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The Effect of Adequate Funding and Health Service Provision on Micro Health Insurance Growth: The Case of BEPHA in the NWR of Cameroon

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Abstract

Purpose: Inadequate financial support and provision of poor-quality health services among the health facilities are major causes behind poor performance of Community Health Financing (CHF). The objective of this study was to investigate the effect of adequate funding and health service provision on micro health insurance growth, taking BEPHA as a case study.

Methodology: The descriptive and explanatory research designs were used in this study. Data was collected by administering questionnaires to 400 respondents. Interviews were also carried out on 10 staff of BEPHA. Data were analyzed using descriptive statistics, correlation, and multiple regression analysis.

Findings: In results regarding BEPHA financing, 70% of those interviewed believed it is high while 30% indicated that it is low. Out of 400 participants 191 (47.8%) of them perceived services offered by BEPHA partner hospitals as fair while 182 (45.5%) perceived their services as good. The correlation results showed a strong positive and significant relationship between sufficiency of BEPHA financing ($r= 0.802$, $p < 0.05$) and quality of BEPHA health services ($r = 0.667$, $p < 0.05$) with the growth of BEPHA as a health insurance scheme. The multiple regression analysis results showed that sufficiency of BEPHA financing ($\beta=0.166$; $p < 0.1$), has a positive and significant effect on growth of BEPHA. The quality of BEPHA health services ($\beta=0.200$; $p < 0.1$) also has a significant positive effect on growth of BEPHA. Concisely, the study revealed that the funding and quality of BEPHA health services can determine the variations in the growth of BEPHA health insurance scheme.

Recommendations: This study thus recommended that, the scheme should reduce the waiting period for minor health risk to at most 2 weeks while the 6 months waiting period for major health risk including delivery should be reduced to one (01) month to increase finances from large enrolment. It also recommended the sensitization of health personnel on good customer service principles to increase service quality at these partner health facilities.

Keywords: *Micro-health-insurance, funding, health services, Growth, BEPHA, Cameroon.*

INTRODUCTION

The World Health Organization (2010) considers health insurance a promising means for achieving universal health-care coverage. Adebayo et al. (2015) reiterated that a hopeful avenue to provide universal financial protection for the informal sector and the rural population is community-based health insurance (CBHI). However, he added that low-income and middle-income countries (LMICs) had difficulties achieving universal financial protection, which was primordial for universal health coverage. Tafor (2014) emphasized that although improved health is a key factor for human development; access to inclusive, quality health care has proved elusive in many low-income countries. According to Isik and Ndifusah (2013) many policy analysts had expressed fears that at the current rates of progress, Sub-saharan Africa will not be able to provide satisfactory health care to its inhabitants by 2020, and will not achieve any of the United Nations sustainable development goals due to increasing poverty.

Mutual health organizations had as objective to facilitate the Universal Health Coverage. However, the numerous difficulties being faced by Micro Health Insurance (MHI) hinder its growth and performance, which in turn discourage people from enrolling and benefitting from its services. According to Tafor (2014) and Arhin-Tenkorang (2001) the absence of risk protection and cost has become a barrier to seeking and obtaining quality health care. Surprisingly, enrolment into health insurance scheme was not obligatory in Cameroon. This is despite the fact that there had been little change in Cameroon's health indicator and that life expectancy has instead declined (Isik and Ndifusah 2013). In the light of all this, there is an obvious need to increase healthcare accessibility to Cameroon population particularly the poor by at least eliciting and handling the obstacles to enrolment into MHI in Cameroon. This is thus one of the major objectives of BEPHA.

The acronym BEPHA stands for the Bamenda Ecclesiastical Province Health Assistance. It is a solidarity health scheme that has the status of a Common Initiative Group (CIG) and the following are its Principles: Risk Pooling (Insurance), Solidarity, Participation and Charity (BEPHA *FAQs*, 2012, p.6). The Bamenda Provincial Episcopal Conference in August 2007 in Kumbo approved BEPHA to become operational following the result of the pilot scheme in Mamfe diocese. BEPHA was launched in 2008 by the Bishops of the Ecclesiastical Province of Bamenda because they observed that God's children were living in misery brought about by abject poverty, and because of this, they were unable to afford quality health care. Many who visited the health centers or hospitals were unable to pay their medical bills and sometimes forced to work in the Health Units to make up for such bills. Some resorted to selling household items or borrowing for which they were often exploited. Others preferred not to seek medical care at all while some resorted to auto-medication. A majority of these patients delayed at home hoping for some improvement and most often report for treatment when their condition had aggravated. A handful of patients resorted to traditional practitioners or roadside drugs for cheaper treatment which is very dangerous to their health. Lastly some of these patients resort to prayers for the hope of a miracle. The result of the above has often been that the patient suffers for a longer period; the family ends up spending more money, energy and other resources; or the person dies rather prematurely (BEPHA History, 2012).

BEPHA was thus initiated and promoted by the Bishops of the Ecclesiastical Province of Bamenda to stop this long-suffering in the population. The services are not limited to catholic Christians but to the general public are for the public irrespective of tribal, cultural and religious affiliations. There it started in the five Dioceses in the Ecclesiastical Province of Bamenda viz: Buea, Bamenda,

Kumbo, Mamfe and Kumba, each with its corresponding BEPHA Diocesan office and management coordinated by a central coordinator at provincial level (BEPHA Job Description, 2010, p.2). This paper thus seeks to investigate if funding adequacy and quality of Health Service Provision has an effect on Micro Health Insurance performance in BEPHA.

LITERATURE

This work makes use of the expected utility theory (EUT) by Daniel Bernoulli (1700–1782), an eighteenth–century mathematician, which has so far been the most widely used theory in explaining the demand for health insurance Odeyemi recalled that the expected utility hypothesis (due originally to Daniel Bernoulli 1738) states that individuals choose between alternatives to maximize expected utility. He went on saying, "EUT states that a person's demand for insurance is reflected in their degree of risk aversion and preference for income certainty. This means that this theory proposes the use of health insurance will increase if the service qualities are high. State dependent theory says that consumers' utility or taste is influenced by their state, i.e. socioeconomic status, health status and at the same time by their degree of risk aversion. Demand for health insurance depends to some degree on the anticipation about need for medical care and the magnitude of insurance payoff (Odeyemi, 2014). According to this theory, rational people always choose only those options that can offer good results. This theory considers reward and punishment as benefit and cost respectively and the theory holds that the human action is dominated by their desires of getting good rewards (Ericksson, 2011). Hence, if the health care delivery package of a MHI scheme is not attractive people will not enroll in it.

According to Tafor (2004) public resources allocated to the health sector in Cameroon remain one of the lowest in Africa in terms of GDP. Out of the US$61 per Cameroonian, spent on health in 2010, the government contributed only US$17, which is 28% of which US$8 was provided by international donors. Therefore, the cost of healthcare is largely borne by individuals through out-of-pocket payments. To Odeyemi (2014) uncertainty in healthcare comes with financial uncertainty, which results from cost of treatment and loss of income ensuing from workdays lost due to illness. Although health insurance does not typically provide income protection directly, it can ensure access to treatment on time, which in turn reduces wage loss resulting from illness. This increases utility of the insured and provides some level of certainty making them better off than those who are not insured at that time. In Cameroon where more than 50% of the population lives under the poverty threshold, out-of-pocket payments represented 68.4% of total health expenditures in 2009. Unfortunately, this mode of payment limits access to quality healthcare to only the relatively rich. Moreover, large out-of-pocket expenditures can dramatically impoverish entire households. Prepayment and sharing the burden of sickness through community-based health insurance (CBHI) have been recognized as keys for making health care affordable among the poorest (Noubiapet al., 2013).

Odeyemi (2014) in his systemic review reported a number of factors affecting implementation of CBHI. He revealed that governance challenges faced by CBHI schemes which appeared as recurring themes in Nigeria and other SSA countries are: failure to account for the inability of the target population to pay for scheme membership, lack of clear legislative and regulatory frameworks coupled with inadequate financial support and unrealistic enrolment requirements. One of the challenges of CBHI is the regressively of its contributions; because a flat enrolment fee is charged, both the poor and the rich contribute the same amount in premium (Adebayo et

al., 2015). They further added that other factors that affect CBHI in Ghana are; the cultural belief that setting money aside for health care could attract disease, low levels of income or lack of financial resources. Gouda et al. (2016) said there is sufficient evidence that suggests access to healthcare services is limited for the poor, largely due to scarce financial resources. Antabe et al. (2019), précised that CBHI schemes are intended to cover the costs (or some part of) of healthcare services. He added that evidence indicates that less than 10 percent of the informal sector population in developing nations is covered by CBHI schemes. In the same year, Ojong (2019) concluded that, low-income populations in rural Cameroon use thirteen mechanisms to cover healthcare costs. These were savings; monetary gifts from relatives, monetary gifts from children; monetary gifts from friends, voluntary health insurance, loans from relatives, loans from neighbours and friends, loans from informal financial institutions (IFIs), business loans from microfinance institutions (MFIs), sale of assets, income from economic activity, provision of healthcare on credit and payment by installment.

Literature on the quality of health services the growth of health insurance showed inefficiency in the public provision of health services, and unacceptably low quality of those services all demonstrated the state's inability to meet health care needs of the poor (Mahmood 2015). Adebayo et al. (2015) said problem faced by health insurance schemes include poor quality of available health care, lack of drug/medical supply availability, excessive prescribing, long waiting times, differential treatment, health provider's attitude and technical incompetence. Inadequate education of the population on the benefits of the package, institutional rigidities in payment modality and timing of the enrolment campaign in relation to seasonal revenue fluctuations was also a problem. In Rwanda, CBHIs introduction resulted in increased medical care utilization (including inpatient care, outpatient consultation and medical tests and examinations) for under-fives with acute respiratory illness from 13% of children attending in 2000 to 33% in 2008 (Adusei-Asante 2016).

Existing provision of poor-quality health services among the health facilities was a cause behind poor performance of Community Health Financing (CHF) in some districts (Ndim et al., 2019). To them, the delivery of high quality services was very important for mobilizing demand to enroll in Community Based Health Insurance (CBHI). Their findings showed that some CHF members declare that they will not renew their membership if the quality of healthcare in the health centers does not improve. The above set of literature show that there is a gap for studies on Health insurance in Cameroon in general and Bamenda in particular. This thus warrants a study of this nature that sets out to investigate the effect of adequate funding and service quality on the performance of health insurance.

METHODOLOGY

The design adopted for this study is descriptive and explanatory research design. The study area is Bamenda, BEPHA. The sample size is 400 people within ages 14 and 70 who live in Bamenda and have heard about BEPHA. These participants came from three Colleges and some households in Bamenda municipality (Bamenda 1, 2 and 3) which were also purposively selected. Data was collected with the use of structured self-administered questionnaires and semi-structured interview questions. Data was analyzed using frequencies, percentages, charts and the multiple regression analysis.

The multiple regression model for this study was specified as:

$Y_i = \beta_0 + \beta_1 X_1 + \beta_2 X_2 \beta_3 X_3 + \beta_4 X_4 + \mu_i$

Where; Y = Growth of BEPHA

X_1 = Age

X_2 = Level of education

X3= Sufficiency of BEPHA Financing

X4= Quality of BEPHA Health Services

β_0 = Constant

μ = Error term

RESULTS

The results obtained from the data collected on the field have been presented in table and figures below.

Table 1: Council area where respondents receive treatment

		Frequency	Percent
Valid	Bamenda I	98	24.5
	Bamenda II	160	40.0
	Bamenda III	142	35.5
	Total	**400**	**100.0**

According to table 1, majority of respondents of the study receive treatment in BEPHA partner hospitals located within the Bamenda II council area, followed by those who receive treatment in hospitals within the Bamenda III council areas and others receive treatment in BEPHA partner hospitals within the Bamenda I council area.

Affordability of BEPHA Premium

Figure 1: Affordability of BEPHA's premium

Based on figure 1, out of the 400 respondents of the study 339 (84.8%) of the respondents attested that BEPHA premiums are affordable as opposed to 61 (15.3%) who indicated that the premiums paid on the health insurance is not affordable. This finding maybe the reason why 43

(10.8%) of the respondents were not registered members of BEPHA because they could not afford the premiums to enable them subscribe to the program.

Table 2: Whether BEPHA is beneficial

		Frequency	Percent
Valid	Yes	356	89.0
	No	44	11.0
	Total	**400**	**100.0**

The study also sorted to know whether the BEPHA health insurance scheme is actually beneficial. Based on the perceptions of respondents according to table 2, a majority of the respondents agreed that BEPHA health insurance scheme is beneficial to people as opposed to a little proportion of the respondents who denied that the health insurance scheme is not beneficial. Most of the respondents who denied that BEPHA is not beneficial were not registered members of the health insurance scheme.

Table 3: Trust of respondents in BEPHA insurance scheme

		Frequency	Percent
Valid	Yes	356	89.0
	No	44	11.0
	Total	**400**	**100.0**

Based on the findings in table 3, majority of the participants of the study accepted that they have trust in BEPHA as an insurance scheme as opposed to a small proportion of respondents who refused to have trust in BEHPA as an insurance scheme.

Table 4: Aspects respondents dislike about BEPHA

		Frequency	Percent
Valid	Lack of coverage for some health conditions and drugs	184	46.0
	Delay in issuing BEPHA card	135	33.8
	Six months waiting period for major health risks	13	3.3
	Short expiry date	26	6.5
	Limited to Catholic hospitals	9	2.3
	Cover is less than 75% as per BEPHA policy	4	1.0
	Not applicable in some areas of Cameroon	9	2.3
	Money is wasted if you don't fall sick	7	1.8
	Delay in payment of medical fee	2	.5
	High cost in renewing status	1	.3
	Expensive for people without family	2	.5
	Neutral	8	2.0
	Total	**400**	**100.0**

From the results presented on table 4, a majority of the respondents did not like the fact that the BEPHA health insurance scheme does not cover some health conditions and drugs. This was

followed by those who disliked the fact that there is delay in issuing the BEPHA card making it difficult for them to have access to medical care after paying the subscription fee. A handful of the respondents also disliked the fact that the expiry date of the BEPHA insurance scheme is short. Few of the respondents disliked the six months waiting period for major health risks. Some disliked the facts that the BEPHA insurance scheme was limited to Catholic hospitals. A small proportion of the respondents said money is wasted if they subscribe and do not fall sick. Other respondents representing a very small proportion did not like the fact that health insurance cover is less than 75% as per BEPHA policy. Some respondents who said there is usually delay in payment of medical fee represented and those who said they did not like the fact that the scheme is expensive for people without family, while just a single respondent said there is high cost in renewing her subscription status making it difficult for her to continue on the scheme.

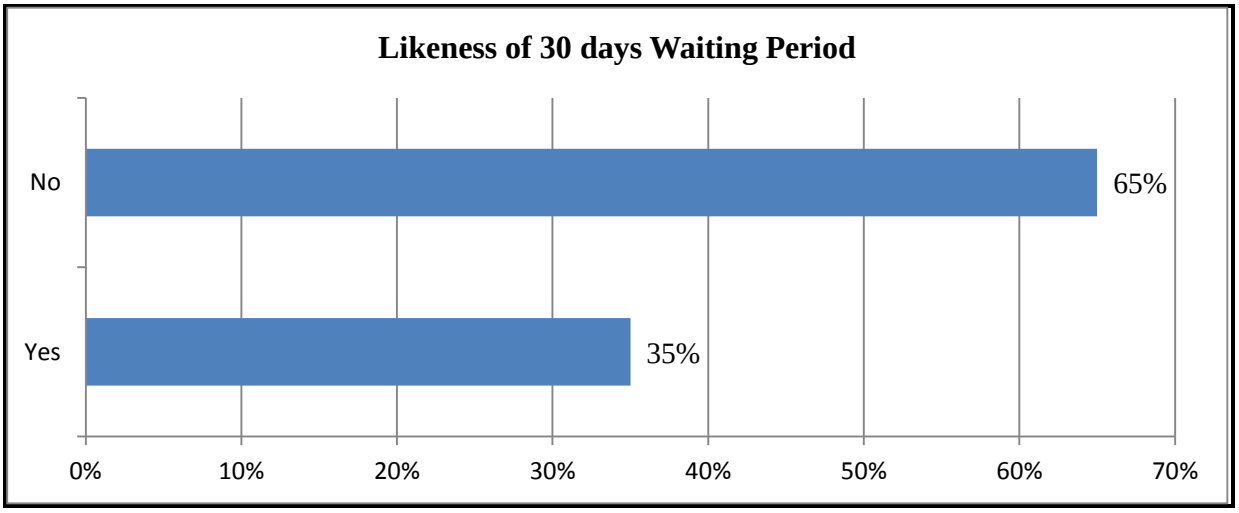

Figure 2: Respondents satisfaction with 30 days waiting period for minor health risks

From the findings in figure 2, a greater proportion of the study participants did not like the 30 days waiting period for minor health risk as opposed to a smaller proportion who shared the opinion that they were okay with the 30 days waiting period for minor health risks.

Table 5: Respondents satisfaction with six (06) months waiting period for major health risks including delivery

		Frequency	Percent
Valid	Yes	141	35.3
	No	259	64.8
	Total	**400**	**100.0**

According to table 5, a majority of the study participants indicated their dissatisfaction with the six (06) months waiting period for major health risks including delivery of BEPHA as opposed to a few who indicated to be okay with the waiting period.

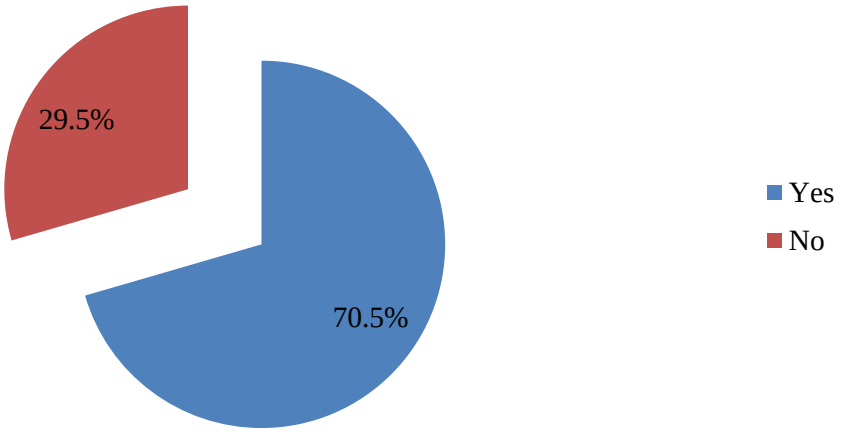

Figure 3: Respondents convenience with the June and November enrolment period

Figure 3, showed that most of the participants in the study felt convenient with the June and November enrolment periods of BEPHA as opposed to just a few participants who did not feel that this enrolment period is convenient for them. The researcher was also interested to know whether BEPHA has adequate financing in its continuing operation. The questions here were directed to 10 staff of BEPHA in the capacities of the manager, accountant, data operators and agents.

Table 6: Respondents assessment of BEPHA's financing adequacy

	Rate	**Frequency**	**Percentage**
i) Is BEPHA financing adequate for the payment of staff?	Yes	5	50
	No	5	50
	Total	**10**	**100**
ii) Is BEPHA financing adequate for payment of members' treatment bills to partner Health facilities?	Yes	9	90
	No	1	10
	Total	**10**	**100**
iii) Is BEPHA financing adequate for covering of administrative cost?	Yes	6	60
	No	4	40
	Total	**10**	**100**

Table 6 show that 5 (50%) of the BEPHA staff accepted that BEPHA financing is adequate for the payment of staff salaries as opposed to 5 (50%) who refused that BEPHA financing is adequate for the payment of staff. In addition, out of 10 staff of BEPHA contacted, 9 (90%) were of the opinion that BEPHA financing is adequate for the payment of members' treatment bills to partner health facilities, while just 1 (10%) out of the 10 respondents denied that BEPHA financing could adequately pay members' bills to partner health facilities. Also, out of 10 respondents who were employees of BEPHA 6 (60%) were of the opinion that BEPHA financing is adequate for covering administrative cost as opposed to 4 (40%) of the respondents denying this assertion.

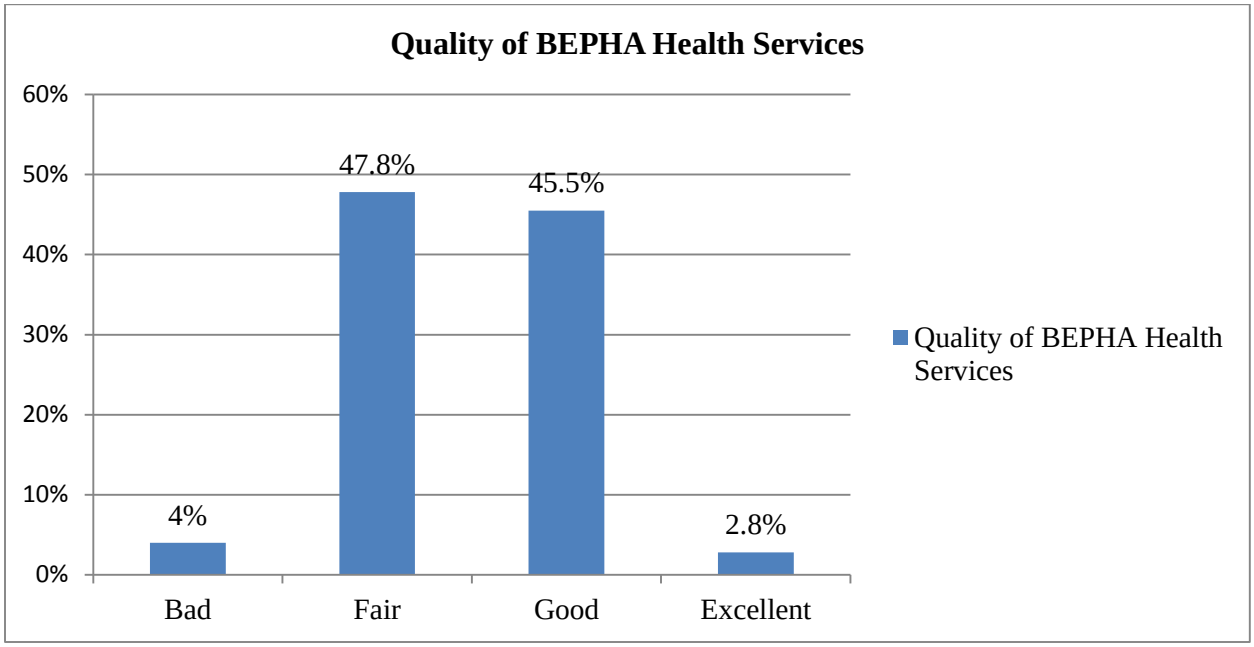

Figure 4: Qualities of health services in BEPHA partner hospitals

From the findings as shown in figure 4, a greater proportion of the study participants perceived the services offered by BEPHA partner hospitals to be fair, followed by participants who perceived their services to be good, while just a few respondents shared the opinion that services offered by BEPHA partner hospitals are excellent. On the other hand, some of the participants attested that BEPHA partner hospitals services are bad. On average, we can say that the services offered by BEPHA partner hospitals are fair.

Table 7: Problems encountered in BEPHA partner health facilities

	Frequency	Percent
Long waiting time	198	49.5
Lack of order-First come first serve rule absent	28	7.0
All of the above	87	21.8
None of the above	66	16.5
The value for money than human life	2	.5
Too expensive drugs	4	1.0
Reduction is not done in all hospitals	1	.3
Some nurses are rude to patients	12	3.0
Some doctors ignore filling the card	1	.3
Neutral	1	.3
Total	**400**	**100.0**

According to table 7, long waiting time was the highest problem that respondents encountered in BEPHA partner health facilities. This was followed by participants who attested that there is lack of order in BEPHA partner health facilities- that is the first come first serve rule is absent in BEPHA partner health facilities, while some participants of the study said they encountered the problem of the nurses being rude to them. In addition, a few respondents said the problem they

encountered at BEPHA health facilities were the expensive nature of drugs, while participants who said some doctors ignored filling the cards and that reduction is not done in all hospitals constituted a very small proportion out of the number of respondents.

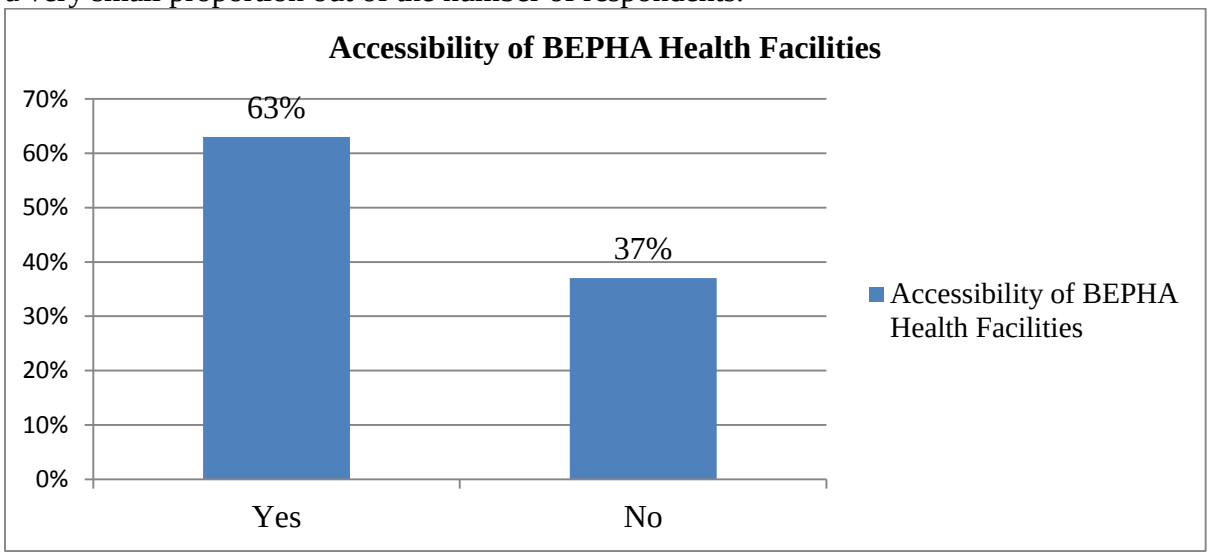

Figure 5: Accessibility of BEPHA health facilities

Based on Figure 4 above, a majority of the respondents of the study accepted that BEPHA health facilities are easy to reach as opposed to a smaller proportion of respondents who denied the fact that BEPHA health facilities are easy to reach.

Relationship between quality of health services and Growth of BEPHA

The results of the correlation between quality of health services, adequacy of BEPHA financing and the growth of BEPHA, is presented below.

Table 8. Correlation results

	Quality of BEPHA Health Services	Adequacy of BEPHA financing	Growth of BEPHA
Adequacy of BEPHA financing	.655*	1.000	.802**
	.040	.	.005
	10	10	10
Quality of BEPHA Health Services –X3	1.000*	.535	.816**
	.	.111	.004
	10	10	10
Growth of BEPHA – X3	.816**	.802**	1.000
	.004	.005	.
	10	10	10

The results shown in table 8 indicate a strong positive and significant relationship between sufficiency of BEPHA financing ($r= 0.802$, $p < 0.05$) and the growth of BEPHA as a health insurance scheme. Meaning that as financing increase, BEPHA growth increases largely. The results also indicate a strong positive and significant relationship between quality of BEPHA health services and the growth of BEPHA. The correlation statistic ($r =0.816$, $p < 0.05$) is an indication

that an increase in the quality of BEPHA health services will lead to a significant increase in the growth of BEPHA and vice versa. Meaning that as quality of health services offered by BEPHA partner hospitals increases, BEPHA growth increases largely.

Regression Analysis

This section reports the results of the regression analysis conducted to examine the influence of sufficiency of BEPHA financing and quality of BEPHA health services on the growth of BEPHA as a health insurance scheme. The multiple ordinary least squares (OLS) technique was used to conduct this analysis. Diagnostics tests for multi-β. Results as reported on Table 9 below indicate that, the problem of collinearity was minimized. Results of the VIF statistics were all close to 1. The conditional indices were also small below 15; further indicating that multicollinearity was not present in the model. The F-test and R-square statistics also showed that the model was robust for analysis.

Table 9: The effect of sufficiency of BEPHA financing and quality of BEPHA health services on the growth of BEPHA as a health insurance scheme

Variable	Coefficient	t	Sig.
(Constant)	0.893	-0.280	0.791
Age	0.083	1.508	0.192
Level of Education	0.238	-0.524	0.623
Sufficiency of BEPHA Financing	0.166	4.523	0.006***
Quality of BEPHA Health Services	0.200	2.500	0.054*
F-STAT	0.011		
R SQUARE	0.799		

An assessment of the fitness of the model was confirmed with a significant F statistic of value. Computed overall F statistics [$p < 0.011$] was significant with an adjusted R square of 0.799, suggesting that 79.9% of the variations in the Growth of BEPHA can be accounted for by the independent variables. The age and level of education has no statistical significant influence on the impression of the quality of health services provided by BEPHA. The results further show that sufficiency of BEPHA financing ($\beta=0.166$; $p < 0.1$), has a positive and significant effect on growth of BEPHA. This therefore suggests that when BEPHA financing increases, their growth too will increase. The quality of BEPHA health services ($\beta=0.200$; $p < 0.1$) has a significant positive effect on growth of BEPHA. Therefore, if quality of BEPHA health services increases, BEPHA will experience growth. These findings are in line with the expected utility theory (EUT) which states that individuals choose between alternatives to maximize expected utility. The "EUT states that a person's demand for insurance is reflected in their degree of risk aversion and preference for income certainty. This means that this theory proposes the use of health insurance will increase if the service qualities are high. If health insurance has adequate financing, the quality of health services will be increased and this will in turn encourage new members to enroll for the scheme to maximize their utility. This cycle will keep going round leading to the growth and stabilization of the BEPHA Scheme.

CONCLUSION

This study focused on determining how adequacies of BEPHA financing and quality of health services affect BEPHA growth. The study leads to a conclusion that adequacy of BEPHA financing

is an important determining factor of BEPHA's growth. This means that low premiums collection will inhibit the ability of the BEPHA health insurance scheme in covering for operational and medical expenses of their members which will subsequently lead to the collapse of the scheme. Interview with BEPHA staff supported this standpoint of the study. It revealed that premiums collection by the BEPHA health insurance scheme has actually dropped due to the displacement of members in crisis affected areas and non-benefit from the scheme by initial subscribers thereby leading to financial constraints in; payment of staff, payment of members' treatment bills to partner health facilities and covering of BEPHA administrative cost. From the results, the study also concluded that the quality of health services provided by BEPHA partner health facilities has a direct bearing with the growth of the BEPHA health insurance scheme. Therefore, if the services provided by BEPHA partner health facilities are poor, there will be a decline in the growth of the BEPHA health insurance scheme. Nevertheless, if BEPHA partner health facilities provide quality health services to registered members of BEPHA, the health insurance scheme will grow. Evidence from the study supported this conclusion by revealing that; long waiting time at BEPHA partner hospitals, lack of order (that is non-respect of the first come first serve principle) and rudeness of some nurses at the BEPHA partner health facilities have been problems encountered by BEPHA health insurance subscribers. This has actually reduced the rate of enrolment and payment of premiums to the scheme thereby leading to low growth of the BEPHA health insurance scheme.

RECOMMENDATIONS

From the above conclusions, this study recommends that the expiry date of the BEPHA health insurance cover can be extended to attract more subscribers into the scheme thereby ensuring the growth in premium and consequent sustainability of the scheme. It also recommends that the scheme should reduce the waiting period for minor health risk to at most 2 weeks as suggested by some members who participated in the study, while the 6 months waiting period for major health risk including delivery should be reduced to one (01) month or no waiting period. It also recommends the institution of the first come first serve rule and reducing the waiting time at the BEPHA partner health facilities by employing a BEPHA staff for each institution. In addition, sensitizing health personnel on good customer service principles will go a long way to increase service quality at these partner health facilities. Where BEPHA cannot employ staff, it could remunerate the existing staff to offer the extra services such as filling of BEPHA consultation forms needed

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