2	61	72	89
General government expenditure on health as a percentage of total government expenditure	8.5	8.5	7.4	9.6
External resources for health as percentage of total expenditure on health	4.3	7	2.5	12
Social security expenditure on health as a percentage of general government expenditure on health.	2.6	2.6	16.3	7.8
Out-of-pocket expenditure as percentage of private expenditure on health.	94.5	94.5	87.8	56.6
Total expenditure as a percentage of GDP	5.2	5.1	4.1	6.2
Private expenditure on health as a percentage of total expenditure on health	68.9	70.4	63.9	52.8
General government expenditure on health as a percentage of total expenditure on health	31.1	29.6	36.1	47.2
Private prepaid plans as % of private expenditure on health	-	-	4.1	31.7

Table constructed form WHO report of 2013. Source form World Bank.

An important part of health expenses still occurred in the informal sector (under the table sale of drugs in health facilities, directs payments to caregivers, purchasing drugs and care in illicit health facilities). In state-own health facilities, user fees are collected and managed by health district management boards and or district hospital management boards whose membership is made of representatives from caregivers, communities and administrative authorities. 10% of the bill is paid by someone out of the household or from salaries or available money in 62%, savings in 24% and loans in 8% of cases.

When considering the overall amount, savings paid approximately 93%. Analysis by the Centre for the Development of Best Practices in Health Cameroon of the cost structure for curative health shows that drugs and medicines represent 81% versus 14% for consultation, nursing and hospitalization; transport expenses represent 3% of the total. In 2006, the monthly expenditure for curative care was $ 2.98 per capita [$3.43 for women –$2.51 for men; $ 4 in urban areas versus $1.9 in rural areas]. Despite several mechanisms implemented by the government and its technical and financial partners to improve financial accessibility, [harmonization of drugs prices in all the regions ; creation of a budgetary line for indigents in some health facilities ; anti TB drugs free of charges, antiretroviral drugs free of charge since 2007; HIV screening tests free of charges for pregnant women, prisoners and students ; 65% price reduction for essential drugs in state□own health facilities ; price reduction for insulin from $ 28.77 to $ 6.16; subsidies of some anti cancer drugs], the level of out□of‐pockets payments by households remains as high as 94,5% according to the World Health Statistics Report 2010 (12).

3.2. Spending

In light of the poor results in health indicators, Cameroon overall spends quite a lot compared to Sub-Saharan African countries (**Figure 8**). Public spending in the health sector in Cameroon is, however, low. While public resources allocated to health have progressively increased over the past ten years, they remain one of the lowest in Africa in terms of GDP (**Figure 9**) at 1.5 percent of GDP. Compared to other CEMAC countries, Cameroon has been for the last decade the country that has allocated the lowest share of its public spending to health (**Figure 10**). The cost of health care is thus largely borne by households and Cameroon has one of the highest levels of direct payments from the users (out-of-pocket) relative to total health expenditure in all of Sub-Saharan Africa.

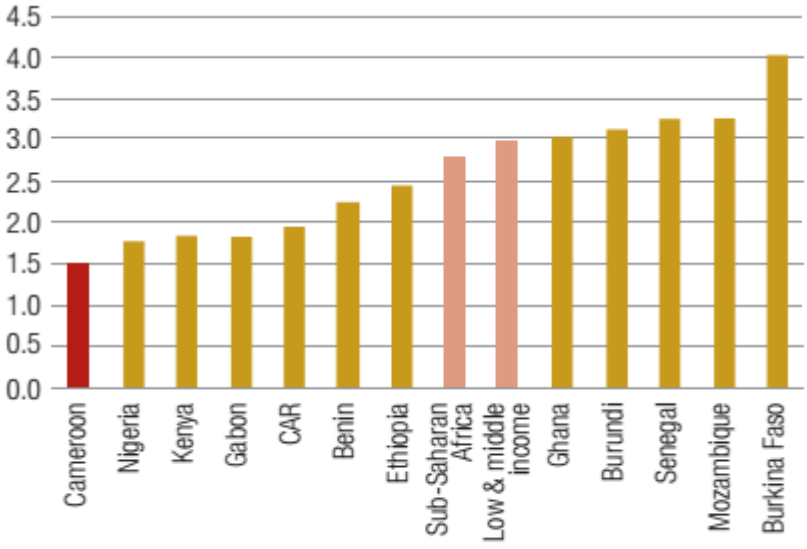
Cameroon health system has two important features;

It is a pluralistic system because it is characterized by multiple sources of financing and health care providers. The main financing sources are**;** Government, Public enterprises, Foreign aid donor, Private enterprises, Households, Religious missions, NGOs (STK). It is also a vertical system in the sense that financing sources deal most of the time directly with the providers without going through intermediaries or financing agents.

As can be seen, in **Table 4**, households are by far the most important source of health spending. This is reflected on the value of private health expenditure health as a percentage of total health expenditure; this is

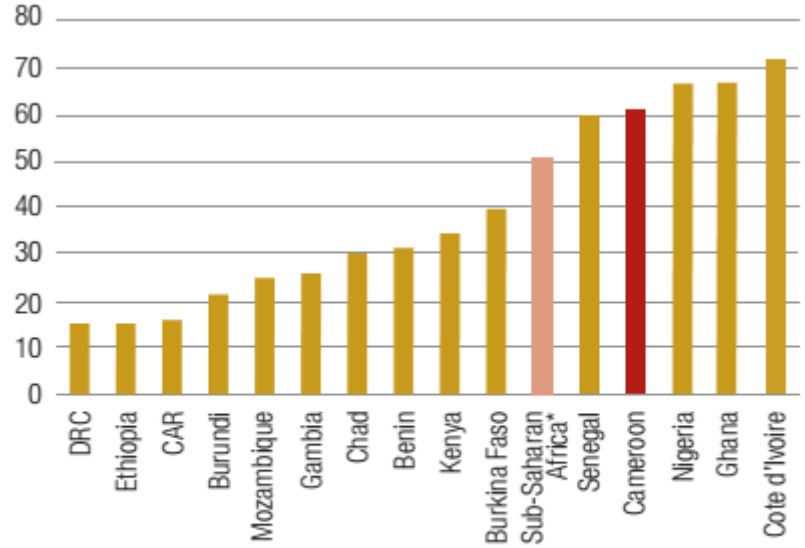
compounded by the value of out-of-pocket payment. Bulk of government spending is through the Ministry of Public Health, following allocations by the Ministry of Finance.

Figure 8: Health Expenditure 2010 (U S per capita)



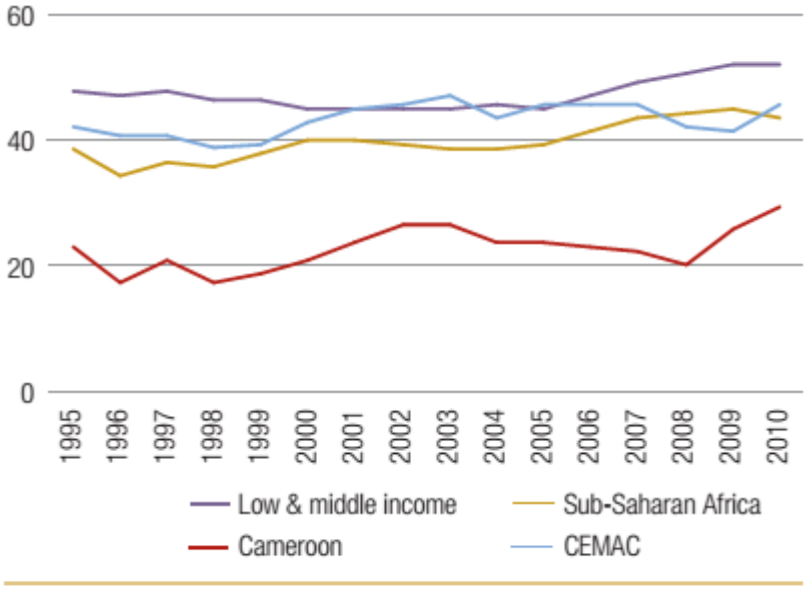
Source: World Development Indicators.

Figure 9: Public Health Expenditure of Selected Countries (percent of GDP)



Source: World Development Indicators.
* excluding South Africa, Somalia and Zimbabwe.

Figure 10: Public Health spending selected Countries 1995 to 2012 (% total health expenditure).



Source: World Development Indicators.

A smaller fraction of government spending is through; Ministry of Armed Forces in its own facilities, providing health services to the military and police; Ministry of National Education which has hygiene and occasional immunization activities for school children; Ministry of Higher Education on its university hospital; Ministry of Social Affairs which occasionally carries out various community health programs.

Quite good external financing data are obtained from individual donor agencies in and out of the country in **Table 4.** For example in 2012 the US donate $8.5 million to Cameroon through center for disease control (CDC). In the case of public enterprises it should be noted that some have their own health facilities and those without own facilities use private for-profit facilities for their workers. In addition to user fees and profits from the sale of drugs, religious missions and NGOs finance a small part of their activities from donations in the form of staff, drugs, and equipment from their denominations abroad. For example Cameroon Baptist health board has been receiving donations from North American Baptist conference (13).

3.3. Reasons for Low level of Government Spending.

Cameroon has a very low level of government financing when it comes to healthcare. Apart from the fact that countries with high proportion of informal sector also has a low level of government spending (high out-of-pocket spending see figure below appendix 1) in health the low level of government financing in Cameroon is partly to be traced to the severe and unprecedented macroeconomic crisis that hit the country during the period 1986 – 1995 which provoked a fall in per capita income from $1020 to $635 (14). The impact of the crisis on government health spending than on was more severe private spending.
A second explanation for the low level of government health spending relative to private spending is that the country has had a long tradition of privately financed health care. Since colonial times the Catholic and Protestant church missions in Cameroon developed an important and reliable not-for-profit network of health services operating with user fees. Even government health care which, until recently, was officially supposed to be free has never really been free; patients knew that they had to pay for drugs and bribe to receive care.

3.4. Risk Pooling.

Like we saw, the burden of health finance is largely born by household and risk-pooling mechanisms are quasi-inexistent. State measures to avert and alleviate social risk are minimal. The public social insurance system (Caisse nationale de prévoyance sociale, CNPS) was for a long time notoriously overextended, poorly managed and under-performing, and in the past has often been plundered as a slush fund for the government. Some progress in management practices have been recognized in recent years. The state health care system is similarly overextended, and has been compromised significantly by corruption. Family structures and other primary solidarity networks are the only viable options for reducing risk, and still function comparatively well. Informal institutions exist to compensate for gross social differences, but they are limited in scope and quality. In rural areas, social risk is still largely absorbed by "traditional" family-based relationships of solidarity. This system is crumbling in the cities. Sometimes there is equivalent coverage through informal savings associations (tontines) or through the solidarity of church congregations.

3.4.1. Insurances Companies

Like other insurance coverage health insurance in Cameroon remain very low small and one of the key reasons for the low penetration of insurance in Cameroon is a poor awareness level and lack of trust on these insurers corruption is also playing a major rule here. Another major reason is that being insure or not, is not an obligation so nobody is being punished for not having insurance coverage. With this in mind and coupled with the results from those covered by the state social program, many find it difficult to confine their resource to any risk pooling scheme weather private or public

In 2005, only 17% of Cameroonians were covered. Five years later, it has less than 10%[1]. Insurance companies like AXA and Allianz insurance offers health care coverage packages (15).

3.4.2. Company Insurance Schemes.

Most companies have internalized insurances schemes which are in some cases obligatory but in most cases it is voluntary. Contribution is collected by direct deduction from the pay check of the employee and this money is placed in an account own by the company. In case of illness a percentages of the employee expenses is reimbursed depending on the agreement of the scheme.

3.4.3. Mutual Health

The Cameroonian government to address less insurance coverage issue, has set a target of covering 40% of the population by health mutual and create at least one per district by 2015. Communities organize to achieve this objective to ensure access to care for people. It is an association to ensure the solidarity, access to quality care to members through contributions. Mutual health is a common initiative group of people. Mutual offers the opportunity to treat a wide variety of illnesses at integrated health centers, Religious and state hospitals. When you get register with the mutual group, you can gain service like; Laboratory tests, The X-ray, ultrasound, Generic drugs, Hospitalization, Surgery, ANC, coverage of the birth amongst others. The payment of

the annual contribution entitles you to a support 75% of health expenditures to a maximum of 290,000 CFA (about 600 US dollars). To be a member you just need to fulfill the following (16);

- Pay your membership fees 1000 CFA ($ 2).
- Pay an annual fee of 14,000 CFA ($ 30) covering 1-4 recipients.
- Pay 3500 CFA ($ 7) for each additional beyond 4 people person.
- Provide a passport size photo for each beneficiary enrolled.

These mutual are very unpopular and are experiencing a lot of failures. In 2005, about sixty MS were operating with a demographic coverage under 1% (17). Main reasons of the failure of exclusively community based health insurance particularly in rural areas is the weak management capacities, the power imbalance between healthcare providers and mutual health management body as well as the exclusion of healthcare providers from the conception and management of mutual health.

3.4.4 Cameroon Social Security Fund

Social Security (provided by CNPS) that also not yet includes in its services the health coverage protects only formal sector workers and civil servants. This practice excludes a significant portion of the population that comprises the non-agricultural sector informal and informal non-agricultural sector. The Cameroon social security system consists of three branches: (18)

- accidents at work, occupational diseases
- family benefits
- invalidity, old-age, death (survivors)

Treatment is provided to workers by employers according to the labor code. However a certain number of treatments have been provided through the National Health Service since 1962. Cameroon social security legislation does not actually include a ‘health care’ branch. Contributions are paid on wages up to a ceiling of $ 617, except in the case of work accidents, where contributions are paid on the whole salary10. Insured person: 2.8% of covered earnings. Employer: 4.2% of covered payroll. The guaranteed minimum wage is $58 (28,216 CFA francs) per month for 40 hours of weekly work in public or private non-agricultural businesses.

4. Conclusion and Recommendations

It will no crime to say the nation is not a healthy one, and no news saying that the country like other African countries faces enormous health care challenges which is demonstrated by grim health outcomes. The country still faces a high under-five child mortality rate (122 deaths per 1,000), the life expectancy is still very low (53 for both sex at birth and 16 for both sex above 60 year).Healthcare financing burden is still highly born by household (98%) with quasi-inexistent prepayment and risk-pooling mechanism in place, thus out of pocket payment is at its maximum even in government health facilities. This situation, couple "with under the table payment" expose a lot of household to catastrophic health expenditure and push the poor further in to poverty.

This issue of catastrophic expenditure is unbelievably dismally. A country with 98% out-of-pocket payment gives one a picture of how low progressivity of healthcare finance equity is. Government can handle this by reducing health care finance mechanism fragmentation thereby encouraging mutual health schemes that

is already taking place in some parts of the country. Secondly the government should also increase coverage for the mandatory national social insurance scheme for formal sectors. This will encourage cross-subsidization between the schemes and thus help address the issue of catastrophic health expenditure.

Health facilities are dilapidated with weak management and poor health management information system. Higher doctor to patient ratio is a major issue, this condition is compounded in that these doctors turns to concentrate in urban areas (19) making the already bad situation in the rural areas worst.

Proposals here could be a re-look into the state recruitment and retention of these practitioners. Many doctors turn to abandon their post because of poor incentive schemes. Incentives for recruitment and retention should be but monetary and non-financial. This will ensure the provision and maintenance of health supplies and equipment for clearly defined essential service provision couple with salaries bonuses for rural posting.

Corruption has and it is still playing a huge role in destroying the country's health system and finance. This has led to the missing of huge slices of the state budget. General state budgeting and financing of health system should be re-considered with emphasis on program-base budgeting and result-based financing. These will bring in flexibility in preparation and execution of the budget by line ministries while holding them accountable for their actions. Result-based finance plays a role in performance and encouraging improvement not only in the health outcomes of the country but also in the management of the health system in general.

APPENDIX

Appendix 1: Physical capital for providing services and care

Category	2009
1st category Hospitals	4
2rd category Hospitals	4
Regional hospitals and Assimilated	11
District hospitals	164
District medical center	155
Integrated Health Centers	1888
Health Centers Private non-profit	559
Care practices	384
Private Hospitals nonprofit	93

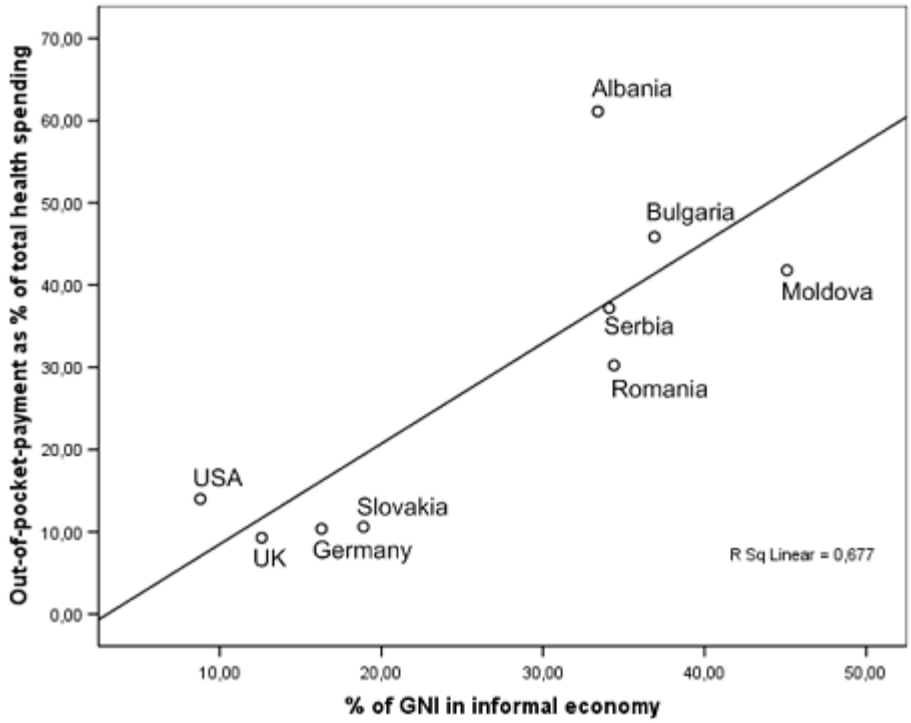
Source : MINSANTE/DOSTS

Appendix 2: Population Ratio per structure

Population	Surface area Km^2	Density	Public integrated health centers	Private health centers	District health centers	Districts hospitals	Private pharmacies	Average population per health center	Average population per hospital
19 406 100	457 442	35	1 888	760	155	164	331	109 023	118 330

Source : Ministère de la Santé Publique, 2010

Appendix 3: The relationship between the size of informal sector and out-of- pocket spending



Source- GTZ (2010) addressing the issue of healthcare financing-

Map 1

Map 2


Limite des provinces
Limite de département
Douala
Chef lieu de province
EXTREME NORD
Maroua
TCHAD
Garoua
NORD
NIGERIA
Ngaoundéré
ADAMAOUA
NORD-OUEST
Bafoussam OUEST
SUD-OUEST
LITTORAL
Douala
CENTRE
Bertoua
R. C. A
EST
SUD
Ebolowa
GUINEE EQUATORIALE
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CONGO

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