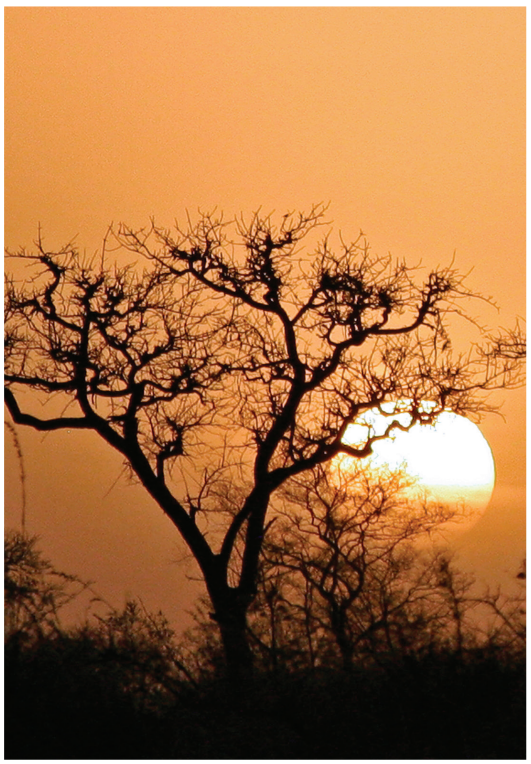
CAMEROON ECONOMIC UPDATE

TOWARDS GREATER EQUITY

A SPECIAL FOCUS ON HEALTH



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Towards Greater Equity

A Special Focus on Health

July 2013

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ABBREVIATIONS AND ACRONYMS

BEAC	*Banque des États d'Afrique Centrale* (Central Bank of Central African States)
CAR	Central African Republic
CEMAC	*Communauté Économique et Monétaire de l'Afrique Centrale* (Economic and Monetary Community of Central Africa)
CFAF	CFA Franc
CPI	Consumer Price Index
CU	Customs Union
DHS	Demographic Health Survey
DRC	Democratic Republic of Congo
ECCAS	Economic Community of Central African States
ECOWAS	Economic Community of West African States
GDP	Gross Domestic Product
HMIS	Health Management Information System
IMF	International Monetary Fund
LPG	Liquefied Petroleum Gas
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
OPSF	Oil Price Stabilization Fund
RBF	Results-Based Financing
SAM	Social Accounting Matrix
SNH	*Société Nationale des Hydrocarbures* (national oil company)
SONARA	*Société Nationale de Raffinage* (national refinery)
US$	United States Dollar
VAT	Value Added Tax
WEO	World Economic Outlook
WHO	World Health Organization
y-o-y	Year-on-year

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INTRODUCTION

With these *Cameroon Economic Updates*, the World Bank is pursuing a program of short and frequent reports analyzing the trends and constraints in Cameroon's economic development. Each issue, produced bi-annually, provides an update of recent economic developments, as well as a special focus on a topical issue.

The *Cameroon Economic Updates* aim to share knowledge and stimulate debate among those interested in improving the economic management of Cameroon and unleashing its enormous potential. The notes thereby offer another voice on economic issues in Cameroon, and an additional platform for engagement, learning and exchange. This sixth issue of the *Cameroon Economic Updates* is entitled "Towards Greater Equity —A Special Focus on Health".

There has been little improvement in Cameroon's health indicators over the past two decades. The under-five child mortality rate has only been reduced slightly, while life expectancy has, in fact, declined. The burden of health care financing is largely born by households, and risk-pooling mechanisms are quasi-inexistent. Furthermore, the limited public resources allocated to health do not seem to be deployed where they are most needed. As a result, substantial disparities exist in health outcomes between rural and urban areas, as well as across socio-economic groups.

The introduction of program budgeting in 2013 should improve the efficiency of public spending. Line ministries will have now more flexibility in preparing and executing their budgets, but will also be held accountable for results. In addition, an effective data collection and management system would help decision-makers monitor health outcomes more regularly and ensure that budgetary allocations are based on needs and performance. Cameroon could also begin taking steps towards an extension of prepayment and risk-pooling mechanisms, such as mutual health organization and mandatory formal sector insurance. By reducing individual costs, such policies would increase access to health services for the poor and protect them from spending shocks due to health emergencies.

A results-based approach in health, which provides funding based on results and rewards performance through additional budgetary allocations and bonuses, is currently being piloted in Cameroon. The preliminary results of this approach are encouraging. An extension of this initiative may be an option to improve health services and outcomes, and ensure greater coverage of health services.

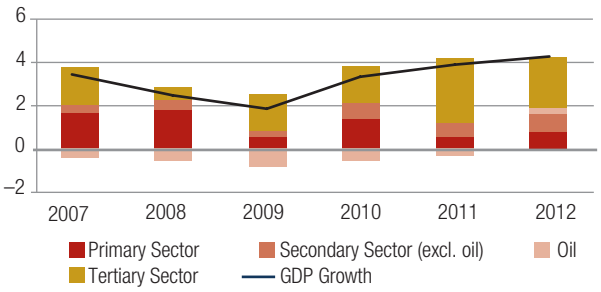
RECENT ECONOMIC DEVELOPMENTS

Growth

In spite of slow economic growth worldwide, recent estimates confirm that Cameroon's economy continued to gain momentum in 2012 (Figure 1). Growth is estimated to have reached 4.4 percent in 2012 (compared with 4.2 percent in 2011) on the back of continued strong performance both in oil and non-oil activities. Credit to the economy has, however, been subdued, rising by 2.6 percent.

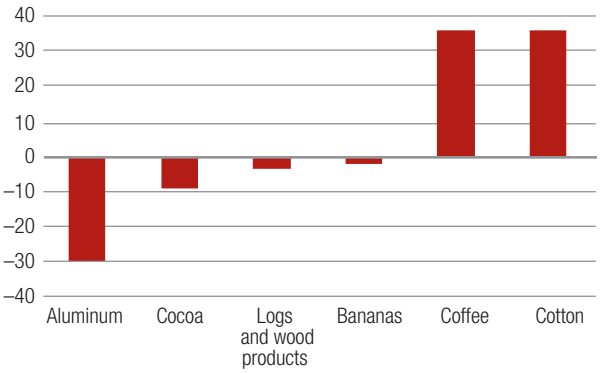
As in 2011, the tertiary sector was the main driver of growth, expanding by more than 5 percent, with transports, communications and financial services being particularly dynamic. In the primary sector, economic growth was mainly driven by industrial and export-oriented agriculture, especially by the production of coffee, cotton and rubber (Figure 2). Cotton production, for instance, is estimated to have expanded by more than a third following the return of farmers to the sector coupled by an expansion of production areas.

FIGURE 1: Sectoral Contributions to GDP Growth, 2007–12
(in percent)



Sources: Cameroonian authorities and Bank Staff calculations.

FIGURE 2: Export Performance, 2012
(y-o-y percent change in volume)

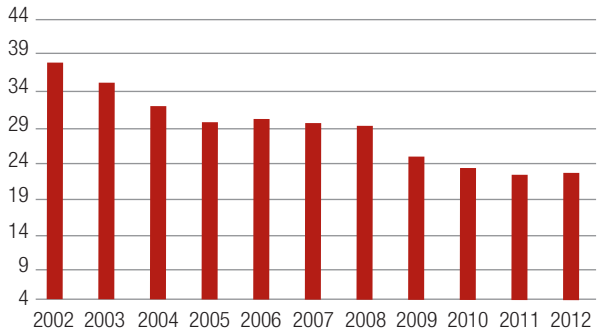


Sources: Cameroonian authorities and Bank Staff calculations.

Problems related to electricity production and delays in the oil sector have dampened, however, economic performance and pushed growth to the lower end of our projection range. Activities in electricity, gas, and water slowed down in 2012, expanding by a mere 0.4 percent (compared with 3.6 percent in 2011) because of low rainfall and delays in the operations of the new gas-fired power plant in Kribi. Worsening electricity shortfalls have, in turn, hampered the aluminum sector: estimated exports were down by a third in 2012.

In the oil sector, as expected, the downward trend in production observed over the past years was reversed in 2012 and oil production expanded to 22.4 million barrels, compared to 21.6 million barrels the year before (Figure 3). This reversal also allowed an expansion in oil exports, narrowing the country's external trade deficit from 2.3 percent of GDP in 2011 to 1.6 percent of GDP in 2012. The pick-up in oil production was, however, lower than projected

FIGURE 3: Oil Production 2002–2012
(in mio barrels)

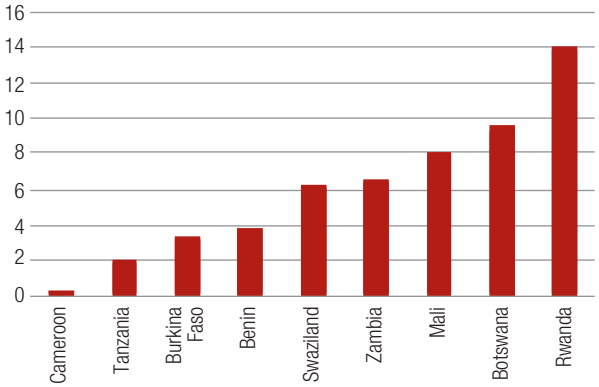


Source: SNH.

(at 3.5 percent instead of 5.1 percent) because of operating delays in new fields.

Economic growth remains nevertheless disappointing in Cameroon. Poor infrastructure, an unfavorable business environment, and weak governance continue to hamper economic activity and make it difficult to reach the growth rates needed to reduce poverty in a sustainable manner. The rates of economic growth observed over the recent past have not been fast enough to deliver tangible improvements in the living conditions for the average Cameroonian. Overall, poverty rates in Cameroon have virtually stagnated between 2001 and 2007, and disparities between regions have widened, as pointed out in previous issues of our *Cameroon Economic Update*. Meanwhile, many other African countries have managed to reduce their poverty rates, sometimes quite significantly (Figure 4).

FIGURE 4: Reduction in Poverty, Selected Countries, Early 2000s-Late 2000s,
(in percent of population)

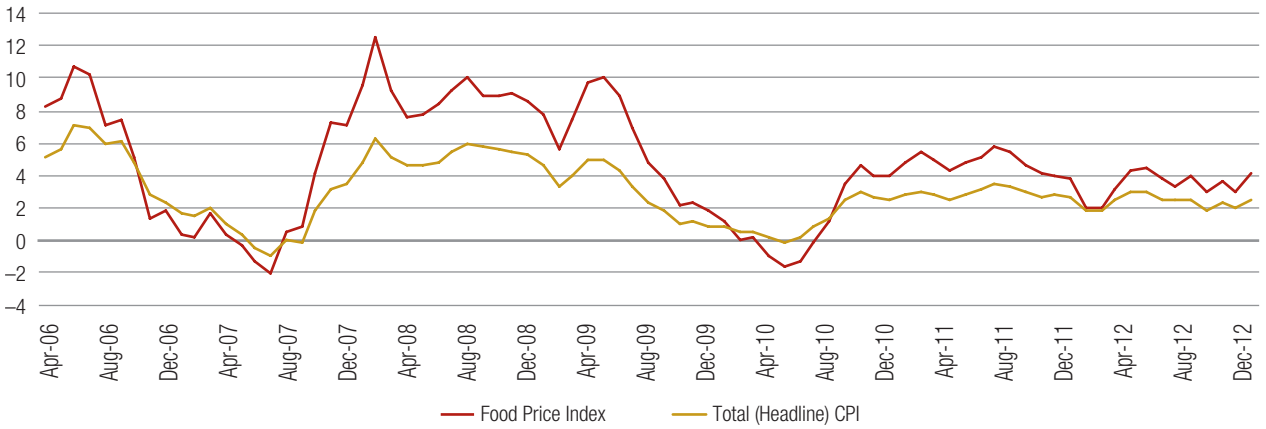


Sources: Cameroonian authorities and Bank Staff calculations.

Inflation

The pace of inflation slowed down in 2012, remaining below the 3 percent regional convergence criterion (Figure 5). The overall price level increased by 2.5 percent in December (y-o-y) compared to 2.7 percent over the same period the year before.

FIGURE 5: Selected Prices: 2006–12
(y-o-y change in percent)

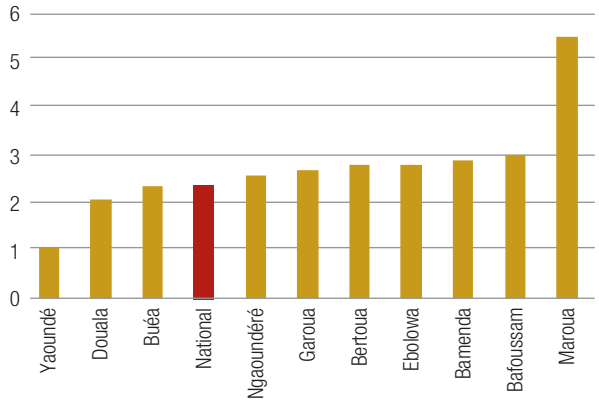


Sources: Cameroonian authorities and Bank Staff calculations.

Inflation was mainly driven by pressures on food prices, peaking at 4.5 percent (y-o-y) in May, but subsiding following improved food distribution and strong harvests. The stability of retail prices for petroleum products has also contributed to containing inflationary pressures.

The rise in prices is, however, unevenly spread across the country's territory (Figure 6). In 2012, inflation was lowest in Yaoundé and Douala, the two main cities, with rates at 1.0 and 2.1 percent on average, respectively. Price pressures were the highest in Maroua (Far North) at 5.5 percent. These price pressures were partly the result of the widespread floods in the region in August and September which caused substantial material destruction, including homes, agricultural land (rice fields primarily), and killed an important number of livestock. The difference in inflation rates may also indicate poor infrastructure, especially in the North, making it expensive to transport goods.

FIGURE 6: Average Inflation by Major City
(in percent)



Sources: Cameroonian authorities and Bank Staff calculations.

Fiscal Performance

On the fiscal side, the latest estimations for 2012 are consistent with the projections presented in the January 2013 issue of the *Cameroon Economic Update* (see Table 1). On a cash basis, the overall 2012 deficit (including grants and before payment obligations) is estimated to be lower than budgeted, primarily as a result of higher oil revenues caused by stronger-than-expected international oil prices. Estimated total spending was in line with the budget, with slight slippages in current spending compensated by lower capital outlays in the last quarter of the year. As a result, the non-oil primary deficit is estimated to have shrunk by almost two percentage points of non-oil GDP, going from 8.6 percent of non-oil GDP in 2011 to 6.7 percent of non-oil GDP in 2012.

TABLE 1: Fiscal Performance, 2011–12
(in percent of GDP)

	2011 Est.	2012 Budget	2012 Jan Proj.	2012 Est.
Revenue and Grants	**18.8**	**17.8**	**18.9**	**18.9**
Oil Revenue	5.3	4.4	5.1	5.4
Non-oil Revenue	13.0	12.9	13.2	13.1
Grants	0.5	0.5	0.5	0.4
Total Spending	**21.8**	**20.0**	**19.7**	**20.0**
Current Spending	15.4	13.8	13.5	14.1
Capital Spending	6.4	6.2	6.2	5.9
Overall Balance	**–3.0**	**–2.2**	**–0.8**	**–1.1**
Payment Obligations	–0.5	–0.2	–0.2	–0.9
Overall Balance on a cash basis	**–3.5**	**–2.4**	**–1.0**	**–2.0**

Sources: Cameroonian authorities and Bank Staff calculations.

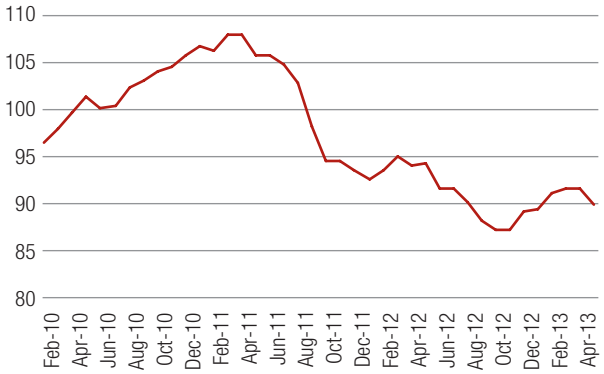
These narrower fiscal deficits on a cash basis reflect, however, a continued accumulation of new payment obligations (particularly related to fuel subsidies). These payment obligations — the stock of which is estimated to have reached about 5 percent of GDP at end 2012 — will continue to put pressure on the Government's cash position. SONARA, the national oil refinery, as well as fuel importers, faces revenue shortfalls stemming from the Government's policy of freezing retail prices for petroleum products. As mentioned in previous issues of our *Economic Update*, the budgeted amount for compensating for these costs falls short of the likely actual figures: in 2012 an estimated CFAF 450 billion (3.5 percent of GDP) was needed instead of the CFAF 170 billion that was budgeted. Despite the cancellation of substantial levels of unpaid taxes, an accumulation of new payment obligations to SONARA — reaching 0.3 percent of GDP — could not be prevented in 2012.

Outlook for 2013

With the construction of large infrastructure projects and continued efforts to improve agricultural productivity, the economic momentum observed in 2012 is expected to carry over into 2013. The production at the Kribi gas station (216 MW) is expected to reduce power bottlenecks. In addition, the arrival of a new operator in the telecommunication sector is expected to foster investment and activity in this sector. Furthermore, the oil sector is projected to continue its recovery, with production estimated to increase by a further 15 percent in 2013. This would push overall economic growth to about 5 percent in 2013.

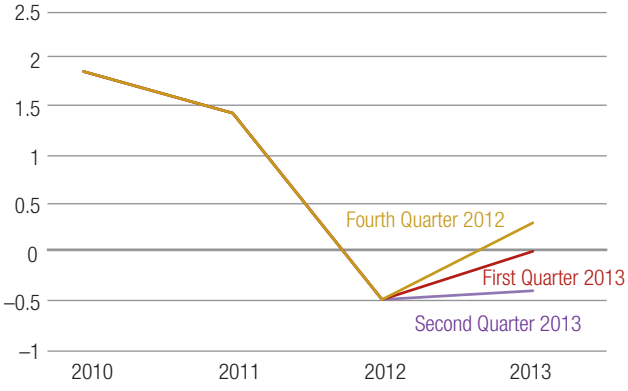
Uncertainty, however, will likely continue to surround developments in advanced economies, making any economic projections particularly challenging. According to the most recent release from the European Commission, confidence remains weak in the Eurozone and will continue to weigh on investment and big-ticket consumption decisions (Figure 7). The regular quarterly surveys of professional forecasters, carried out by the European Central Bank, capture

FIGURE 7: Euro-zone — Economic Sentiment Indicator, 2010–13
(Index 100 = 2000)



Source: European Commission.

FIGURE 8: Euro-Zone 2013 GDP Growth Mean Point Projections
(in percent)

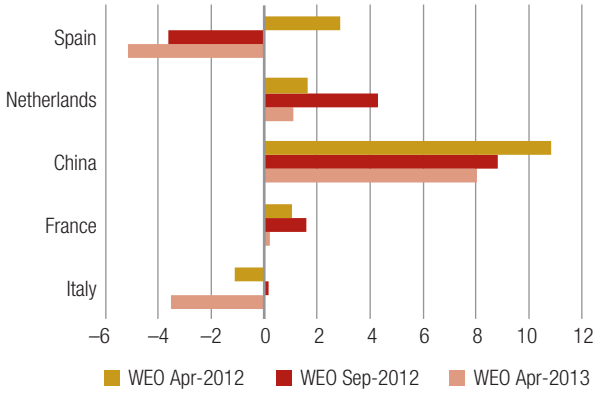


Sources: Survey of Professional Forecasters, European Central Bank.

this growing gloom. The average 2013 growth forecast for the Eurozone has declined over the past quarters, indicating now the expectations of a continued economic contraction (Figure 8).

More worrisome, the latest vintages of the IMF's World Economic Outlook indicate continuous downward revisions for projected imports for Cameroon's main export markets, with demand in many markets expected to decline in 2013 (Figure 9). Import volumes are now expected to decrease in Spain and Italy — the first and fifth largest export markets for Cameroon — by about 5 percent and 3.5 percent, respectively. Furthermore, the pick-up in the economy

FIGURE 9: 2013 Import Volume Projections, Main Trading Partners
(variation in percent)



Source: International Monetary Fund.

expected in the Netherlands and France six months ago has given way to a prospect even gloomier than a year ago. Although remaining in positive territory, even projections for demand in China have been subject to downward revisions.

Concerning fiscal performance, on the basis of the first quarter, the projections for 2013 would indicate a wider overall fiscal deficit in Cameroon than in 2012. Budgeted revenues are based on ambitious expectations for the country's economic growth and for international prices for crude, and thereby are subject to downside risks. Furthermore, the cost of fuel subsidies remains under budgeted, which undermines transparency, and will weigh again on the cash position and execution of the budget. A continued freeze of retail petroleum prices would require an estimated CFAF 430 billion (about 3 percent of GDP), but only CFAF 220 billion have been budgeted. Upcoming local elections could add further pressure on spending, as could the resolution of the situation of some financially troubled banks and financial losses expected from certain state-owned enterprises.

Options for going forward

Against this backdrop, efforts to increase the Cameroonian economy's resilience to shocks should be strengthened, possibly through increased trade diversification, prudent debt management, and increased efficiency in public spending. The latter would include an examination of the various possible options to reduce the budgetary burden caused by subsidies, especially those for petroleum products.

Diversifying trade partners

With high-income countries continuing to restructure, rebalance, and restore their fiscal policies to a sustainable path, export prospects to

TABLE 2: Fiscal Performance, 2013
(in CFAF billion)

	2013 Budget	2013 Q1	2013 Est.
Revenue and Grants	**2649**	**586**	**2582**
Oil Revenue	705	100	711
Non-oil Revenue	1878	486	1815
Grants	66	0	56
Total Spending	**2971**	**468**	**3078**
Current Spending	2014	366	2207
Capital Spending	957	102	871
Overall Balance	**–322**	**118**	**–496**
Arrears	–26	–44	–44
Overall Balance on a cash basis	**–348**	**74**	**–540**

Sources: Cameroonian authorities and Bank Staff calculations.

Cameroon's traditional markets will remain limited. In this environment, Cameroon could think about diversifying its export markets even further away from its traditional partners. A more diversified product base, as well as more diversified markets, would increase the resilience of the economy and reduce its vulnerability to external shocks.

More than half of developing country trade is now with other developing countries (up from 37 percent in 2001). Even excluding China's exports to other developing countries and its imports from them, trade between the remaining developing countries has also outpaced trade with high-income countries by a wide margin over the last decade. Interestingly, the rapid expansion of intra-developing country trade reflects more than just trade in commodities, with the value of developing-country exports of manufactures rising at about the same rate as the value of commodities as a whole.

As already pointed out in last year's July issue of our *Cameroon Economic Update*, Cameroon is ideally positioned to take advantage of the economic opportunities offered by greater trade. Due to its strategic location neighboring Nigeria, the Democratic Republic of Congo (DRC), and Gabon, and potential crossing point to the landlocked countries of Central Africa (Chad and the CAR), Cameroon is a natural hub for the region with the port of Douala as the main entrance.

In addition, the country is diverse with a geography that ranges from Sahelian semi-desert in the north through grassland to equatorial forest in the south, favoring varied economic and agricultural activities. Furthermore, Cameroon is endowed with significant natural resources, including oil, high value timber species, and agricultural products (coffee, cotton, cocoa). Untapped resources include natural gas, bauxite, diamonds, gold, iron, and cobalt.

Seizing trade opportunities in the regional context could provide a good learning ground for becoming competitive on the world scene. The region seems to offer promising markets for Cameroonian products, especially agricultural ones, and may be easier to enter, as their standards would be closer to those of Cameroon. In this regard, the CEMAC Customs Union (CU) should become a reality through the adoption of a harmonized tariff nomenclature, standards, common customs regulations, and a regional payment system. Beyond CEMAC, there would be a need to facilitate trade between CEMAC countries and the DRC, as well as the rest of the ECCAS.[1] Cameroon could also capitalize on the trading potential with the vast consumer market in Nigeria and, through Nigeria, access the entire ECOWAS regional market.[2]

Traders in Cameroon are still faced, however, with burdensome procedures for both exports and imports. It takes for instance 12 documents to import a commodity and 11 documents to export one in Cameroon as compared to an average of about 6 to 8 in a sample of emerging economies. Port efficiency needs to be improved. Dwell time at Douala — the amount of time a shipment waits at the port — was 18.6 days in 2010, compared to an average dwell time of four days in Durban (South Africa), 11 days in Mombassa (Kenya) and 14 days in Dar es Salaam (Tanzania). Movements of freight inland should also be made easier and cheaper. This would require, in addition to better roads, a more competitive transport sector and fewer roadblocks.

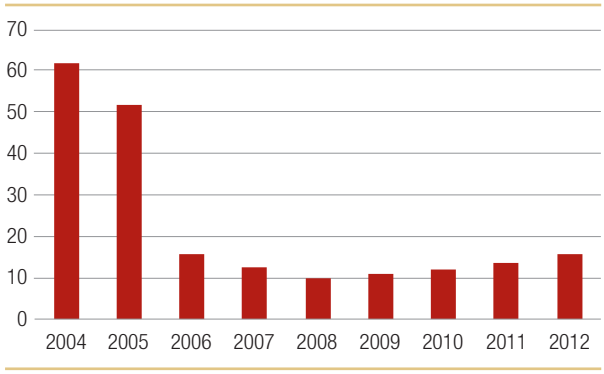
Prudent debt management

The most recent joint IMF-World Bank low-income country debt sustainability analysis indicates that Cameroon's risk of debt distress remains low, opening the possibility for some limited non-concessional

[1] CEMAC refers to the Economic and Monetary Community of Central Africa. Member countries include Cameroon, Chad, the Central African Republic, Equatorial Guinea, Gabon, and the Republic of Congo. ECCAS (the Economic Community of Central African States) is a wider grouping of Central African States and includes, in addition to the CEMAC countries, Angola, Burundi, the Democratic Republic of Congo, Rwanda, and Sao Tome and Principe.

[2] ECOWAS (the Economic Community of West African States) includes Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.

FIGURE 10: Public Debt, 2004–12
(in percent of GDP)



Sources: Cameroonian authorities and Bank Staff calculations.

borrowing. In this context, the authorities are actively using the room provided by the country's low level of public debt to tap non-traditional creditors and the nascent domestic capital market by issuing a Government bond and Treasury bills (Figure 10). These provide alternative sources of financing for the budget, complementing any possible shortfall in fiscal savings.

Tapping the emerging domestic capital market could, however, also be a source of vulnerability. In this regard, efforts to create a liquid secondary market for Government bonds would help sustain investors' interest in future bond issues. Improvements in fiscal reporting would also foster investors' confidence, since it will make the Government's fiscal position more transparent. Furthermore, stronger project selection and preparation would contribute to ensuring that the proceeds of new borrowing would be put at the most productive use.

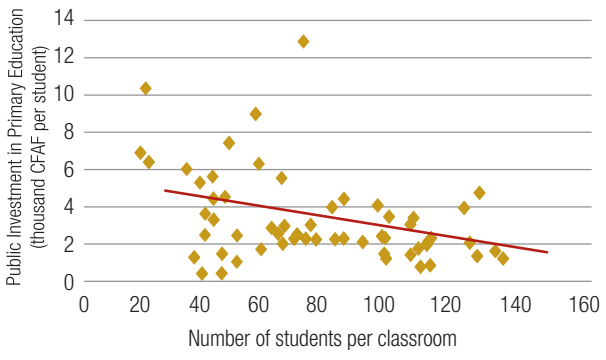
As the Government is turning to non-traditional creditors and non-concessional external borrowing, its debt management capacity would also need to be strengthened, building on recent achievements. The ongoing crisis in advanced economies offers in this regard both opportunities and challenges. Banks in advanced economies seem to be increasingly interested in Cameroon's economy, attracted by its economic growth and low debt levels. At the same time, the financial conditions attached to these loans may not always be attractive for the country or be easily analyzed.

The National Committee for Debt Management has become fully operational and its Technical Committee is meeting regularly to discuss technical issues on debt management. The authorities are strengthening their analytical capacity to better analyze foreign lending proposals and are making progress in the preparation of a Medium-Term Debt Management Strategy. Protection against operational risks has also improved with a more rigorous and secure debt recording system, ensuring safe backups of the databases. However, the legal framework governing debt management could be clarified and institutional responsibilities centralized.

More effective public spending

Cameroon could also try to increase the value of the public money it spends. In many areas, public spending does not seem to be going where it could have the highest impact. Per student public investment in primary education does not seem to be driven by the needs of classrooms, for instance (i.e. the number of students by classrooms). According to the data from the project logbook (*Journal des projets*), the departments where the number of pupils per classroom was the highest in 2011

FIGURE 11: Public Investment in Primary Education (2012) vs. Number of Students (2011)



Sources: Cameroonian authorities and Bank Staff calculations.

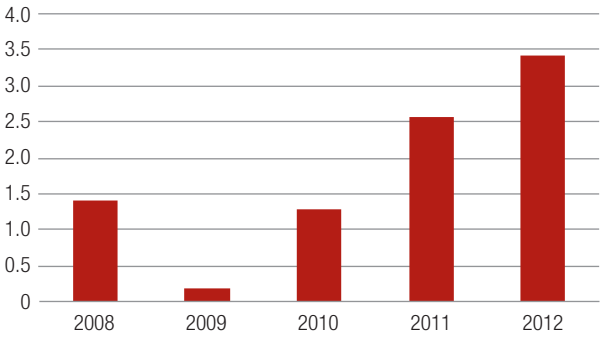
received the least investment per pupil the following year (Figure 11).[3] As we will see in the next chapter, a similar observation can be made in the health sector.

Reducing the fiscal burden of fuel subsidies

The composition of public spending could also be examined to enhance its efficiency. In this regard, the increasingly significant burden represented by subsidies, particularly fuel subsidies, is a source of concern. The costs in terms of GDP related to the decision to freeze retail fuel prices have steadily increased and are the highest in the region (Figures 12 and 13), putting pressure on other budgetary items that may be more conducive to growth or shared prosperity.

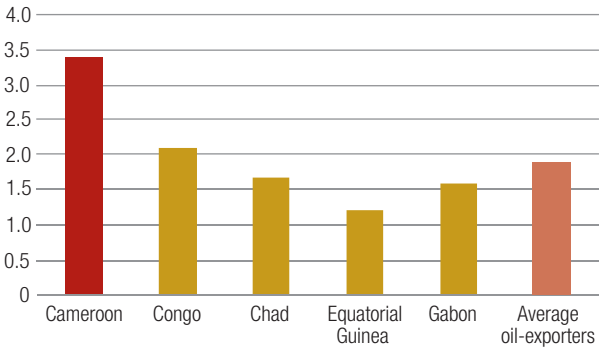
Subsidies on petroleum products (excluding kerosene) benefit mainly the richest segment of the urban population: the richest 10 percent (Figures 14 and 15). By contrast, subsidies on kerosene, used mostly for lighting, favor more the rural areas and are less biased, although the richest still benefit the most from this policy (Figure 16). Even in terms of people's income (estimated by their consumption), fuel subsidies do not favor the poorest segments

FIGURE 12: Cost of Fuel Subsidies, 2008–2012
(in percent of GDP)



Sources: Cameroonian authorities, IMF Staff estimations.

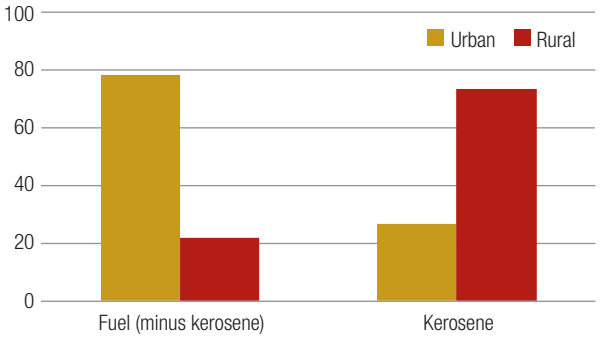
FIGURE 13: Cost of Fuel Subsidies — Selected Countries, 2012
(in percent of GDP)



Sources : CEMAC member countries and IMF Staff estimations.

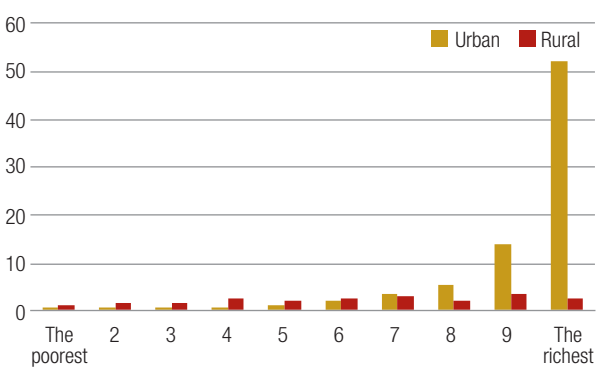
[3] The project logbook covers public investment by project. Only 30–50 percent of the total investment of budget (deconcentrated and decentralized spending, as well as some centralized expenditure) can be mapped geographically.

FIGURE 14: Distribution of Fuel Subsidies by Location
(in percent)



Sources: Cameroonian authorities and Bank Staff calculations.

FIGURE 15: Distribution of Fuel Subsidies (excl. kerosene) by Income Group and Location
(in percent)



Sources: Cameroonian authorities and Bank Staff calculations.

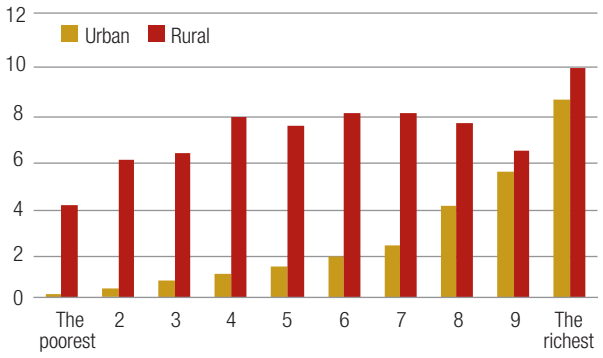
of Cameroon's population, representing only about 2 percent of their income (Figure 17).

Transport, public administration and forestry are the most important consumers of petroleum products and thus the largest beneficiaries in absolute terms of the freeze in fuel prices (Figure 18). The transport sector accounts for 30 percent of total intermediary fuel consumption (i.e. fuel not directly used by consumers or exported), while the public administration and forestry each account for about 15 percent. Agriculture, although representing a large share of economic activity and employment, is only a marginal consumer of fuel even when the transport of agriculture products is taken into account (1.3 percent of total intermediary fuel consumption).

The need for these subsidies, as well as the various possible options to reduce the budgetary burden they represent, should be openly and candidly discussed. As highlighted by other countries' experience (Box 1), a comprehensive and carefully planned approach is essential. The context and constraints to reform should be appropriately analyzed and understood before making any decisions on the sequencing, timing, and extent of price changes. Consultations with stakeholders and the population at large should also be undertaken to determine an acceptable and sufficient package of compensatory measures and avoid surprises.

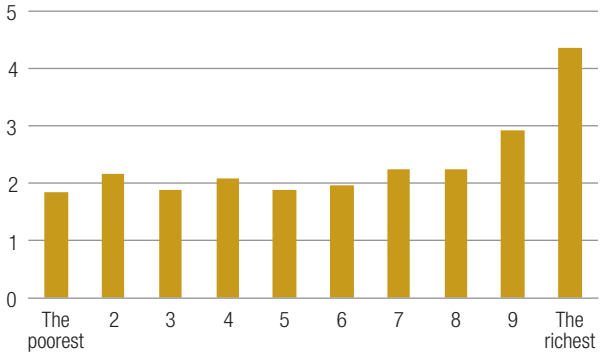
In this regard, interviews and discussions with focal groups undertaken in Cameroon on the subject of fuel subsidies have revealed a very low level of knowledge on the issue. This would suggest that a significant effort is still required to communicate both the cost and benefits of the current subsidy policies, and the importance of reform, notably in terms of fiscal space available for public investments. A phasing out of fuel subsidies would create the fiscal space for urgently needed investments in other sectors. Reallocating the CFAF 430 billion (3 percent of GDP and 17 percent of total Government revenue) projected to be spent on fuel subsidies in 2013 to sectors such as education or health could significantly improve the living conditions

FIGURE 16: Distribution of Kerosene Subsidies by Income Group and Location
(in percent)



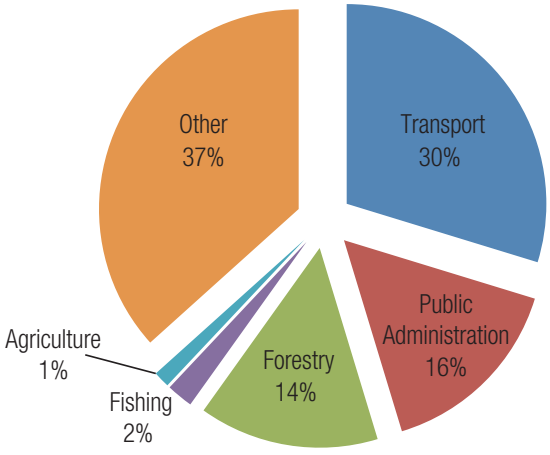
Sources: Cameroonian authorities and Bank Staff calculations.

FIGURE 17: Fuel Subsidies as Share of Consumption by Income Group
(in percent)



Sources: Cameroonian authorities and Bank Staff calculations.

FIGURE 18: Fuel Consumption by Sector
(in percent of total intermediary fuel consumption)



Sources: Cameroonian authorities and Bank Staff calculations.

Box 1: Reforming Fuel Subsidies - Selected Case Studies

Indonesia (1997-2005)

Context: Reforming fuel subsidies has been a persistent policy challenge in Indonesia. Indonesia has attempted to tackle subsidy reform a number of times to improve the fiscal position and achieve other policy objectives such as improving energy efficiency and protecting the environment.

Reforms since 1997: The first two attempts of cutting subsidies in 1998 and 2003 were unsuccessful. Drastic cuts instead of a gradual approach, poor communication and general dissatisfaction with the Government led to violent protests and the measures were finally rolled back. Concerned over the increasing fiscal pressure from fuel subsidies, the Government undertook two large fuel price increases in 2005. As a result, the price of diesel fuel doubled and that of kerosene nearly tripled. Protests again took place in opposition to the reform, but with less intensity than before. The Government was led by President Yudhoyono who was first elected in 2004 and won a convincing reelection in 2009.

Mitigating measures: The 2005 reforms were accompanied by unconditional cash transfers for the poor which covered 19.2 million households (35 percent of the population). Other measures included the health insurance for the poor program, school operational assistance program, and expanded rural infrastructure support project. A number of analyses have credited the reduced intensity of protests in 2005 to the creation of these welfare programs.

Lessons: A rapid reduction in subsidies can generate opposition to reform, while a popular Government and a clear communication strategy increase the likelihood of success. Targeted cash transfers have proved to be effective and popular mitigating measures.

Philippines (1996)

Context: The Philippines are a net oil importer. Until the late 1990s, the downstream oil sector was heavily regulated, resulting in price subsidies of fuel products when international oil prices rose. The Oil Price Stabilization Fund (OPSF) stabilized domestic prices of fuel products by collecting or paying out the difference between regulated domestic prices and actual import costs. Increases in domestic prices were politically difficult to implement. As a result, the national Government had to replenish regularly the OPSF.

Reforms: Initially, the political environment was not conducive to a fuel subsidies reform, because President Ramos had won the election only by a small margin and his party was a minority in both chambers of Congress. Nevertheless, a public communication campaign began at an early stage and included a nationwide road-show to inform the public of the problems of oil price subsidies. While the president's party was a minority in Congress, he set up a coordination body between the executive and the two chambers of Congress and used it to prioritize the oil deregulation bill and forge consensus on it. In 1996, the Government passed the law to abolish the OPSF and allow the prices to move freely. The industry remains liberalized today and movements in international oil prices have been passed through onto domestic prices.

Mitigating measures: The 1996 law included a transition period during which fuel product prices were adjusted monthly using an automatic pricing mechanism. During this period, the Government provided transfers to the OPSF to absorb price increases in excess of a threshold. More recently, the authorities announced several measures to mitigate the impact of the food and fuel crisis in mid-2008. The Government launched a package of pro-poor spending programs that are financed by windfall VAT revenue from high oil prices. The policy package included electricity subsidies for indigent families, college scholarships for low-income students, and subsidized loans to convert engines of public transportation to less costly LPGs. In addition, the Government distributed subsidized rice to low-income families and started a conditional cash transfer program.

Lessons: The Philippines' experience underscores the importance of planning, persistence, and a good communication plan in achieving a successful outcome. The survival of the reform to date can be attributed due to its comprehensiveness and mitigating measures for the poor during the 2008 fuel price hike which helped maintain popular support.

Source: International Monetary Fund (2013a).

of Cameroon's people, its human capital, and its productivity. The effect on the overall price level would also be limited.

An increase in fuel prices could have direct and indirect effects on the cost of living for households. Directly, households are affected through their own consumption of gasoline or kerosene. Indirectly, they are also affected since petroleum products are used as intermediary products in many sectors and their higher price will feed into the price of the final good produced by these sectors.

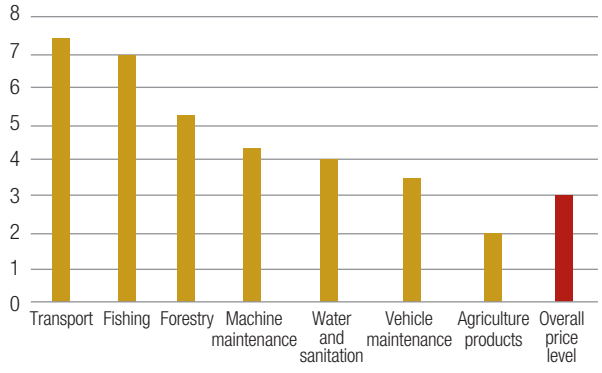
To capture both these effects, the interdependence of sectors needs to be taken into account and a Social Accounting Matrix (SAM) multiplier analysis has been used for this purpose. A SAM is an input-output table, representing the transactions being carried out between sectors for a given year. It describes all the income received and expenditures made by households and various sectors, thus capturing the linkages within the economy.

Using this framework, the hypothetical effect on prices of several scenarios for fuel price reform can be simulated for illustrative purposes. Removing all fuel subsidies, for instance, would imply an increase of 43 percent, 55 percent, and 105 percent for gasoline, diesel, and kerosene, respectively, and lead to a one-time adjustment of about 3 percent in the overall price level (Figure 19). The highest increases would be observed in transport, fishing, and forestry (7.5 percent, 7 percent and 5.2 percent, respectively).

The effects of alternative scenarios could be worked out. Assuming these same increases as above for all petroleum products except kerosene would suggest a one-time overall price adjustment of about 2 percent. Because subsidies for kerosene do not account for the bulk of the fiscal costs, excluding them from a price adjustment would not erode much the potential fiscal savings of this action. This scenario would generate fiscal savings of about CFAF 350 billion (2.7 percent of GDP). Yet another example where the prices for all petroleum products except again kerosene would rise by CFAF 150 would lead to a one-time overall price adjustment of only 1.1 percent, but save the budget about CFA 210 billion (1.6 percent of GDP).

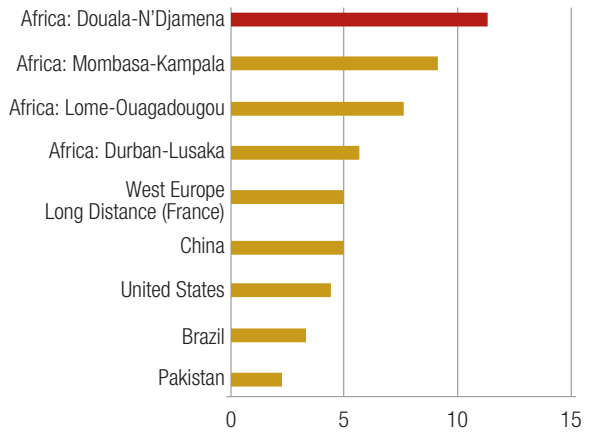
These one-time price adjustments could be further contained through accompanying measures. The price structure for petroleum products contains for instance a number of taxes that could be revisited and simplified. Furthermore, as mentioned in last year's July issue of the *Cameroon Economic Update*, over-regulation plagues the transport systems in Cameroon. Transport prices charged to shippers tend to be disconnected from the actual vehicle operating costs. The system seeks to protect existing transport

FIGURES 19: Price Changes by Product
(in percent)



Sources: Cameroonian authorities and Bank Staff calculations.

FIGURE 20: Average Transport Prices: A Global Comparison, 2007
(in US cents per tkm)



Source: World Bank.

operators at the expense of encouraging competition. Inefficient operators and aging truck fleets are thus kept afloat, pushing down the quality of road transport services to the lowest level possible, since there is no incentive to offer better services. As a result, the average transport price on the Douala-N'Djamena corridor, for instance, is about 11 cents per ton Km: almost double than that of China, three times higher than in Brazil, and more than five times higher than in Pakistan (Figure 20).[4]

[4] Teravaninthorn and Raballand (2009).

HEALTH IN CAMEROON

Introduction

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

In light of the aim of making Cameroon an emerging economy, the lack of progress in health outcomes should be a source of concern. The role of human capital has been recognized as being indispensable to economic growth. Good health raises human capital and therefore the economic productivity of individuals and, thereby, the economic growth rate of the country as a whole. Better health increases workforce productivity, whether skilled or unskilled, by improving general physical and mental capacities, such as vigor, cognitive functioning and reasoning ability, and by reducing illness and incapacity. Furthermore, good health helps improve levels of education by increasing levels of schooling and scholastic performance. Without a labor force with the minimum levels of education and health, an economy is not able to sustain an appropriate and continuous growth path.

The availability of appropriate and timely data on health is problematic in Cameroon. No annual report on health statistics has been produced in over a decade. This does not mean that there is no data on health generated in Cameroon, but there is little standardization, collection, consolidation, and analysis. Health centers routinely fill in reports to the district authorities which are officially in charge of data collection, planning, and monitoring and evaluation. In addition, donors and the regional MOH administration regularly request reports on health activities. This routine data is, however, rarely compiled at the national level. As a result, Government and donors rely on ad hoc and punctual surveys such as national household survey or Demographic and Health Surveys (DHSs) to assess and measure outcomes in Cameroon's health sector.

This chapter draws on the recently-completed Country Health Status Report for Cameroon and is able to describe Cameroon's health profile, discuss the resources allocated to health (financial and staffing), and suggest some options going forward. The introduction of program budgeting in 2013 should improve the efficiency of public spending, narrowing the gap between needs and budgetary allocations. In addition, a more effective data collection and management system would be called for; prepayment and risk-pooling mechanisms such as mutual health organization and mandatory formal sector insurance may need to be extended; and approaches rewarding performance currently being piloted in Cameroon could be rolled out further.

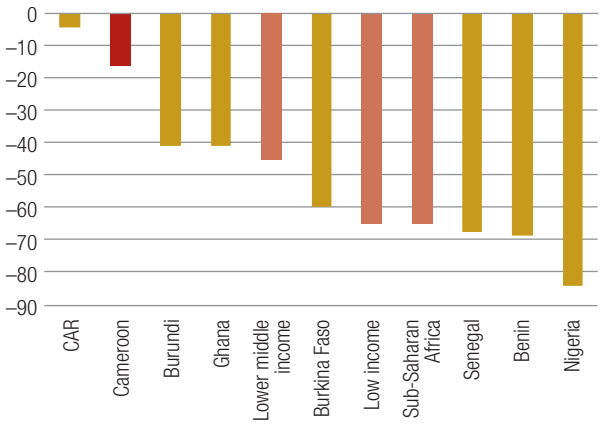
Cameroon's Health Profile

Over the last two decades, there has been little change in Cameroon's health indicators. The under-five child mortality rate has slightly improved.

About 16 more children out of every 1,000 survive their first five years in Cameroon than two decades ago. This slight progress pales, however, compared to an average of 65 additional children surviving in Sub-Saharan Africa (Figure 21). Life expectancy in Cameroon has even declined since 1990 by about two years, while countries in Sub-Saharan Africa have on average gained about five years (Figure 22).

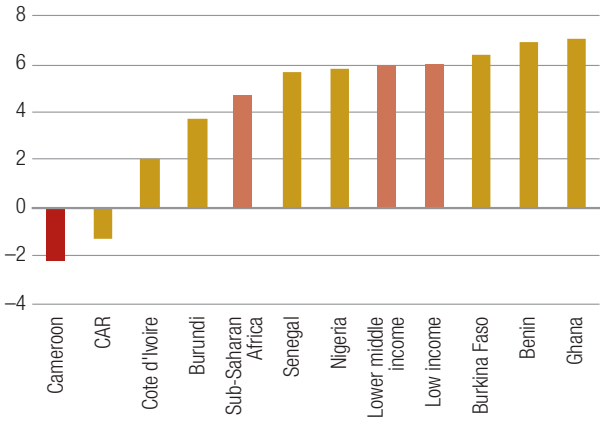
As a result, Cameroon's health indicators lag behind those of the rest of Sub-Saharan Africa and behind those observed in countries to which Cameroon is economically comparable (Figures 23 and 24). For instance, Cameroon has one of the highest under-five child mortality rates in the world (122 deaths per 1,000 live births), exceeding the average in developing Sub-Saharan Africa (108 deaths per 1,000 live births) with malaria, pneumonia and diarrhea being the main causes of death. Similarly, its maternal mortality ratio is also higher than the average for Sub-Saharan Africa and has increased substantially over the past decade. The ratio is slightly higher than those observed in countries such as Liberia and Sudan, and even higher than neighboring CAR and Chad. Pregnancy and

FIGURE 21: Changes in Under-5 Child Mortality Rates, 1990–2010
(per 1,000 live births)



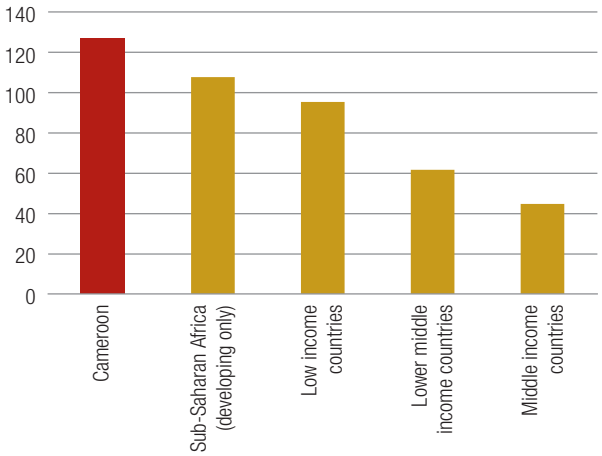
Sources: World Development Indicators, Bank Staff calculations.

FIGURE 22: Changes in Life Expectancy at Birth, 1990–2010
(in years)



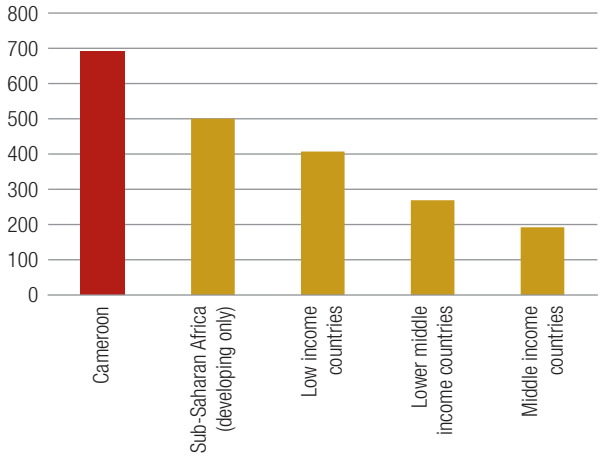
Sources: World Development Indicators, Bank Staff calculations.

FIGURE 23: Under-5 Child Mortality, 2011
(per 1,000 live births)



Source: World Development Indicators.

FIGURE 24: Maternal Mortality, 2010
(per 100,000 live births)



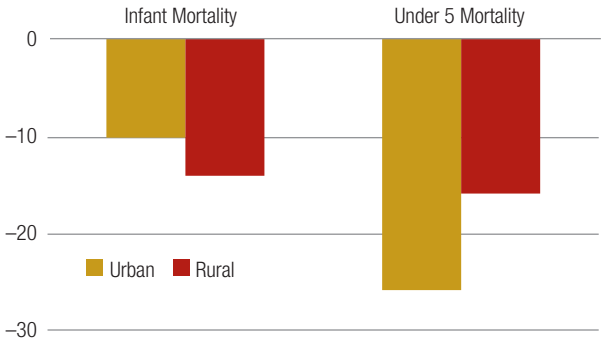
Source: World Development Indicators.

childbirth remain significant risk factors for mortality: One woman dies every two hours from complications from pregnancy or childbirth, and one pregnancy out of 127 is fatal.

Within Cameroon, substantial disparities exist in health outcomes between rural and urban areas and across socio-economic groups. According to data from DHS, progress has been made between 2004 and 2011 in reducing infant mortality rates both in rural and urban areas, and across income levels (Figures 25 and 26). Reductions in under-five child mortality rates have been most pronounced in the middle quintiles. Indicators of malnutrition (height and weight for age) also suggest that the nutritional status of the population has overall improved since 2004, although the share of children significantly below the average has increased in the poorest quintile (Figure 27). Despite this progress, mortality levels remain substantially higher, however, among the poor and in the rural areas (Figures 28 and 29). For instance, the under-five child mortality rate in households in the poorest quintile (i.e. the poorest 20 percent of households) is more than twice as high as that observed in households in the richest quintile.

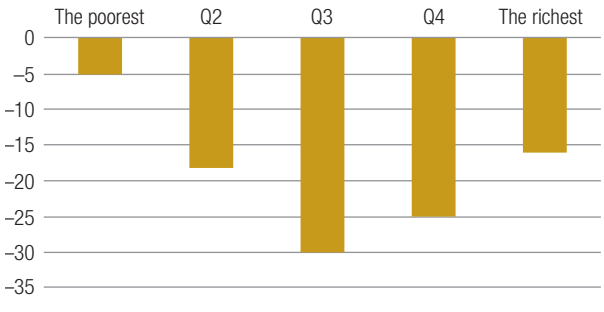
At the regional level, a similar story can be told. Significant progress has been made to reduce infant and under-five child mortality in many regions, but major geographic discrepancies remain (Figures 30 and 31). The greatest reductions in child mortality were observed in the East (90 per 1,000 live births)

FIGURE 25: Changes in Infant Mortality Rates by Location, 2004–2011
(per 1,000 live births)



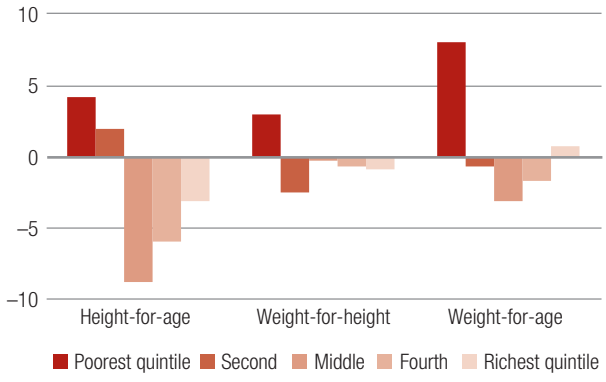
Sources: DHS-MICS (2011), DHS (2004), Bank Staff calculations.

FIGURE 26: Evolution of Under 5 Mortality Rates by Socio-economic Status, 2004–11
(per 1,000 live births)



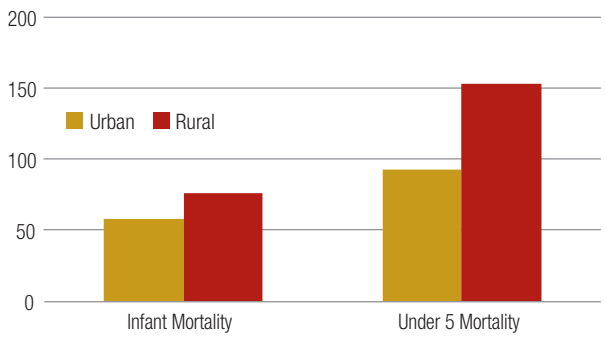
Sources: DHS-MICS (2011), DHS (2004), Bank Staff calculations.

FIGURE 27: Changes in Malnutrition, 2004–11 by Socio-economic Status
(in percent below -2SE)



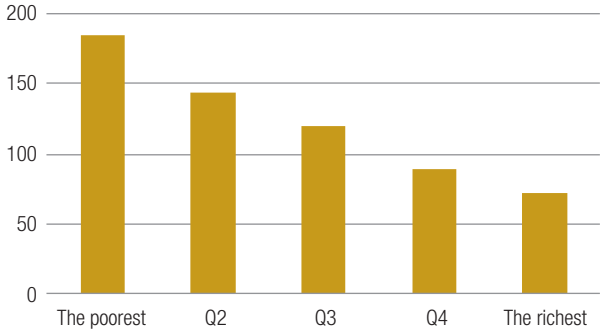
Sources: DHS-MICS (2011), DHS (2004), Bank Staff calculations.

FIGURE 28: Infant Mortality Rates By Location, 2011
(per 1,000 live births)



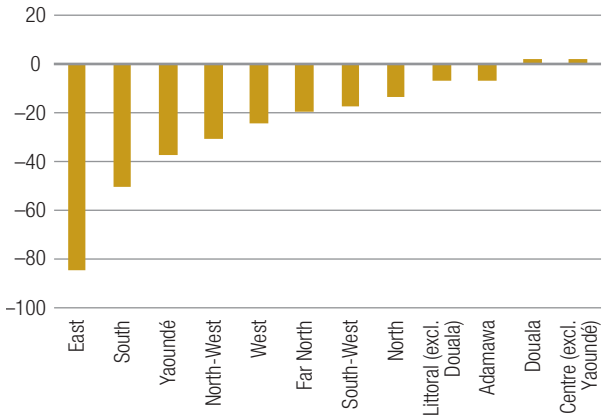
Sources: DHS-MICS (2011), Bank Staff calculations.

FIGURE 29: Under 5 Mortality Rates by Socio-economic Status, 2011
(per 1,000 live births)



Sources: DHS-MICS (2011), Bank Staff calculations.

FIGURE 30: Changes in Under-5 Child Mortality by Region, 2004–11
(per 1,000 live births)

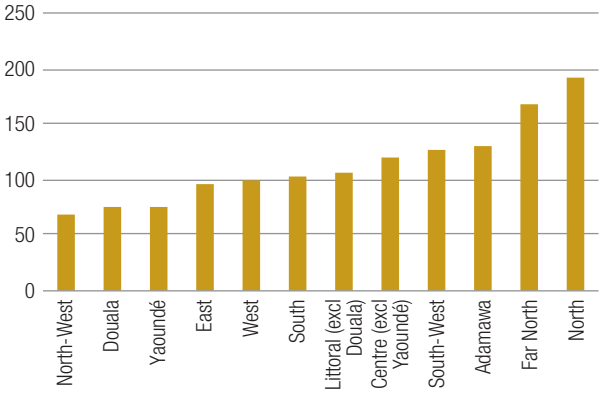


Sources: DHS-MICS (2011), DHS (2004), Bank Staff calculations.

and the South (50 per 1,000 live births), while the rate hardly changed in Douala[5]. Child mortality remains nevertheless extremely high in the poorest parts of the country, such as the North or the Far North, where close to 20 percent of the children born die before their fifth birthday (191 deaths and 168 deaths per 1,000 live births in the North and the Fart North, respectively).

[5] Changes in under-five mortality rates between 2004 and 2011 may be over-estimated for the Eastern region because of sample size constraints in that region in the 2011 DHS-MICS.

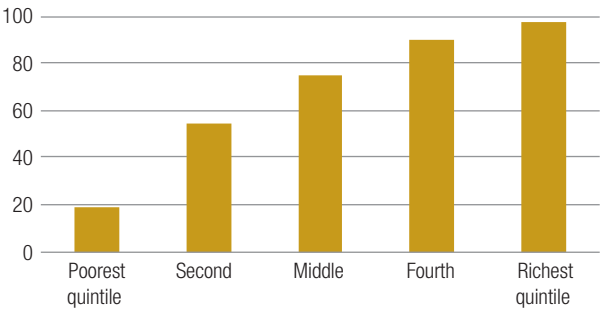
FIGURE 31: Under 5 Mortality by Region, 2011
(per 1,000 live births)



Sources: DHS-MICS (2011), Bank Staff calculations.

Similar observations can be made in terms of utilization of health services. While the use of pre-natal health service is close to 100 percent for the richest quintile of the population, it is below 60 percent for the poorest. The richer you are, the more likely you are to benefit from delivery assisted by a qualified professional (nurse and/or doctor). The poorest are more likely to be assisted by a friend or a traditional midwife. Coverage for assisted deliveries among the richest quintile is almost five times higher to that observed in the poorest quintile (Figure 32).

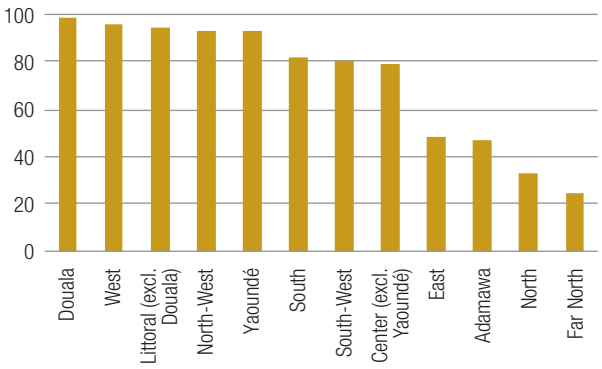
FIGURE 32: Assisted Deliveries by Socio-economic Status, 2011
(in percent)



Source: DHS-MICS (2011).

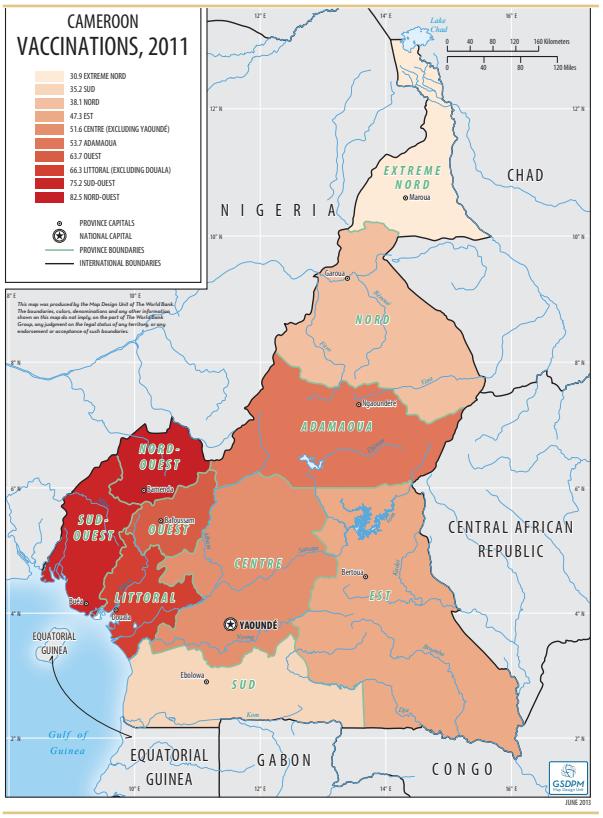
Geographically, the Northern Regions have the fewest assisted deliveries (Figure 33). Between the two most recent DHS surveys (2004 and 2011), the percentage

FIGURE 33: Assisted Deliveries by Region, 2011
(in percent)



Source: DHS-MIS (2011).

FIGURE 34: Percentage children aged 12–23 months fully vaccinated, 2011



of childbirth deliveries that were assisted by a health professional increased on average from 61.7 percent to 63.6 percent. In the Far North, however, only 21.8 percent of births were attended by skilled personnel, compared to 93 percent in the Littoral and 91.6 percent in the West.

Substantial differences in maternal mortality also show that pregnancy-related deaths are substantially higher in rural than in urban areas. Women and newborns in poor and rural communities have a higher risk of death and higher chances of early childbirth (young people aged 10 to 24 in these segments of the population have a 33 percent pregnancy rate). Similarly, as shown in Figure 34, the proportion of children aged 12–23 months with full immunization varies from 30.9 percent in the Far North to 82.5 percent in the North West.

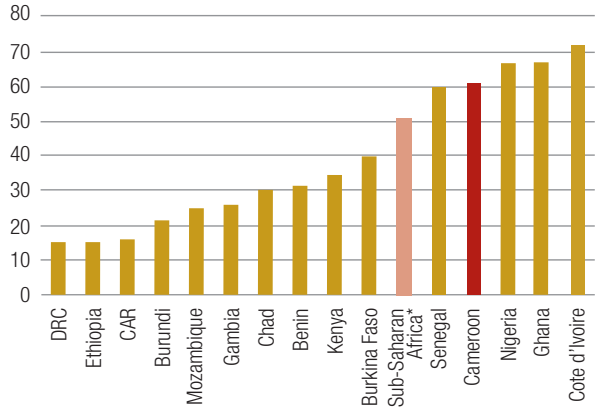
Resource Allocation

Why are there such great variations in health outcomes across geographic locations and socio-economic status? An efficient and well-performing health system should ensure that individuals have access to effective preventive and curative health care. A good health care financing strategy would thus aim at reducing inequalities in access to services, preventing individuals from falling into poverty as the result of catastrophic unplanned medical expenses, and protecting and improving the health status of populations by ensuring financial access to these essential services.

The way health care is financed affects the overall performance of health systems. Direct purchasing of health services when needed by an individual (user fee) is a driver of inequity, as it depends on this individual's wealth. This effect can be mitigated, however, through prepayment mechanisms such as health insurance, pooling the risk at the level of a group of contributors. Alternatively, public spending financed by general taxation and external support could fund the delivery of health services and facilitate cross-subsidization from the wealthy to the poor.

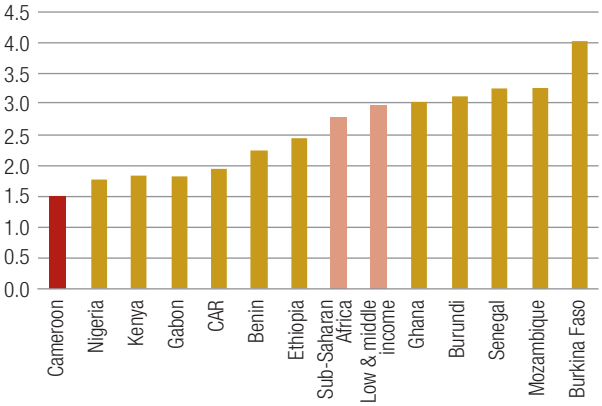
In light of the poor results in health indicators, Cameroon overall spends quite a lot compared to Sub-Saharan African countries (Figure 35).

FIGURE 35: Health Expenditure, 2010
(in US$ per capita)



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

FIGURE 36: Public Health Expenditure, Selected Countries, 2010
(in percent of GDP)



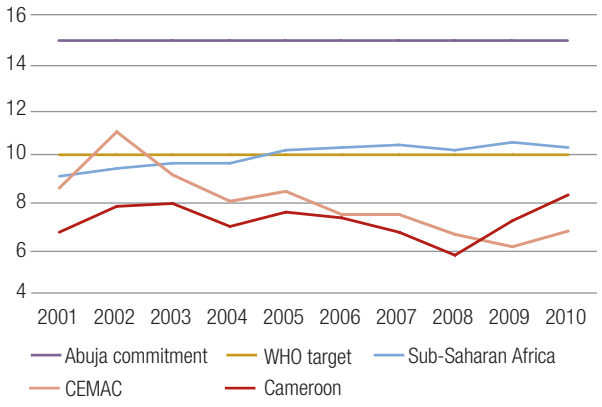
Source: World Development Indicators.

Cameroon spends US$61 per person on health, above the average for Sub-Saharan Africa excluding South Africa (US$ 51), and in line with countries such Senegal and Nigeria. These numbers include spending in health sector from Government, external donors, and private sources (i.e. out-of-pocket payments from beneficiaries).

Public spending in the health sector in Cameroon is, however, low. While public resources allocated to health have progressively increased over the past ten years, they remain one of the lowest in Africa in terms of GDP (Figure 36) at 1.5 percent of GDP. Relative to the total budget of the Government, the share allocated to the health sector in Cameroon also falls below the average of Sub-Saharan African countries and has only recently moved above the average of CEMAC countries (Figure 37). The budget share allocated to health in Cameroon also falls short of the WHO recommendation of 10 percent, as well as of its Abuja commitment. The Government of Cameroon pledged in 2001 in Abuja, along with other members of the African Union, to allocate 15 percent of its annual budget to the health sector. In spite of this, public spending for health over the last decade has never exceeded 9 percent of the total budget.

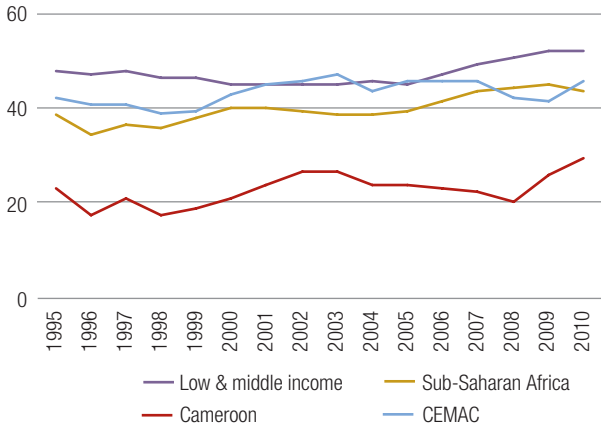
As a result, out of the US$61 per Cameroonian spent on health in 2010, the Government contributed only US$ 17 (i.e. 28 percent — of which US$ 8 were provided by international donors). Compared to other CEMAC countries, Cameroon has been for the last decade the country that has allocated the lowest share of its public spending to health (Figure 38). The cost of health care is thus largely borne by households and Cameroon has one of the highest levels of direct payments from the users (out-of-pocket) relative to total health expenditure in all of Sub-Saharan Africa. Out of 37 countries in Africa with available data for 2009, Cameroon had the fifth highest level of out-of-pocket spending relative to total spending (Figure 39).

FIGURE 37: Public Health Expenditure, 2001–10
(in percent of Budget)



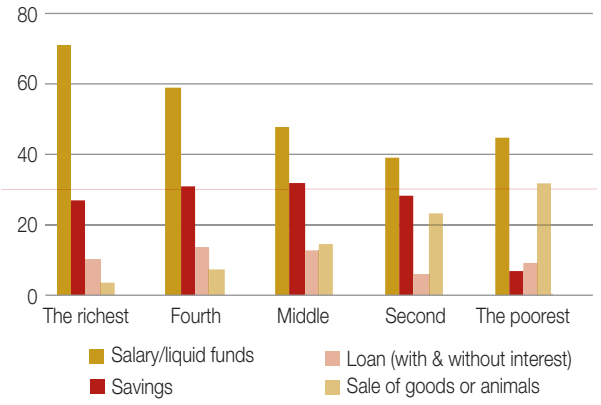
Source: World Development Indicators.

FIGURE 38: Public Health Spending, Selected Countries, 1995-2012
(in percent of total health expenditure)



Source: World Development Indicators.

FIGURE 40: Sources of Household Health Care Financing, 2011
(in percent)

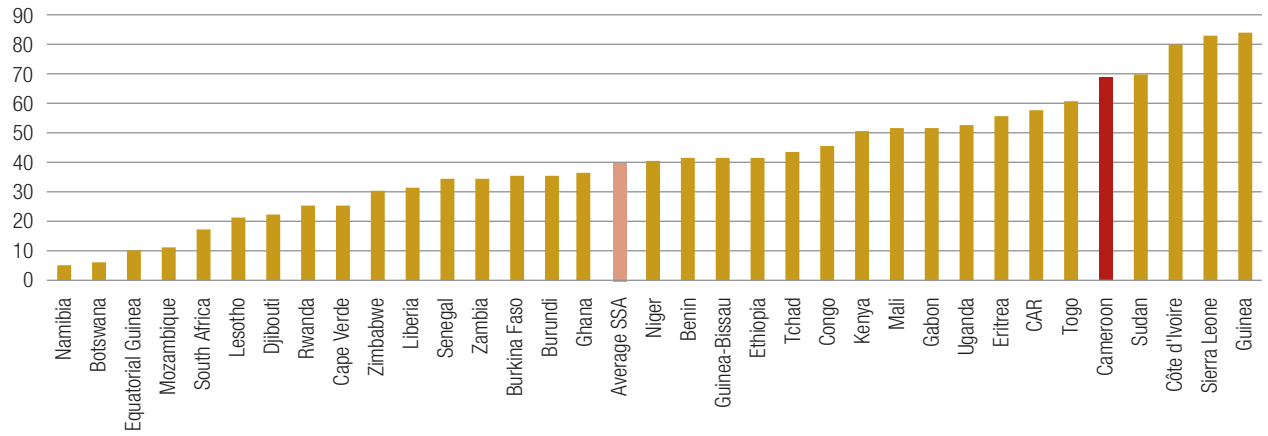


Sources: DHS-MICS (2011), Bank Staff calculations.

Usually when user fees are charged, all patients pay the same price regardless of their capacity to pay. Consequently, the risk of financial catastrophe and impoverishment is high. When prepayment mechanisms are not available and patients pay at the point of service, the sick bear all of the financial risks associated with paying for care. The user must decide if he can afford to receive care, and often for poor households this means choosing between paying for health services and paying for other essentials, such as food or education. Often households are forced to sell household goods or livestock in order to cover the cost of health services. According to the 2011 Cameroon Demographic and Health Survey-Multiple Indicator Cluster Survey (DHS-MICS), among households who sought any type of health care, the poorest income quintile was eight times more likely to cover medical expenditures through the sale of household goods than the richest quintile (Figure 40).

One way to reduce reliance on direct payments is to encourage risk-pooling and prepayment methods to finance health care. Risk-pooling mechanisms are, however, quasi non-existent in Cameroon. In 2006, there were 120 micro-insurance schemes covering approximately one percent of Cameroon's population. Since then, Cameroon has put in place a Strategic Plan for the Promotion and the Development of

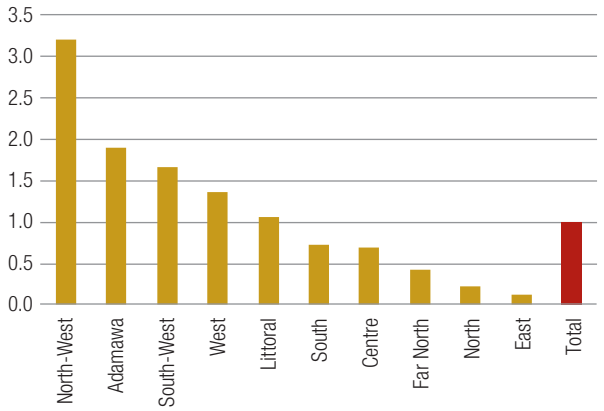
FIGURE 39: Out-of-pocket Health Expenditure, 2009
(in percent of total health expenditure)



Source: World Development Indicators.

Mutual Health Insurance (2005–2015), which aims to cover 40 percent of the population by 2015 through mutual health insurance schemes, but little progress has been made with only one percent of the population being covered in 2010. Here, also, important regional disparities can be observed, with health insurance coverage in the North-West about thirty times higher than in the East (Figure 41).

FIGURE 41: Health Insurance Coverage, 2009 *(in percent of population)*



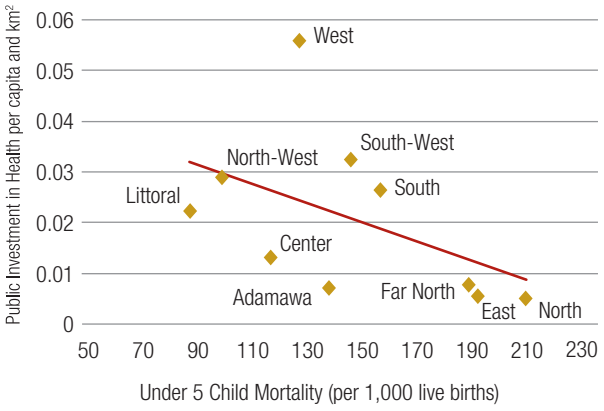
Sources: Etude Diagnostique des Mutulles de Sante au Cameroun (2010), Bank Staff calculations.

Several factors contribute to the low coverage and sustainability of these schemes. Information and awareness among the beneficiary populations are not widespread. Membership is low and in turn revenue collection is limited. Relations with contracted health care providers are poor. In addition, financial and technical support as well as leadership from the associated ministries tends to be limited.

Longer-term plans for expanding prepayment and incorporating community and micro-insurance into the broader pool are also important. Pools that protect the health needs of only a small number of people are not viable in the long run. A few episodes of expensive illness will wipe them out. Multiple pools, each with their own administrations and information systems, are also inefficient and make it difficult to achieve equity. Usually, one of the pools will provide high benefits to relatively wealthy people, who will not want to cross-subsidize the costs of poorer, less healthy people.

Even when public resources are allocated, available data suggest that they may not be deployed where they are most needed. According to the data from the DHS and from the project logbook, for instance, public investments do not seem to be related to the needs of the population. Regions where under-five child mortality was high in 2004, for instance, received on average less investment in health in per capita terms during 2010–12 (Figure 42).[6] The same observation can be made with regards to assisted deliveries: regions with lower rates of assisted deliveries in 2008 received, on average, less public funding in subsequent years (Figure 43).

FIGURE 42: Public Investment in Health (average 2010-12) vs. Child Mortality (2004) by Regions

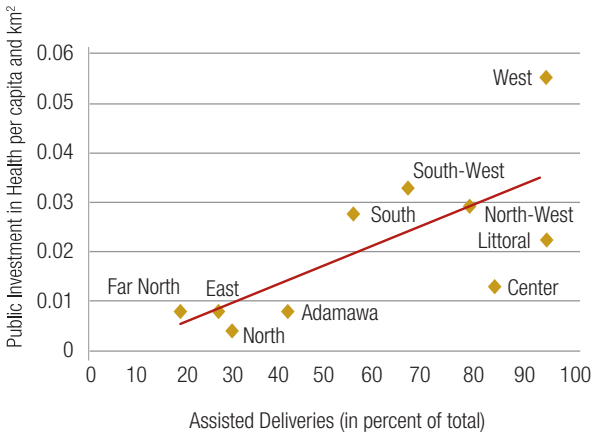


Sources: Cameroonian authorities and Bank Staff calculations.

A similar story unfolds regarding health personnel. Cameroon enjoys one of the highest densities of nurses and doctors in Sub-Saharan Africa (Figure 44). With 1.9 doctors per 10,000 people, for instance, Cameroon is significantly above the average of 1.3 doctors per 10,000 people in Sub-Saharan Africa. The country has also almost twice as many doctors as the minimum recommended by the WHO (1 doctor per 10,000 people). The main issue regarding

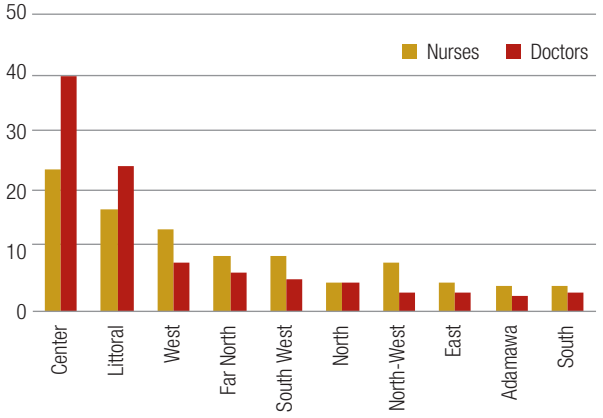
[6] These numbers take also into account each region's area to recognize that providing a given service to a population sparsely scattered will cost more than if the population was more densely concentrated.

FIGURE 43: Public Investment in Health (average 2010-12) vs. Assisted Deliveries (2008) by Regions



Sources: Cameroonian authorities and Bank Staff calculations.

FIGURE 45: Health Staff — Regional Distribution, 2011
(in percent of total)

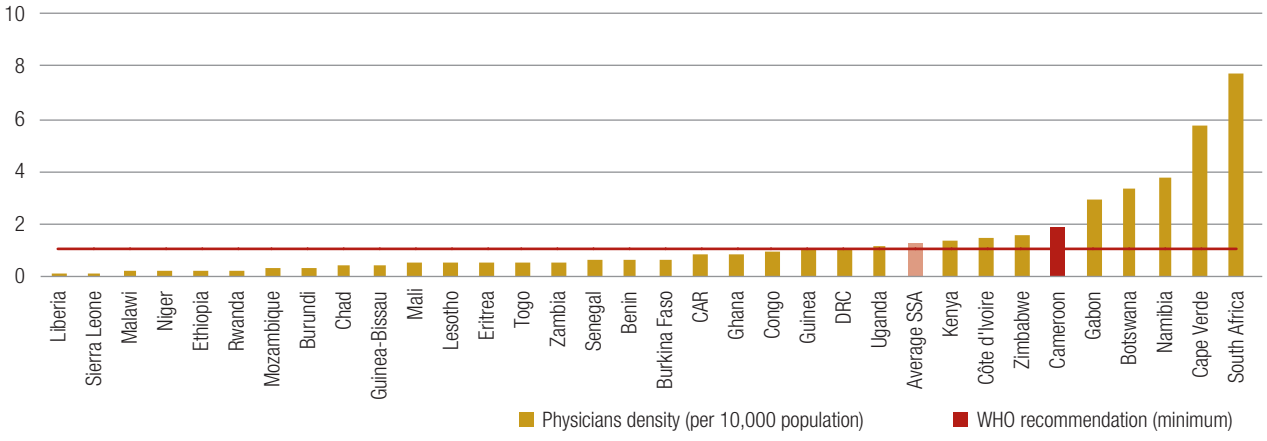


Source: Cameroon Health Workforce Census (2011).

human resources in the health sector is thus not the numbers, but their distribution across the country.

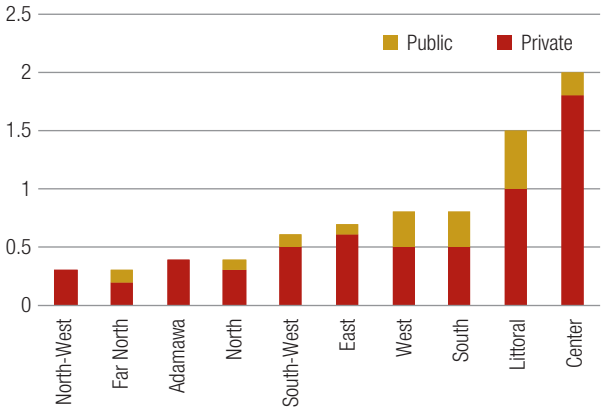
The distribution of health professionals is highly urban-focused and varies significantly by region (Figures 45 and 46). The majority of physicians in the country are based in urban areas and more than half of Cameroon's health workforce is employed in three administrative regions: the Center, Littoral and the West, which are home to the three largest cities in Cameroon (Yaoundé, Douala, and Bafoussam). The Center Region (including Yaoundé), home to only 18 percent of the population, accounts for almost 40 percent of the physicians. On the other hand, the Far North, which is also home to 18 percent of the population, has only eight percent of physicians. In addition, absenteeism in Cameroon is a problem, especially in rural remote areas, and contributes to the migration of health personnel towards urban centers. Data from a recent World Bank study (2012a) showed that only 32 percent, 45 percent and 58 percent of health facilities in the South-West, North-West and East regions, respectively, operated with full staff on the day of the survey.

FIGURE 44: Physician Density, Selected Countries, 2009
(per 10,000 people)



Source: World Development Indicators.

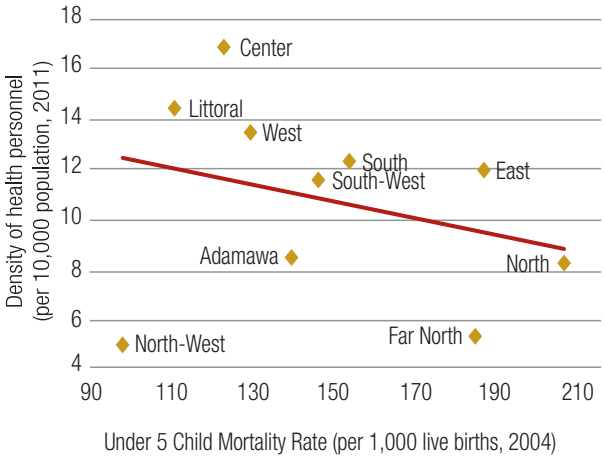
FIGURE 46: Number of Doctors by Region, 2011
(per 10,000 people)



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

Furthermore, the distribution of health workers does not seem to follow health needs. Looking at the infant mortality rates across regions in 2004 and the density of health workers (measured as a ratio to population) in 2011, density is the lowest in the regions where health outcomes are the poorest (Figure 47). The North, Far North and Adamawa Regions had the highest infant mortality rates in the country, but some of the lowest densities of health workers.

FIGURE 47: Under 5 Child Mortality Rate (2004) vs. Health Personnel Density (2011)

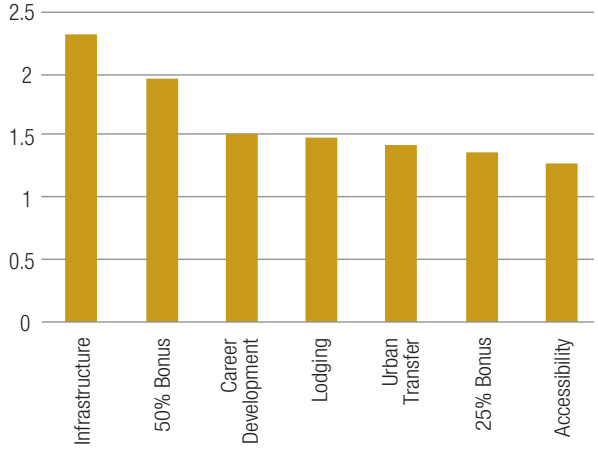


Sources: Cameroonian authorities and Bank Staff calculations.

Incentives for health staff to work in difficult environments or to perform are limited. Even though bonuses to health staff are provided, they are based on skills (i.e. training) and vary based on grade and years of services rather than performance. Similarly, there are limited career options or opportunities for career development working in rural areas. In fact, being far from urban centers tends to have a negative impact on promotion opportunities. Overall, health staff are therefore better off working in urban centers, where living conditions are better, salary and premium identical, and the chances of being promoted higher relative to staff in rural areas.

Financial incentives are, however, not the only driver of motivation. A recent survey of health professionals conducted in the Center, North and East Regions of Cameroon showed that an increase of 50 percent in salaries was not as important as good working conditions, i.e. the availability of equipment and material (Figure 48).[7] Were health workers, doctors and nurses to be given appropriate equipment and supply of medicine, they would be more than twice more likely to choose a rural posting than without this incentive. Rewarding working in difficult conditions by accessing training and offering opportunities to progress career-wise is also an important factor of motivation to ensure retention and service delivery in remote areas.

FIGURE 48: Preferences for Rural Job Postings
(odd ratios)



Sources: Cameroonian authorities and Bank Staff calculations.

[7] The survey covered 351 health professionals (doctors and nurses) and medical students.

Options for Going Forward

Program Budgeting

The introduction of program budgeting starting in 2013 should improve efficiency of public spending. The new approach places the line ministries at the center of the budget cycle. These ministries will have now more flexibility in preparing and executing their budgets, but will also be held accountable for results. As such, program budgeting addresses many of the critical short-comings that have affected the country's public expenditure management in the past: excessive centralization of the budget processes, leading to low budget execution and poor strategic allocation of resources; and poor value-for-money and quality of service delivery.

Production and use of high quality data

In this new budget environment, one major challenge for Cameroon will be to ensure that resource allocation in the health sector is evidence-based. Setting up an effective data collection and management system would be critical to help decision-makers monitor health outcomes more regularly, and ensure that budgetary allocations are based on needs and performance. Data to be collected would have to be prioritized and standards provided for, to ensure that the additional data collected by external actors are comparable and usable. A well-designed functioning health management information system (HMIS) would not only enable the Ministry of Public Health to design evidence-based policy and be reactive to unforeseen shocks (e.g. capturing early signs of epidemic), but also assess implemented policies.

In Rwanda, Burundi and Burkina Faso, for example, the Ministries of Health are able to maintain an up-to-date HMIS thanks to the use of incentives and sanctions for the generation and use of HMIS data at the health facility, district and sub-national levels. Health facilities receive poor performance points and even financial sanctions if they do not submit their monthly HMIS report on time. Management of facility-level data is a key criterion in the evaluation of the performance of managers.

Risk-sharing mechanisms and access for the poor

Cameroon could take steps towards designing policies that foster access by the poor to health-enhancing services and protect the poor from catastrophic health spending. The extension of prepayment and risk-pooling mechanisms such as mutual health organizations, mandatory formal sector insurance and potentially cross-subsidization

Box 2: More Health for Every Dollar: Results-Based Financing

What is Results-based financing?

Results-Based Financing (RBF) is an instrument that links financing to pre-determined results, with payment made only upon verification that the agreed-upon results have actually been delivered. RBF for health refers to any program that transfers money or goods to either patients when they take health-related actions (such as having their children immunized) or to healthcare providers, when they achieve performance targets (such as immunizing a certain percentage of children in a given area).

What Makes Results-based Financing different?

Traditionally funding for health has been directed toward inputs—salaries, construction, training, equipment. Improved health was assumed to follow, but this has not always happened. Despite billions of dollars over the last decade, many countries in Africa are still falling short, particularly in areas that require a functioning health system. Sub-Saharan Africa, for instance, has the highest rate of maternal deaths in the world with an average of about 900 deaths per 100,000 live births. Child deaths and malnutrition are also serious problems.

The fundamental issue is the poor performance of the public health care system, including low levels of physical access in some places; poor quality of care; a lack of adequate incentive structures for health workers; weak management; and inadequate data of sufficient quality to monitor and evaluate progress. Individuals must demand services; health workers must be motivated to deliver adequate care; and the institutions they work for must be encouraged to make the systemic changes required to achieve health goals. RBF flips the whole equation on its head, starting with the result—more children immunized, for example—and letting health workers and managers on the ground decide how to achieve them.

The Potential of RBF

A number of developing country experiences strongly suggest that RBF can work. There are currently three countries (Rwanda, Burundi and Sierra Leone) with nationwide programs and 14 countries with ongoing pilots. These programs help improve health; strengthen health systems; spur innovation, creativity and country ownership; and encourage reforms that confer authority and flexibility to local service-delivery levels, fostering problem-solving where it is most needed.

When poor patients or households have been offered financial or material rewards for adopting health-promoting practices, they respond and health indicators improve. Similarly, when health workers and facilities are given bonuses upon achieving targets, those targets tend to be met. Results-based financing has also been shown to help to increase patient demand for health services.

In addition to improving health, results-based financing can also contribute to strengthening a country's health information system. Because accurate monitoring and evaluation of RBF schemes require the development of robust health information and management systems, incorporating the RBF concept, even into donor funds aimed at specific diseases, reinforces efforts to improve the timeliness, credibility and accuracy of national reporting and monitoring, thus contributing to improving the overall capacity of a country's health system.

Source: L. Morgan (2012)

between the two could contribute to reducing financial risks associated with illness.

Second, the introduction of pro-poor financing mechanisms, such as conditional and unconditional cash transfers and vouchers for health services, could improve equity and efficiency by increasing public investments in health while reducing private spending by the poor. The introduction of voucher-type systems such as *"kits obstétricaux"* to subsidize the monitoring of pregnancy are currently being piloted in the Far North, North, Adamawa and East regions.

Getting the incentives right

The national health workforce should be distributed in a manner that responds to the severe geographic imbalances in health outcomes in Cameroon and improve coverage of essential health services. The question is how to ensure health personnel will stay in rural areas. In this regard, health workforce retention policies should include a combination of both monetary and non-financial incentives. The package could include the provision and maintenance of supplies and equipment for the delivery of a clearly defined set of basic services, in addition to salary bonuses for rural postings. Implementation of this policy may be more effective if health facilities were first classified according to varying levels of remoteness, allowing greater compensation to those serving in more remote or difficult areas.

In addition, more efficient approaches to purchasing services should be sought. In order to improve health outcomes in rural areas of Cameroon, financing and payment mechanisms related to rural health worker recruitment and retention should consider a common performance-based approach that improves governance at the local level through transparent budgeting and allocation, personnel evaluation, democratization of decision-making processes, patient-oriented services, improved reporting and verification, and financial incentives to health care providers.

Results-Based Financing (RBF) has shown promising preliminary results in health worker retention and service delivery outcomes in rural areas (Boxes 2 and 3). This new approach to improve health service delivery outcomes is currently being piloted in the North-West, South-West, East and Littoral. In each region, performance contracts govern results-based payments to facilities, including performance bonuses for health workers employed at contracted facilities. Currently over 400 primary and secondary care health facilities have signed RBF contracts.

The RBF strategy in Cameroon has adopted an additional "equity bonus" mechanism, where health facilities located in "difficult" zones receive up to 50 percent higher payment levels for services

Box 3: The Right Incentives Lead to Measurable Results in Rwanda

In an effort to improve maternal and child health, Rwanda began paying for performance at the health facility level in 2006. At the time, health workers and facilities were in short supply (only 36 hospitals and 369 health centers in a country of nine million people, and only one doctor per 50,000 inhabitants). Many people lacked access to care, and the quality of care was often low.

In 2001, three non-Governmental organizations working in Rwanda attempted to address the problem by raising health workers' salaries. Nothing changed. Then they tried linking bonuses directly to performance — for example, if the health worker or facility could show that ten more women had given birth in a facility rather than at home where women risk dying from complication, they would receive a bonus. Paying for performance worked.

Following three successful RBF pilots, the Government of Rwanda designed and implemented a nationwide RBF scheme, folding a rigorous impact evaluation into the roll out. Results released in 2009 revealed significant improvements in the deliveries and preventive care visits by young children.

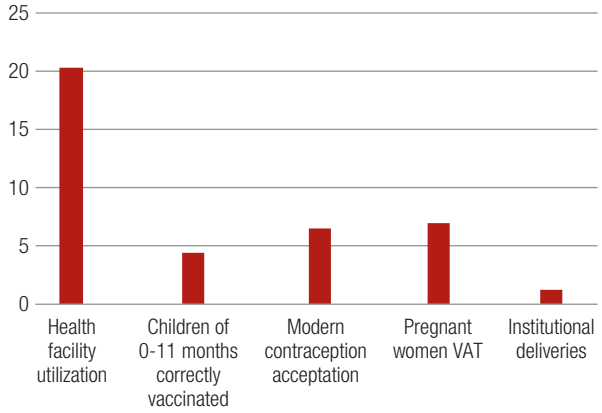
Source: F. Niyuhire (2010)

provided. Such an approach responds to both improved financing incentives for health workers and provision of medical equipment and supplies, the two job attributes identified as the most important in employment decisions for health professionals, and thus could be an important strategy to improving health worker recruitment and retention in rural areas.

In addition, results-based financing could contribute to improving health facility management practices. By reinforcing transparency and providing health facilities with autonomy to manage their own resources for investing in improved service delivery, efficiency gains can be achieved through better targeted resource management at the local level. By paying for services that can be delivered at health centers (such as non-complicated deliveries), RBF allows hospital resources to be used for complicated care.

The evaluation of the first two years of implementation of RBF in Littoral was recently completed. Comparing over a two-year period (2011-13) facilities where RBF has been implemented with ones where no reform has taken place, results suggest that coverage of key services such as outpatient consultations, antenatal care, child immunization, and use of modern contraception all have increased significantly in RBF facilities (Figure 49). In the North-West, South-West and Eastern regions of the country, a rigorous impact evaluation of RBF is currently under implementation to measure the impact of results-based financing on health outcomes. Results will be available in 2015 and are expected to contribute to generating evidence-based policies for health sector interventions in Cameroon.

FIGURE 49: Increase in Services in RBF Facilities, Littoral, 2011-12
(in percent)



Sources: Cameroonian authorities and Bank Staff calculations.

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