POLICY BRIEF

Strategic Health Purchasing in Cameroon

A Summary of Progress, Challenges, and Opportunities

MAY 2021

STRATEGIC HEALTH PURCHASING FOR UNIVERSAL HEALTH COVERAGE IN SUB-SAHARAN AFRICA

The Strategic Purchasing Africa Resource Center (SPARC), a resource hub hosted by Amref Health Africa with technical support from Results for Development (R4D), aims to generate evidence and strengthen strategic health purchasing in sub-Saharan Africa to enable better use of health resources. SPARC and its technical partners created a framework for tracking progress in strategic health purchasing and are applying it in countries across sub-Saharan Africa to facilitate dialogue on what drives progress and to promote regional learning.

CAMEROON AT A GLANCE

- Population (2019): **25.9 million**
- GDP per capita (2019): **US$1,508**
- Poverty headcount at $1.90/day (2015): **26%**
- Life expectancy (2018): **58.9 years**
- Current health expenditure (CHE) per capita (2018): **US$54**
- Domestic government expenditure as % of CHE (2018): **6%**
- Out-of-pocket expenditure as % of CHE (2018): **75%**
- External expenditure as % of CHE (2018): **9%**

Source: World Bank Databank

Health Financing Schemes in Cameroon

Cameroon, a lower-middle-income country, aims to improve health sector performance and achieve equitable and universal access to quality health services, as outlined in the government's *Stratégie Sectorielle de la Santé 2016-2027*. Specific targets related to strategic purchasing include: 1) performance-based financing in 90% of health facilities and 2) validation of the effectiveness and quality of all health care services by 2027. Cameroon currently has more than 30 health financing schemes, 19 of which are dependent on donor funding. The main categories of schemes in Cameroon include:

- **SUBSIDIZED HEALTH CARE.** The Ministry of Public Health (MOPH), through various donor-funded vertical programs, subsidizes free care for specific diseases (such as HIV/AIDS), specific population groups (such as pregnant women), or a combination (such as malaria in children under age 5).
- **PERFORMANCE-BASED FINANCING (PBF) PROGRAM.** Largely funded by the World Bank, this program provides incentives to public, private, and faith-based health facilities to deliver a package of basic health services.
- **VOUCHER PROGRAM.** This donor-funded program, *Chèque Santé*, improves access to maternal and neonatal care in the country's three northern regions. Women obtain a voucher for a package of maternal and neonatal services by paying a fee that represents 10% of the actual cost.
- **MUTUAL HEALTH ORGANIZATIONS (MHOs).** Cameroon has 17 voluntary MHOs, covering 0.15% of the population with a limited package of medical services.
- **PRIVATE HEALTH INSURANCE.** Voluntary private insurance covers 0.75% of the population, mostly employees of large private and parastatal companies.
- **NATIONAL HEALTH INSURANCE (NHI).** Established in 2016 but not yet operational, this compulsory scheme will be financed by public resources, household contributions, and donor funding.

Table 1 compares the purchasing functions in these schemes.

Table 1. **Purchasing Functions in Cameroon's Health Financing Schemes**

	Subsidized Health Care	Performance-Based Financing (PBF) Program	Voucher Program (*Chèque Santé*)	Mutual Health Organizations (MHOs)	Private Health Insurance
% of Current Health Expenditure (2015)*	13%			7%	
Main Purchaser(s)	MOPH program departments	Regional Funds for Health Promotion (RFHPs)	*Agence Régionale du Chèque Santé*	MHOs	Insurance companies
Governance	Departments within MOPH run these programs, which target priority services or population groups. Providers receive in-kind transfers and have limited financial autonomy.	MOPH is the regulator. RFHPs have taken over the purchasing function from contract development and verification agencies, but lines of responsibility are unclear. Providers have financial autonomy to use funds according to Ministry of Finance (MOF) guidelines for use of public funds.	*Agence Régionale du Chèque Santé* is under the authority of the Regional Fund for Health Promotion, with clear lines of accountability. Providers have some financial autonomy to use these funds according to MOF guidelines for use of public funds.	MHOs are regulated by RFHPs. The annual general assembly of members is responsible for strategic purchasing decisions (benefit package, contracting, etc.), while the management is in charge of implementing decisions of the general assembly and day-to-day operations of the organization. Providers have financial autonomy to use these funds.	Private insurance companies are governed under the Central African Economic and Monetary Community zone and Cameroon's *Le Code des Assurances de la CIMA* of 1995. Provider payment tariffs are defined by MOPH. Private and public providers have financial autonomy over these funds.
Financial Management	The annual budget is based on the budget preparation circular that provides guidance for preparing the MOPH budget and the Medium Term Expenditure Framework and is approved by Parliament. Budget overruns are not allowed but still occur frequently. Sometimes donors finance the budget deficits.	The annual budget is based on projected utilization of targeted services and the previous year's expenditure. Budget overruns are not allowed but still occur. Donors sometimes supplement budgets when deficits occur.	The annual budget is based on payment rates for services and expected utilization by the target population. Budget overruns are not allowed and rarely occur.	The annual budget is based on projected member contributions. Budget overruns are not allowed but still occur. The general assembly must approve the use of reserves to cover deficits.	The annual budget is based on projected revenue from member premiums. Budget overruns are not allowed and rarely occur.
Benefits Specification	Malaria, tuberculosis (TB), HIV, and maternity services	Outpatient consultations, TB, vaccinations, maternity care and family planning, nutrition, and community care	Package of maternity care services	Consultations, laboratory, X-rays and other diagnostic tests, medications, and hospitalizations	Packages of preventive and curative services
Contracting Arrangements	Loose agreements with public providers	Selective contracting with public and private providers; quality standards included in contracts	Selective contracting with public and private providers	Selective contracting with public and private providers; quality standards included in contracts	Selective contracting with public and private providers
Provider Payment	In-kind payment; no financial transfers	Fee-for-service	Fee-for-service	Fee-for-service	Fee-for-service
Performance Monitoring	Monthly facility activity reporting on DHIS2; visits by supervision team	Monthly facility activity reporting on DHIS2; RFHP quarterly verification of health visits and quality of care	Monthly facility activity reporting on DHIS2; RFHP monitoring	Reports by medical advisors	Some patient satisfaction interviews after hospitalization

** Global Health Expenditure Database*

Progress and Challenges in Strategic Health Purchasing

Cameroon has made some progress on strategic purchasing through the PBF and voucher programs, which have well-defined benefit packages that are aligned with the payment mechanisms, selective contracting arrangements with providers, and output-based provider payment, mostly simple fee-for-service.

Highlights of progress and remaining challenges in each of the purchasing functions are described below.

GOVERNANCE. There are multiple purchasers with wide variation in institutional arrangements. The main purchasing agency is the government, through the MOPH and RFHPs. PBF is the only scheme with a clear purchaser-provider split. Health facilities have financial autonomy over PBF funds, but public facilities must follow public financial management guidelines for planning, budgeting, execution, and accounting for public funds, which may impose some limitations. For example, facilities are required to return part of their surplus revenues to the central level rather than being able to retain them for use at the facility level.

FINANCIAL MANAGEMENT. All of the schemes have a defined process for setting the purchaser's budget as well as mechanisms to track budget execution/spending. Budgetary spending controls are not well enforced, however, and budget overruns occur frequently.

BENEFITS SPECIFICATION. All of the schemes have specified benefit packages, but the packages are not harmonized and transparent processes for revising the packages are lacking. The subsidized schemes have disease-focused benefit packages, while the benefit packages for the PBF and voucher programs aim to address high maternal and child mortality in Cameroon by prioritizing services for women and children. The PBF and voucher programs have explicitly defined service delivery standards, while the other schemes do not. Misalignment of benefit packages and MOPH programs leads to significant gaps and overlaps in coverage for certain populations, as well as inefficiencies.

CONTRACTING ARRANGEMENTS. All but the subsidized care scheme have contracts or agreements in place between the purchaser and providers. Most subsidized health care schemes include only public providers, but the PBF, voucher program, MHOs, and private insurers have selective contracting with private providers. The PBF and voucher program contracts specify the range and quality of services to be provided, standard treatment guidelines, and claims information to be submitted to the purchaser. In other schemes, quality is often not a factor in contracting decisions, and contracts are rarely suspended or canceled for poor performance.

PROVIDER PAYMENT. Most of the schemes rely on fee-for-service payment to providers, which is linked to the scheme's service delivery objective of increasing utilization of priority services. PBF provides additional financial incentives for achieving targets, while the voucher scheme's payment is divided into a fixed payment for the service and a variable payment linked to quality and adherence to contractual obligations. The funding flows and payment systems across different schemes are not harmonized and create conflicting incentives for providers. In some cases, the incentives lead providers to focus solely on specific services or indicators that result in higher payment.

PERFORMANCE MONITORING. Provider performance monitoring occurs in some form across all of the schemes, but it is generally not automated and is not often used for purchasing decisions. The PBF purchaser routinely monitors provider performance, and provider payment is directly tied to the accuracy and timeliness of data. The voucher program's purchaser routinely monitors provider performance and has documented significant reductions in institutional maternal and neonatal mortality rates compared to women and newborns not covered by the program. In the other schemes, inadequate and fragmented monitoring and information systems make it difficult to proactively identify adverse provider behaviors and implement corrective measures.

Table 2 summarizes progress made in strategic purchasing functions along the dimensions of progress defined by SPARC for the five operational schemes in Cameroon. (See the annex for a detailed explanation of how the levels of progress are indicated using ○, ●●, and ●●●.)

Table 2. **Progress Made Across Purchasing Functions in Cameroon**

Purchasing Function	Indicators of Strategic Purchasing	Subsidized Health Care	PBF Program	Voucher Program	MHOs	Private Insurers
Governance	Purchasing functions have an institutional home that has a clear mandate and allocation of functions.	○	●●●	●●●	●●	●●
	Providers have autonomy in managerial and financial decision-making and are held accountable.	○	○	○	○	○
Financial Management	Purchasing arrangements incorporate mechanisms to ensure budgetary control.	○	●●	●●	○	●●
Benefits Specification	A benefit package is specified and aligned with purchasing arrangements.	●●	●●●	●●●	●●	●●
	The purchasing agency further defines service delivery standards when contracting with providers.	○	●●	○	○	○
Contracting Arrangements	Contracts are in place and are used to achieve objectives.	○	●●●	●●●	●●	●●
	Selective contracting specifies service quality standards.	○	●●●	●●●	●●	○
Provider Payment	Provider payment systems are linked to health system objectives.	○	●●	●●	●●	●●
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	○	○	○	○	○
Performance Monitoring	Monitoring information is generated and used at the provider level.	○	●●	●●	○	○
	Information and analysis are used for system-level monitoring and purchasing decisions.	○	○	○	○	○

Despite these areas of progress, a number of challenges limit strategic health purchasing in Cameroon. Low public financing, at only 6% of current health expenditure (CHE), and high out-of-pocket (OOP) spending, at 75.6% of CHE, mean that strategic purchasing is limited in its potential impact. Only 20% of CHE is managed by the various health financing schemes. Fragmentation of financing schemes, with their multiple payment systems, reduces purchasing leverage that could enable progress toward universal health coverage (UHC) in Cameroon.

Unclear division of power between the MOPH and purchasing entities leads to overlaps in functions for defining benefit packages, provider payment systems, and contracting policies. Purchasing agencies are not held accountable for using funds efficiently, ensuring access to high-quality health services, or reporting on performance indicators. Further, health facilities have limited autonomy in financial management and have no opportunity or power to negotiate with purchasers on benefit packages or payment rates.

Opportunities to Improve Health Purchasing

Cameroon has many small pockets of progress in strategic purchasing, but the positive effects on the health system are limited because of the high degree of fragmentation and small amount of funds flowing through each mechanism. The country could build on the progress to date by harmonizing or consolidating purchasing power in fewer schemes. The planned NHI may be an opportunity to reduce fragmentation of health financing by merging the numerous donor-funded vertical programs and government subsidies and channeling high out-of-pocket spending into prepayment for the compulsory scheme.

Another viable strategy before the NHI becomes operational may be to harmonize benefit packages across the numerous schemes to reduce overlap and duplication and to engage enrollees when defining or revising benefit packages. Purchasers may also design payment systems more strategically and give providers greater autonomy in financial management while holding them accountable for service quality and compliance with purchasing and accounting rules.

Finally, Cameroon may benefit from building on improvements to the purchasing functions and information systems developed under the PBF and voucher schemes to achieve the country's 2027 goals of linking payment to provider performance and validating effectiveness and quality of health care services.

SPARC and its technical partners view strategic purchasing as a way to improve resource allocation, provide coherent incentives to providers, and improve accountability for health resources. As next steps, SPARC's partner in Cameroon—Research for Development International—will validate the SPARC findings with Cameroonian stakeholders and determine appropriate actions to make further progress in strategic purchasing as a way to achieve UHC in Cameroon.

This policy brief is based on a strategic purchasing progress assessment whose details are reported in the following publication: Sieleunou I, Tamga DDM, Tankwa JM, Munteh PA, Tchatchouang EVL. 2021. Strategic Health Purchasing Progress Mapping in Cameroon: A Scoping Review, Health Systems & Reform, 7:1. *www.tandfonline.com/doi/full/10.1080/23288604.2021.1909311*

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Annex. **Strategic Purchasing Progress Indicators**

Governance	**Purchasing functions have an institutional home that has a clear mandate and allocation of functions.**	○	An agency or agencies have responsibility for carrying out one or more purchasing functions, but mandates are not clearly defined and capacity is weak.
		●●	An agency or agencies have responsibility for carrying out most or all purchasing functions and capacity is improving, but some overlaps and gaps in responsibilities remain. Mechanisms are in place for stakeholder engagement.
		●●●	An agency or agencies have responsibility for carrying out all purchasing functions, capacity is strong, and there are no overlaps or gaps in responsibilities. There is inclusive and meaningful stakeholder engagement.
	Providers have autonomy in managerial and financial decision-making and are held accountable.	○	Public providers have no autonomy or extremely limited autonomy to carry out financial and managerial functions, and they have limited ability to respond to financial incentives created by provider payment systems.
		●●	Public providers are given a larger degree of financial and managerial autonomy, but accountability mechanisms are weak.
		●●●	Public providers are given a large degree of financial and managerial autonomy, and accountability mechanisms are effective.
Financial Management	**Purchasing arrangements incorporate mechanisms to ensure budgetary control.**	○	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending, but these mechanisms are not well enforced.
		●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, but budget overruns routinely occur.
		●●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, and budget overruns rarely occur.
Benefits Specification	**A benefit package is specified and aligned with purchasing arrangements.**	○	A benefit or service package is defined and reflects health priorities, but it is not well specified, is not a commitment, and/or is not aligned with purchasing mechanisms.
		●●	A benefit or service package is defined, reflects health priorities, and is a commitment, but it is not well specified and/or not aligned with purchasing mechanisms.
		●●●	A benefit or service package is defined, reflects health priorities, is a commitment, is well specified, and is aligned with purchasing mechanisms, and a transparent process for revision is specified.
	The purchasing agency further defines service delivery standards when contracting with providers.	○	The purchaser defines some general standards for delivering services in the package (e.g., for gatekeeping), but enforcement through contracts is weak.
		●●	The purchaser defines some general service delivery standards and some specific service delivery standards (e.g., number of prenatal care visits) that are enforced through contracts.
		●●●	The purchaser defines general service delivery standards and specific service delivery standards in line with national service delivery policies and clinical protocols, and service delivery standards are enforced through contracts.
Contracting Arrangements	**Contracts are in place and are used to achieve objectives.**	○	Loose agreements are in place between the purchaser and public providers for specified services in exchange for payment instead of or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●	Formal agreements are in place between the purchaser and public providers for specified services in exchange for payment or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●●	Formal agreements are in place between the purchaser and public and private providers to help achieve specific objectives, and they are linked to performance.
	Selective contracting specifies service quality standards.	○	The purchaser has loose, nonselective agreements or contracts with all public providers and selective contracts with some private providers based on some definition of quality standards.
		●●	The purchaser contracts at least somewhat selectively with public and private providers based on accreditation or some other definition of quality standards.
		●●●	The purchaser contracts selectively with public and private providers based on uniformly applied quality standards.
Provider Payment	**Provider payment systems are linked to health system objectives.**	○	Some output-based payment is used.
		●●	Output-based payment is used, and payment systems are linked to specific service delivery objectives.
		●●●	Output-based payment is used and is linked to specific service delivery objectives; payment systems are harmonized across levels of care, and they allow purchaser budget management.
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	○	Provider payment rates are determined based only on the purchaser's available budget.
		●●	Provider payment rates are determined based on the purchaser's available budget and at least one other factor (e.g., cost information, priorities, or negotiation with providers).
		●●●	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.
Performance Monitoring	**Monitoring information is generated and used at the provider level.**	○	Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting, claims audits, quality audits).
		●●	Provider-level monitoring is at least partially automated and is used for purchasing decisions.
		●●●	Provider-level information is automated, fed back to providers, and used for purchasing decisions.
	Information and analysis are used for system-level monitoring and purchasing decisions.	○	Some form of analysis is carried out at the system level (e.g., service utilization, medicines prescribed, total claims by service type).
		●●	System-level analysis is automated and carried out routinely.
		●●●	Information and analysis are used for system-level monitoring and purchasing decisions.