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#08

SUSTAINABLE DEVELOPMENT GOAL 4 OF 2030 AGENDA :

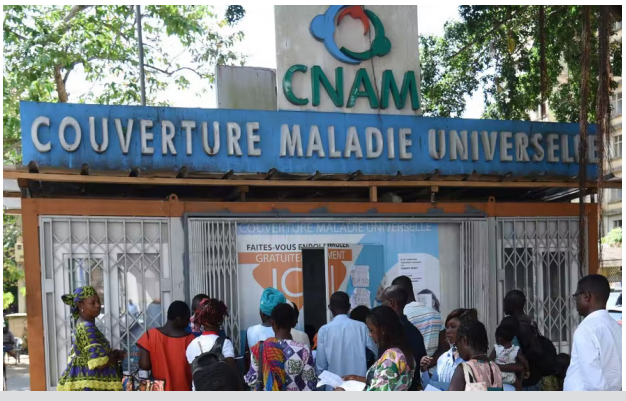
UNIVERSAL HEALTH COVERAGE, HOW FAR COULD CAMEROON BE READY?

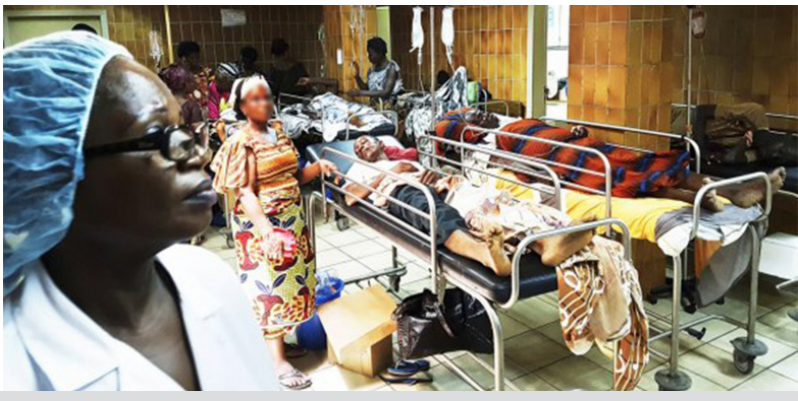
The **Universal Health Coverage** (UHC) is a set of health and social objectives that ensure the access of the population as a whole to quality health services, irrespective of the financial resources of each individual. It, therefore, promotes the exercise of the right to health as a human right by dissociating access to services from the ability to pay. Based on (i) universality, (ii) national solidarity, and (iii) the responsibility of all, the UHC aims at a policy of social justice in order to reduce inequalities in access to health care for the population and to promote health insurance.

In this regard, the United Nations General Assembly adopted on 12 December 2012, Resolution A/67/L36 for the Universal Health Coverage. It is on the strength of this political commitment that it occupies a prominent place in the 2030 Agenda of the Sustainable Development Goals adopted in September 2015. Goal 3[1] spelled out in target 8 commits to : « **Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all** ».

Similarly, the African Union's Agenda 2063 in its Aspiration 1 places particular emphasis on the health of the population. This is why, African countries have committed themselves by launching in 2017 a process that aims at, eventually, endowing themselves with a Universal Health Coverage system. In Cameroon, the Head of State, in his 31 December 2017 address, underlined the need to complete the reflections on implementing a Universal Health Coverage in Cameroon. Since then, the Government has been working on it.

1 – Relating to good health and well-being





It is thus in line with this strong political commitment that the National Development Strategy (NDS30) has prioritized the reinforcement of the health system that aims to *: (i) improve the efficiency of the health system by taking advantage of decentralization, (ii) establish the Universal Health Coverage, (iii) promote the development of a local pharmaceutical industry, (iv) promote hospital performance and quality approach in health facilities ; (v) strengthen geographic accessibility to health care, (vi) have qualified and motivated health personnel, and (vii) improve health governance* (cf. NDS30, Pillar 2, page 75 section 4.3.4)..

It is in this vein that the Health Sector Strategy (HSS 2016-2027), aligned with the NDS30 and the 2035 VISION has as its objective **: Cameroon, a country where universal access to quality health services is guaranteed for all social classes by 2035, with the full participation of communities**.

However, it would appear that despite the progress made, Cameroon still faces huge health needs and the pressure on its health system keeps increasing. The drop in child and infant mortality is a major challenge. The prevalence of HIV/AIDS, malaria and other endemic diseases as well as malnutrition remains persistently high. This burden has inevitably and unfortunately increased since January 2000 with the Covid-19 health crisis with around 120,000 cases and 1,927 deaths (figure as of 21 April 2022). In addition, economic, social, geographic and ethnic inequalities between men and women remain of considerable magnitude in the health sector. On another level, chronic non-communicable diseases are increasing at an alarming rate and represent a challenge from both a prevention and treatment perspective.

In view of the above and despite the strong political will, the implementation of the UHC in Cameroon raises pertinent questions, including the following: **how far can Cameroon be ready to implement the UHC in 2022, meaning 8 years from the deadline of the SDG and the end of the NDS30?** While we are aware of the huge efforts made by the Government and its partners on the one hand, and households on the other hand, our reflection aims to determine the optimal critical path to achieve it by identifying the different milestones on the way. **In plain language, can Cameroon afford the luxury of achieving the UHC optimally and completely? If so, within what time frame?**

1. What is the UHC?

For the benefit of everyone, Universal Health Coverage is a target to be achieved. It is an ideal for every health system which entails providing the entire population with the health services that they need without any prior financial constraints. To achieve this, the UHC requires the transformation of the entire health system to encompass the full range of basic health services, including health promotion, prevention, treatment, rehabilitation and palliative care.

The Universal Health Coverage is often confused with the Universal Health Insurance Coverage (CMU) which is a health insurance and just a phase of the UHC coming at the end of the process.
Achieving the UHC therefore requires a number of prerequisites, the most important being : ***(a) a solid, efficient, and well managed health system capable of producing adequate quality health products; (b) a sufficient health personnel that is trained and motivated; (c) the adequate availability of medicines and health equipment; and (d) the control of the cost of care.***

Achieving this overall objective requires four stages that follow a specific order :

1). Structuring the health system to make it meet the needs of the populations;
2). Reinforcing health care services;

3). Improving the performance of the health system, and
4). Implementing a Universal Health Coverage (UHC).

2. The universal health coverage in the Cameroonian health environment

We, therefore, understand that the UHC involves requirements not only on health care services but also on the conditions of access, in other words on the demand. To this end, we think it is important to present a rapid overview of Cameroon's need for the success of the UHC.

2.0. Overview of Cameroon's health map

Cameroon's health map has shown improvements year on year for the past 20 years. According to the data of MINSANTE, the number of health facilities has increased by about 6% from 2016 (that is 5,852 health facilities) to 2019 (6,202 health facilities).

Overall, the density of health facilities, all categories combined, is around one health facility per 4,227 inhabitants (WHO standard is one health center per 10,000 inhabitants). However, there are huge disparities in the distribution of these health facilities across the country. The regions at the bottom of the ranking are the Far-North (1 health facility per 10,161 inhabitants), the North (1 health facility per 9,352 inhabitants), and Adamawa (1 health facility per 7,118 inhabitants).

The specific analysis on the health facilities of the public sector shows that the average national density is 1 health facility per 9,113 inhabitants. Major cities like Yaoundé and Douala have the lowest density respectively with 1 public health facility per 58,753 inhabitants and 1 public health facility per 55,245 inhabitants. The Far-North Region (1 health facility per 11,850 inhabitants) and the North Region (1 health facility per 10,862 inhabitants). In addition, each Region of the country has recently (2021-2022) been provided with a Regional Hospital Center, a category 2 health facility.

Table 1: Some health indicators in Cameroon and in Africa (comparable countries in 2015)

Health Indicators	Cameroon	Algeria	South Africa	Kenya
Density of hospital beds (per 10,000 inhabitants)	15	17	28	14
Current health expenditure per capita in US$ million	210	932	1148	168
Gross mortality rate per 1,000 inhabitants	10,8	5,7	11,1	8,3
Average life expectancy	50,3	66,3	54,4	55,6

Source : World Bank htpp://databank.worldbank.org/data/source/health-nutrition and population statistics and WHO (Regional office for Africa) Health status in the WHO African region

2.1. The main challenges of the Cameroonian health system

Despite many efforts, the national health system still faces huge shortcomings including an inadequate and poorly adapted health care services, a poor technical platform and an inefficient drug supply network (according to specialists of the field), the lack of a mechanism for the financial protection of patients, the weakness of the prevention system, etc. In addition, there is a lack of human capacity and the distribution of the health card is not yet perfect (in terms of infrastructure level).

As of 21 September 2021, data show that MINSANTE employs a total of 39,720 staff including 11, 346 civil servants, 4,846 contractual staff, 3,412 decision makers, and 20 116 temporary staff. The table of needs indicates a shortage of approximately 2,000 specialists, 500 general practitioners, and 30,000 nurses (MINSANTE 2021).

Table 2: Estimate of the needs in health personnel in Cameroon

Type of personnel	Number
Specialists	2000
General practitioners	500
Nurses	30 000
Others	22 500
Total	**55 000**

Source : MINSANTE 2021

In addition, a better structuring of health care services is expected given the delays in launching of the hospital reform and the obvious limitations of the project to strengthen the performance of the current Cameroonian health system. The 2016-2027 Health Sector Strategy (HSS) attempts to address this situation, but its implementation remains limited. The biggest difficulty in implementing the HSS is the poor mobilization of the necessary funds.

2.2. Summary of needs for achieving the UHC

Our analysis will be done on 4 axis (or steps) that were raised to lead to the complete UHC based on data from secondary sources and the extensive documentation that contributed to develop the 2016-2027 HSS.

2.2.1. Structuring the health system

Building a strong, accountable and resilient health system requires the definition of capacity needs. **This work has been done as part of the development of the funding strategy, but the document has not yet been validated**[2] . However, there is clearly a gap between the organizational level and the funding level of the health system in Cameroon. Although it has the characteristics of a centralized system, the Cameroonian health system operates, most often, in a decentralized way. This constitutes a de facto mixed structure that requires a very high level of funding worthy of a developed country. This is far from being the case.

2.2.2. Reinforcing health care services

The needs identified to improve the quality of health care service should require the following key measures/actions (with no presumption of being exhaustive) :

a) The improvement of the quality of health map and medical density

The health map has been improved in quantitative terms (the number of health facilities has increased significantly) but the issue of their inequitable distribution throughout the national territory remains. In addition, the number of health personnel per inhabitant remains very low, at 0.8 doctors per 10,000 inhabitants. This figure falls short not only of WHO standard of 1 doctor per 10,000 inhabitants, but also of other African countries such as Tunisia and South Africa respectively with 14 doctors per 10,000 inhabitants and 9 doctors per 10,000 inhabitants (WHO, 2020).

2 - Situation according to MINSANTE as of 30 April 2022

Table 3 : Number of doctors per 10,000 inhabitants in 2019

	Cameroon	South Africa	Kenya	Ivory Coast	Algeria	Ghana
Number of doctors per 10,000 inhabitants	8	90	20	23	170	10

Source : World Bank / WHO

b) Availability of health products and improvement of the pharmaceutical system

CENAME, the center in charge of this area, does not meet all expectations. Street drugs remains a very large market, and this situation does not help guarantee the quality of drugs in Cameroon despite promises made by authorities to curb this phenomenon.

c) Setting up of laboratories and technical platforms

There is still an insufficient number of laboratories in the country, despite efforts made to improve the technical platform.

d) A health information system that needs to be upgraded.

Several efforts are being made to upgrade health information in Cameroon with the establishment of a health information system. But the latter is facing a problem of data collection, processing and centralization, the main reason being the scarcity of funding.

e) The issue of health financing circuit

One of the most crucial problems of the Cameroonian health system is the mismanagement of health funding. A large part of public health funding is not used to solve health problems3. In this regard, the PETS2[4] survey noted the difficulty of a reliable assessment of the resources lost in the expenditure chain. It estimated that the wastage rate by level of budget execution (rural or urban area) by targeted budget line and by services involved was around 53%.

f) The setting up of a good public health governance

As concern governance, there are still many shortcomings particularly at the level of coordination. Some health system entities operate as if there were no national action plan. Most often, isolated actions, which do not respect the guidelines laid above, are taken. A perfect illustration was experienced in the management of Covid-19 where heads of school and university establishments made decisions without waiting for national instructions.

3 - See Camercap-Parc (2019), Inefficiency of budget programming in Cameroon, Study Series No 10.

4 - Public expenditure Tracking Survey, carried out by the NIS Cameroon

g) Strengthening community health through health promotion

The functioning of the Cameroonian health system shows that prevention remains the weakest link, even though it is the number one objective. This problem originates from the deterioration of community health. It should be remembered that African health systems were built on the basis of primary health care.

2.2.3. Improving the performance of health care services

The emphasis at this level is on some key criteria that include the access and geographic coverage, equity, quality and safety, responsiveness and humanization of care, and the continuous search for efficiency.

Indeed, despite the several efforts made, Cameroon remains among the countries with the lowest life expectancy in good health (about 51 years). The mortality rate is decreasing but remains high. In the context of humanizing care, much emains to be done in view of the many medical errors and the failures in the protection of medical secrecy.

2.2.4. The setting up of a universal health care coverage as an intermediary step

The complete achievement of the UHC requires the prior success of the CMU. The latter itself requiring a number of prerequisites including:

i. A feasibility study to assess the long term risks (Actuarial Studies). At the present stage, this first part of the work has not yet been completed.

ii. The selection of funding mechanisms. In developing the UHC, Cameroon estimated the amount of money needed. The project focuses on the usual mechanism of the contributions from the population. However, several categories of the population will find it difficult to keep up with this approach.

iii. The definition of population coverage. **Population coverage is clearly spelled out in the UHC project developed by the Ministry of Public Health. It is a good point** !

iv. An evaluation of the benefits to be offered and a definition of the costs control mechanisms. The benefits to be offered have been defined within the framework of the basket of care which contains nearly 182 diseases.

v. The recruitment, selection, and payment scheme of providers. Services will be offered in all public health establishments, but the method of payment for providers is not defined.

vi. The definition of an organizational structure. It involves making a choice between a decentralized and centralized structure, depending on the needs and the socio-cultural environment in which the health system operates.

In view of the above, several steps have not yet been taken to implement the UMC, a condition to have access to the UHC. It is like that the Probation exam for the Baccalaureate in Cameroon. **Can we objectively imagine Cameroon moving towards the UHC ?**

3. The thorny issue of financing

Beside the 4 steps defined in point 1 to access the UHC, another crucial question remains pending and unresolved. **Who finances? And how?**

3.1. Overall health financing in Cameroon

Health financing in Cameroon mainly relies on state budget allocations under the coordination of the Ministry of Public Health5 and direct payments from households. In addition, there is also funding from local governments, health insurance, NGOs, and external funding.

According to latest estimates, total current health spending amount to 5% of GDP (WHO, GHED 2019). Public and private domestic financing of these expenditures accounts for 13% of the total amount, while external financing sources provide nearly 19 %. The bulk of spending comes from direct household payments which account for more than 70% of the total amount.

This is quite a heavy amount to pay according to civil society organizations and the private sector which have been working, since 2016, on developing a strategy for health financing in Cameroon with the view to reducing direct payments, by at least 30%, when purchasing services. Indeed, according to the results of fourth Cameroonian Household Survey ECAM4 (2014), nearly 4% of households consider themselves impoverished by out-of-pocket payment for health services.

Specifically, it should be noted that the Cameroonian Government plays a major role in health financing through investments and subsidies for the treatment of some illnesses. Indeed, the health sector being one of the priority sectors of the development strategy, the country has allocated, for more than 10 years, a share of the budget ranging between 3.9 and 7.2% of the total, to the Ministry of Public Health. To this must be added the various aids from special funds to respond to chocks affecting the health of the population. However, despite the emphasis placed on the human capital as reflected in the NDS30, and the ratification of the recommendations of the Abuja Declaration of 2001 which provided for an allocation of 15% for the health function, it is a known-fact that Cameroon is still struggling to reach this percentage.

Table 4 : MINSANTE budget over the last 5 years (in billions of FCFA)

Year	2018	2019	2020	2021	2022
Annual allocation	174	207,9	188,81	197,12	207
Total budget %	3,8	4,2	4,3	3,5	3,5

Source: MINFI, FL of different years

Although the existing coverage system aims to facilitate access to health care for all, current statistics reveal that only 6.46% of the Cameroonian population is covered by a social health protection mechanism. It also emerges that the vast majority is not part of any financial risk protection scheme. This last aspect reinforces the burden of direct payment borne by households. As concern insurance risk pool, only 2% of the population is a member of mutual health insurances (MINSANTE, 2018).

5 – In addition to the Ministry of Public Health, other ministries and public institutions also have an important health component. This is the case of MINDEF with an acceptable military hospital open to the general public covering the military regions of the county; the NSIF with a network of health facilities among the most important in the country, Catholic and Protestant Churches etc,)

3.2. The current financing of UHC project in Cameroon

According to estimates by the National Technical Group (NTG) on the implementation of universal health coverage in Cameroon, the country will need, cumulatively, about FCFA1.4 billion to optimally implement the UHC by 2030.

The costs will not only be borne by patients but by the entire population and the State. This is will done through the pre-payment and "risk pooling". According to the NTG, three actors should participate in its financing, namely the State, households, and partners. The estimates are contained in the table below.

Table 5 : Distribution for the contributions for UHC according to funding sources in billions of CFA

Funding sources	State	Households	Development partners	Total
Contributions in FCFA	1000	350	50	1 400

Source : CAMERCAP-PARC, from the data of the summary of works by the NTG on the UHC.

The state will contribute FCFA985 billion (we have decided to round up to 1,000). The share of households, which will be collected through fees, is about FCFA350 billion or a third and the pledges made by donors which amount to FCFA50 billion. From this perspective and apart from the direct contributions of individuals, it is important to explore funding niches that will undoubtedly give a new impetus to financing the expected contribution of the state. Beside these conventional financing, additional funding is needed to optimally carry out the UHC project.
What could the State do to generate such an amount? Where would the money come from? How can it be generated?

These are the questions that lead us to make some economic policy proposals that could enable the State to secure additional funds. If we make a linear projection, following the trends in the recent years, the budget of the Ministry of Health will probably be around FCFA260 billion in 2030. **This means a gap of nearly FCFA730 billion to be filled**.

4. Where and how to get the FCFA730 billion ?

The figures announced may seem deterrent, but in such a project and given the spin-offs, it is entirely possible and realistic. The amount can be realistic in a variety of ways, including savings on current expenditures, productivity gains from actions taken, and or new levies. Our proposal is a mix of these different approaches.

4.1. Improving health care services

Health systems are an essential component of healthy populations and play a crucial role in achieving development goals. They not only prolong the years of life but also increase the working capacity of the populations.

Within this framework, to achieve the UHC, health reforms must be undertaken to ensure cost effectiveness and sustainability by assessing the functioning of these systems against three objectives: a more efficient use of public resources, an optimal production of quality health care and an access to quality health care with particular emphasis on prevention.

Requiring a profound reform of the system and given the current state of things, achieving this objective will take approximately 10 years.

4.2. Putting in place a process to control costs

Among the prerequisites of the UHC, there is the issue of controlling the costs of health services. It should be noted that the health care market is not subject to the principle of competition, so prices should not fluctuate as it is the case on the market of ordinary goods and services. Hence the need for a mechanism to reduce the effects of competition.
As for this objective, it can be carried on at the same time as the previous objective. However, it requires about 3 years.

4.3. Innovative approaches in the financing of the CMU

After the successful implementation of a quality health care service and a process of controlling health care costs, it is important to put in place a CMU that enables the populations

to receive quality health care without risk of impoverishment. Using innovative approaches will make it possible to finance the gap of 70 billion CFA francs.

4.3.1. Social transfers and social net programme

Social transfers in kind are individual goods and services provided to households, whether these goods and services were purchased on the market by the Government or ISBLM or were produced by them (non-market production).

Within the framework of the management of the Covid-19 pandemic in Cameroon, these transfers were materialized through the redistribution of donations from the Head of State, private and public companies, as well as individuals to help the poorest people in the face of this pandemic. The donations distributed were made up of prevention equipment (containers, soaps, masks, hand sanitizers, etc), medicines, foodstuffs as well as financial support. There was no formal accounting of the amounts of these transfers between actors of the institutional sectors, under the accounts of the nation[6].

At the institutional level, **the national social safety net programme** has been put in place by the Government since 2014 with funding from development partners, notably the World Bank (IDA loans). Social nets are considered to be a mechanism to fight extreme or chronic poverty. The chronic poor are the hard core of poverty. Social safety nets thus contribute to fighting against inequalities, fighting against vulnerability, and the expression of national solidarity in favor of the poorest. The Cameroon Social Nets Project is part of the Government's policy of inclusive growth and the implementation of its social protection policy. It has been implemented since 2013 under the supervision of the Ministry of Economy, Planning and Regional Development (MINEPAT) with the financial support of the World Bank through 4 types of programmes, notably :

i. ***The unconditional direct ordinary cash transfers programme (OCT) with accompanying measures(...)*** that allows each beneficiary household to receive, for 24 months, the total sum of FCFA360,000 in cash transfers at the rate of FCFA20,000 every two months and FCFA80,000 on the 12th and 24th months ;

ii. ***The emergency cash transfers programme (ECT).*** **[...]** pin which each beneficiary household receives, for 24 months, the total sum of FCFA180,000 in cash transfers at FCFA30,000 every two months ;

iii. ***The Covid-19 emergency cash transfers programme (ECT)*** which is executed in the chief towns of the 10 regions and the city of Limbe. Each beneficiary household receives two (02) monthly payments of FCFA45,000 each and a payment of FCFA90,000 in the last month for a total amount of FCFA 180,000.

iv. ***The labor-intensive public works programme (LIPW)*** which aims (...) through the funding of small community projects (...). Each beneficiary receives the amount of FCFA1,300 per day of work for a total of 60 days of work.

An evaluation of the pilot project found that cash transfers had a variety of positive effects including **improving the basic social needs of the poor in health**, education, and nutrition. Other benefits included **improved health behaviors**, children's school attendance, and financial inclusion.

In total, from 2013 to 2022, the Social Safety Net Project has benefited 2,000 households (about 15,100 persons) from 2013 to 2015; phase 2 targeted 82,000 households (about 619,100 persons) from 2016 to 2019, and for the 2022 period. The Project is currently receiving additional funding that will help target nearly 291,500 households selected across the country, or 2,200,825 persons that will be directly targeted.

The project is expected to target a total of 375,500 households (approximately 2,835,025 individuals) by the end of 2022. With this expansion, the social safety net coverage should reach 25% of the poor population in Cameroon.

We, therefore, believe that in the light of this experience, the UHC could build on this experience and these achievements to add a sustainable financing string. By lifting the most vulnerable populations out of extreme poverty, to make them economic agents (in good health, which reduces health expenses) capable of contributing to the financing of the economy and therefore of the UHC.

6 - The social accounting matrix is developed by services in charge of the economic accounts of the nation. It is an essential tool for modeling a country's economy, particularly through the computable general equilibrium model (CGEM)

4.3.2. Tontines and informal insurances such as emergency funds

The latest official statistics on financial inclusion in Cameroon and the access to modern financial services by households are not very telling7. According to the NIS, the vast majority of active population works in the informal sector. Without a stable revenue, these categories are by default excluded from the modern financial system (banks and microfinance) and find refuge in tontines.

The tontine is a grouping of individuals wishing to pool their savings in order to have a larger sum of money to invest or resolve a problem. All Cameroonians know how the various types of tontines operate and we will not go into details.

What is interesting in tontines and in relation to our analysis is the guarantee and mutual insurance component of the members of each group. Indeed, according to the variants, each member must have an insurance fund that is used to assist one or more members in times of difficulty, sickness, or even death, according to rules adopted and known by all members.

To encourage them, we could integrate health and complementary insurance of the formal sector.

In view of this social and solidarity dimension rooted in the minds of Cameroonians (irrespective of the region of the country) we believe that the UHC project should be able to draw inspiration from it and build on the achievements of "risk pooling" to develop an innovative mechanism for the UHC financing fund.

4.3.3. Community solidarity/charity/ sponsorship and volunteering

It has been experimented and seen in full-scale and spontaneously in the peak of the Covid-19 pandemic (2020-2021). National solidarity was organized at the local level, among neighbors and strangers to help people on the front line or those directly or indirectly affected. At the national level, a national solidarity fund was put in place by the President of the Republic with an initial endowment and was receiving contributions from various sources in cash and in kind. This health crisis has driven the people to redefine human relations in terms of collective identity, citizenship, and otherness.

It is worth noting that, since 1993, Cameroonian law requires public establishments providing primary medical care to contribute 10% of their monthly revenues to the Health Solidarity Fund.

This fund, which should be the responsibility of the Ministry of Public Health, was created to serve as back-up financial reserves during health emergencies. However, no information about the management rules of this fund or its activities has ever been published.

Under this section, we could activate the sponsorship and RSE of large national companies which could be offered a tax deduction to encourage them to make this effort of national and community solidarity. Volunteering could also find a place here.

In our opinion, this financing could be better organized with a greater traceability for a conclusive efficiency in terms of contribution to the objective of UHC.

4.3.4. Informal sector dynamic in Cameroon

Like most African countries, Cameroon is experiencing a sharp growth of the informal sector. The NIS estimates the contribution of the informal sector to the GDP at % for the year 2020 and about y% of the active population.

Contrary to what may be commonly imagined, it is not a non-tax sector, but rather poorly taxed and often in non-official and therefore traceable networks. The interest in our study for the completeness of the UHC lies in the strong margin of this sector in terms of voluntary or mandatory levies to finance the UHC. It all depends on the communication around the issue, the stakes, and the benefits for all and sundry. The key lies in guaranteeing traceability, transparency, and therefore the efficiency of the model.

In addition, given the precariousness of their activities, actors of the informal sector have developed capacities for repurposing, flexibility, and adaptability. We have for instance the repurposing of dressmakers and tailors into producers of washable masks available at affordable prices to citizens during the peak of the Covid-19 crisis. Similarly, informal actors in metallurgy and plastics sectors have proposed several solutions for hand washing devices to be installed in public places. The informal sector also helped to avoid a complete lockdown of production activities in the early hours of the crisis when Europe was at a complete standstill.

In the end, this informal sector dynamic can be exploited to support the innovative funding sources of the UHC through specific levers.

7 - NIS, survey on financial inclusion (FINSCOPE) 2017 & 2020

4.3.5. Traditional pharmacopoeia

One of the most worrying heading of expenditure, which raises the overall cost of the UHC, is the « MEDICINES" heading. Due to the scarcity or absence of a local pharmaceutical industry, almost all drugs are imported. National development strategies over the past twenty years (PRSP, GESP and then NDS30) have always mentioned health as a priority sector, and the pharmaceutical sub-sector as one of the critical areas. But to date, not much has changed.

On another level, the fight to give recognition to traditional medicine and local pharmacopoeia is not yet over, although there is some progress on the political and scientific level. Thus, the recent case of the Covid-19 has fueled debates. Africa developed several initiatives. The latter were manifested through proposals of healing drugs against the virus. Some received support and encouragement. In Cameroon, we have Monseigneur Samuel KLEDA, the Catholic Archbishop of Douala, herbalist who developed a drug based on medicinal plants. Dr. Marlyse PEYOU, biochemist, who proposed "Ngul be tara" a drug based on plants with antiviral, analgesic, and antibiotic properties among others, packaged in the form of tablets and syrup. There is also Dr. Euloge Yiagnini Mfopou and many other practitioners and researchers with evidence of their contribution to curing persons tested positive for Covid-19.

We can confidently assert with authority that one of the reasons for the resilience and low morbidity and mortality due to Covid-19 in Africa is certainly the use of traditional medication. The so-called "grandmothers'" solution have been reinforced: infusion, concoction, traditional sauna with plants and tree barks, etc.

We believe that the size and use of traditional medication can bring substantial gains by reducing the quantities and the costs of imported medicines, which are sometimes not really effective. Developing a local drug industry will help create jobs and thus generate direct and indirect income to help finance the UHC.

4.3.6. Securing agricultural incomes

The impact of poverty varies greatly across the Cameroonian territory. The most striking and noticeable is the gap between the urban area and the rural area which is the most affected. However, it is a fact that the rural populations, a majority of them living on farming, sometimes have a higher annual income than the urban populations[8]. However, the structural impoverishment of these population is mainly due to the lack of capacities by the beneficiaries of these incomes to manage the sometimes significant amount that suddenly land in their hands at specific periods (during sales once a year) whereas they have lived most of the year in precariousness and privation. It is therefore the issue of managing the volatile flows and not the volume of resources.

Indeed, Cameroonian small-scale farmers are not yet organized as agricultural entrepreneurs. They do not have any bookkeeping, neither material nor even less financial. To this end, securing agricultural incomes, through an approach that ensures regular remuneration throughout the year, appears to be a definite advantage for reducing poverty among rural populations. This allows them to contribute to the financing of the UHC.

4.3.7. A levy on alcohol and tobacco

Alcohol and tobacco are unavoidable and proven causes of disease in all human societies. As a result of alcohol consumption, many people get diseases such as cirrhosis of the liver, inflammation of the liver (hepatitis), inflammation of the pancreas (pancreatitis), etc, that easily lead to death, to which must be added accidents on public roads or in homes. Smoking also takes its toll on the human body. According to the results of the survey on smoking among adults, conducted in 2013 by the National Institute of Statistics, in collaboration with the WHO, 1.1 million adults use tobacco products and the country deplores about 66,000 deaths per year due to tobacco use.

If we apply the principle common among environmentalists known as "polluter – payer", we can fully support the introduction of a tax by causal effect on tobacco and alcohol. The ultimate goal is not to collect as much money as possible, but to use financial dissuasion (a kind of tariff barrier) to help prevent diseases caused by these two scourges.

The benefits are therefore achieved upstream through the reduction of instances of illnesses, and if necessary, through the recovery of additional funds to finance the UHC.

DSimulations based on the average amount of alcohol and cigarettes consumed per person per year (see 2019 WHO ranking on alcohol consumption and the global study on smoking funded by the B&M Gates Foundation) have allowed us to suggest some solutions.

8 - CAMERCAP-PARC, La sécurisation des revenus agricoles et ruraux par un modèle de salarisation. Policy brief # 04, mars 2017

One of these solutions is a levy – consumption tax – on each unit of alcohol or cigarette which could vary between FCFA2 to FCFA5 per unit consumed. This source could help generate revenues for the UHC of up to FCFA100 billion by 2030.

4.3.8. Hygiene and sanitation tax/ residence tax

According to the WHO, insalubrity is one of the main causes of disease in the world and in developing countries in a more direct way, and therefore of deaths. In Cameroon, it is the main cause of waterborne diseases and the epidemic affecting the populations both in urban and rural areas. This is the case of malaria, cholera, and water-related diseases. The respect of hygiene and sanitation measures by the populations is therefore an important lever toward the UHC. In Urban areas, one can imagine that each household pays a lump sum to the competent CDT to ensure hygiene and sanitation in the immediate environment in order to guarantee a healthy environment. In this respect, as in other countries, a share of the residence tax could be included in this line.

4.3.9. Optimizing mandatory contributions to public finance (tax an non-tax revenues, social contribution, etc)

Since 2018, CAMERCAP-PARC has carried out a set of studies on optimizing state revenues, focusing on the one hand on tax revenues and non-tax revenues and on the other hand on budget programming. All these studies have concluded that there is a clear shortfall on public finance revenues – by improving the design and the programming of state budget and public services entities, and by ensuring better transparency and accountability of revenues through optimized statistical information systems. The estimated benefits, without changing the tax base, amount to over FCFA1,000 trillion per year. With less than 10% of this revenue due and collected to be allocated to the UHC, a gradual contribution of up to FCFA110 billion by 2030 can be achieved without much effort.

In the end, all the above proposals would gradually contribute to the financing of the UHC as shown in the table below.

Les gains estimés sans toucher à l'assiette fiscale actuelle sont de l'ordre de plus de 1000 milliards de FCFA par an. En prenant moins de 10% de cette recette due, et
Recouvrée que l'on affecterait à la CSU, on obtiendra sans gros effort une contribution graduelle pouvant atteindre 110 milliards de FCFA d'ici à 2030.

Au final, l'ensemble des propositions ci-dessus contribuerait de manière graduelle au financement de la CSU comme l'indique le tableau ci-dessous:

Table 6: Estimated additional gains of the innovative approaches for the financing of the UHC (in billions of CFAF)

		2023	2025	2030
1	Social transfers / social net	40	90	120
2	Tontines, assistance funds and related	5	10	20
3	Community solidarity/charity/volunteering	30	50	75
4	Informal sector dynamic	5	10	20
5	Traditional pharmacopoeia	5	10	25
6	Securing agricultural incomes	50	70	130
7	Tax on alcohol and tobacco	50	85	100
8	Hygiene and sanitation tax	25	50	100
9	Prevention and fines on road offenses			
10	Optimizing mandatory contributions (tax and non-tax revenues, social contributions, etc.)	40	60	140
	Total	**250**	**435**	**730**

Source : CAMERCAP-PARC

5. Conclusion/Recommendations

This reflection shows that Cameroon is far from being able to provide Universal Health Coverage in an optimal and complete way by 2022. The road is still long and critical (according to operations research). We have outlined below a timeline based on the steps to be taken to achieve this by 2030, which corresponds to a dual commitment: that of the SDGs and that of the NDS30. To achieve this, a set of coordinated actions with strict timing and tangible results must be carried out immediately, with the constraint that every delay of missing result takes off the path and away from the goal.

Table 7 : Adjusted timetable for the complete implementation of the UHC in Cameroon

	2022	2023	2024	2025	2026	2027	2028	2029	2030 Completeness of the UHC
Structuring the health system									
Strengthening health care services									
Improving performance									
Implementing a CMU									
Complete UHC									

Source : (c) CAMERCAP-PARC.

For this reason, it is necessary to DREAM that it is possible, DARE the right actions to get there, and INNOVATE to make tomorrow better

(c) Camercap-Parc.cm

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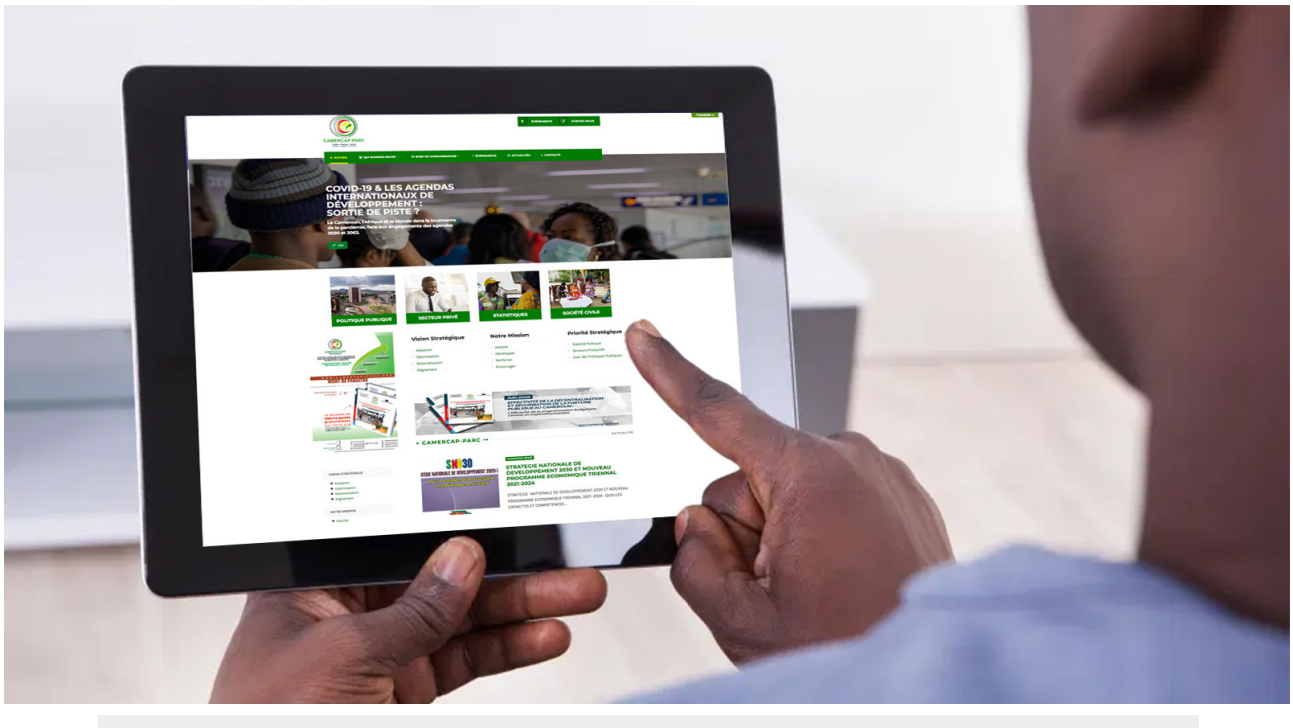

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