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Universal Access to Healthcare in Cameroon: Financing Sources

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ABSTRACT

Purpose: The research aims to identify sustainable sources of funding the implementation of Universal Health Coverage (UHC) in Cameroon, in response to the current situation where households finance 70% of healthcare costs, and healthcare is largely unaffordable for many social groups.

Material and Methods : The study used an exploratory qualitative approach in the Bangue Health District in the Littoral Region of Cameroon. Fifteen people participated in this study during ten days. Participants were selected using the purposive sampling method. Data were collected by means of a semi-structured interview guide. A general inductive approach was used to analyse the collected data.

Findings: The main findings indicated that the identified funding sources are primarily based on local resources, including: 1) the State, through the budget allocated to healthcare; 2) the implementation of a health tax based on different sectors of activity; 3) contributions from the Diaspora; and 4) assistance from external and internal partners. Resource mobilisation could be carried out by decentralised government departments, with management overseen by an autonomous UHC body created for the project.

Implications to Theory, Practice and Policy : Considering the findings, the State should : 1) Raise public awareness and provide training on UHC ; 2) Equip healthcare facilities with adequate human and material resources ; 3) Decentralise the structures for collecting UHC-related funds ; 4) Ensure the security of the collected funds to operationalise UHC effectively.

Keywords: *Funding Sources, Universal Access to Care, Universal Health Coverage*

INTRODUCTION

The strength of a healthcare system depends on its ability to offer the population better access to healthcare. It is therefore important for every individual to achieve an optimal level of health. As one of the regalian duties of a state is to ensure the health of its populations, Universal access to healthcare strives for equity of access to healthcare. According to the International Labour Organisation (ILO), in 2005, nearly 80% of the African population had no access to basic healthcare. To Owoundi (2013), in Cameroon, the population bears 70% of the financial burden of healthcare expenditure. It can be said that, the national health budget is inadequate and poorly distributed. Cost recovery through direct payment for care, health services and medicines is the system currently used to access health services required by the population. According to Bitha (2018), people living in poverty and indigence are unable to take partial or full responsibility for their health problems. Furthermore, a survey carried out in the Bangue Health District in the city of Douala in Cameroon, revealed during exchanges with members of the local community, difficult conditions of access to care and health financing for the population. In order to improve access to health care and services for all social strata, including the poor and the poorest, Cameroon has developed and is currently implementing the Universal Health Coverage project. This is a new healthcare access policy designed to ensure that everyone benefits from protection against financial risks, access to quality essential healthcare services, and access to safe, effective, quality and affordable essential medicines and vaccines.

UHC is, therefore, a healthcare policy focused on integration and social cohesion, aiming to make healthcare services accessible to all social groups without the risk of impoverishment. Here, a woman who could not give birth in the hospital due to the lack of an available ambulance; there, a child who could not receive a rapid malaria diagnostic test; further away, a man who couldn't afford to get tested to check if he had prostate cancer. Every day, Sub-Saharan families struggle to find the financial, human, and social resources to get medical care. All these families, regardless of their socio-economic status, face the same challenge: the financial challenge. Yet, it is important to note that, under the Universal Health Coverage project, basic health issues should be addressed without families going into debt to receive care. However Ridde and Sane (2021) highlight the importance of healthcare funding based on support from international partners and the World Bank. However, these authors also point out another challenge: the sustainability of such a funding source. This raises questions about the durability and effectiveness of healthcare financing based on external aid, especially given that such aid could cease at any moment.

Many authors have studied UHC and its implementation in developed countries, and it is based on this research that healthcare system models have emerged, protecting populations from many endemic diseases in these regions. Furthermore, some research has been conducted in certain African countries. But, in Sub-Saharan Africa, and more specifically in Cameroon, there is very little research on UHC with a particular focus on funding sources. In the same line, Ridde (2021) highpoint the insufficiency of public funding and advocates for deeper consideration of alternative funding sources. WHO (2023) indicates that on November 2023, over two million Cameroonians were already enrolled, but he main issue raised was the lack of resources for funding UHC.

This health policy raises the question of sources of funding for the sustainable operation of such a system, in terms of access to healthcare in Cameroon, in a context of general poverty. In view of the above, we undertook a field study with the guiding principle: what are the sustainable sources of funding for the UHC project in Cameroon, in order to ensure free and sustainable access to healthcare for the population?

Statement of the Problem

Josephson (2017) maintains that, in many low-income countries, healthcare is currently funded by a combination of tax revenues, out-of-pocket payments, and external financing. There is a tension between the objective of mobilising resources for healthcare, which suggests maintaining patient payments, and the goal of universal access, which suggests eliminating this contribution. Many countries do not want to lose direct revenue from the population, and premium payments become the preferred option. Josephson proposes two approaches to generating healthcare funding sources in Sub-Saharan Africa: the classic phasing approach and the component-based phasing approach. The limitations of the classic approach include the fact that significant resources can be allocated from the outset to the administrative management of health insurance. The component-based phasing approach relies on different components of healthcare funding and service provision. But in the case of Cameroon what are the sustainable sources of funding the Universal Health Coverage project?

MATERIAL AND METHODS

To collect data, a field survey was conducted in the Bonamoussadi Health Area in the Bangue Health District, Douala 5th Subdivision, littoral Region in Cameroon. The target population consisted of all households and administrative authorities of the Bangue Health District. This was an exploratory qualitative study. The purposive sampling technique was used to select a sample of 15 participants from the different social strata most represented in the population, including the public, the para-public, the private, the informal, the unemployed and the indigent sectors. Data were collected using a semi-structured interview guide, over a 10-day period. Descriptive analyses were carried out and ethical considerations respected.

Potential Sources of Funding for UHC in Cameroon

Potential sources of funding for the UHC in Cameroon should take into account the local socio-economic and cultural context. In its guiding principle of national solidarity, the UHC would like to integrate the contribution and participation of all social strata and all sectors of formal and informal activity, each according to its income. Eight (8) main sources of financing for the UHC have been identified. These are presented below:

1. **The State's contribution to the CSU:** this could be through the State's annual health budget. Part of this budget could be transferred to the UHC's management body. This state contribution could be estimated at 15% of the annual state budget, in line with the 2001 Abuja agreement (WHO, 2013). Not only did the African states sign the Abuja agreement in 2001, but the WHO also encourages countries to respect this agreement. According to the WHO Regional Office, by 2023, universal health coverage will be operational in Cameroon, with more than 2 million people already registered (WHO, 2023). This shows that if the State becomes more involved, the project will become a reality. In the words of P1: *"The Cameroonian government is already making efforts to deal with child malaria, but if the 15% of the national budget is really allocated to health, we will be doing much better than we are at present".*
2. **A health tax to be charged on all public and private sector employees:** this could be estimated at 5% or less of the basic salary, and will allow a contribution to be made according to income. It would be deducted at the base at the end of each month by the MINEFI and other relevant departments, and paid to the UHC management body. This finding is consistent with the thinking of Josephson (2017), who explains that in the fight against social inequality, a deduction can be made from the wages of all employees. P2 reported:

> "If there are taxes in the payslip, why not also introduce a 5% health tax. It's not that significant, as long as it's properly explained to those concerned".

3. **A health tax to be collected from each trader** who usually pays his communal market tax can be introduced. It could be estimated at 5% of the value of the tax usually paid. This communal health tax will therefore be added to the usual tax. Berthelemy (2008) and collected daily by the existing mechanism (communal agents). It could be paid monthly to the UHC's management body by the mayor's office. P3 said:

> "With my many children here, since every day we pay the tax for the place we occupy, we can once add a few extra francs for health. Here in Douala, business feeds the man, but a single bout of illness can send your entire capital to hospital. Just as we have the "emergency fund" tontines, we can save money by paying a health tax for sickness, which helps a lot, especially as we have a lot of children to look after..."

4. **A health tax imposed on each micro-business** (store, bar, cybercafé, sewing shop, etc.) that usually pays its taxes could be introduced. It could be estimated at 5% of the value of the tax usually paid. This health tax will then be added to the usual tax and collected by the existing mechanism. According to Davoodi et al. (2003), it is necessary to reduce healthcare expenditure even for small trades. The funds will therefore be deducted by the tax authorities when the usual tax is paid, and transferred monthly to the UHC management body. P4 reported:

> "If we introduce a tax of even 5% for the health of each employee and his family, that's not bad! You just have to manage it properly".

5. **A taxable health tax on everyday consumer goods could be introduced.** The government could introduce a small 1% increase in the tax on imports and exports of everyday consumer goods (rice, soap, bread, sugar, etc.). These funds will be collected by the tax authorities when the tax is paid by royalty payers (importers, wholesalers and retailers). The funds collected will represent the consumer's contribution to the UHC. They will be transferred once a year to the UHC management body. As Bitha (2018) points out, the aim is to involve all social strata in financing the UHC. The cost of everyday consumer goods may eventually see a small increase. P5 put it this way:

> *As an accountant and manager, I understand the project well. The Ministry of Health, in conjunction with the Ministry of Commerce, must add a symbolic franc to cover the cost of sickness. We could call it a "health tax". Because, since these are everyday consumer products, we cannot increase a tax beyond 1%.*

However, the relevant government departments, in collaboration with the actors concerned, will assess the need for such a change, and will monitor prices to ensure consumer protection.

6. **A health tax on all consumer products that are potentially pathogenic or likely to cause illness among consumers could be introduced.** These products could include: alcoholic beverages, sweetened soft drinks, sugar, cigarettes, certain edible oils, etc. This tax could be estimated at 5% of the cost of production (manufacturing or import). P5 goes on to say:

> *Even the beers we drink make us sick... don't talk about tobacco any more, it will be really interesting, to raise the price and explain that this will indirectly contribute to the cost of illnesses linked to the consumption of these substances, so I am also in the manufacturing chain... even 5% is reasonable.*

The tax will be collected by the tax authorities (Cessou, 2017), and paid once a year to the UHC, which will pay a portion to the care centres for people who become ill as a result of consuming the said product(s) (Hypertension and diabetes centres, anti-tuberculosis centres, cancer centres, obesity centres). According to

7. The contribution of Cameroonians living outside the national territory (Diaspora) could be mobilised. A fund-raising campaign could be set up once a month by each Cameroonian diplomatic representation abroad. Funds will be collected by each embassy or consulate. Cameroonian nationals living abroad will be able to contribute each month, according to their income. A minimum amount equivalent to 5,000 FCFA may be required per contribution. P9 reported:

> *"We can encourage our compatriots abroad to also participate in the project, as it is done in the Congo for example..., without setting an excessive amount, we could set a scale of a minimum of 5,000 FCFA per month. This would ensure that, if the project is well managed, the large amount they often send to their families when they're ill would be very much reduced."*

However, no maximum limit will be set. The funds collected can be transferred each month to the UHC's management body by the diplomatic representation (Bissal, 2013). To this end, in the event of a need formulated by the authority of a diplomatic representation, a staff member, a community health specialist (a person holding at least a Master's degree in community health) practicing in Cameroon, with a minimum of 5 years extensive experience in these health issues, may be assigned to the diplomatic representation in question to carry out tasks related to the UHC (fundraising, promotion of the UHC among the diaspora and the host country, etc.).

8. External financing could eventually be mobilised. Funds obtained in this context would come from bilateral and multilateral cooperation, aid and possibly loans. According to Boudan (2017), this is a non-priority source of funding on which the operation of the UHC should not depend and whose availability would be an additional contribution to the funds mobilised at local level. P10 declared:

> *"External organisations (WHO, UNICEF, UN...) already provide support to Cameroon, and all priority public health programmes are supported and financed by these external partners".*

The funds collected in this context will be transferred to the UHC's management body, which will determine how they are used (Jacquemot, 2012).

Table 1: Summary of Sources and Mobilisation of Potential UHC Funding in Cameroon

N°	Origin of funds collected	Value of health tax	Mechanism for mobilizing funds	Periodicity of fund collection	Periodicity of fund transfer to CSU	Destination of funds collected
1	State of Cameroon	15% of budget allocated to MINSANTE.	Deduction of 15% of MINSANTE budget by MINEFI	Once a year at the beginning of the budget year	Twice a year	CSU management body
2	Employees of the public and private sectors	5% of the basic salary	Withholding of funds by MINEFI and other competent departments	Once a month	Once a month	CSU management body...
3	Traders.	5% of the value of the tax usually paid	Collection of funds by communal agents	Once per working market day	Every 3 months	CSU management body
4	Microenterprise	5% of the value of the tax usually paid	Collection of funds by tax agents	Once a year	Once a year	CSU management body.
5	Staple goods	1% tax on imports and exports of staple goods	Collection of funds by tax authorities on payment of this tax	On each transaction (import and export)	Once a year	CSU management body.
6	Potentially pathogenic consumer products	5% of production cost (imported or manufactured)	Collection of funds by tax authorities	Once a year (end of year)	Once a year (end of year)	CSU management body.
7	Cameroonians living outside the national territory	A minimum amount equivalent to 5,000 FCFA will be required	Collection of funds by each Cameroonian embassy or consulate abroad	Once a month	Once a month	CSU management body
8	Possible external financing	No fee required	Collection of funds by relevant financial services	As soon as available	As soon as available	CSU management body

This table shows that, from the participant's perspectives, the values of the health tax proposed for UHC range from 5% to 15%, with the value that could be deducted from Cameroonians' income not exceeding 5%. The mobilisation mechanisms, periodicity and destination of the funds deducted correspond to the verbatim proposed by the participants. This shows that people believe in the UHC. In line with that, Berthelemy and Seban (2009) insist that the implementation of the UHC project reduce the gap on health equity and increase the satisfaction of population. All that remains is to reassure that the funds collected will properly be managed. But, in practice, these funds can only be mobilised if there is a law on UHC to govern the implementation of this project.

Moreover, the literature highlights the important role that the Cameroonian government plays in healthcare financing. As noted by WHO (2023), 50.4% of UHC funding in Cameroon comes from the State, among those enrolled in UHC. Ridde (2021), as well, emphasised the crucial role of international partners as a source of external funding for UHC, which aligns with the findings of this study. Similarly, Bitha (2018) and Ndjana (2016) proposed a health tax, which should be levied on employees' salaries in the public and the private sectors. But apart from these sources identified by previous authors, this research work innovated by suggesting other

sources of the UHC. These include: Traders, Microenterprises, Staple goods, potentially pathogenic consumption products; and Cameroonians living outside the national territory. This study also stands out by proposing mobilisation mechanisms including but not limited to ministries, municipalities, embassies, and consulates as collection centres. In addition, a specialized body, not directly linked to the State, would handle fund management to ensure greater transparency, governed by legal standards.

CONCLUSION

The objective that motivated to carry out this research work was to identify the possible and sustainable sources of UHC. It emerged from this work that the participants proposed 8 main sources, which have been presented in this article. It can therefore be said that UHC in Cameroon is a project which sources of funding can emerge at local level and make its operation possible in the Cameroonian context. However, this study, far from being perfect, has its limitations. First, since the study is qualitative, the sample size is small, meaning that the participants could be expanded on a larger scale. Additionally, the study was conducted in only one city, even though it is the economic capital, and replicating the study in other areas could potentially yield different opinions. Furthermore, the list of sources is far from exhaustive. In other contexts of the country, especially among highly vulnerable individuals or even the very affluent, opinions might differ from those recorded above. It is also possible that other country-specific factors, such as the political climate and socio-cultural aspects, were not considered in this study, which calls for additional research.

Nonetheless, the implications of this study are numerous. Decision-makers, through this study, will have a clearer vision of the potential sources of UHC funding in Cameroon. At the level of political governance, there would be greater satisfaction among the population regarding their healthcare needs, with the immediate consequence being stability among leaders, fewer strikes and public discontent, an overall improvement in well-being, and a healthier youth capable of being more productive. This could lead to a longer healthy life expectancy and a reduction in overall mortality in the population. The creation of a special body for UHC management will allow for the recruitment of new employees, thereby reducing unemployment. From a global perspective, the country would improve its score in terms of achieving the Sustainable Development Goals (SDGs), specifically SDG No. 3, which is related to health. These are just a few of the benefits of this study.

However, external funding could complement domestic funding to ensure that the UHC functions more effectively. It would therefore be essential to explore and mobilise all possible sources of funding, to ensure an efficient and sustainable UHC in Cameroon. Moreover, it would be interesting to explore other research areas, such as the operationalisation of UHC in Cameroon. What pathologies will be included in the package? Will it be the same in rural areas as in urban ones? What are the obstacles to the full involvement of populations in resource mobilisation? Additionally, how can we address the thorny issue of public fund embezzlement? How can we minimise this practice, especially as large financial investment funds are about to be mobilised? These are some avenues for future investigation in the pursuit of a more effective UHC.

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