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FINANCING OF UNIVERSAL HEALTH COVERAGE AND FAMILY PLANNING

# Financing of Universal Health Coverage and Family Planning

# A Multi-Regional Landscape Study and Analysis of Select West African Countries: Cameroon

**January 2017**

This publication was produced for review by the United States Agency for International Development.
It was prepared by Jenna Wright, Karishmah Bhuwanee, Ffyona Patel, Jeanna Holtz, Thierry van Bastelaer, and Rena Eichler for the Health Finance and Governance Project.

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**January 2017**

**Cooperative Agreement No:** AID-OAA-A-12-00080

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**Recommended Citation:** Wright, Jenna, Karishmah Bhuwanee, Ffyona Patel, Jeanna Holtz, Thierry van Bastelaer, and Rena Eichler. 2016. *Financing of Universal Health Coverage and Family Planning: A Multi-Regional Landscape Study and Analysis of Select West African Countries*. Report prepared by the Health Finance & Governance Project. Washington, DC: United States Agency for International Development.


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# FINANCING OF UNIVERSAL HEALTH COVERAGE AND FAMILY PLANNING

# A MULTI-REGIONAL LANDSCAPE STUDY AND ANALYSIS OF SELECT WEST AFRICAN COUNTRIES

# CAMEROON

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# ACRONYMS

| | |
|---|---|
| **ANAM** | *Agence Nationale d'Assistance Médicale* / National Agency for Medical Assistance (Mali) |
| **ANAM** | *L'Agence Nationale de l'Assurance Maladie* / National Health Insurance Agency (Benin) |
| **APSAB** | *Association Professionnelle des Societés d'Assurances du Burkina Faso* / Professional Association of Insurance Companies of Burkina Faso (Burkina Faso) |
| **CAMNAFAW** | Cameroon National Association for Family Welfare (Cameroon) |
| **CAMS** | *Cellule d'Appui aux Mutuelles de Santé* / CBHI Technical Support Cell (Cameroon) |
| **CANAM** | *Caisse Nationale d'Assurance Maladie* / National Health Insurance Fund (Mali) |
| **CBHI** | community-based health insurance |
| **CNPS** | *Caisse National de Prévoyance Sociale* / Social Security (Cameroon) |
| **CNSS** | *Caisse Nationale de Sécurité Sociale* / National Social Security Fund (Burkina Faso, Guinea) |
| **CONSAMAS** | *Concertation Nationale des Structures d'Appui aux Mutuelles et Assurances de Santé* / National Coordination of CBHI Schemes and Health Insurances (Benin) |
| **CPS** | *Cellule de Planification et de Statistique* / Planning and Statistics Unit (Mali) |
| **DHS** | Demographic and Health Survey |
| **FCFA** | West African CFA franc (Burkina Faso) |
| **FP** | family planning |
| **GIZ** | *Deutsche Gesellschaft für Internationale Zusammenarbeit* / German Corporation for International Cooperation (Cameroon) |
| **HFG** | Health Finance and Governance Project |
| **HIV/AIDS** | human immunodeficiency virus / acquired immunodeficiency syndrome |
| **HSDP** | Health and Social Development Plan (Mali) |
| **INAM** | *L'Institut National d'Assurance Maladie* / National Agency for Medical Assistance (Togo) |
| **INSD** | *Institut National de la Statistique et de la Démographie* / National Institute of Statistics and Demography (Burkina Faso) |
| **IPM** | *Institution de Prévoyance Maladie* / Sickness Insurance Institution (Senegal) |
| **IPRES** | *Institut de Prévoyance Retraite et Sociale* / Institute of Social Welfare and Retirement (Senegal) |
| **IUD** | intrauterine device |

| | |
|---|---|
| **MPHH** | Ministry of Public Health and Hygiene (Mali) |
| **MPSWSS** | Ministry of Public Service Work and Social Security (Burkina Faso) |
| **MS** | *Ministère de la Santé* / Ministry of Health (Togo) |
| **MSHA** | Ministry of Solidarity and Humanitarian Action (Mali) |
| **MWCFP** | Ministry of Women, Child and Family Promotion (Mali) |
| **NGO** | non-governmental organization |
| **NHA** | National Health Accounts |
| **NHFS for UHC** | National Health Financing Strategy toward Universal Health Coverage / *Stratégie nationale de financement de la santé vers la CSU* (Guinea) |
| **PDS** | *Plan de Développement Sanitaire* / Health Development Plan (Niger) |
| **PMAS** | *Le pool micro-assurance santé* / The micro health insurance pool (Senegal) |
| **PNDS** | *Plan National de Développement Sanitaire* / National Health Development Plan (Benin, Guinea, Togo) |
| **PRODESS** | Programme for Social and Health Development (Mali) |
| **PROMUSCAM** | *Plateforme des Promoteurs des Mutuelles de Santé au Cameroun* / Platform for the Promotion of CBHI (Cameroon) |
| **RAMED** | *Régime d'Assistance Médicale* / Medical Assistance Mechanism (Mali) |
| **RAMU** | *Régime d'Assurance Maladie Universelle* / Universal Health Insurance Plan (Benin) |
| **RH** | reproductive health |
| **ST-AMU** | *Secrétariat technique de l'assurance maladie universelle* / universal health insurance technical secretariat (Burkina Faso) |
| **STI** | sexually transmitted infection |
| **TB** | tuberculosis |
| **UEMOA** | *L'Union Economique et Monétaire Ouest Africaine* / West African Economic and Monetary Union (Niger) |
| **UHC** | universal health coverage |
| **UN** | United Nations |
| **USAID** | United States Agency for International Development |
| **UTM** | *Union Technique de la Mutualité Malienne* / CBHI Technical Unit (Mali) |
| **WARHO** | West Africa Regional Health Office |
| **WHO** | World Health Organization |

# ACKNOWLEDGEMENTS

This study was funded by the United States Agency for International Development (USAID), and implemented by the Health Finance and Governance Project.

Mr. Abdoulaye Ba, Senior Health Financing Consultant, supported data collection and key informant interviews in Cameroon, Guinea, Mali, and Senegal. Dr. Birahime Diongue, Senior Health Financing Consultant, supported data collection and key informant interviews in Benin, Niger, and Togo. Dr. André Zida, Senior Health Financing Specialist, supported data collection and key informant interviews in Burkina Faso.

The leadership, support, collaboration, and input of USAID/West Africa Regional Health Office (WARHO) colleagues were critical in completing this landscape study and analysis. The authors are grateful for the support provided by Dr. Eleonore Rabelahasa, Senior Health Systems Strengthening and Policy Advisor (WARHO), and Ms. Rachel Cintron, Health Office Director (WARHO). The authors recognize the active participation and collaboration of USAID Missions and multiple implementing partners and non-governmental institutions in Benin, Burkina Faso, Cameroon, Guinea, Mali, Niger, Senegal, and Togo. The authors are also grateful for the input and collaboration provided by Ministries of Health and other government agencies in these countries. The authors are grateful to all the key informants, who shared their time and wisdom (see Annex C for the list).

Finally, the authors are thankful to Bry Pollack (Abt Associates) for editing, Alain Schuster and Julie Verbert (ASJV Associates) for translating, and Erin Miles and Audrey Hanbury (Abt Associates) for designing the report.

# EXECUTIVE SUMMARY

Recognizing that a healthy population promotes economic development, resilience, and strength, many governments have started pursuing a universal health coverage (UHC) agenda. The international community, national governments, and private organizations and individuals are converging on the principle that universal access to family planning is a goal worthy of increased financial investment. Improved access to family planning is also important for a country's economic development, and it helps countries improve key population health outcomes for mothers, newborns, and children.

The reality of limited resources for health care has brought increased scrutiny of how health care is financed. To reach UHC, governments are looking to pursue more and better spending mechanisms for health care and to promote financial protection for households. While there is no single or perfect model for financing health care, the health policy community can draw on international experience to identify best practices.

The purpose of this report is to present findings of a landscape study of observed trends and lessons learned from fifteen countries across multiple regions. We conducted detailed analyses of eight countries in West Africa: Benin, Burkina Faso, Cameroon, Guinea, Mali, Niger, Senegal, and Togo ("core countries"). We reviewed the health financing landscapes of seven additional countries at various stages of achieving UHC to draw lessons learned and inform potential strategies: Ethiopia, Ghana, Indonesia, Kenya, Malaysia, Nigeria, and South Africa ("reference countries").

Parties interested in the report may include Ministries of Health or national UHC agencies, regional governments, UHC stakeholders in the West Africa region, the United States Agency for International Development / West Africa Regional Health Office and country Missions, and the private sector.

Chapter 1 of the report discusses the landscape study findings from an analysis across the fifteen countries. Chapters 2–9 of the report present in-depth findings from the eight core countries, including descriptions of each country's health financing landscape and its government's strategies for UHC and family planning, a discussion of the country's health financing challenges and strengths, and potential opportunities for high-impact interventions that could improve the country's health financing landscape for UHC and family planning.

## Government Strategies to Pursue Universal Health Coverage and Universal Access to Family Planning

All fifteen governments mentioned UHC or a similar concept in major government health sector strategies, although most countries do not intend to reach universal coverage during their strategy's timeframe. Instead, governments generally plan to implement measures to increase population coverage under existing or new initiatives with a gradual scale-up. In general, countries' UHC strategy documents embrace the concept of progressive universalism, as described by Gwatkin and Ergo (2011) and adopted by the 2013 Lancet Commission on Investing in Health (Jamison et al. 2013). That is, they include multiple strategies to improve coverage for the poor, the informal sector, and the formal sector (and imply this will happen simultaneously). Most countries had specific strategies for engaging the private sector under their umbrella UHC strategy. Family planning, however, was often absent from the main policy documents and was often addressed in separate family planning or reproductive health strategy documents. Governments with separate strategy documents for family planning appear to have more concrete and specific action plans for family planning, whereas governments that mention family planning in a broader health system strategic plan demonstrate less detailed plans.

Although the fifteen countries vary in terms of coverage and use of family planning, many of the strategies for improving access to family planning are common to all of them, such as increasing awareness and demand through social marketing, task shifting to allow for community-based distribution, and increasing the number of distribution points for family planning services.

## Health Financing Mechanisms in Core and Reference Countries, and Private Sector Engagement

Even in the least fragmented health care systems, health services are financed through a plurality of mechanisms. Most or all of the health financing mechanisms described below are included in the health financing landscape of all fifteen countries. Levels of service coverage, population coverage, and financial protection varied.

These coverage levels are a key way to measure a country's progress toward UHC and universal access to family planning. To assess the latter, one can evaluate the degree to which health financing mechanisms cover family planning services (i.e., seek to ensure their delivery), the percentage of the population who can and do access those services under each mechanism, and what degree of financial protection is provided for family planning.

Chapters 2–9 of this report elaborate on each of these mechanisms in the eight core countries; lessons from the seven reference countries are woven into the multi-regional analysis of Chapter 1.

**Government-financed provision of health services exists in all study countries.** Government funding to facilities allows them to operate without charging patients the full cost of providing services. The government often does the purchasing; in some countries, community committees are established to have a say in how facilities spend available funds. In many low- and middle-income countries, the purchasing mechanism employed by government purchasers is *input-based financing* (e.g., paying for health worker salaries, commodities, and infrastructure). Governments often pair such direct financing for health services with *demand-side financing* (e.g., paying for services on behalf of patients to reduce financial barriers to accessing care) to improve equity of access to health services.

User fee waivers or vouchers are two examples of pro-poor financing mechanisms, reducing cost sharing by poor and vulnerable households. Malaysia's experience as an upper middle income country with near-universal health coverage through the public health delivery system provides valuable lessons for West African countries as economies grow, health systems mature, and governments face new challenges arising from an epidemiological transition and an aging population. Governments can implement legal frameworks now to enable health system reforms to address changing needs.

In general, at least some family planning commodities are provided free in facilities and by community health workers who receive public financing, but these distribution systems can be improved. A voucher scheme in Kenya provides targeted subsidies for safe motherhood, long-term family planning methods, and gender-based violence recovery services. These subsidies benefit households as well as public and private providers. They may be applicable in the West African context, where governments are seeking to reduce financial barriers to priority services such as family planning, and to encourage demand and quality improvements among public and private providers.

**Social health insurance** is often part of a government strategy to purchase health services for members by mobilizing and pooling funds from public and private sources and based on members' ability to pay. Many governments plan to implement or scale up social health insurance schemes and have passed laws to this effect. However, mobilizing the required resources to adequately subsidize even basic benefits for citizens with limited or no ability to contribute can be a challenging and much longer process.

The rollout of Indonesia's ambitious single-payer system starting in 2014 is partly a result of a legal action brought by citizens to hold the government accountable for the 2004 law on the National Social Security System. Nigeria's Basic Health Care Provision Fund needs to receive annual budget appropriations to ensure it gets implemented. In 2012, legislation addressing Ghana's National Health Insurance Scheme reform required inclusion of family planning to be determined by the Minister of Health, but three years later, the government had yet to provide the policy directive and implementation guidelines necessary to make family planning methods part of the scheme. South Africa's government is in advanced preparations to scale up National Health Insurance in a multi-phased approach that is expected to span more than a decade.

Governments need to allocate significant funding to scale up social health insurance, so many countries focus social health insurance programs on employees in the formal sector, where administration is most feasible. However, unequal financial protection between the formal sector (often the wealthier households) and the rest of the population can create a cycle of inequity and higher levels of fragmentation in the health system.

**Community-based health insurance (CBHI)** is often included the UHC strategies of low- and middle-income countries because of its perceived comparative advantage in targeting and enrolling underserved, uninsured, and largely informal-sector populations into risk-pooling schemes. While increasing the number of CBHI schemes may seem feasible for governments in the short term, the model often leads to government-sponsored health financing mechanisms. For example, in Ghana, community members initially volunteered to manage the schemes; however, eventually they migrated into a more professional management arrangement, and the scheme managers became salaried government staff.

Enrollment in CBHI schemes is often voluntary or not enforced, so schemes are often vulnerable to *adverse selection*, where disproportionate enrollment by high-risk individuals accompanies non-participation by low-risk individuals. CBHI initiatives such as Ethiopia's may eventually evolve into larger risk pools once that transition is operationally feasible for the government. That transition could be beneficial for ensuring CBHI scheme members get financial protection for health services provided by regional or national hospitals.

**Private health insurance** is a health financing mechanism present in the fifteen study countries, although its role varies from country to country. Private health insurance tends to target wealthier households and workers in the formal sector. There are, however, a few rare examples of private health insurers and private CBHI schemes targeting lower-income households or workers in the informal sector. Some private companies voluntarily offer employees premium subsidies or other health benefits for private health insurance in order to attract and retain skilled people, in Kenya and Nigeria, for example. In general, this model does not contribute significantly to population coverage in countries with small formal sectors.

**Household out-of-pocket spending** means households pay providers directly for health goods and services at the time of service. This is the dominant financing mechanism in most of the fifteen study countries. Households in all countries invariably pay out of pocket for some health services or commodities, as seen even in Malaysia, where most services are provided free or at very low cost through a strong network of public health facilities. In countries with low levels of other health care financing and risk-pooling mechanisms, out-of-pocket spending on health care accounts for the majority of household spending, and household spending as a proportion of total health expenditure is generally quite high.

There is growing interest in mobilizing private financing. Because household spending is already a large proportion of total health spending and core countries have relatively small formal sectors, this study did not identify many examples of how to engage the private sector in health financing. However,

governments can improve equity and increase efficiency by implementing health financing mechanisms that spread risk among a large pool and protect households from catastrophic costs. Governments must continually reform the health system to pursue better and more-equitable coverage for the population, and the path to UHC needs to evolve over time as population needs and demands change.

Government-subsidized programs that lack the resources to cover all citizens will by necessity or design cover a subset of the population. This can undermine social solidarity and equity, however, and potentially derail the goal of *progressive universalism*. Smaller-scale or more-targeted health financing mechanisms can promote more-equitable access to essential services. Additionally, ensuring universal access to family planning through UHC initiatives is critical.

Many governments of the core countries in this study envision simultaneous interventions to improve financial protection for health care and pursue UHC: finance health facilities with public funds, scale up social health insurance, and encourage the establishment of CBHI schemes to contribute to population coverage of hard-to-reach populations. With relatively small formal sectors, core countries will need to dramatically grow the number of CBHI schemes in order to reach near-universal enrollment among their populations. Population coverage of CBHI and other forms of insurance is low in most of them.

This study's review of health financing landscapes in all core countries reveals several opportunities for each to expand on, or introduce, new health care financing mechanisms that can increase coverage for health care and family planning.

# 4. CAMEROON

## 4.1 Country Snapshot

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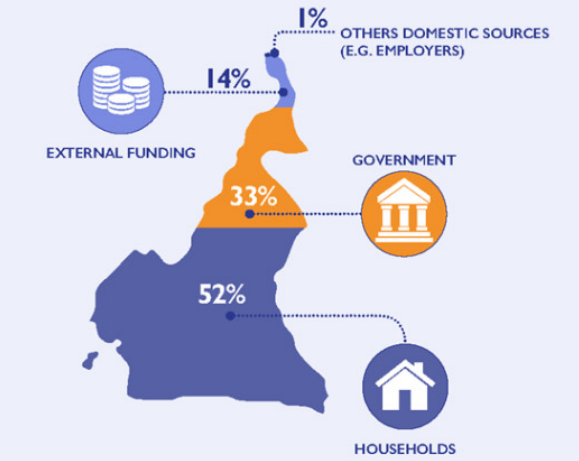
# FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

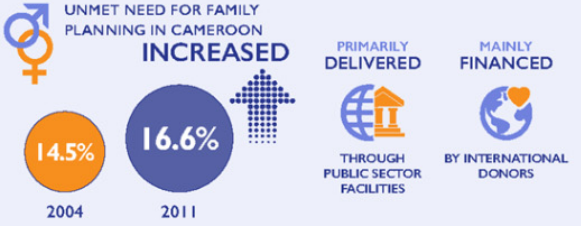
# Cameroon

## Cameroon's Strategies for Improving Coverage of Health Services

### TOTAL HEALTH SPENDING BY SOURCE




### FAMILY PLANNING




### KEY INDICATORS

| Indicator | Value (Year) |
|---|---|
| Population | 23,344,200 (2015)* |
| General government expenditure on health as a percentage of total government expenditure | 6% (2011)** |
| Total current health spending per capita | US$47 (2011)** |
| Private prepaid plans as a percentage of total expenditure on health | Not available |
| Unmet need for family planning | 17% (2011)*** |
| Married women currently using any modern method of contraception | 14.4% (2011)*** |
| Married women currently using long acting reversible contraceptives (IUD, injections or implants) | 3.9% (2011)*** |
| Sexually active unmarried women currently using any modern method of contraception | 48% (2011)*** |

* World Health Organization. Global Health Observatory. http://www.who.int/gho/en. Accessed June 2016.

** http://apps.who.int/nha/database/Select/Indicators/en Accessed July 2016

*** Institut National de la Statistique (INS) et ICF International. 2012. Enquête Démographique et de Santé et à ndicateurs Multiples du Cameroun 2011. Calverton, Maryland, USA : INS et ICF International

Cameroon's primary strategy for achieving UHC is through community-based health insurance for the informal sector, which accounts for 40% of those living below the poverty line. In 2009, population coverage of community-based health insurance was 1.30%.[1] The 2011-15 National Health Development Plan aims to achieve 40% coverage by 2015 by setting up one community-based health insurance scheme in every district.[2] The government also provides subsidized health care to the indigent, free care to pregnant women through a voucher scheme, and free malaria treatment for children under five. A Ministry of Health Steering Committee is developing a road map for UHC. The road map will define the benefit package and establish a health financing strategy. Private health insurance in Cameroon is limited to a small number of wealthier households. There are 16 registered insurance companies that provide private health insurance; their annual premium for a four-member household is approximately USD 780, compared to USD 24 for community-based health insurance.[3] Several public-private partnerships exist in Cameroon, such as the Employers Group of Cameroon (GICAM) that joined forces with the Ministry of Health to establish a fund for anti-retroviral drugs. In 2011, 24 percent of women of reproductive age used a contraceptive method, half of which were obtained through a health facility and half through retailers, friends or relatives.[4] The private sector is active in the provision of contraceptives including through social marketing; it provides contraceptives to 27% of users.[5]

## Challenges and Opportunities

Population coverage for community-based health insurance is very low and well below government targets. This is partly due to unaffordable premiums and lack of flexible payment schedules. There is mistrust of community-based health insurance schemes, and the general population widely considers insurance a product for the wealthy. Cameroon has an opportunity to bolster schemes to improve the value they offer to communities.

1 EPOS/ Service d'Appui aux Initiatives Locales de Développement. 2009. Etude diagnostique et cartographique des MS au Cameroun.
2 Ministry of Public Health. 2011. 2011-15 National Development Plan. Cameroon.
3 http://cameroon.thebeehive.org/content/22/1869. Accessed June 2016
4 Institut National de la Statistique (INS) et ICF. International. 2012. Enquête Démographique et de Santé et à Indicateurs Multiples du Cameroun 2011. Calverton, Maryland, USA
5 Ibid.

Figure 1: Cameroon County Snapshot

## Public and Private Sector Roles in Health Financing

The public and private sectors contribute to three main health financing functions:

| RESOURCE MOBILIZATION | RISK POOLING | PURCHASING |
|---|---|---|
| **THE PUBLIC SECTOR'S ROLE IN HEALTH FINANCING** | | |
| • General tax revenue (33% of THE)<br>• Grants or loans from development partners (14% of THE) | • Health services available at public health facilities<br>• Community-based health insurance schemes pool risks at the scheme level | • The government purchases these services for the population at public health facilities:<br>• Central, regional and district governments pay for services through these mechanisms:<br>» Partially subsidized care for the general population<br>» Fully subsidized care for the indigent and pregnant women<br>» Malaria treatment for children under 5<br>• The government is scaling up performance-based financing nationally (funded by the World Bank and Global Financing Facility) |
| **THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING** | | |
| • Household out-of-pocket payments (51.4% of THE)<br>• Household voluntary prepaid contributions (0.74% of THE) | • Private voluntary insurance schemes pool risk at the scheme level, although population coverage in Cameroon is low due to lack of affordability | • Households are the main private purchasers of health services |

## Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

**PUBLIC SECTOR**

| | POPULATION SEGMENT: FORMAL SECTOR | INFORMAL SECTOR: NON-POOR | INFORMAL SECTOR: POOR/ VULNERABLE |
|---|---|---|---|
| Publicly-financed health services | ✓ | ✓ | ✓ |
| Voluntary community-based health insurance | | ✓ | ✓ |

**PRIVATE SECTOR**

| | POPULATION SEGMENT: FORMAL SECTOR | INFORMAL SECTOR: NON-POOR | INFORMAL SECTOR: POOR/ VULNERABLE |
|---|---|---|---|
| Voluntary private health insurance | ✓ | | |
| Out-of-pocket spending | ✓ | ✓ | ✓ |

### ABOUT THE SERIES

This country snapshot is one in a series of 15 produced by the Health Finance & Governance Project. The snapshots capture information on public and private financing programs for family planning and health services that support country plans to reach universal health coverage. View the series and a summary report at: www.hfgproject.org.

## 4.2 Background

Health financing is a core building block of a health system and a key enabler of progress toward universal health coverage and universal access to family planning. Governments often use a plurality of health financing mechanisms to advance toward universal health coverage. In Chapter 1, we presented trends across the health financing landscape across fifteen countries in multiple regions and drew lessons that may be applicable in Cameroon and other West African countries. This chapter describes the health financing landscape in Cameroon and identifies opportunities where the government and other stakeholders can develop, strengthen, and expand their health financing mechanisms to progress toward universal health coverage and access to family planning.

Health financing specialists from USAID's Health Finance and Governance project collected the information presented below. HFG performed desk research and in-country data collection (key stakeholder interviews, policy and planning document collection) to map public and private health financing mechanisms in the country and identify potential opportunities where the government might expand population, service, or financial coverage for health and family planning services.

Official policy documents from Cameroon that are currently available do not explicitly mention UHC as a goal. Since 2015, the government and donors have been working together to develop an official UHC strategy. A team of donors and government representatives is working on simplifying and merging a number of existing financial protection mechanisms so that this strategy can be operational in 2016 (Nchewnang-Ngassa 2015). Key informant interviews suggest that a steering committee led by the Ministry of Health is also finalizing a UHC action plan that includes the development of a health financing strategy, development of an institutional framework for UHC, definition of a benefit package for UHC, and clarification of the role of CBHI. The government's primary strategy for achieving UHC is through CBHI, since this can help provide financial risk protection to the biggest population groups (rural and informal sectors).

## 4.3 Cameroon's Health Financing Landscape

In Cameroon, the financing mechanisms that provide access to health services are government-subsidized services, the Social Assistance Scheme (*Régime d'Assistance Social*), social security, CBHI, private health insurance, and household out-of-pocket payments.

### 4.3.1 Government-financed health services

The Ministry of Health provides subsidized health services via a network of health centers and district and national hospitals. In May 2016, Cameroon received US $100 million from the World Bank and US $27 million from the Global Financing Facility (GFF) to improve reproductive, maternal, neonatal child, and adolescent health services (World Bank 2016a). Cameroon's GFF investment case supports family planning services that are part of the Strategic Plan for the National Multi-Sectoral Program for Combating Maternal, Newborn & Child Mortality in Cameroon (2014-2020).

Broadly, the GFF investment case will support "innovative high impact interventions, such as (i) a development impact bond to attract private financing to make increased resources available immediately to scale up Kangaroo Mother Care; (ii) cash transfers to support adolescent girls; (iii) results-based financing to enhance girls' education; and (iv) initiatives focused on strengthening community health structures" (GFF 2016). Cameroon has been piloting payments to providers based on pre-defined indicators of performance related to increasing access to, and improving quality of, maternal and child health services. This initiative is expected to be gradually extended to all regions in the country by 2021.

The *Deutsche Gesellschaft für Internationale Zusammenarbeit* (GIZ) is also helping to strengthen provision of family planning services in public facilities (GIZ n.d.).

### 4.3.2 *Régime d'Assistance Social* for vulnerable populations

The *Régime d'Assistance Social* provides full subsidies for vulnerable populations (e.g., the poor and orphans and vulnerable children) receiving care in government facilities. The scheme is funded by the Ministry of Social Affairs, which since 2010 has transferred funds to the local authorities (*Collectivités Territoriales Décentralisées*) to pay providers for health services on behalf of the indigent population. Services covered include surgeries, prescriptions, and medical evacuations.

### 4.3.3 Social Security *(Caisse National de Prévoyance Sociale)*

*Caisse National de Prévoyance Sociale* (CNPS) is obligatory for formal sector workers, civil servants, and their dependents. Premiums are paid in full by employers. CNPS covers work-related accidents (curative care, prosthetics and orthopedic care, transport) and a basic package of maternal health services (prenatal consultations, delivery, infant consultations until 6 months). Care is provided for free at CNPS's four facilities, but care through other health facilities is also reimbursed.

Many employer contributions to CNPS are overdue. In 2016, CNPS was owed nearly US $100 million in premium contributions (*Actu Cameroun* 2016). Between October and December 2016, CNPS has been cracking down on arrears from state, parastatal, and private companies.

### 4.3.4 Community-based health insurance

As of 2010, there were reportedly 158 CBHI schemes covering 251,062 beneficiaries, representing 1.3% of the population (PROMUSCAM 2010). A 2006-2015 Strategy for Promotion and Development of CBHI was developed and aims to establish: a minimum benefit package for universal coverage; a National Center for the Promotion of CBHI that will support a network of provincial centers; a steering committee for the strategic plan that includes the Ministries of Public Health, Labor, Finance, and Social Affairs and other partners; and a legal code and text for CBHI.

In general, the government does not subsidize premiums for CBHI, although in some *communes* (Kumbo and Bamenda) the local authorities have subsidized premiums for the indigent population. Members must pay co-pays at the time of care of up to 25% of the cost of care. The remainder is covered by the CBHI, with pre-defined limits for consultations, hospitalizations, deliveries, and surgeries.

The CBHI Technical Support Cell (*Cellule d'Appui aux Mutuelles de Santé,* CAMS) was established by the Ministry of Health in 2001 and is responsible for defining the strategy to support CBHI, maintaining a national directory of the CBHI schemes, and helping CBHI to negotiate contracts with health facilities. *Plateforme des Promoteurs des Mutuelles de Santé au Cameroun*, which promotes CBHI, was created in 2006 to provide technical support to CBHI schemes (e.g., facilitating information exchange, training) and to promote CBHI nationwide.

Other challenges to increasing the population coverage of CBHI include lack of flexible payment schedules, mistrust of CBHI and institutions that manage health insurance in general, and lack of capacity of staff who manage CBHI. There is a real need to increase demand for CBHI by promoting its benefits. Insurance is still seen as a product for the rich, and understanding of how insurance can help is lacking. Many question the value of making regular premium payments for a health episode that may never occur versus paying out later if and when it does occur. They may view their social networks as an adequate safety net, preferable to insurance.

CBHI schemes contract with public and private health providers. Development partners such as the World Bank, GIZ, and the African Development Bank have supported CBHI, by funding initial training, feasibility studies, operational costs, supervision, and monitoring and evaluation. Key informant interviews highlighted that a 2011 evaluation by GIZ found that CBHI schemes it supported were not financially viable. Following restructuring of CBHI, results have been more positive and the schemes were extended to other *communes* such as Boyo and Bamenda.

### 4.3.5 Private health insurance

There were 190,408 health insurance policy holders in 2014, representing less than 1% of the population (Ministry of Public Health 2016). Family planning is excluded from the benefit package. Private insurance is affordable for the wealthiest; average annual premiums cost FCFA 155,000 (US $265) per adult, versus average annual premiums for CBHI of FCFA 15,000 (US $26) for a family of four. Most private health insurance is purchased by private employers, on behalf of employees. In general, members must pay co-pays at the time of care of up to 25% of the cost of care.

In 2012, sixteen companies provided health insurance products. Health insurance accounted for 25% of total insurance revenue in Cameroon in 2012. Private health insurance companies are overseen by the Ministry of Finance and regulated by the Inter-African Conference on Insurance Markets.

### 4.3.6 Household out-of-pocket

Households are the biggest contributor to health financing, with out-of-pocket spending representing 52% of total health spending.

## 4.4 Progress Toward Universal Health Coverage and Universal Access to Family Planning

The government of Cameroon is expanding CBHI to provide health services to rural and informal sector households. The 2011-2015 National Health Development Plan aimed to increase the population coverage of CBHI to 40% by 2015, by creating at least one CBHI scheme in every district. CBHI is seen as a key mechanism to provide financial risk protection to the informal sector, which accounts for more than 80% of the employed population (and 40% of the population who live below the poverty line; Nkoa and Zogo n.d.). This compares with less than 2% of the population who were covered by a financial risk protection scheme in 2010 (PROMUSCAM 2010).

The health sector in Cameroon benefits from several public-private partnerships between the Ministry of Public Health and companies in sectors such as telecommunications, extractive industries, and insurance. To increase private sector financing for health care, the Employers' Group of Cameroon signed a public-private partnership with the Ministry of Public Health to establish a fund for anti-retroviral drugs. This fund will be used to procure drugs from vetted suppliers (Brunner et al. 2014).

In family planning, ProFam is a network of more than 100 private and faith-based clinics that use social franchising to provide family planning services. Clinics are admitted to PROFAM after verification that they provide quality services and employ qualified personnel and agree to undergo regular control and supervision. The PROFAM network conducts regular social mobilization campaigns toward targeted populations using social marketing techniques. The Cameroon National Association for Family Welfare (CAMNAFAW), an International Planned Parenthood Foundation (IPPF) affiliate, also provides family planning and reproductive health services in its network of private clinics and conducts social mobilization campaigns. IPPF typically supplies CAMNAFAW with family planning commodities, and the United Nations Population Fund has provided supplies during stock outages (Brunner et al. 2014).

The 2015-2020 National Family Planning Action Plan calls for a framework for cooperation with the private sector so that more private facilities can offer family planning services. The government would like to increase social franchises by 100 for each year of the plan. Tariffs for contraceptives were set by the government in August 2014; patients typically pay for the consultation and enjoy subsidized prices for commodities. But these subsidies are not being applied in all facilities, creating a financial barrier for adolescents. It is unclear whether and how family planning services will be incorporated into the benefit package for CBHI going forward. By 2021, the government is expected to support 50% of total family planning needs (World Bank 2016b).

## 4.5 Opportunities in Health Financing

Premiums for CBHI still remain unaffordable for the poorest. If population coverage for CBHI is to increase, many people will require partial, if not full, subsidies. The upcoming health financing strategy will need to respond to this challenge. Coalition 15%, a civil society organization, has called for a 0.3% tax on all government revenues that would be earmarked for universal health coverage. Integrating existing mechanisms into one risk pool could help the financial sustainability of these schemes by reallocating resources from population groups who use fewer health services to those who need them more.

As CBHI scales up, it is important to clearly outline the operational aspects. This includes understanding utilization patterns and costs of health services in order to calculate tariffs that are financially sustainable; collecting regular premiums from people such as agricultural workers who do not have a regular salary (e.g., through health savings accounts); using biometric identification cards to prevent fraud; and providing health facilities with the legal authority to sign contracts with CBHI schemes (Ministry of Public Health 2016). Strengthening umbrella organizations such as CAMS and *Plateforme des Promoteurs des Mutuelles de Santé au Cameroun* to provide technical—and financial—support will also help.

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