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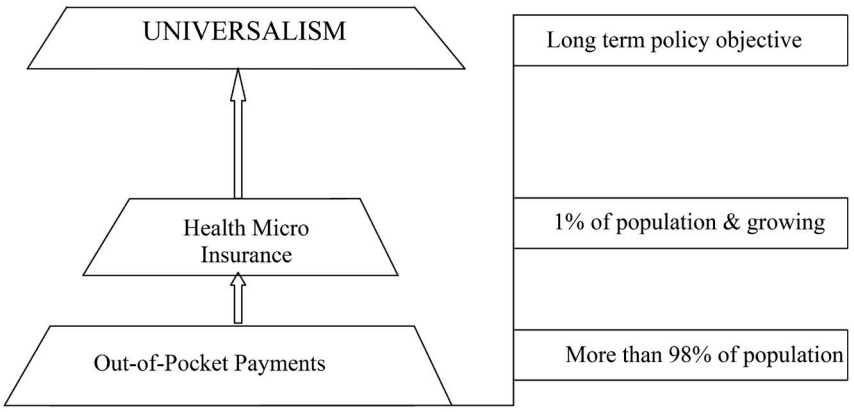
Princewill Che Tafor

Health Care Financing through Micro Insurance in Cameroon

A Prelude to Universalism



Layers and Trend in Health Care Financing in Cameroon

JYVÄSKYLÄN YLIOPISTO

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Editors
Jussi Kotkavirta
Department of Psychology, University of Jyväskylä
Pekka Olsbo, Timo Hautala
Publishing Unit, University Library of Jyväskylä

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ABSTRACT

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This study is concerned with health micro insurance (HMI) as a health financing option for Cameroonians striving to access equitable and quality health care. Quite often issues of health care financing have been relegated to the background in the health care narrative. At the fore of contemporary discourse on access to quality health care, are issues of the absence of health infrastructure, lack of qualified medical personnel, and prevalence of corruption in developing countries like Cameroon. As such, this thesis seeks to highlight the important, yet less talked of issue of equitable health care financing. This is all the more crucial in low income countries like Cameroon. Here, there is no state funded social security system for health due to a narrow tax base and the cost of private health insurance is exorbitant. In such a scenario out-of-pocket payments at the point of service, with its catastrophic consequences becomes the only avenue to access quality health care for most residents.

In order to remedy the situation the government of Cameroon and other global actors like WHO, ILO and the World Bank have recently been advocating HMI as a medium term solution to the health care financing conundrum. Despite the well documented evidence of the numerous advantages of HMI, Cameroonians are lukewarm in embracing this novel health care financing option. In this regard, I seek to investigate why Cameroonians are not rushing to join the HMI scheme despite its merits. Universal provision of health care remains the ultimate long term goal. As such, I wish to determine whether HMI, militates for or against the long term policy goal of universalism.

I employ the mixed methods research approach in the empirical search for answers to these questions. In the process, I take full advantage of the methodological eclecticism offered by mixed methods, navigating in equal measure between the quantitative and qualitative strategies. The theoretical orientation for this research is anchored on what I refer to as, the Social Policy Approach and Community Resource Mobilization Theories. Individually, these theories shed light on various aspects of the three tier structural framework adopted for this study. These structural layers are – out-of-pocket payments, health micro insurance and Universalism.

Some findings from this study have been quite surprising like, the absence of the important legal framework, attitudinal challenges presented as financial limitations and others. These findings have informed on the challenges and opportunities in Cameroon's quest for equitable access to quality health care via HMI with a long term Policy objective of universalism.

Keywords: Health care financing, out-of-pocket payments, HMI, Universalism, equity.

Author's address Princewill Che Tafor
Department of Social Sciences and Philosophy
P.O. Box 35, FI-40014 University of Jyväskylä
princewill.c.tafor@jyu.fi

Supervisors Professor Marja Järvelä
Department of Social Sciences and Philosophy
P.O. Box 35, FI-40014 University of Jyväskylä

Docent Sakari Taipale
Department of Social Sciences and Philosophy
P.O. Box 35, FI-40014 University of Jyväskylä

Reviewers Professor Olli Kangas
Research Director
Social Insurance Institute of Finland (KELA)
P.O.Box 450, FI-00101

Professor Risto Tuominen
Professor of Public Health
FI-20014 University of Turku

Opponent Professor Olli Kangas
Research Director
Social Insurance Institute of Finland (KELA)
P.O.Box 450, FI-00101

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gallantly joggled work, studies and family duties in my absence with a smile and wonderful sense of humour that was heart warming. It made the demanding job of this research attainable.

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ABBREVIATIONS

ADB	African Development Bank
BEPHA	Bamenda Ecclesiastical Province Health Scheme
CBHFS	Community based health financing scheme
CBHI	Community based health insurance
CEMAC	The Central African Economic and Monetary Community (Communauté economique et monétaire de l'Afrique centrale)
CFA	African Financial Cooperation (Coopération financière en Afrique)
CTB	Belgian Technical Cooperation (Coopération Technique Belge)
DB	Doing Business
GDP	Gross domestic product
GGEH	General government expenditure on health
GTZ	German Agency for Technical Cooperation (Deutsche Gesellschaft für Technische Zusammenarbeit)
HMI	Health micro insurance
ILO	International Labour Organization
IMF	International Monetary Fund
MHO	Mutual health organization
NGO	Non-governmental organization
NSIF	National Social Insurance Fund
PEH	Private expenditure on health
SAILD	Support Service to Grassroots Initiatives of Development (Service d'appui aux initiatives locales de développement)
TEH	Total expenditure on health
UNO	United Nations Organization
WHO	World Health Organization

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1 INTRODUCTION

Health is an invaluable component of human existence. Frenk et al. (2005: 22) hold that health has an intrinsic value (it produces wellbeing) and an instrumental value (it is an important determinant of economic development). The instrumental value of health is evident with the increasing reliance on health indicators such as life expectancy, infant mortality and others defined by institutions like the World Bank in its annual Human Development Index Report. The intrinsic value of health was formalized many years ago by the Universal Declaration of Human Rights (1948). Article 25(1) states that everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family including; food, clothing, housing and medical care. However, access to inclusive, quality health care has proved elusive in many low income countries (Preker et al. 2007).

What if the main challenge in accessing quality health care in Cameroon is not the absence of health care facilities or health personnel, as is often stated (WHO 2010, Monekosso 2008, Mbaku 2007)? How important is the issue of health care financing in accessing quality health care? Arhin-Tenkorang (2004: 165) states that, in the absence of risk protection, cost becomes a barrier to seeking and obtaining quality health care. These financial barriers from the formal health care systems often lead would-be patients to resort to self-medication and other practices that sometimes injure their health. This study seeks to investigate the often minimized role played by health care financing in access to quality health care in Cameroon. The general focus is on the demand side of health financing as opposed to supply side financing. Zooming in further on the demand side of health care financing, this study takes a closer look at the emerging contribution of health micro insurance (HMI) in facilitating access to quality health care.

1.1 The trilogy of health care financing

Health care financing involves the basic functions of collecting revenue, pooling risk and purchasing goods and services (WHO 2000). Developing countries face a number of policy challenges in financing their health systems. Primarily, these governments need to raise revenues in an efficient and equitable way to provide individuals with essential health services and financial protection against financial losses caused by illness and injury. The second policy challenge is managing these revenues in a way that pools health risks equitably and efficiently. Finally, governments must ensure the purchase of health services in an allocatively and technically efficient manner (Callahan and Wasunna 2006: 138).

Raising or collecting revenue is the most challenging in this policy trilogy. It has to do with the way health systems raise money from households, businesses and external sources. Many low income countries rely heavily on private, un-pooled, out-of-pocket payments at the point of delivery as a key financing mechanism for health care (Chankova et al. 2008: 265, ILO 2010b: 37). This is a deeply inefficient form of health care financing, resulting in significant gaps in coverage and in access to health care, thus leading to impoverishment (Van Doorslaer et al. 2006). A global comparative survey reveals that, while public sources dominated health care expenditure on average (as a percentage of GDP) in Europe, the Middle East and Asia, private expenditure dominated it in Africa. Meanwhile, in North America, Latin America and the Caribbean, health care financing came from private and public sources in almost equal measure (WHO 2009).

A major obstacle to be addressed by low income countries is how to make the shift from individual, out-of-pocket payments to some kind of pooled resource mobilization for health care financing. In order to achieve this, policy makers need to provide answers to some revenue collection concerns. They include, among others, questions regarding the level of prepayments (full versus partial with some co-payments). Are payments mandatory or voluntary and what is the waiting period? After addressing these concerns, the focus now moves to the second function of the health financing trilogy, which is the pooling of risk.

Pooling risk has to do with the accumulation and management of revenues so that members of the pool share collective health risks, thereby protecting individual members from large, unpredictable health expenditures (Gottret and Schieber 2006: 46). Insurance, whether traditional or micro has at its core the element of risk pooling. Members in the risk pool who do not suffer a loss within a particular period basically pay for the losses suffered by other pool members. Churchill (2006: 14) states that insurance reduces vulnerability as pool members replace the uncertainty of losses with the certainty of making small, regular premium payments. Such a normative orientation of minimizing vulnerability may be straightforward in developed economies, with a long

tradition of insurance. The situation is more challenging in low income countries, however, where insurance is a fairly recent concept. Promoters of such initiatives, therefore, have to undertake intensive sensitization first, to educate the populace on the concept of health insurance and on enlarging this risk pool.

According to Barr (2004: 105), the double intellectual bases of insurance are the law of large numbers and gains from trade. Barr argues that individuals may face uncertainty, but groups can face approximate certainty. As such, it is the relative probability about the aggregate certainty resulting from the law of large numbers that permits individuals to make gains from trade by agreeing to pool their risks. Therefore, the importance of a large risk pool cannot be overemphasized

After collecting revenue and pooling risks, the final step in the health care financing trilogy is the purchase of goods and services for pool members. In determining the kinds of services to be covered, insurers pay great attention to the probability of the insured risk occurring. Generally, insurers prefer risk with low probability of occurrence but with higher cost, for instance hospitalization, while the insured prefer high probability loss like outpatient treatment (Radermacher et al. 2006: 72, 73, Preker et al. 2002: 147). When the benefit package has been determined, it is logical to define the modes of service delivery. This entails entering into contractual relations with health care providers – public or private – and to establish the mode of settling claims. Many options abound, such as direct payments to health care providers of 100% or co-payments with patients' contributions. In other instances the patient pays the totality, to be reimbursed later. All these arrangements for financing health care have different consequences and outcomes. This study seeks to determine how the various options operate in addressing access to equitable health care in Cameroon.

It is worth emphasizing that the trilogy applies to both the supply and the demand sides of health care financing. However, this study is exclusively focused on the demand side. Demand side financing systems place purchasing power into the hands of consumers to spend on specific services at accredited facilities (Pearson 2001, Ruff et al. 2011). A common example is the use of vouchers or other evidence of entitlement to a specific level of services (Ensor 2003). On the other hand, supply side health financing entails payments for the construction of public facilities like hospitals, salaries for personnel and other consumables like drugs.

Health micro insurance (HMI) is an instance of entitlement different from vouchers forming part of demand side health financing. The gradual shift in emphasis from supply to demand side health financing has been accentuated by a number of factors. One such factor is the weak evidence of the impact on outcomes from supply side interventions, for instance, spending on rural health infrastructure (Filmer et al. 2001). The primacy of HMI in this research is intended as a precursor to studying the health care financing challenges of out-

of-pocket payments and the possibility of realizing the long term goal of universalism in Cameroon.

HMI is one approach to realizing the benefits of risk pooling in the absence of a national risk pooling programme (Dror and Jacquier 1999). These benefits include amongst others the likelihood that those who need health care will be able to obtain it in an affordable and timely manner. It also allows resources to be transferred from the healthy to the sick (Davies and Carrin 2001). Out-of-pocket payments, meanwhile, entail direct payment by the individual seeking medical care at the point of service. These include over-the-counter payments for medicine and fees for consultation and services. This health care financing regime prevents millions of people from receiving health care when they need it. For those who do obtain treatment, it can result in severe financial hardship, even impoverishment (WHO 2010c: XI). Universal health coverage is advanced by the WHO as the next logical step after HMI in attaining inclusive health care financing (WHO 2008). The challenges and opportunities involved in the application of these three components, within the context of Cameroon's health care financing policy, will be investigated in this study.

1.2 A multi-layered approach

Health care financing in Cameroon is the social entity in this research. In order to embark on a logical study of this social whole, its components are separated into layers. These layers are; out-of-pocket payments for health services, micro insurance and the long term goal of universal health care provision for residents. These layers are presented in Figure 1.1.

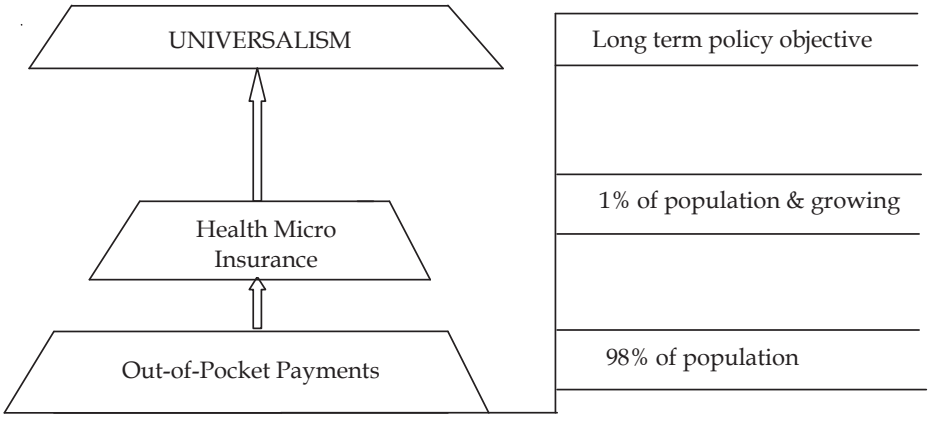

FIGURE 1.1 Layers of health care financing. Source: Government of Cameroon 2005.

The box at the base of Figure 1.1, labelled out-of-pocket payments represents the vast majority of Cameroonians – the 98% shown on the right, who finance

health care directly from individual payments at the point of service. As stated in section 1.1, this mode of financing health care has negative consequences, such as delays in seeking health care and the unpredictability of health care cost (Davies and Carrin 2001). As a result, the government of Cameroon and international NGOs have been promoting the movement from out-of-pocket payments to risk pooling via HMI, as indicated by the upward arrow. However, the response has been less than enthusiastic, with barely 1% of the population enrolled, as shown on the second bar to the right of Figure 1.1. HMI is not an end in itself. The long term objective is the move to universal health coverage. This is typified by the upward arrow linking HMI and universalism. The length of this arrow is an indication of the long time period required, from the conceptualization of universalism to realization in Cameroon. The percentages on the right of Figure 1.1 add up to 99%. The remaining 1% not indicated on Figure 1.1 is distributed between private health insurance policy holders and public service employees covered by social insurance.

According to Mason (2006: 6), some studies are designed with multiple layers or components but with a clear sense that these deal with integrated parts of a whole. It is such a multi-layered approach that I adopt for this study. At the base of Figure 1.1 is the out-of-pocket component. It involves payments for health care made by consumers at the point of service. Out-of-pocket payment leads to catastrophic health care cost (Gilson 1997; Palmer et al. 2004). This happens when people are ill and have no money. They are forced to sell meager family assets or borrow at high cost. Delays in seeking medical care sometimes lead to otherwise avoidable deaths. As a result, poverty and vulnerability reinforce each other in an escalating downward spiral (Churchill 2006: 12). Catastrophic health care cost in such circumstances is suffered by the vast majority of the populace with no prepayment health care coverage. As shown in Figure 1.1 above, 98% of Cameroonians rely on out-of-pocket payments to finance health care. Due to the negative consequences associated with this mode of financing health care, there is need for a shift toward a more equitable regime such as HMI.

Increasingly, governments in low income countries and international donors are promoting HMI, also known as Mutual Health Organization (MHO) or Community-based Health Insurance (CBHI) or Community Based Health Financing Schemes (CBHFS) as a means for providing financial risk protection (Chankova et al. 2008: 265). HMI schemes are typically designed, owned and managed by the community they serve, such as health districts or trade associations. They are usually not for profit and are based on the principles of mutual aid and social solidarity (Bennett et al. 2004). The existence of HMI in Cameroon was officially recognized in 2000 when the ILO identified nine schemes (Government of Cameroon 2006: 10). Despite overwhelming evidence that HMI can reduce catastrophic health care costs for their members, and increase their utilization of modern health care facilities (Atim 1999; Jakab and Krishnan 2001; Schneider and Diop 2001; Jütting 2004), Cameroonians are reticent in joining such schemes. However, membership is growing, though at a

snail pace. This study will search for the reasons for this reluctance. I will also be looking at the challenges and opportunities inherent in MHIs. I am equally interested in discovering whether HMI enhances or hinders the government's overall policy of health system equity anchored in the long term goal of universalism (McIntyre et al. 2005: 29).

The third and final component in this multi-layered study of health care financing in Cameroon is universalism. In Figure 1.1 universalism appears at the apex because it is the culmination or logical progression from out-of-pocket payments through HMI then attaining universal health care coverage for Cameroonian residents. According to the World Health Report (WHO 2008: 25), the fundamental step a country can take to promote health equity is to move towards universal coverage. Callahan and Wasunna (2006: 87) state that universal coverage refers to a system of health care that provides everyone with full access to adequate care, whether through direct taxation, mandatory employer – employee contributions, or affordable private insurance, or some combination of these. Universal health care coverage does not come cheap. Unfortunately, due to the limited tax base, governments in low income countries do not have sufficient revenue to finance universal health coverage (McIntyre et al. 2005). For most low income countries therefore, universalism at best constitutes a long term health care financing policy objective. How achievable this policy objective is in Cameroon will be one of the guiding questions for this study.

It is essential to state that the order of the three tier multi-layered structure of this study presented in Figure 1.1 is by no means static. The order might be reversed, with universalism at the bottom and out-of-pocket payment at the top. This will be the case when it comes to the chronological discussion of the facts as I perceive them. For instance, in Figure 2.1, in Chapter 2, the order of the layers has been reversed, with universalism appearing at the bottom. Above it, there is HMI, followed by out-of-pocket payments. All these come under the canopy of health care financing, which is the overarching social phenomenon in this study. However, no matter the order in which they appear, these three layers remain the structural framework within which this study is anchored.

1.3 Historical Lessons from the North on the Creation of Welfare Systems

Two phases can be distinguished in the historical development of the welfare state in the economic North. There is the 'poor law period' from the sixteenth to the eighteenth and nineteenth centuries and the 'liberal break' in the nineteenth century (Rimlinger 1971). The execution of the national poor laws was mainly left to local communities. Meanwhile, the liberal break with its core ideas of individualistic freedom, equality and self-help produced many divergences

among these countries. Some of the divergent routes taken by these nations will be examined with a view to providing a historical context for understanding the emergent welfare programmes like universalism via HMI in Cameroon. I will begin with and elaborate more on the German experience because many writers trace the beginning of the present-day welfare state to Germany (Heclo 1974, Dorwart 1971, Rimlinger 1971).

In Germany, welfare has its origin in the Christian charitable ethos. For a long time the Church alone was responsible for measures that are now called social policy. Ecclesiastical authorities established hospitals and homes, and gave relief to the poor, sick and old (Zöllner 1982:17). The scenario is partially similar to that in present-day Cameroon, where religious institutions create and run hospitals, mostly in rural areas where no public hospital existed previously. However, unlike in sixteenth-century Germany, these services are not free even to the poor. However, in the absence of any prepaid health care financing, these faith based hospitals unlike public hospitals will not refuse to provide health care to the poor for lack of money.

In later years still in Germany, urban poor laws were passed. In 1530 one such law stipulated that towns and communities were to sustain their own poor (Zöllner 1982: 18, Heclo 1981: 389). This responsibility was later transferred to the state by the Common Law for the Prussian State of 1794. It stipulated that 'The State is responsible for the provision of food and lodgings for those citizens who are unable to support and fend for themselves'. Unfortunately these poor relief laws were also punitive in nature. They entailed the temporary loss of the right to vote and hold public office (ibid).

A step further from the poor laws and motivated by solidarity, guilds established and managed 'guild collection boxes'. These are funds into which each member of the guild had to contribute regularly. In case of illness, these funds met the cost of treatment in particular hospitals with which they had agreements (Zöllner 1982). This is the modus operandi of present-day HMI in Cameroon. Later these schemes were extended to other occupations and were made compulsory with obligatory contributions by both workers and employers. Though successful, the programmes were not without limitations. There was the issue of a small pool, which was addressed by extending the scheme to other occupations and eventually making it compulsory. Also, there was the coexistence of various funds with discrepancies in prerequisites and types of benefit (ibid.). Just as with present day HMI in Cameroon, such a scenario makes for non-portability of members' benefits. These challenges notwithstanding, the schemes constituted important building blocks for social insurance in Germany. This is particularly the case with the Sickness Insurance law which came into force on 1 December 1884.

Another route toward the welfare state worth examining is that taken by Britain. In early nineteenth-century Britain, social welfare has been described as 'minimal' with the individualist philosophy advocating self help and condemning state intervention (Pierson 2006). Following a large number of strikes in 1924, the activities of trade unions were barely tolerated than

encouraged. Ambitious schemes for national cooperative movements to challenge the prevailing economic system were abandoned in favour of more modest and unco-ordinated movements in some key industries for the purposes of collective bargaining (Ogus 1982: 158). Even the relief offered from the Poor Laws Act of 1601 was designed to be unattractive. This was evident in the Poor Law Report of 1834 which reflected the popular view consistent with the individualist and self-help ideology that poverty resulted from idleness. In this vein, overgenerous welfare was considered an incentive to pauperism with the resulting burden on the community (ibid.: 161). On the other hand, the report also argued that the new system should contain three elements: reduced eligibility, the workhouse test and administrative centralization (Barr 2004: 18).

Interestingly, the supposed progress emanating from the development of voluntary savings through friendly societies was still anchored within the framework of the individualist ideology. Its members sought mutual protection against illness and to support surviving dependants after the death of a member. Unfortunately, it did not cover the bulk of the working population because only the more affluent workers were able to meet the friendly societies' requirements. Nevertheless, their expansion led to the granting of a special legal status (Ogus 1982). A number of reasons have been advanced for the relative late development of social insurance in Britain. These include, among others, the enduring strength of the individualist ideology. Secondly, collectivist political movements were slower to develop in Britain. Thirdly, the rapid expansion of private and voluntary collectivist welfare, though elitist institutions like the friendly societies, diluted demand for universal schemes (ibid.). However, Hay (1975) distinguishes three reasons that led to liberal reforms: pressure from below, changing attitudes to welfare provision and institutional influences. As such, in 1911 the National Insurance Act was enacted, which provided among other benefits wide sickness coverage.

I will now turn to the path pursued by some of the Scandinavian countries towards a welfare regime. According to Kuhnle (1981: 136), the Nordic countries historically shared some fundamental similarities. For instance, they all had voluntary sickness and burial funds or societies. All the countries had poor laws with administrative responsibility placed in communities. For purposes of brevity, I will focus on two of the Nordic countries – Denmark and Finland – which represent opposing ends of the spectrum in variables such as political representation, socioeconomic development and timing of compulsory insurance.

In 1849 Denmark put an end to royal absolutism and introduced a system of representative democracy. This resulted in the spread of the principle of self-reliance. Meanwhile, Finland was not yet an independent country hence it had no representative democracy with widespread suffrage. Therefore, Finland faced higher barriers to effectuate social legislation (Kuhnle 1981: 141). In Denmark the strong principle of self-reliance led to a multiplication of mutual aid societies from 1865 to 1875. As a direct consequence of this, Denmark in 1892 enacted a law on sickness insurance, which involved state subsidies to

voluntary funds. Meanwhile, Finland waited till 1963 to legislate for compulsory universal sickness insurance, probably due to its late industrialization (Kangas and Palme: 2005: 20-21).

The preceding discussion reveals that, from humble initiatives like HMI, Cameroon can eventually attain universal coverage in the long run, like other countries did starting with the voluntary societies. However, as with the Northern countries, Cameroon will have to expand the risk pool persistently from communities to regions and eventually nationwide. This will depend to a large extent on enlarging the democratic space to achieve real representative democracy, without this it will be difficult to enact social legislation, as the case of most Northern countries in the nineteenth century has shown.

1.4 General Objectives of the Study

Even within the African context, Cameroon can be considered a late starter in the HMI sector. The emergence of HMI in Cameroon came more than a decade later than in Senegal and Ghana. The first HMI schemes were officially identified in Cameroon in the year 2000 in a study undertaken by the ILO (Government of Cameroon 2006: 10). This entails that Cameroon has to do a lot of catching up in order to raise the level of participation in HMI to that of other African countries. In more general terms, therefore, one of the objectives of this study is to investigate the opportunities available to and challenges facing HMI promoters in Cameroon.

HMI is typically designed to meet the health financing needs of the poor who quite often cannot utilize formal health services for lack of cash to make out-of-pocket payments required at the point of service. Increasingly, there is evidence that a reasonable number of low income populations who would otherwise have no financial protection against the cost of illness are being reached by HMI (Arhin-Tenkorang 2000, Palmer et al. 2004). I will seek to verify the veracity of this assertion in this study. As a relatively new health care financing mechanism in Cameroon, I am interested in finding out the target population's perception of HMI.

Of equal interest is the role of the Cameroon government concerning the shift in policy emphasis from out-of-pocket payment to HMI. According to Bennett et al. (2004: 17) the role of government in the oversight and promotion of HMI is contested and varies from one country to another. While some analysts argue that governments have an important role to play in the policy and regulatory environment within which HMIs operate, others are concerned that the premature intervention by government will deprive HMIs of the grassroots initiative which is one of their main characteristics. Identifying the level of the Cameroon government's intervention in the HMI programme is one of the objectives of this study. Is the government more interventionist or isolationist? Particular attention will be paid to the policy orientations aimed at providing an enabling environment for HMI operations. It will be worthwhile

to investigate the contribution of HMI toward the long-term objective of universal health coverage advanced by the WHO (WHO 2008). These, in a nutshell, are the broad based objectives of this research.

1.5 Organization of the Study

This thesis falls into two parts, though it has not been formally divided. The first part consists of Chapters 1 to 5, and Chapters 6 to 9 make up the second part. In the first chapter, 'Introduction', I present a bird's-eye view of the social phenomenon under investigation, which is health care financing in Cameroon. It explains the trilogy of health care financing and its application within the context of Cameroon. I also state the *raison d'être* for my choice of research topic as well as shedding some light on the multi-layered structure of this research.

Chapter 2 deals with the theoretical orientation of the study. The theories have been grouped under two headings: social policy and collective resource mobilization. They provide a theoretical lens through which I study health financing in Cameroon. In Chapter 3, I address the problem underlying the social reality under investigation. Inequality is presented as the main social challenge in health care financing in Cameroon. HMI, also known as community based health financing, is introduced as a short- to medium-term measure to address such inequality. A long-term solution seems to be a gradual transition from out-of-pocket payments for health care to universalism for all in Cameroon. Chapter 4 treats the aim of the research and the all important methodological decisions for the study. It touches on the choice of mixed methods research and its suitability for this study. In Chapter 5 I present the country context of the study which is Cameroon.

The second part includes chapters dealing with issues emanating from the empirical findings. In Chapter 6, I present the quantitative data and in Chapter 7 I present the analysis of the quantitative data conducted with the aid of SPSS version 18 for Windows. Chapter 8 deals with the presentation and analysis of the qualitative data. Finally, in Chapter 9 I discuss the salient findings and draw the necessary conclusions emanating from the study and make proposals for further research.

2 THEORIES: SOCIAL POLICY APPROACH AND COLLECTIVE RESOURCE MOBILIZATION

Health care financing is the overarching social phenomena in this study. Health care service users who do not belong to HMI schemes and are obliged to make out-of-pocket payments will be investigated to understand how non-members perceive micro insurance. These constitute the vast majority of health care consumers in Cameroon. The next step will be a study on health micro insurers. This will provide an insight into members' experiences with HMI schemes, informing on the opportunities and challenges therein. The third tier will entail an investigation into the possibility of universal health provision for Cameroonians. In such a multi-layered study, it is evident that no single theory can succinctly provide an overall orienting lens. A multiple theoretical perspective is the choice for this research. Alford's theory of structural interest, the economic theory of state intervention and the institutional theories of politics are grouped in this study, under the rubric 'Social Policy Approach'. Meanwhile, Hechter's theory of solidarity, the national values approach and the social democratic model, constitute 'Collective Resource Mobilization' Theories. These theories are diverse yet constitute a 'unified, systematic explanation of a diverse range of social phenomena' (Schwandt 1997: 54).

These theories were chosen because individually they provide guides to understanding the various components of this multi-layer research. For instance, Alford's theory of structural interest will inform on the repressed interest in this study, represented by the poor who rely on out-of-pocket payments to finance health care. The economic theory of state intervention provides justification for the involvement of the government of Cameroon in HMI issues for reasons of economic efficiency or social justice. Institutional theories of politics provide explanation concerning the bureaucratic inertia affecting the enactment of laws regulating HMI in Cameroon. Hechter's theory of solidarity informs on the dynamics of group formation which is crucial in the success of HMI schemes which are created and owned by group members. The national values approach sheds light on some customs and traditional values of Cameroon which might be acting as inhibiting or enhancing factors toward the

spread of HMI as a mode of prepayment for health care. Finally, the social democratic model was chosen as a possible political model for Cameroon, with a long-term goal of providing universal health care coverage to its citizenry. The contribution of these theories guiding the investigations in this study will become clearer as we proceed in this chapter.

Health care financing rests on the triple concept of (1) resource mobilization, (2) pooling risk and (3) purchasing goods and services. These can be understood through social policy and liberal theories of society. HMI deals with the ability of communities to constitute themselves into a group in order to mobilize resources for the sake of sharing health risk. That is why I rely on resource mobilization theories to facilitate an understanding of the group dynamics involved in constituting HMI schemes at community level. Universal provision is the long-term goal of most health care financing programmes. Theories of social justice will guide the search for meaning and justification for the pursuit of universalism in Cameroon's health financing policy.

The main social phenomenon in focus is the role of HMI in Cameroon's health financing. Is it detrimental or instrumental toward designing a long-term policy of universal health care provision? Theoretical lenses to explain the role of HMI in Cameroon's health financing have been clustered into theories bordering on the social policy approach and collective resource mobilization. According to Jordan (2006), three major issues confront governments' social policy in the twenty-first century, these are: (1) How to meet the needs of the poorest members of their population. (2) Are these measures imbedded into their domestic social order, and (3) Are they sustainable given finite resources? One may argue that the social policy challenges of societies cannot be limited to these three. For instance, the challenge of maintaining social cohesion in an increasingly conflict laden twenty-first century needs to be highlighted. However, the social policy approach as articulated in this study revolves to a large extent around these three major concerns.

Equally, collective resource mobilization as used in this research requires some explanation. HMI is community based, owned and managed by the community. Hence, it is commonly referred to as community-based health care financing (Bennett 2004). Members of a given community come together to pool their financial and human resources to meet their health financing needs in the absence of any social security system. In order to fully understand its modus operandi I have sought guidance from collective resource mobilization theories. With these theories, the emphasis is on the sense of the self that is derived from membership in large, dispersed social categories and the sociocognitive processes that underlie such identification (Brewer and Silver 2000: 153). In the case of HMI, the sociocognitive process begins with the realization within a given community of the need to pool resources together for improved health care financing. It is materialized with the mobilization of human and financial resources to create the community health insurance venture.

Data for this study were collected neither to test nor to build theories. On the contrary, the various theories used are important in their own right, because

they provide a backcloth and rationale for the research that is being conducted. They also provide a framework within which the social phenomena can be understood and the research findings interpreted (Bryman 2008: 6).

2.1 The Social Policy Approach

I chose to begin this section with the Social Policy Approach because health care financing constitutes the conceptual canopy for this study, as stated in the introduction to this chapter. The Social Policy Approach provides the theoretical platform for the activity of social policy making to promote wellbeing (Alcock 2012: 5). In the absence of social security provisions, HMI becomes a worthy alternative to enhance wellbeing in health care financing in Cameroon. The Social Policy Approach is therefore, intended to lay the theoretical ground work for this research. Thereafter, I will discuss Collective Resource Mobilization Theories in the later part of this chapter. Collective Resource Mobilization Theories will shed more light on the complexities involved in pooling resources by marginalized communities to finance health care via micro insurance. At this juncture, it is worth stating that social policy is concerned with the social relations necessary for human wellbeing and the systems by which wellbeing may be promoted (Dean 2012). I argue, based in part on the Social Policy Approach that, attempts to strengthen HMI in Cameroon capture these relations for human wellbeing and the system promoting it.

In this study, I am discussing three theories within the Social Policy Approach. These are by no means exhaustive, nevertheless, they succinctly explain different aspects of the broader concept of social policy within the context of this research. Alford's theory provides useful insight into the conflicting interests within the health sector. Of particular interest is his presentation of repressed interest (Alford 1975). This corresponds with the interest of the urban poor and rural masses that make up the bulk of micro insurance adherents – the main thrust of this study. The economic theory of state intervention is discussed because of its forthright arguments for state intervention on the dual motives of efficiency and social justice (Barr 2004, Rawls 1972). Efficiency and social justice are indispensable concepts in the sustainable management of HMI programmes. Lastly, I co-opt institutional theories of politics under the social policy approach because they provide explanations for the functioning of community health financing as an institution. They equally shed light on the workings of public institutions concerned with health care, like hospitals and ministries of health and social security.

2.1.1 Alford's Theory of Structural Interest in Health Care

In 1975 Robert Alford outlined a theory of structural interests to explain the interactions he observed between various stakeholders in the New York health system. Alford argues in his thesis that the structures of health services tend to systematically and automatically privilege certain interest groups. Therefore, 'the principal barriers to health care reform lie in the power of strategically structured interests' (Alford 1975: xiii). Alford does not define 'interests', other than stating that they should not be seen as synonymous with pressure groups or interest groups. This suggests that he implicitly espoused an 'ideal-regarding' concept whereby the analyst (rather than the actor) identifies interests, while it is interest groups that act in pursuit of their perceived interest (Checkland et al. 2009: 608). Nevertheless, Alford identified three categories of interest.

2.1.1.1 Dominant Interests

Alford (1975) identified the interests of the medical profession as the 'dominant structural interest' in health care. He referred to this group as professional monopolists. The medical profession includes doctors, medical schools and public health agencies that have an interest in maintaining 'control of the supply of physicians, the distribution and cost of services and the rules governing hospitals' (p. 14), but doctors in clinical practice are the most important interest group representing the professional monopoly (p. 194). Alford states that the interests of professional monopolists 'are affected differently by various programmes of reform. But they share an interest in maintaining autonomy and control over the conditions of their work, and professional interest groups will – when that autonomy is challenged – act together in defence of that interest' (p. 192). The successful revolt by consultants in the United Kingdom against a new system for appointing junior doctors to training positions demonstrates that clinicians remain the dominant power group, if they choose to use their power (Williamson 2008). The structure of social, economic and political institutions as they exist in any given time provides the source of power to the professional monopolists (Alford 1975: 191).

However, the dominant interest as identified by Alford cannot be applied stricto senso with regard to health financing in Cameroon. Alford identified doctors, medical schools and public health agencies as the dominant interest. These dominant interests provided the answer to his original question: what interests are systematically served by current structures? One cannot objectively claim that out-of-pocket payments for health care in Cameroon serve the interest of this group to the extent they are willing to maintain the status quo. I therefore share the view, espoused by Barnard and Harrison (1986) and Harrison and Ahmad (2000), that the identity of structural interests is an empirical matter. In this study I have made use of Alford's repressed interest to a larger extent and the challenging interest only minimally.

2.1.1.2 Challenging Interests

According to Alford, internal and external social pressures and resulting shifts in structures will give rise to 'challenging interests', seeking to establish themselves as the new legitimacy. 'The changing technology and division of labour in health care production and distribution and the shifting reward to social groups and classes are creating new structural interests which I label corporate rationalization' (p. 15). Corporate rationalizers constitute civil servants in government health departments carrying out the wishes of politicians, executive health service managers, public health doctors, and deans of medical schools. This group also includes many academic commentators on health care and health services – seeking the rational use of resources for a defined population of patients. For managers of the system, these pressures imply a need for greater coordination between services and more efficient bureaucratic management (Checkland et al. 2009: 609). An example of attempted corporate rationalization at the macro level is the state requirement that 'expansion of health care facilities need to be approved by an administrative decision' (Alford 1979: 202). Interestingly, Alford cautioned against overemphasizing the difference between the dominant and challenging interests as both of them are the modes of organizing health care.

Civil society actors and international NGOs advocating for HMI in Cameroon may be likened to the challenging interests articulated in Alford's theory. However, they are not challenging any dominant interest served by the current structure. Their challenge is against out-of-pocket payment and its catastrophic health consequences on the repressed interest.

2.1.1.3 Repressed Interests

Repressed interests are held by the community. These interests are heterogeneous with respect to their health needs, ability to pay and ability to organize their health needs into effective demands. The nature of institutions guarantees that they will not be served unless extraordinary political energies are mobilized (Alford 1979: 14). The repressed interests in the context of Alford's study were the poor, the uninsured and those whose incomes pushed them just above the threshold for Medicaid (US state programmes for the poorest people) assistance. He termed these interests 'negative structural interests' because no social institutions or political mechanisms in the society insure that these interests are served (ibid: 15).

The reality in Alford's case study is synonymous with present-day health financing in many low income countries in general and Cameroon in particular. These states cannot afford tax funded social security. A majority of the people are employed in the informal sector, hence they cannot benefit from contributory workers' schemes. Private insurance is too expensive and out of reach for the majority. As such, more than 90% of the population has no form of health insurance. They rely on out-of-pocket payment at point of service with its catastrophic socio-economic consequences. Only 4.6% of GDP is spent on health, and the social security expenditure on health as a percentage of total expenditure on health is a paltry 0.1% (WHO 2005).

Hyo-Je Cho (2000) found similarities between Alford's theory and his study of a dispute between practitioners of oriental medicine and western biomedicine in Korea. He states that it reaffirmed the essentially passive nature of community interest within the structural constraints of health care. Nevertheless, it also demonstrated the possibility of an active involvement of the community in sectional conflicts (Hyo-Je 2000: 130). Within the HMI setting, such conflicts may take the form of disputes between the HMI scheme and the promoters who are mostly local and international NGOs. It may also be between the HMI and the health providers, namely hospitals.

Through massive enrollment and taking part in peaceful conflict resolution, HMI in Cameroon can be empowered to improve the status of the uninsured as a repressed interest group. In India, for instance, the Self-Employed Women Association's (SEWA) Integrated Social Security Scheme was initiated in 1992. It is a trade union of more than two million women, all workers in the informal sector. SEWA goes beyond health insurance, providing life insurance and asset insurance. Women who pay the annual premium of 72.5 rupees – 30 rupees of which is earmarked for the Medical Insurance Fund – are covered to a maximum of 1200 rupees per year in case of hospitalization in any registered (private or public) facility (Preker 2004: 208). However, the ability of HMI to improve the status of the uninsured as a repressed group is limited. For instance, Criel and Waelkens (2003) argue that often even modest sums like $1 per month as a premium for community health insurance are beyond the means of the poorest members of the community.

Alford's theory informs my decision to identify bureaucrats and politicians responsible for enacting legislation on HMI in Cameroon as the dominant interest. However, it is important to note that the dominant interest in Alford's theory is motivated by selfish interest. Meanwhile, the inertia of the dominant interest in Cameroon to enact legislation for HMI is due to limited resources to provide subsidies to the scheme (Bennett et al. 2004). The challenging interest in Alford's theory sheds light on the interest of promoters in this study. These are local and international NGOs like the ILO. They are the principal advocates of HMI as a short- to medium-term solution to inequality in health care financing. The repressed interest in the theory is synonymous with the interest of grassroots community members in my study. These constitute more than 90% of the population who rely on out-of-pocket payments for health care bills.

With insight from Alford's theory, I am able to distinguish these three groups in my study, thereby framing different questions for each group. This is justified by the fact that each group has distinct interests and thus resorts to different approaches to achieve their goals. Identifying each group makes it possible to focus on them separately in order to gain a fuller understanding of the social phenomenon under study which is health financing via HMI in Cameroon.

One of the criticisms levied against Alford's theory is its 'situated nature'. Checkland et al. (2009) argue that the categories identified by Alford relate to

New York City in the late 1960s. Nevertheless I hold the view that Alford's repressed interest – those whose incomes pushed them just above the threshold for Medicaid – are similar to out-of-pocket consumers of health care in present-day Cameroon.

2.1.2 Economic Theory of State Intervention

The economic theory of state intervention seeks to develop a framework that (a) explains and (b) justifies or fails to justify the fact that the state produces and/or allocates some goods such as health care and education, but leaves others like food to the private market. The main issues concern *economic efficiency* and *social justice*. The efficiency aim is common to all theories of society, but the redistributive goals depend crucially on which definition of social justice is chosen (Barr 2004: 64). The definitions of social justice espoused in this study are those advanced by Rawls (1972) and Miller (1976) in their respective theories of social justice. These will be discussed later. For now, I will present the efficiency arguments for state intervention in health care financing.

2.1.2.1 Interventions for Reasons of Efficiency

Efficiency is generally defined by the quantitative relationship between input and output. It can be expressed by the ratio of output/input. The larger the ratio, the more efficient the activity will be (Liu and Mills 2007: 354). Economists often divide efficiency into technical and allocative efficiency (Rosko and Broyles 1988). Technical efficiency means that the output can be maximized by using a given set of inputs. For example, a public hospital is provided with a fixed combination of inputs in terms of the types of inputs and the amount of each input. If the hospital can produce the maximum amount of output by using these sets of input, the hospital can be called technically efficient (Liu and Mills 2007: 355). Meanwhile, allocative efficiency means that the production is made at the best combination of inputs so that the cost of production can be minimized. Allocative inefficiency occurs if the cost for producing a given amount of output can be reduced by changing the combination of inputs without changing output, or if the output can be increased by adjusting the combination of inputs without increasing the total cost (ibid.).

According to Barr (2004: 66), economic efficiency, also known as Pareto optimality, is about making the best use of limited resources given people's tastes. The optimal quantity of any good, ceteris paribus, is that at which the value placed by society on the marginal unit equals its marginal social cost. Economists like Stiglitz (2000) and Varian (2002) maintain that for a general equilibrium to exist three conditions must hold simultaneously.

- Productive efficiency means that the activity should be organized to obtain maximum output from given inputs. This is what engineers mean when they talk about efficiency.

- Efficiency in product mix implies that the optimal combination of goods should be produced, given existing production technology and consumer tastes. The fact that it is possible to build a hospital cheaply is not, per se,

justification for building it. The resources involved could perhaps give the people greater satisfaction if they were used to build a school or to reduce taxes instead (Barr 2004: 67).

- Efficiency in consumption means that consumers should allocate their income in a way that maximizes their utility, given their incomes and the prices of the goods they buy. In formal terms, the marginal rate of substitution must be equal for all individuals (ibid.).

The *invisible hand theorem* asserts that the market clearing set of outputs will be the efficient output bundle only if a number of assumptions hold. These are collectively called the standard assumptions and concern perfect competition, complete market, no market failures and perfect information (ibid.: 73, 74).

- Perfect competition implies a large number of firms and individuals with no entry barriers in any market. Also for perfect competition to exist agents must have equal power – there can be no discrimination. This assumption is frequently breached and hard to correct.

- Complete markets would provide all the goods and services for which individuals are prepared to pay a price that covers their production cost. This however, is not always the case. Markets will generally fail to supply public goods. Secondly, they may consider certain risks uninsurable, capital markets may fail to provide loans, and finally a commodity may not be supplied because a complementary market is absent.

- The ideal of no market failures is particularly difficult to attain as this assumption can be easily violated in one of three ways: public goods, external effects and increasing returns to scale. It is therefore almost unattainable in health care financing as well as in other market oriented situations.

- Perfect information focuses on the extent to which economic agents are well informed. It requires at least three types of knowledge: about the quality of the product, about the price and about the future.

If one of the standard assumptions fails, the resulting market equilibrium may be inefficient. State intervention for reasons of efficiency becomes appropriate. It can be through regulation, finance (subsidies or taxes), direct production or income transfers (Barr 2004: 72, 73). On the other hand, neo-liberals criticize state intervention via welfare services, because they are provided by state monopolies which are insulated from the efficiency-inducing pressure of market competition (Clarke et al. 1987: 135). However, in this study, intervention for reasons of efficiency invites states to intervene through legislation protecting HMI funds, providing doctors to rural hospitals and supplying sufficient drugs for hospital pharmacies.

Goodin (1988: 236) provides a different approach to market failures and the need for the state to intervene on the grounds of efficiency. He presents three kinds of market failures that invite the welfare state to intervene for reasons of efficiency. The first reason is when the good is a public good. As an example he cites "investment in human capital." Goodin argues that, economically, people are just another resource. As such the welfare state

contributes to economic efficiency by guaranteeing the preconditions for making the most effective utilization of this resource. The welfare state does this by ensuring that people are healthy, educated, well fed and by other measures. The second efficiency reason for welfare intervention has to do with economies of scale. Turning specifically to insurance, Goodin notes that there are substantial economies to be exploited from the pooling of risks inherent in group schemes (Goodin 1988: 240, Hannah 1986). The third type of market failure that would necessitate state intervention for reasons of efficiency is concerned with imperfect information, as stated by Barr (2004) above. However, Goodin goes further, to argue that where the state possesses better information on what people want and how to get it, then a case can be made for what he calls 'the superior efficiency of non-market, state-directed allocations' (ibid: 241).

Having examined the need for state intervention due to efficiency reasons, the logical question is – what form should this intervention take? Direct public provision is one alternative and state regulation of private market providers is another (Goodin 1988: 240). Due to the low tax base in most low income countries, the first option is not feasible in the short term. Meanwhile, Barr (2001: 43) takes the argument a step further by suggesting that making insurance compulsory removes the inefficiency caused by non-insurance. This is possible for persons who are risk adverse, by whom the purchase of insurance is seen as welfare improving. On the other hand, individuals who are risk prone will attempt to escape the net, thereby raising the cost of enforceability (Barr 2001: 34, 43). There is therefore no easy way out. Nevertheless, the state has to intervene in markets to ensure that citizens receive basic social services at reasonable cost.

2.1.2.2 Interventions for Reasons of Social Justice

According to Rawls, the primary aim of institutions is social justice. He states that 'each person possesses an inviolability founded on justice that even the welfare of society as a whole cannot override' (Rawls 1972: 2). Justice to Rawls has a twofold purpose: it is desirable for its own sake on moral grounds, and importantly, institutions will survive only if they are perceived to be just. The resulting arguments deal with the distribution of goods, interpreted broadly to include also liberty and opportunity. Two principles emerge from Rawls's theory of social justice.

- *The liberty principle*: Each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others (Rawls 1972: 60).

- *The difference principle*: Social and economic inequalities are to be arranged so that they are both (a) to the greatest benefit of the least advantaged and (b) attached to offices and positions open to all under conditions of fair equality of opportunity (ibid.: 83).

Possible conflict between the two principles is ruled out by a *priority principle*, which gives the first principle absolute priority over the second. A reduction in the liberty of the least well off cannot be justified even if it is to their economic

advantage. Subject to these two priorities, the two principles can be regarded as a special case of a simpler, more general conception of justice, in which 'all social primary goods – liberty and opportunity, income and wealth – are to be distributed equally unless an unequal distribution of any or all of these goods is to the advantage of the least favoured' (ibid.: 301).

Rawls's theory of social justice has been criticized by a number of observers. The first principle is criticized because the list of liberties is considered too narrow, the principle of tolerance (e.g. of diversity of goals) inherent in Rawls's definition of liberty may reflect class bias, and because some issues are left unresolved – for instance, what liberty should be accorded to racists (Barr 2004: 50). Other critiques dispute the priority given to liberty. Poor people might well be willing to trade some liberty for greater social or economic advantage (Barry 1973: 6). The second principle is criticized for its crucial dependence on the maximum-minimum dichotomy, which it is argued, is the optimal outcome only under very restrictive assumptions (Arrow 1973, Letwin 1983).

Another perspective on a theory of social justice is advanced by David Miller. He states that social justice has three distinct features (Miller 1976):

- *Rights* – e.g. political liberty, equality before the law.
- *Deserts* – i.e. the recognition of each person's actions and qualities (implies that someone who works longer hours should receive more pay).
- *Needs* – i.e. the prerequisite for fulfilling individual plans of life (an individual incapable of work should not be allowed to starve).

The main thrust of Miller's argument is that the definition of social justice depends crucially on the society being discussed. In a pure market economy, justice will be defined in terms of rights and deserts. A collectivist defines justice as distribution according to need. He criticizes utilitarians and Rawls for not taking into account the conflicting claims of rights, deserts and needs but blur them into a single indistinct whole (Barr 2004: 50).

State intervention for reasons of social justice gains relevance in this study when one considers the fact that Cameroon is a signatory of the Universal Declaration of Human Rights. Article 25(1) of this declaration states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2.1.3 Institutional Theories of Politics

The third set of theories discussed under the rubric of 'Social Policy Approach' in this study, institutional theories of politics, are of great significance to this

study at different levels. At the macro level, they invite the researcher to pay close attention to the two ministries responsible for HMI in Cameroon, the Ministry of Public Health and the Ministry of Labour and Social Security. At the macro level still, these theories illuminate my investigation into the social and political processes that autonomous state bureaucrats as well as parliamentary committees engage in, as they enact social policy relevant to HMI. Stepping down to the meso level, the contribution of stakeholders like international and national NGOs in HMI will be researched via the critical lens of institutional theories. Finally, at the micro level, we have the community-based health financing schemes which constitute the spine of this study. Here, institutional theories will elucidate the numerous challenges inherent in such a grassroots organization. Researching through these different levels with the theoretical lens provided by institutional theories of politics is a conscious choice. I intend to gain an insight into what works and what does not at the institutional level concerning HMI in Cameroon.

The Cameroon government has set an ambitious target of 40% HMI coverage of the population by 2015. This places a huge responsibility on institutions charged with elaborating social policy. It is for this reason that I have included theories of institutional politics in this research. Whereas social theories of political pressure assume that the expression of demands is efficient – that the final result is proportional to the strength of the initial demand – an alternative approach asserts that the mechanisms by which social pressures are transmitted to political decision-makers are crucial. This is referred to as institutional theories of politics (Immergut 1992: 19).

Similarly, if societal groups are the agents for social reform, their effectiveness as a political voice depends on the political landscape (institutions) in which they must perform. The most important feature of this terrain is shaped by the constitutional design of the state. Comparative historical analyses have revealed four features of state structure that affect social policy outcomes: (1) the role of autonomous state bureaucrats, (2) the state's administrative capacity, (3) the design of political institutions, and (4) the feedback effect of past policies (Maioni 1998: 20).

Bureaucrats are also strategically important to influence the enactment of a universal health financing policy in the future, given the design of Cameroon's political institutions (see Chapter 5). Immergut (1992: 23) states emphatically, 'At the bureaucratic level, we may note that no programme was ever introduced without the very active participation of high-level bureaucrats. Reforms tended to be prepared initially in the executive governments, with interest group consultation following, indicating that interest group opinions responded to government policies rather than initiating them.' This is however, not the reality with HMI in Cameroon. Here, interest groups – notably the ILO and local civil society organizations – advocate for HMI and a legal framework. The role of the state comes in proposing legislation to regulate the sector.

Political institutionalization becomes invaluable in such a scenario. It is the process through which organizations and procedure acquire value (Huntington

1968). In a restricted sense, institutionalization means the development of bureaucratic capacity to govern, from a societal point of view (Alford and Friedland 1985: 117). HMI is a pro poor health financing regime. It has the potential to provide health care insurance for more than 90% of inhabitants in low income countries (Atim 1999). Institutions working to achieve this are definitely striving to govern from a societal perspective. Unfortunately, the reality is often different, particularly in low income countries. Skocpol (1992: 527) asserts that conforming to the needs and capacities of the organizations within which bureaucrats and politicians must maneuver, they often evolve policies that are not necessarily responses to the demands of social groups.

Institutionalization depends on four key characteristics of a stable bureaucratic state: (1) *Adaptability* is the ability of political organizations to survive environmental challenges such as the succession of a new generation of political leaders or changes in organizational function. (2) *Complexity* may involve both multiplication of organizational subunits, hierarchically and functionally, and differentiation of separate types of organizational subunits (Huntington 1968: 17-18). (3) *Autonomy* refers to governmental and political independence from particular social groups. (4) *Coherence* refers to the degree of consensus with which active participants regard the functional boundaries and the procedures of political and governmental organizations. These requirements have been succinctly articulated by Alford and Friedland (1985: 118).

2.1.3.1 Types of Institutional Theory

Elster (1989) states that an institution seems to act, choose and decide as if it were an individual but it is also created by and made up of individuals. To Elster therefore, an institution can be defined as a rule enforcing mechanism. Institutions affect us in a number of ways: by inducing us to act in a certain way; by forcing us to finance activities that we would not otherwise pay for; enabling us to do things that we could not otherwise do (Elster 1989: 148). Concerning this study, the Cameroonian legislature can enact legislation governing HMI, in particular encouraging mass adhesion through subventions. In an extreme scenario, it might make HMI compulsory as with motor vehicle insurance. For such a measure to succeed, substantial state subsidies will be required in order to set payments for HMI premiums even lower than the current rate of 1$ per month.

According to March and Johan (1989), institutionalists can be classified into three theoretical types: historical institutionalist, rational choice and organizational theory. Historical institutionalists argue that the legacy of each country's experiences, patterns of institution building and organization of social interests are important in the adoption of social policies. Preexisting organizations determine, out of the numerous social cleavages, which ones will be important in the political sphere (Immergut 1992: 20). I contend that it was such preexisting institutions that in 2005 decided to initiate widespread adherence to HMI in Cameroon. The aim was to reduce the number of persons

relying on out-of-pocket payments with its catastrophic consequences such as delays in seeking medical care due to lack of cash.

I will shed some light on the rational choice theory before discussing the institutionalist underpinnings of the theory. In its simplest form, the rational choice theory posits that, when faced with several courses of action, people usually do what they believe is likely to have the best overall outcome. Actions are valued and chosen not for themselves but as a more or less efficient means to a further end (Elster 1989: 22). As a theoretical typology for institutions, the rational choice perspective holds that the ways in which institutional rules, for instance, the sequence of parliamentary votes or the constitution of legislative committees, are enacted can affect the strategic interests of political participants. These rules determine which way the pendulum will swing between the competing interests (Popkin 1986).

The third approach of thinking institutionalism has its roots in the organization theory. It starts from a recognition of the limits on human cognition. It stresses the ways in which techniques for processing information compensate for these limitations and analyses their impact on organizational decisions. Standard operating procedures decide what kinds of information should be used to make decisions and how to make those decisions. This sort of 'bounded rationality' restricts choice by ordering information, and hence enables individuals with contrary purposes to achieve coordinated action (Herbert 1957, Immergut 1992). This is possible where the state's capacity to enact reform is quite strong. However, the reality in Cameroon and most low income countries is of states with weak capacities to carry out beneficial social policy reform.

2.1.3.2 State Structure and Capacity for Social Policy Reform

Governmental institutions, electoral rules, political parties and prior public policies create many of the limits and opportunities within which social policies are devised and changed by political actors over the course of a nation's history (Skocpol 1992: 517). Writing of America's failure to enact meaningful social reform like other western countries, Skocpol claims that the fraternal political parties of nineteenth-century democracy were internally weakened as elections became less intensively competitive. As a result the social policy reform gains by maternalist voluntary associations in a dozen state legislatures could not be translated into a comprehensive nationwide social policy reform. This is due in part to the fact that in the USA state and federal courts repeatedly used their powers of constitutional review to strike down laws. The scenario was further compounded by the fact that 'the federal state of courts and parties was undergoing an uneven and fragmentary transformation into a partially bureaucratic, interest-group-oriented system of government' (ibid.). Skocpol's depiction of nineteenth-century American institutions is similar to the present-day institutional reality in Africa in general and Cameroon in particular.

The capacity of most African states to enact beneficial social reform has been compromised by the fact that political activity is mostly dictated by those

who control government. This often generates 'illfare' rather than welfare (Bevan 2004: 98). In this regard, writers have come up with various adjectives to describe African states, such as bifurcated (Mamdani 1996), hybrid (Bayart 1993), or neo-patrimonial (Medard 1992), and some claim many of the states are weak (Jackson and Rosberg 1989). Above all, Bevan (2004) concludes that none are welfare states. However, Botswana can be considered an exception in this regard (World Bank 2013). On the electoral front, while there have been multi-party elections in many African countries since the 1990s, these have not led to democratic accountability (Joseph 1999).

As a direct consequence, individuals in Africa gain more power the closer they are associated to state institutions, and political power brings economic rewards. In this light, the African ruling class has been referred to as a political 'bureaucratic bourgeoisie' (Thomson 2004: 92). According to Thomson, this bureaucratic bourgeoisie consists of ministers, party officials, parliamentarians, bureaucrats, military officers, managers of public corporations and anyone else who exploits their command over state institutions.

The social policy approach and its constituent theories as used in this study have provided a road map for navigating the systems by which wellbeing may be promoted in Cameroon through HMI. However, this does not capture completely the reality of health care financing and its components in this three tier study (see Figure 1.1). In order to have a richer understanding of HMI within Cameroon's health care financing structure, I have included theories of collective resource mobilization.

2.2 Collective Resource Mobilization Theories

Collective, as used in this study, refers to community health financing schemes, commonly referred to as mutual health organizations, in Cameroon. These are groups of individuals who come together to pool their financial and human resources into a HMI fund. The aim is to provide ready finance for medical bills to any member in need, thereby avoiding out-of-pocket payments for health care. Concerning the resources being mobilized, the emphasis is on the attitudinal (trust and reciprocity) component of social capital as opposed to the structural (networks). In making this distinction, Hooghe and Stolle (2003: 2) argue that generalized trust and reciprocity are important prerequisites for cooperative behaviour and the successful solution of collective action problems. The common problem faced by prospective members of the mutual health organization is the absence of social security for health care and the negative consequences of out-of-pocket payments at the point of service.

Collective resource mobilization theories provide variables that capture best, social values and collective attitudes toward health, risk, cohesion and solidarity. These enable the delineation of the community characteristics that create a fostering environment for community financing and those that do not (Jakab et al. 2004: 225). Such characteristics are very important in the success or

failure of HMI collectivities. This is explained by the fact that groups with high levels of membership capital may share a common focus, but unless they have the same mood, no rhythmic coordination will occur. Rhythmic coordination, then, is the result of sets of necessary conditions that are jointly sufficient. No single variable is sufficient to produce rhythmic coordination (Collins and Hanneman 1998: 226). HMI schemes that have attained such coordination are empowered to reach their objective of community financing through prepayment and risk sharing, thereby reducing financial barriers to quality health care. This is the case, for instance, with the Integrated Social Security Scheme of the Self-Employed Women's Association (SEWA) in India (Preker 2004: 208).

Empowering the vast majority with no health social security to finance health care becomes indispensable. The OECD defines empowerment as actions needed to bring about a stronger, better informed voice for poor people with whom they, and those who represent their interests, may influence policy makers. This may require the strengthening of the capacity of organizations that represent the interests of the poor (OECD 2006). In this study, such organizations will include the mutual health organizations responsible for HMI. Empowerment, therefore, is the better way to serve the repressed interest of the vast majority of poor people with no health insurance coverage. 'Power is the generalized capacity to mobilize the resources of the society, including wealth and other ingredients such as loyalties, political responsibility etc. to attain particular and more or less immediate collective goals of the system' (Parsons and Smelser 1956: 49) The equation of power with the mobilization of resources for collective goals leads easily to an institutional mechanism for integrating individual values into a consensus on goals (Alford and Friedland 1985: 70).

The immediate goal of Cameroon's health financing plan is increased adhesion in HMI (Government of Cameroon 2005: 33). The long-term objective as in most social welfare regimes is universal access to health care. Three theories of collective resource mobilization are employed to navigate through the myriad of undercurrents in this social phenomenon – health care financing. These are: the national values approach, Hechter's theory of solidarity and the social democratic model.

2.2.1 The National Values Approach

According to the National Values Approach, the cultural and ideological conditions inherited from each country's past either facilitate or delay governmental actions to promote social security. Skocpol (1992: 16) maintains that inherited values are thought to influence the actions that political leaders choose to take. Such values also affect the ease with which reformers outside the government can build popular support for proposed new policies. However, she contends that such arguments are too holistic and essentialist to account for variations in the fate of different social policies or for changes over time in the fate of similar proposals (ibid.: 17).

It is argued that the difficulty in enacting a comprehensive social welfare policy in the USA is due to its all-encompassing liberal culture in which individual rights are sacred, private property is honoured and state authority is distrusted (Hartz 1955). Similarly, nineteenth and early twentieth-century America has been described as a land of abundance, a market-oriented society whose citizens saw no reason for people to be poor and therefore no reason for any but the most minimal, mostly private, charity (Levine 1988: 23).

In contrast, Cameroon like most African nations has a long tradition of mutual aid societies based on family, peer, tribal or professional affinities. Here, members contribute funds to hand to one member at a time. It is rotatory and is often done to ease the burden of funerals, to assist in weddings and to set up small businesses. Such a cultural practice can be tapped into, to enhance HMI, to pay for members' medical bills in times of sickness (Government of Cameroon 2005: 40, Putnam 1993: 167). Voluntary cooperation – the bed rock of HMI, is easier in a community that has a substantial stock of social capital.

Social capital refers to features of social organization such as trust, norms and networks, which can improve the efficiency of society by facilitating coordinated actions (Putnam 1993: 167). HMI has the potential to make health care financing more efficient if it is anchored on the social capital imbedded in the rotatory aid funds common in Cameroon. Such social capital can be tapped into, not just to strengthen individual HMI schemes but make them less exclusive by extending them nationally and even making participation compulsory (Carroll 2005: 82). This brings us to the twin social capital concepts of bonding (inclusive) and bridging (exclusive).

According to Putnam (2000: 23), bonding social capital is good for undergirding specific reciprocity and mobilizing solidarity (as in HMI). Bridging social capital, by contrast, is good for linkage to external assets and for information diffusion (as in universal compulsory insurance). Another side of the narrative holds that bonding capital is good for 'getting by' while bridging social capital is crucial for 'getting ahead' (Briggs 1998). Drawing parallels with Cameroon, one may infer that membership in HMIs (bonding) permits adherents to 'get by', accessing quality health care without the challenges of out-of-pocket financing. Meanwhile, bridging capital resulting in compulsory universal provision can allow all Cameroonians to 'get ahead' in equitable health care financing. Carroll (2005: 83) takes the argument further, stating that voluntary state subsidized insurance funds have historically constituted vital schools of democracy in the Nordic countries, particularly for those previously excluded from these voluntary programmes. As such, Carroll argues, if embedded in a broader network of corporatist institutions, voluntary subsidized insurance institutions may constitute sites where bridging social capital can be generated. Therefore, the social capital nested in the cultural practice of rotatory aid funds in Cameroon holds huge potential for inclusive social policy reform.

The national values approach provides the theoretical basis explaining the relationship between cultural values like kinship bonds, reliance on traditional

(alternative) medicine, and attitudes toward HMI in Cameroon. The relevance of this perspective on the overall study stems from the fact that, despite the relatively low premium (less than 1$ per month), Cameroonians are not rushing to join HMI. Is this due to the poverty situation of the target population, or a question of ignorance concerning the benefits of prepayments for health care? It is difficult to provide an answer here, however it will soon become clearer, after the data analysis phase of the study.

Nevertheless, literature on the timing of early sickness insurance in Europe reveals that it was partially influenced by the level of socioeconomic development of each country (Kuhnle 1981, Zöllner 1982, Kangas and Palme 2005). However, this cannot be a justification for Cameroonians' reticence to adhere to HMI because, even in relatively affluent urban or semi-urban areas with HMI, the situation is no different. There are no doubt other reasons worth investigating, such as the absence of a legal framework governing HMI. Others include the level of awareness created by promoters and the benefit package proposed to would-be adherents. These notwithstanding, I contend that the national values approach can shed some light on certain cultural practices inhibiting the widespread adoption of HMI given its undisputed advantage over out-of-pocket payments (Atim 1998, Bennett et al. 1998).

2.2.2 Hechter's Theory of Solidarity

Before unraveling Hechter's theory of solidarity, it is worthwhile to throw some light on the original theory of solidarity by Emile Durkheim. In his 1893 classic *The Division of Labour in Society*, Durkheim states that 'we seek in our friends the quality we lack, since in joining with them, we participate in some measure in their nature and feel less incomplete'. In fact, the 'true function' of the division of labour is 'to create in two or more persons a feeling of solidarity' (1893: 55-56). He extended the concept of solidarity by classifying societies into (a) mechanical solidarity, which is traditional, close-knit and associated with subsistence activities, and (b) organic solidarity, which represents modern society with division of labour, increased interdependence and social interaction with members' differentiation (Hulme and Turner 1990: 35-36).

2.2.2.1 Strong Group Solidarity Implies a More Effective Group

I am focusing on Hechter's Theory of Solidarity because it emphasizes group solidarity, the spine of community-based health insurance. In constructing a general theory of solidarity, Hechter differentiates groups from categories, crowds and corporations. 'At a minimum, a group is a collection of individuals who are engaged in a specific type of mutually oriented activity (or set of interconnected activities), entry to which occurs according to one or more criteria of membership' (Hechter 1987: 16). Crowds have no membership criteria, categories lack the activity element, and corporations are defined by ownership rather than joint participation. He defines group solidarity as the extent to which members comply with their corporate obligations to contribute

to the group's joint goods (Hechter 1987). Formally, Hechter proposes that group solidarity = f(ab), a function of the product of the two terms:

a = extensiveness of a group's obligations,
b = rate of member compliance with these obligations.

This equation simply emphasizes that both 'a' and 'b' must be present for the generation of solidarity. In this regard, 'a' is measured in terms of the proportion of a member's resources expected for collective ends. If one interprets parameter b in probabilistic terms as the likelihood that a member complies with a norm, then the product ab yields the average proportion of a member's resources contributed to collective ends (Fararo and Doreian 1998: 13). As rational actors (that is, maximizers of expected utility), individuals will form a group only if membership provides each with a higher level of expected net benefit than that attainable elsewhere. The impetus for group formation, therefore, is the prospective member's desire to obtain the group's joint goods (Chai and Hechter 1998: 36). Prepayments to facilitate health care, is the group's 'joint goods' that HMI members desire to obtain.

As is the case with the National Values approach, it is evident that bonding social capital and bridging social capital resonate with Hechter's theory of solidarity. When individuals have been involved in voluntary cooperation for a substantial time and have developed shared norms and patterns of reciprocity, they acquire social capital with which they can build institutional arrangements for resolving dilemmas over common pool resources (Putnam 1998: 169). Generally, social capital helps people translate aspirations into realities. In this light, Putnam (2000: 288) argues that supporting government through a tax system is a dilemma of collective action. The best way to solve this dilemma, he contends, is by an institutional mechanism with the power to ensure compliance. Social norms and the networks that enforce them provide such a mechanism. These can most assuredly be achieved, via bonding capital in HMI spilling over through bridging capital in the form of universalism in health care financing.

It is important to note that free rider challenges loom large in Hechter's theory. It presupposes that, even though the members have agreed to honour their obligations, each will do better by ignoring them when it is expedient to do so. In other words, if an opportunity exists to gain from others' contributions without contributing, the rational actor will not contribute. Hence, the rate of compliance depends on the extent to which the group can control – through monitoring and sanctions (Fararo and Doreian 1989: 14). Hechter et al. (1992: 79) take the argument to a broader level while discussing social order in a heterogeneous society. They state that even the transfer of individual rights and liberties to a coercive state in return for security does not often result in social order. This, they argue, is because individuals still have an incentive to disrupt order when they can profit by doing so.

In his influential book, *The Cement of Society*, Elster (1989) presents two important concepts of social order. They are predictable patterns of behaviour and cooperative behaviour. The author explains challenges like the free rider which constitute social disorder with the problem of unpredictability. To Elster, unpredictability may be due to the fact that sometimes people have too little knowledge about others to anticipate what they will do. Sometimes they fail to use the knowledge they have. And sometimes no amount of knowledge, however ingeniously used, can help them (ibid.: 2, 3).

Unpredictability or the free rider phenomenon is unlikely in HMI schemes. In other words, it is near impossible for someone to access health care via an HMI scheme without being up to date with his or her monthly contributions. At the point of service, each member's card is checked for regularity of contributions. As a community-based insurance scheme, almost everyone knows each other. Community members are often directly involved in the design and management of each scheme (Preker et al. 2002: 147).

2.2.3 The Social Democratic Model

Increasingly, comparative studies on western industrial welfare states are converging on what Michael Shalev calls the Social Democratic Model of welfare state development. This is the historical construction of a highly centralized trade union movement with a class-wide membership base. It operates in close coordination with a unified reformist-socialist party which, primarily on the basis of massive working class support, is able to achieve hegemonic status in the party system. To the extent that these criteria are met, it is hypothesized that the welfare state will emerge earlier, grow faster, and be structured in ways which systematically favour the interests of labour over those of capital (Shalev 1983: 11).

At this juncture, it is important to take a look at the contribution of the power resource approach in the framing of the Social Democratic Model. The power difference model of conflict holds that, where the difference in power resources between the parties (labour and capital) is great, exchange between them takes place on highly unequal terms. This is due to the fact that a great disadvantage in the power resources makes successful action by the weaker party unlikely (Korpi and Shalev 1980: 307). However, with an improving power position (power resource) labour can more effectively utilize political means - social democratic model to affect the distribution of the fruits of production.

Bevan (2004: 102) insists that those with power engage in activities designed to maintain and enhance their benefits, to keep power, and sometimes to promote social improvement. In order to realize the last objective, the welfare state coordinates social benefits like social insurance, welfare transfers, and public housing, education and health services with industrial regulation. This is achieved by enforcing minimum wages, workplace safety and unionization. These are combined with Keynesian and labour-market policies with the

overriding goal of ensuring economic growth with full employment (Stephens 1979, Korpi 1983, Esping-Andersen 1990, Pierson 2006).

Skocpol (1992: 24) criticizes the social democratic model for providing an insufficient explanation for the development of the western industrial welfare state. She argues that between the 1880s and 1920s in Germany, Sweden, Britain and other nations that launched pioneering paternalist welfare states, social insurance programmes were devised by conservative or liberal politicians and bureaucrats, not by trade unions and social democratic political parties. However, such were the worthy humble beginnings of western welfare that the social democratic model helped propel it to the later stages of universal provision and maximum employment. It is evident that, where social democracy and trade unionism was especially powerful, there emerged encompassing systems of 'social partnership', of class and interest representation within a framework of tripartite consultation and interest intermediation. Hence the social classes, rather than disappearing, became institutionalized agents of collective action (Esping-Andersen 1999: 17). In this light, therefore, social democracy as the cornerstone of the social democratic model is understood as in class organizations and struggles and not anchored exclusively on political party cleavages.

Traditionally, social democrats have sought to deploy democratic institutions to achieve a compromise between the powers of capital, labour and the state. Here, the state seeks to encourage the development of market institutions, protect property and the pursuit of profit within a regulatory framework that guarantees not just the civil and political liberties of citizens, but also the social conditions for people to enjoy their formal rights (Held 2009: 411). For example, during the 1916 elections in Finland, the socialists gained an absolute majority in the Finnish parliament. The social democrats began to make programmatic claims on social insurance, insisting on statutory health, disability and old-age provisions covering all workers. In order not to be left behind, other political parties adopted analogous positions (Kangas 1991: 143). Besides universalism, the social democratic welfare state is particularly committed to comprehensive risk coverage, generous benefit levels and egalitarianism (Korpi 1983, Hicks et al. 1989, Esping-Andersen 1990, Stephens 1996).

Unfortunately, Cameroon like most low income countries with a limited tax base cannot afford such generous provisions. However, building on HMI, political parties, like the Social Democratic Front (now in opposition) can learn from their western counterparts, strategies to enact universal welfare legislation if they come to power. Before proceeding to the next section, Table 2.1 presents the theories used in this study and their relevance to the respective aspects of the study.

TABLE 2.1 Theories and their relevance

Category of Theories	Theories	Relevance
Social Policy Approach	Alford's Theory of Structural Interest	The repressed interest highlights the poor in this study who rely on out-of-pocket payment for health care
	Economic Theory of State Intervention	Justifies government's intervention in HMI for reasons of efficiency and social justice
	Institutional Theories of Politics	Sheds light on bureaucratic inertia delaying a law on HMI in Cameroon
Collective Resource Mobilization Theories	National Values Approach	Customs & traditional values delaying or advancing the growth of HMI in Cameroon
	Hechter's Theory of Solidarity	Informs on the dynamics of group formation – the core of HMI
	Social Democratic Model	Provides a political model for Cameroon with a long tern goal of universalism

2.3 Summary of Social Policy and Collective Resource Mobilization Theories

Alford's Theory of Structural Interest, the Economic Theory of State Intervention, Institutional Theories of Politics, the National Values Approach, Hechter's Theory of Solidarity and the Social Democratic Model are neither exhaustive nor exclusive to community based health financing. However, each theory elucidates a separate component in this multi-layered study of health care financing through micro insurance. This is depicted in the typology represented in Figure 2.1 below. Health care financing being the overarching social entity under study appears at the top. Just below that, on each side, are the two major theoretical categories used in this research, namely Social Policy Approach and Collective Resource Mobilization Theories. Listed below each major category of theory are the individual theories with arrows linking them to the segment of the study where each is applicable. For instance, there are separate arrows linking Alford's Theory of Structural Interest and the National Values Approach to the out-of-pocket payment component of this typology (see Figure 2.1).

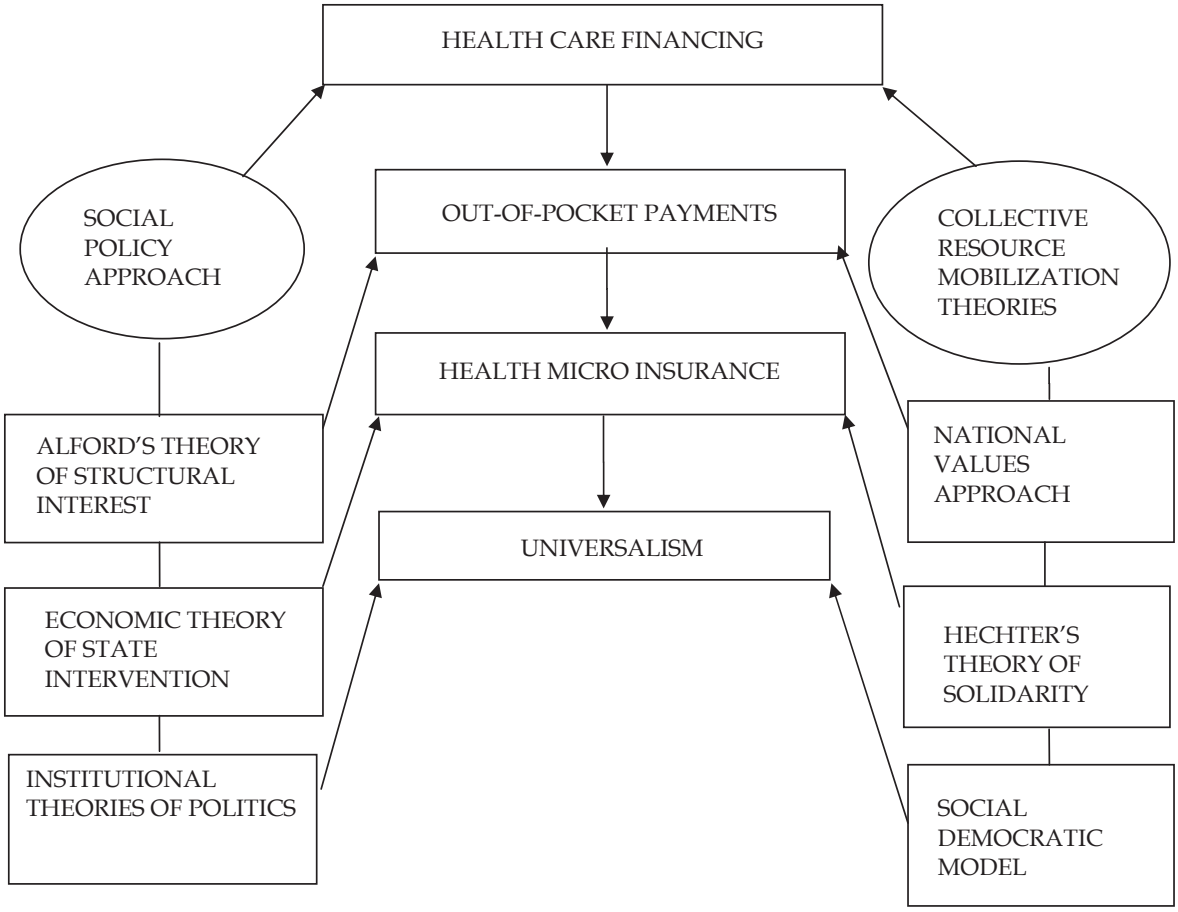

FIGURE 2.1 Theories of Health Care Financing

The reason for this combination of theories is the acknowledgement that health care is certainly a complex social security issue. From the point of view of the beneficiary it encompasses multiple benefits and measures, while on the supply side it is connected to an important sector of the economy involving interrelated financial mechanisms and economic interests (ILO 2010b).

Health care financing is the overarching social reality in this study. I rely on two sets of theories – Social Policy Approach and Collective Resource Mobilization theories – to facilitate the understanding of health care financing in relation to this research, as shown in Figure 2.1. Just below the health care financing block, is that of out-of-pocket payments. In the absence of any viable social security, most people in developing countries finance health care through out-of-pocket payments at point of service. Such financing leads to catastrophic consequences for households (Preker 2004, Churchill 2006). HMI is thus

considered a worthy alternative to out-of-pocket payments. Nevertheless, it is not a panacea for the health care financing needs of the vulnerable. At best, HMI is considered a medium-term objective. The long-term goal for sustainable health financing is universal provision of health care financing as opposed to targeting (Deacon 2009, Mehrotra and Delamonica 2009)

Alford's Theory of Structural Interest is the first of three theories I refer to as the Social Policy Approach. The importance of Alford's theory stems from the fact that any reform of the health care system, including health care financing, is not undertaken in a vacuum but within a given structure. Alford contends that the structure of health services tends systematically and automatically to privilege certain interest groups. As such, the principal barriers to health care reform lie in the power of these strategically structured interests (Alford 1975: xiii). Of principal concern to this study is Alford's concept of repressed interest. He argues that the nature of institutions guarantees that repressed interests will not be served unless extraordinary political energies are mobilized (Alford 1979: 14).

The repressed interests in Cameroon's health care financing structure are those paying for health care out-of-pocket at the point of service. Alford's theory will be applied to understand their challenges, hence the arrow from the theory to the out-of-pocket payment segment (Figure 2.1). Even scholars like Freidson (1970), who focus on elites rather than classes as major 'external' forces, tie the historical trajectory of medicine to the congruence between medical interests and ideology with dominant classes or elites as the principal beneficiaries. The limitation of relying on this theory for this study stems from the differences in time and realities. Alford's structures/interests were situated in New York health establishment of the 1960s. Meanwhile, I attempt to use it within the reality of Cameroon's present day health care financing. However, as stated above, I rely more on Alford's repressed interest which captures succinctly Cameroon's current out-of-pocket health care users.

The Economic Theory of State Intervention seeks to explain why the state will pursue intervention in the health sector and not in other sectors like food distribution. This intervention is mainly for reasons of economic efficiency and social justice. Social health protection is closely linked to the functioning of a strategic social sector – the health sector. This requires an integrated approach towards demand and supply (important economic concepts) in health care (ILO 2010b). On the other hand, when states intervene in the health sector for reasons of social justice, the main goal is to minimize inequality in society.

However, in a scenario where more than 90% of the population relies on out-of-pocket payments to finance health care, as in Cameroon, there are bound to be major inequalities. That is why HMI is increasingly being projected as one of the means of addressing inequality in health care financing. Poland et al. (1998: 787) argue for a redistribution of resources within the health care envelope that would favour primary care and community services. HMI is an example of such community service, worthy of receiving subsidies via resource redistribution for reasons of social justice. This notwithstanding, HMI cannot

eliminate inequity in health care financing. Such is the reality because for the poorest members of society even 1$ per month as HMI premium can be unaffordable.

Institutional Theories of Politics constitute the third approach in the cluster of the Social Policy Approach. At the general level, Maioni (1998: 20) contends that there are four features of the state with a bearing on launching social policy reform. These are: state bureaucrats, the state's administrative capacity, the design of political institutions and the feedback effect of past policies. In well established democracies, there is separation of power between the executive, legislative and judiciary. Each of these government branches can initiate policy reform, even opposition politicians in parliament.

Pressure for the inclusion of HMI into Cameroon's social security policy is exerted mainly by civil society organizations. Institutional theories of politics assert that the mechanisms by which social pressures are transmitted to political decision-makers are crucial. This is referred to as institutional theories of politics (Immergut 1992: 19). According to these theories, if societal groups are the agents for social reform, their effectiveness as a political voice depends on the political landscape (institutions) in which they must perform.

The role of institutions in social security reform cannot be overemphasized when one considers what has been termed institutional inertia or path dependency. This occurs when existing institutional arrangements exert a powerful influence on institutional reforms (Kohl 2001). The existence of institutional inertia and path dependency demonstrates that the existing financial structure of social security schemes can have an important implication for the future financing possibilities of these schemes (Sjöberg 2001). State bureaucracy in Cameroon is hugely influential in the elaboration of a policy for HMI, hence the need for institutional theories of politics. This is more evident when it comes to the universalism discourse, as shown in Figure 2.1 with the arrow linking institutional theories of politics and universalism.

Collective Resource Mobilization Theories constitute the second cluster of theories relied on to explain the challenges of health care financing as applied in this study. Collectives in this sense refer to would-be members of micro insurance schemes. The resources they contribute include human as well as financial.

The National Values Approach is the starting point for the collective resource mobilization approach. It argues that the cultural and ideological conditions inherited from each country's past either facilitate or delay governmental actions to promote social security. An example of the influence of past ideological conditions on the enactment of social security legislation can be seen in the Nordic model of universal provision. Kangas and Palme (2005: 19, 20) state that the bipolar class structure (industrial capitalist and working class) in Central Europe led to social policy on workers' insurance. On the other hand the tripolar class structure of Nordic countries comprised industrial capitalist, working class and independent peasantry as a distinct social class with political representation. As a result of this tripolar class structure, Nordic countries

began to enact laws on national insurance covering the whole population, rather than workers' insurance only, as in many European countries.

The national values approach will be explored in this study to provide an insight into the effects of cultural practices – like reliance on kinship and traditional medicine – on HMI in Cameroon. On the other hand, I will investigate if national values like the traditional mutual aid associations can be relied upon to wean Cameroonians from out-of-pocket payments.

Hechter's theory of solidarity treats group solidarity as the extent to which members comply with their corporate obligations to contribute to the group's joint goods (Hechter 1987). The joint goods of HMI is the total amount contributed by its members to finance the health care of members as the need arises. It is therefore clear that each micro insurance scheme can only be successful in meeting its goals to the extent of members' group solidarity. Solidarity and group solidarity in particular, as developed in Hechter's theory, becomes an important concept in explaining the varying success rate of HMI schemes.

According to theorists of the Social Democratic Model, the welfare state is a result of the growing strength of labour in civil society. Social democracy which is the foundation for the social democratic model relates to class organizations and struggles and is not limited to political party arrangements. The inclusion of the social democratic model in this discourse is guided by the need for a theoretical orientation in the pursuit of universalism as a long-term health financing policy in Cameroon. Apart from universalism, the social democratic welfare state is committed to comprehensive risk coverage, generous benefit level and egalitarianism (Korpi 1983; Esping-Andersen, 1990). The Social Democratic Model can constitute a platform from which the opposition party the Social Democratic Front can launch a welfare agenda if it subsequently gets elected into government in Cameroon.

Both categories of theories (Social Policy Approach and Collective Resource Mobilization Theories) were instrumental in enriching the data analysis process. Beginning with the Social Policy Approach, *Alford's Theory of Structural Interest* in conjunction with empirical data informed the findings of HMI members' use of out-of-pocket payments. The state of Cameroon could rely on the *Economic Theory of State Intervention* for reasons of social justice to justify its enactment of a legal framework for HMI with subsidies. Empirical evidence of bureaucratic inertia is clarified by the Institutional Theory of Politics. The second group of theories – Collective Resource Mobilization Theories – also enhanced the data analysis. For instance, the *National Values Approach* either nullified or validated certain hypotheses touching on some cultural values of Cameroon, like reliance on kinship and use of traditional medicine. *Hechter's Theory of Group Solidarity* illuminated the findings on the strength and weaknesses of various HMI schemes. Finally the Social Democratic Model provided a political model worth considering in Cameroon's quest to attain universalism in health care financing.

3 HEALTH MICRO INSURANCE AND THE EQUALITY ISSUE IN HEALTH FINANCING

Equity, whether in health, wealth or power is rarely, if ever, fully achieved. Some societies are more egalitarian than others but, on the whole, the world is unequal. Value surveys, however, clearly indicate that people care about these inequalities – considering a substantial proportion to be unfair 'inequalities' that can and should be avoided (WHO 2008: 15). One such sector where gross inequalities exist and deserve urgent attention is health care financing.

Health care financing is concerned with the ways and means by which citizens pay for health care services. Countries need to mobilize sufficient resources to provide essential health services for their populations, reduce inequalities in the ability to pay for those services, and provide financial protection against impoverishment from catastrophic health care costs. This can be done through explicit policies affecting three of the health financing functions: collecting revenues, pooling risks, and purchasing goods and services (Gottret and Schieber 2006: 45). Health financing in countries belonging to the Organization for Economic Cooperation and Development (OECD) is predicated upon tax – financed social security, social or private health insurance. However, in non OECD countries, a significant part of the population is engaged in the informal economy. This includes the rural, agricultural self-employed and the urban poor. Because of their inability to pay for contributory insurance, they fall into medical indigence (Dror 2001: 672).

Inequality in health financing does not exist only between countries, it is equally prevalent within countries. Health inequalities, as indicated by morbidity and mortality differences between social classes, educational groups or income strata, may be viewed as a very extreme form of inequality (Fritzell and Lundberg 2005: 173). There is growing evidence that health inequality and poverty reinforce one another in a vicious circle. In a study conducted in 2000, Wilkinson found that the smaller the degree of socio-economic inequality, the healthier the society, in the sense that in these societies death rates tend to be lower and people live longer. This probably is due to the fact that more equal societies are less stressful: people are more likely to trust each other and are less

hostile and violent towards each other. He therefore concludes that, in order to improve health and social capital and create a more inclusive society, the reduction of inequality must be a key political objective (Wilkinson 2000: 3, 67).

Equity in health care financing demands that individuals (or families) with different abilities to pay should make 'appropriately dissimilar payments' for health care. As such, higher income individuals would pay more than those with a lower income level (vertical equity). In the same vein, it is equitable for individuals (or families) with the same ability to pay to contribute the same amount towards their health care costs, referred to as horizontal equity (Wagstaff and Doorslaer 1993). HMI is increasingly being presented in health financing literature as a short- to medium-term solution in achieving equitable health financing in middle and low income countries (Atim 1998, Bennett et al. 1998, Bate and Witter 2003, Churchill 2006). HMI promotes both vertical and horizontal equity because those who can afford only the minimum package pay the minimum of 1$ per month. Meanwhile, those who are able and willing can opt to pay 2$ per month and enjoy wider benefit coverage.

3.1 Health Micro Insurance

HMI, also known as community-based health insurance (CBHI), community based prepayment, mutual health insurance, mutual health organization etc., takes different forms. Bennett (2004) defines them as 'any scheme managed and operated by an organization, other than a government or private for-profit company, which provides risk pooling to cover all or part of the costs of health care services'. Bennett emphasizes the management component. Meanwhile Churchill (2006) views micro insurance as the protection of people with low incomes against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved. This definition is essentially the same as that for regular insurance, except for the clearly prescribed target market – low income people.

According to Gottret and Schieber (2006: 96), community-based health insurance schemes have existed all over the world for centuries. They have served as the building blocks for the creation of social health insurance systems in countries such as Germany, Japan and Korea. The last decade has witnessed the exponential growth of HMI in Sub-Saharan Africa. In West Africa, the number of community-based health insurance schemes grew from 199 in 2000 to 585 in 2003 (Bennett et al. 2004). Interest in cost recovery as a mechanism to mobilize resources for health in low income countries is fading. The attention of the global community has turned increasingly to community-based health insurance for resource mobilization and allocative efficiency (WHO 2008: 26). Cameroon joined the HMI movement in 2000. It has since witnessed a slow but steady growth in the number of schemes.

3.1.1 The Functioning of a Health Micro Insurance Scheme

HMI occupies an important place in this study. I therefore find it necessary to shed some light on this relatively new mode of health financing in Africa. According to Fonteneau and Galland (2006: 382,383), two developments led to the appearance of HMI in Africa in the late 1980s and early 1990s. These are (1) the democratization process and (2) the implementation of the Bamako Initiative.

In many African countries the late 1980s witnessed the start of democratization and the emergence of a civil society. As a result, many initiatives were taken by the population to respond to urgent needs. One such initiative was the associational affiliation of HMI, commonly called Mutual Health Organization (MHO). These were constituted as non-profit, autonomous mutual interest organizations to cater for members' health care financing needs (Fonteneau and Galland 2006: 383).

During the 1990s the Bamako Initiative concerning user fees for health care services was progressively implemented. In the 1980s Sub-Saharan Africa was in deep economic crisis. The obligations to service international debt were crushing their economies. Structural adjustment conditionalities imposed by the World Bank were draconian. National budgets for health, education and other social services were declining despite rapidly increasing populations. At best, state financial allocation to public health could barely pay for staff salaries. As a result, public health services were deteriorating fast. In a bit to remedy the situation, African Ministers of Health, meeting in Bamako in Mali, adopted the Bamako Initiative in September 1987 (Paganini 2004). It required measures for recovery of health care costs through user fees paid by patients, and better access to medicines, particularly generic pharmaceuticals. Finally, there was the need for community participation to enhance the quality of health care (Ridde 2003: 532). These two factors, coupled with the contributions of international NGOs facilitated the emergence of HMI in Africa in the late 1980s and early 1990s. Since its inception, the movement for mutual health organizations has witnessed continuous growth in many African countries.

A common characteristic of HMI or community-based health finance schemes, as the name suggests, is that they are highly localized within a given community. They may develop around geographical entities (villages or districts), trade or professional groupings (trade unions or agricultural cooperatives) or health care facilities. HMI schemes are typically designed by and for people in the informal sector and those in rural areas who are unable to get adequate public, private, or employer-sponsored health insurance. Membership of the scheme is voluntary (Bennett et al. 2004: 2).

As community-based programmes, HMI schemes are bound to have some subtle differences in their *modus operandi* reflecting the socio-cultural dynamics of each community in which they operate. Nevertheless, a typical HMI is initiated by an external partner (outside the community), usually a local or international NGO. It undertakes a sensitization campaign, highlighting the

merits of pooling risk and mobilizing resources to finance health care. The development of HMIs is not a purely bottom-up phenomenon since external actors play a strategic role from the beginning (Fonteneau and Galland 2006: 383).

Once the idea has been accepted, a working group is established in the community to oversee the process of starting the HMI scheme. Subsequently, a general assembly of potential members is convened to agree on the benefits package, premiums and operational modalities; for instance, the waiting period. Decisions concerning the HMI are arrived at on a one-person-one-vote basis. Community-based health finance schemes are nonprofit organizations. They are associations of people rather than capital (Ndiaye et al. 2007: 157).

The brochure of one of the successful HMI organizations in Cameroon, the Bamenda Mutual Health Organization, presents its activities as follows:

- Registration is the equivalent of 2$ per family, paid once
- Contribute 7$ each annually to cover at least four members of a household.

The MHO in return pays:

- 75% of member's consultation bills up to a maximum of 30$ up to three times in a year
- 75% of hospitalization bills up to a maximum of 60$ up to three times in a year
- 75% of delivery bills up to a maximum of 50$ per year
- 75% of surgery bills up to a maximum of 240 per year
- 100% for opportunistic infections, laboratory tests and second line treatment for people living with HIV/AIDS

The Bamenda MHO represents a typical standard operating system for HMI schemes. A second look at the cost/benefit ratio of the scheme above reveals a heavily tilting imbalance in favour of the benefits. For instance, with an annual premium of 7$ one can benefit up to 75% of 180$ in hospitalization costs or 75% of 240$ for surgery in a year. This is feasible when the group size is large enough. When the group size is small, it may lead to some supply side instability (Dror 2001: 673). Solidarity is an indispensable prerequisite for a successful HMI scheme. It allows for cross-subsidies between sick and healthy individuals. Solidarity amongst members is as important as among potential members. Sensitizing people to establish a HMI is easier in communities where the principle of solidarity is entrenched and the degree of social capital is elevated (Radermacher et al. 2006: 74)

3.1.2 Critique of Health Micro Insurance

There is overwhelming evidence that HMI reaches a large number of people on low incomes who would otherwise have no financial protection against the cost of illness (Bennett 2004, Jakab and Krishnan 2004, Churchill 2006). However, the recurrent criticism often levelled against HMI programmes is that the poorest and most vulnerable groups are often excluded from these schemes (Ekman 2004, Jakab and Krishnan 2004, Jütting 2004, De Allegri et al. 2006). Sometimes, even relatively modest premiums like 1$ per month can be too high for the poorest to pay, simply to defray the possibility of future health care costs. Such an affordability barrier has been shown to be a constraint to expanding coverage in most schemes (Bennett et al. 2004, Criel and Waelkens 2003).

In order to improve financial accessibility, governments and philanthropic organizations can subsidize premiums for the very poor. Bennett et al. (2004: 8) highlight the case of Rwanda, where a church subsidized membership for about 3000 widows and orphans. In Tanzania, government and donor funds are used to provide 'matching grants' according to the amount of revenue generated by community health funds. It is intended as an incentive for the scheme to register as many members and generate as much contribution revenue as possible (McIntyre et al. 2005: 29). This implies that areas with lower poverty levels generating larger contribution revenue are able to secure the largest share of subsidies from government and donors, thus raising serious issues of equity. Nevertheless, it is a plausible approach to enhance community participation while securing extra funds for financing health care costs.

Another criticism of HMI schemes is the limited coverage they offer in terms of population and the package of health care. WHO studies indicate that enrolment remain very low in most communities with HMI programmes. The same study states that more than 90% of the schemes do not bear the bulk of the financial risk (Bennett et al. 1998). Dissatisfaction with the package of health offered was also found to be one of the main reasons for low enrolment in Armenia (Poletti and Balabanova 2006). Despite this limited coverage, Polonsky et al. (2009) found that members paid eight times less for health care than non-members in Armenia. Therefore, pooling health risk, even through a micro insurance fund, reduces health care cost. Increasing the health package offered will entail increasing premiums. This may further prevent the poor from enrolling in the scheme. HMI programmes, therefore, may be in a precarious position until substantial funds are acquired from governments or donors.

The principal components of HMI schemes, such as premium levels, collection mechanisms and benefits, vary from one scheme to another. This can make mergers and portability of entitlement very difficult (Ron 2008: 22). Concerning mergers, this implies that two HMI schemes found in two separate communities and promoted by the same NGO cannot merge and be considered as one HMI operating in two localities. With regard to portability and entitlement, it means since each HMI is unique with its own components, an HMI member cannot use the health services beyond the geographical area of his

or her own HMI. This is due to the fact that each HMI scheme contracts with particular health care providers (hospital or health centre) hence, the members can only claim membership benefits at authorized health services. Such a scenario is unfortunate because networking amongst HMI schemes is indispensable if levels of enrolment are to reach the threshold of 50% coverage. Unfortunately, this does not appear to be happening as rapidly as would have been preferred, with a few exceptions such as the network of mutual health organizations in Senegal and Mali (Fonteneau and Galland 2006: 389). Non-professional management of community-based health insurance funds constitutes an additional drawback. Most micro insurance funds are managed by volunteers who often lack the adequate capacity to manage insurance funds (Eklund and Stavem 1996, Roth et al. 2007).

Despite the weaknesses inherent in community-based health financing schemes, they are worthwhile initiatives to minimize inequality in health care financing. Improving financial accessibility through HMI products and geographical accessibility via health services are two strong pillars of a strategy for improving access to quality health care for all (Chankova et al. 2008: 274). Compared with out-of-pocket payments, HMI provides improved and equitable financial access to health. This is due to, among other reasons, the fact that adherents will seek health care earlier and pursue treatment to completion because financial barriers have been minimized with HMI membership. This is usually not the case with out-of-pocket health care consumers, especially the poor in low income countries. Often they delay seeking medical care when ill because they do not have the means to pay at the point of service. Such delays may aggravate the situation as well as lead to further impoverishment (Van Doorslaer et al. 2006). Improving geographical accessibility of health care, calls on the state to provide basic hospital infrastructure per unit of population. These should not be concentrated in the urban centres but extended to the rural areas (Ruff et al. 2011).

3.2 The Role of Primary Health Care

People must possess a modicum of good physical health in order to do well in their everyday lives – whatever they do and in whatever cultural context they find themselves. However, defining health is not easy. Definitions of physical health which focus on physiological impairment are often referred to as 'negative' definitions because they link health with the absence of biological disease (Doyal and Gough 1991: 56). According to this reasoning, therefore, the physical health needs of individuals have been met if they do not suffer in a sustained and serious way from one or more particular diseases (Stacey 1988: 167-172, Monekosso and Martin 2008: 18). Such a narrow view of health is too superficial if one considers emotional stress and its long-term consequences on health. For the purposes of this study, I am adopting the definition of health provided by the World Health Organization in its constitution of 1948, where

health is defined as a 'state of complete physical, mental and social wellbeing, not only the absence of disease or infirmity'.

Attaining acceptable physical health for individuals and society requires substantial human resources, physical infrastructures, equipment and technology as well as capital and recurrent expenditures (Monekosso and Martin 2008: 40). Due to scarcity of resources, and for reasons of efficient allocation, policy makers distribute these health inputs to different geographical areas in different proportions. Unfortunately, this is not often done according to need. Health provision the world over is therefore stratified into different levels.

3.2.1 Levels of Health Care

In their very insightful book Principles and Practice of Community Health, Monekosso and Martin (2008) provide a succinct distinction between levels of health care:

Primary Care

At this level, care is organized for small neighbourhood/village communities (up to about 10.000 people), using comparatively small premises. Primary care often provides first contact care requiring a high level of skill in basic health care for common problems. Organized community participation is vital for the smooth functioning of primary care. Such care is not only feasible but mandatory for small communities in all countries. It is essential care provided locally with a view to ensuring total population coverage. A successful primary health care programme will result in a reduction of infant mortality rate. There will be improved physical, mental and social fitness of the population due to a considerable reduction in morbidity and mortality. Finally, better control of the habitat and sanitation measures will free more land of disease vectors.

Secondary care

Secondary health care covers a sizeable region, comprising towns/cities and associated rural districts. The combined population is often above 100,000. It operates in general/provincial hospitals or preventive medicine units, requiring high levels of skill in serious life threatening problems. Secondary care often provides referral support for local health services, leading to a moderate reduction in morbidity and mortality from life threatening diseases and injuries.

Tertiary care

This is organized for large populations (generally up to one million). Using highly specialized hospitals, tertiary care concentrates on problems beyond the reach of the general specialties. It is the summit of the health services pyramid in large countries and the terminal point of the referral network, for instance, university teaching hospitals. Tertiary care leads to

further reduction, though relatively small, in morbidity and mortality due to uncommon or complex health problems.

These three levels of health care have been maintained in most developing countries which inherited this model from colonialist western countries. However, WHO in its 2008 report decries the discrepancies that exist between the levels of primary health care of low income countries and of resource rich countries of the North. The emphasis on primary health care (PHC) is because it is the entry point to the health care chain. Primary health care also operates where the vast majority of the people in low income countries reside. The WHO report states that it is unacceptable that in low income countries, primary health care should only deal with a few priority diseases. In some instances, PHC is reduced to a stand-alone health post or isolated community health care worker. PHC in low income countries is often synonymous with low-tech, non-professional care for the rural poor who cannot afford the improved care offered in the secondary and tertiary levels (WHO 2008: XVII).

In order to remedy the situation, Monekosso and Martin (2008: 30) argue that African health systems urgently need reforms and substantial transfusion of resources. They state that the most important resource needed, apart from equipment, is a motivated community health team, led by a community health physician collaborating with other community leaders, willing to integrate health care with other socio-economic development efforts. The secondary and tertiary health levels in developing countries have equally been negatively affected by the massive migration of highly skilled doctors and nurses to greener pastures in the North (ibid.).

3.2.2 The Appeal of Primary Health Care

According to the Alma-Ata Declaration of 1978, PHC is essential health care based on practical, scientifically sound and socially acceptable methods made universally accessible to individuals and families in the community through their full participation and at a cost that the country and community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It is the first level of contact of individuals, families and communities with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (WHO/UNICEF 1978).

The Alma-Ata conference mobilized a primary health care movement of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the politically, socially and economically unacceptable health inequalities in all countries. The declaration was unequivocal about the values pursued: social justice and the right to better health for all, participation and solidarity (WHO 2008: XII). In order to achieve these lofty goals, the momentum that the shift in paradigm thinking about health brought after the conference should be maintained. There needs to be a shift from tertiary care, which is costly and serves the rich few, to

PHC reaching the majority. The challenge is more daunting for people living in low-growth health economies of Africa. Moreover, states must avoid the error of investing disproportionately in tertiary care compared with primary health care (ibid.: XIX).

There are shortcomings inherent in health care delivery that a well structured primary health care can minimize. Top of the list is the fragmentation of care. The excessive specialization of health care providers discourages a holistic approach to the individuals and families they deal with and do not appreciate the need for continuity in care (Starfield 2002). Health services for the poor and marginalized groups are often highly fragmented and under-resourced (Moore 2003). Development aid often adds to the fragmentation through uncoordinated aid policies by different donors prioritizing different sectors (Shiffman 2008). Primary health care can ameliorate this weakness in health care delivery because it is people centred and rests on solidarity. This bonding of communities with health providers can facilitate follow up of patients at family and individual levels.

Misdirected care can equally lead to negative consequences on the overall health care of citizens. Resource allocation is concentrated around curative service at great cost, neglecting the potential of primary prevention and health promotion, which can prevent up to 70% of the disease burden (Fries et al. 1993, WHO 2002b). The key PHC concepts of essential drugs, access to clean water, sanitation and antenatal care have dramatically reduced morbidity and mortality (WHO 2008: XII).

The reality with inverse care is closely related to misdirected care. However, the focus is on the people. Hart (1971) argues that the people with the most means, whose needs for health care are often less, consume the most care, whereas those with the least means and greatest health problems consume the least. To exacerbate matters, public spending on health services often benefits the rich more than the poor in high and low income countries alike (Filmer 2003, World Development Report 2004, Hanratty et al. 2007). Reorienting public health policies towards PHC will redress this health financing inequity in favour of the poor. Figure 3.1 presents a graphic summary of the realities of inverse care and misdirected care.

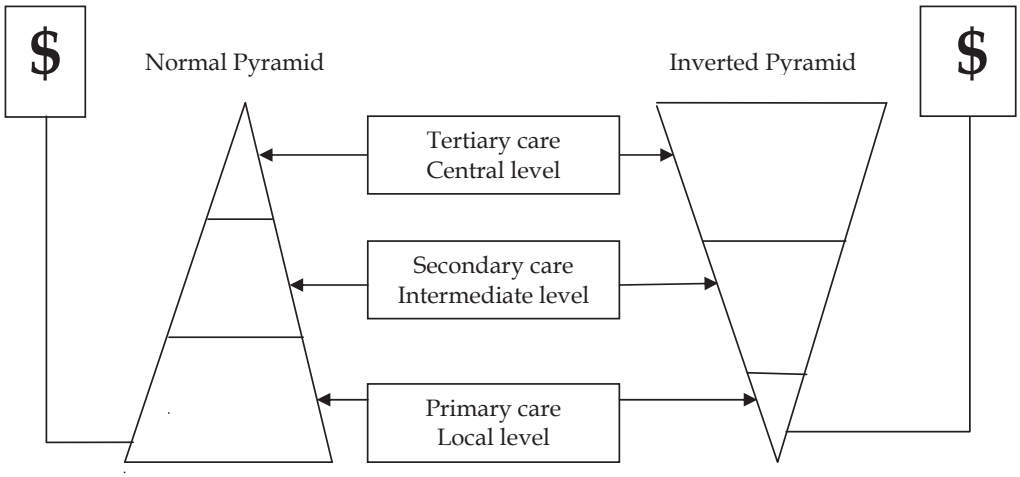

FIGURE 3.1 Pyramids of health care financing (Source: Monekosso and Martin 2008)

Traditionally, the pyramid for health care financing is upside down (inverted pyramid) as seen in Figure 3.1. The distribution of funds and personnel for primary health care, compared with costly hospital based care, is in inverse proportion to the numbers of people that need to be reached (Monekosso and Martin 2008: 39). Redirecting financial and human resources to PHC will improve the situation. However, to reverse the pyramid to (normal pyramid) and attain equity in health care financing will require a system based on solidarity contributions, beginning with mutual health funds of community groups (ibid.: 41).

A majority of the HMI schemes in Cameroon are operational at the primary health care levels. This is where the bulk of the populations' health care needs are met as shown in Figure 3.1. (Normal pyramid). As was stated in Chapter 1.2, HMI is also known as community-based health insurance or community-based health financing schemes. This implies that HMI schemes are mostly operational at the community levels or villages. The community levels are equally the entry point of the health care chain, where PHC begins. It is therefore not surprising that HMI schemes and PHC levels share a common geographical delimitation.

3.3 Rights Based Approach or Sector Wide Approach to Health

Globalization has had and continues to have considerable influence in various aspects of economic, political and social life of citizens the world over. One of such domains is in health. Increasingly, countries' health and other public policies (especially in low income countries) are being influenced by global institutions. These are multilateral, governmental and non-governmental

organizations, all increasingly embedded into a notion of transnationalism (Yeates 2008, Yeates and Holden 2009). Championing the globalization of health policy are institutions like, the WHO, the World Bank, the ILO, regional bodies like the African Union and many international NGOs. These institutions bring with them concepts that enrich the discourse on health in general and health care financing in particular. Rights based and sector wide approaches to health care are two such concepts.

The rights based approach to health is derived from a framework assigning rights and obligations to individuals, groups and states. These global standards are grounded in the idea that states are obliged to provide, among others, acceptable basic standards of health care which will improve the ability of households to manage health risk, as well as improve living standards (Piron 2004: 4). Only the state can guarantee strong entitlement to people of this sort, though this does not require that it directly provides the satisfiers in question – it can regulate, legislate, subsidize and in other ways ensure that other agencies, including private ones, do so (Gough 2000: 8).

A rights-based perspective to health policy builds on three inseparable ideas: universality, equity and comprehensiveness (Filho 2008: 2). While universality and equity are self explanatory, comprehensiveness requires some clarification. It implies that the social response to address inequity and attain universality must be comprehensive enough to be able to break those factors that cause people to be excluded from exercising their rights and attaining equity (ibid.). In the long term, such policies should be able to reduce diseases, early deaths or loss of quality of life as well as reducing inequitable differences among social groups (Diderichsen et al. 2001).

The sector wide approach to health has evolved due to the increase and diverse flow of aid money into the health sector. This has led to a lot of fragmentation and increase in the cost of transactions (Shiffman 2008). In an attempt to achieve a more integrated approach to health development, there has been a gradual shift from project based assistance to sector based approaches (Dickinson et al. 2007: 1). These are considered to promote country leadership, and increase the use of local systems for programme design, implementation, financial management and monitoring and evaluation (ibid.).

In 2000, the government of Mozambique and its development partners established a Sector Wide Approach to Programming (SWAP) in health. Mozambique's SWAP soon became widely cited in international health circles as an epitome of the advantages of working sector wide. These are: improved government leadership, greater sector policy and strategic focus, more effective use of aid to the health sector and lower transaction costs (Martinez 2006: 1). According to Martinez, the public expenditure for health in Mozambique more than doubled between 2001and 2004, thanks to the spectacular increase in the volume of common funds helped by the moderately increasing government expenditure.

The rights based and the sector wide approaches have both played an important role in the introduction and growth of HMI in Cameroon. For

instance, it was the ILO that in 2000 initiated the first feasibility studies on HMI in Cameroon (Government of Cameroon 2005). While in the field for data collection, I identified more than five international NGOs working toward the spread of HMI in Cameroon. Despite their diverse origins, these NGOs coordinated their interventions to avoid fragmentation. As such, where applicable, they all advocated a rights-based approach to health financing by calling on government intervention. This can be done by providing a legal framework for HMI (The Farmers Voice: December 2010). Alternately, these NGOs advocate a sector wide approach to health financing for the poor via HMI. It is therefore obvious that globalization of health policy in general and health financing in particular is central to the growth of HMI in Cameroon.

Globalization encompasses many things. However, of interest to this study is the aspect of globalization relating to the international flow of ideas and knowledge, the sharing of cultures and global civil society (Stiglitz 2006: 4). As stated above, a number of international NGOs are actively involved in promoting the culture of prepayments for health care via HMI in Cameroon. These international civil society actors include among others the German Agency for Technical Cooperation (GTZ) and the Belgian Technical Corporation (CTB). Globalization has also led to renewed interest in the international intergovernmental institutions of the United Nations. Two such institutions are the ILO, promoting decent working conditions, and the WHO, which has been especially concerned with improving health conditions in the developing world (Stiglitz 2002: 10). The ILO has been at the fore of promoting HMI in Cameroon. The ILO and WHO have been promoting the concept of prepayments for health care in Cameroon since the beginning of the present century. In this regard, globalization has been a positive driver in the growth of HMI in Cameroon.

3.4 The Social Protection Floor Initiative and Health Financing

Let me tarry a while around the internationalization of health care policy with a cursory view of the latest initiative. The social protection floor initiative was launched in April 2009 after the realization that the global financial and economic crisis has led to lower incomes, fewer employment opportunities and reduced access to social services (ILO and WHO 2009). Accordingly, an agreement was reached on nine initiatives to address the global crisis. The Social Protection Floor Initiative was developed by the ILO and WHO, working in collaboration with a group of UN cooperating agencies and international development partners, in Geneva in November 2009. The sixth initiative is the social protection initiative. The Social Protection Floor is a global and coherent social policy concept that promotes nationally defined strategies that protect a minimum level of access to essential services and income security for all in the present economic and financial crisis and beyond. A national social protection floor proposes a basic set of rights and transfers that enables and empowers all

members of a society to access a minimum of goods and services and should be defended by all decent societies at all times (ibid.).

The services and transfers of relevance to this study involve access to water and sanitation, adequate nutrition and health. Concerning transfers, the initiative calls on governments to make social transfers in cash and in kind, paid to the poor and vulnerable to provide a minimum income and health security. The importance of social health protection has been highlighted by several international resolutions such as the 'Resolutions and Conclusions concerning Social Security' of the International Labour Conference (ILC) in 2001, and the 'Resolution on Sustainable Health Financing, Universal Coverage and Social Health Insurance' of the World Health Assembly (WHA) in 2005. The 'Global Campaign on Social Security and Coverage for All', founded in 2007, stresses the need to ensure access to essential services for the most vulnerable groups (OECD 2009: 145).

Health care in general and health care financing in particular, receive much international attention because good health promotes economic growth (Sachs 2002, Bloom et al. 2004, Gyimah-Brimpong and Wilson 2004). The WHO's Macroeconomic Commission on Health estimates that a 10% increase in life expectancy leads to an additional increase of 0.3–0.4 percentage point in the annual per capita income. Anchored on the core values of universal access, solidarity, equity and social justice, social health protection comprises all the instruments that aim at removing financial barriers preventing access to health services and protecting people from the impoverishing effects of medical expenditures (OECD 2009: 145). This captures succinctly the principal axis upon which this study is predicated. It will become clearer in the next chapter which explains the aim of this study.

4 AIM OF THE STUDY AND RESEARCH METHODOLOGY

HMI was officially identified in Cameroon in 2000 (Government of Cameroon 2006: 10). It is therefore a fairly new health care financing concept. Nevertheless, this study seeks to investigate why there has not been a significant reduction in out-of-pocket expenditure on health. According to the WHO, out-of-pocket expenditure as a percentage of private health expenditure in Cameroon is a staggering 94%. Meanwhile, social security funds as a percentage of general government expenditure on health for the same period (2009) was 4.7% (WHO 2010). I therefore wish to search for opportunities and challenges facing HMI in Cameroon in its relatively short history.

HMI is not an end in itself, rather it is a short to medium-term strategy towards the gradual adaption of universal health care financing in Cameroon according to the Johannesburg Declaration of 2007. The declaration calls on African countries to progressively provide universal access to essential health care (African Union 2007). In the absence of a solid tax base from which to finance universalism, HMI provides a viable option for an equitable and inclusive health care financing regime for Cameroonians. As such, I will be investigating the opportunities available to and challenges facing HMI promoters in Cameroon. However, other objectives are:

- Identify the main stakeholders involved in the micro insurance scheme in Cameroon and their respective roles in its set up and functioning.
- Assess the perception of Cameroonians concerning micro insurance schemes. By its very nature, micro insurance is owned by the community. It is thus important that there should be a committed and accountable community based management committee that is trusted by the contributors (Jakab and Krishnan 2004, Schneider 2005).
- Identify any long-term strategy towards universal health care financing. This is in line with the Abuja Declaration of 2001 which calls on African countries to step up financing for health to 15% of GDP (for Cameroon, the figure is 4.6%).

4.1 Research Questions

The literature on health care financing is rife with evidence attesting to the negative and catastrophic consequences of out-of-pocket payments for health (Preker 2004, Churchill 2006, Van Doorslaer et al. 2006). Yet more than 90% of Cameroonians rely on out-of-pocket payments to finance health care costs, despite the availability and affordability of HMI with 1$ per month as premium. This reality is further confounded by the fact that Cameroon has a long standing tradition of mutual aid societies grounded on solidarity and self help. These are solid foundations for a successful HMI agenda (Government of Cameroon 2005). However, evidence from the field reveals a slow and sometimes tortuous take off of HMI since its official identification in 2000.

The main research question therefore is why have Cameroonians not embraced HMI with enthusiasm despite the benefits it offers? To answer this question, I will be looking beyond HMI institutions. State social security policy needs to be scrutinized. Taking the investigation further, I need to get the people's perspectives on HMI. It is hoped these might shed some light on the prospects and challenges facing HMI in Cameroon.

In order to gain a deeper understanding of this social reality, answers will be sought to some specific research questions.

1. Who are the main stakeholders involved in the micro insurance programme in Cameroon and what are their respective roles in its set up, management and success or failure? Among the principal stakeholders are the promoters of the scheme. They comprise local and international NGOs, like the ILO, German Technical Cooperation, the French Development Fund and others. The aim is to find out whether they undertake sufficient sensitization before, during and after the setting up of an HMI in a community. How suitable is the payment/benefit package they propose to the people (Poletti and Balabanova 2006)? Health care providers constitute an indispensable axis in the HMI structure. Health insurance is as good as the available health facilities providing services for the insured risk. Distance to the nearest health facility was shown to be an important factor influencing enrolment in HMI schemes in Rwanda (Schneider and Diop 2004: 258-259). I will also be investigating whether these health providers respect to the letter the terms of contract they sign with HMI organizations, or do they constitute part of the problem of moral hazard prevalent in most insurance schemes (Radermacher et al. 2006: 67)? Stakeholders, no matter how much they try, cannot force people to adhere to HMI programmes. It therefore depends on the volition of members of the community where HMIs operate.

2. The second specific research question therefore is: How do members and non-members perceive HMI schemes in the communities where they are operational?

3. Finally, I wish to discover how the HMI scheme contributes to or detracts from Cameroon's overall health system equity, especially its drive towards universal health care provision for its citizenry. The challenge here is that, in the context of Cameroon, with no viable social security policy, HMI appears as a double edged sword. On the one hand, it can provide a worthy launch pad for the elaboration of universal social security for its citizens, as was the case with the creation of social health insurance in Germany, Japan and Korea (Gottret and Schieber 2006: 96). On the other hand, it is feared that the success of HMI might lead the government to renege on the Johannesburg Declaration 2007, calling on African countries to progressively provide universal access to essential health care. In which direction the pendulum is swinging in Cameroon's health financing policy will be investigated in this study.

4.2 Methodology

In writing this chapter, I feel the need to explain my choice of mixed methods for this research. Mixed methods research is increasingly anchored in the *zeitgeist* of social and behavioural sciences in the last ten years (Hart et al. 2009, Invankova and Kawamura 2010). Despite this increasing trend toward mixed methods in social and behavioural sciences, I am still asked the question repeatedly by colleagues: why mixed methods for your study? Of course, my choice is not based on the fact that it is presently 'trendy or academically fashionable' to undertake mixed methods research. This choice has been dictated by the requirements of my research questions. Teddlie and Tashakkori (2010) state categorically that the specifics of the research questions will determine the choice of the best tools to use, which may be qualitative, quantitative or mixed.

In order to investigate the underpinnings of my main research question, I have relied on three sub-questions, employing qualitative and quantitative tools where appropriate. First, I use qualitative methods to ascertain the main stakeholders in Cameroon's HMI sector. This gives me the freedom to pick and choose persons identified from literature and my personal observations as being directly involved with HMI. With qualitative interviews, I ask varying questions to determine their specific roles and contributions to HMI. In my second sub research question, I relied on quantitative questionnaires. It allows me to gain an understanding of members' and non-members' perception of HMI and their experiences with other modes of health care financing, like out-of-pocket payments or private insurance.

This structured questionnaire also provides an opportunity to test certain hypotheses, like reliance on traditional medicine or assistance from family to pay medical bills. I equally had the opportunity to interview many more persons – 202 for this study. Finally, with the help of key informant interviews, I sought from two high level social security policy designers the link between HMI and Cameroon's vision for universal health care financing. Such interviews gave me the opportunity to get answers that could not be provided by grassroots or meso level interviewees. It also allowed for follow up questions where appropriate for further clarification.

Writing specifically on mixed methods, Teddlie and Tashakkori argue strenuously that they 'favoured an overarching question that potentially requires a structured quantitative approach and an emergent and holistic qualitative type of approach. A consequence of such a question is that it may be broken into sub questions, each requiring a different (qualitative or quantitative) approach to answer' (Teddlie and Tashakkori 2010: 18)

At this juncture, it might be helpful to revisit my principal research question as stated above (see Chapter 4.1). Why have Cameroonians not embraced HMI with enthusiasm despite the benefits it offers? This is the overarching research question. It has been broken into three sub-questions, as elaborated in Chapter 4.1, in order to search for a fuller understanding of the HMI phenomenon in Cameroon.

Another reason for the use of mixed methods research strategies for this study is the fact that it is a multi-layer study, as explained in Chapter 1.2. I am therefore mixing methods to answer questions about connecting parts, segments or layers of a social whole. In this study, the social whole is health care financing in Cameroon. The parts or segments are: out-of-pocket payments, HMI, and universalism. According to Mason (2006), some studies are designed with several or multiple components. As such, different methods may be applied because each part is felt to be the best suited to its own specific part of the problem being researched, and in combination, they give a better understanding of the whole.

In this study, understanding the whole will involve the search for an explanation as to the people's conceptions of HMI. This will include currently registered members and non-members of HMI programmes, both in rural and urban areas where the scheme is operational. I also attempt to get an insight into the strategies and challenges of various stakeholders in order to discover whether they are leading to long-term universal provision or not. It is only after navigating through these segments of the study that we can attempt an answer to the overarching question. Certainly, no single method (quantitative or qualitative) can sufficiently provide answers to this question, hence the choice of mixed methods for this study.

The logical question then is: What is mixed methods all about? How will it be employed as a methodological strategy in the search for an understanding of the social reality of HMI in Cameroon? While definitions of mixed methods research abound (Creswell and Plano 2007, Teddlie and Tashakkori 2010), I

prefer that by Johnson et al., for its simplicity and holistic orientation. They state that mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative view points, data collection, analysis, inference techniques) for the broad purpose of breadth and depth of understanding and corroboration (Johnson et al. 2007: 123).

A distinct characteristic of mixed methods research is what has been referred to in mixed methods research literature as *methodological eclecticism* (Hammersley 1996, Yanchar and Williams 2006). Teddlie and Tashakkori maintain that *methodological eclecticism* means that practitioners of mixed methods select and then synergistically integrate the most appropriate techniques from a myriad of qualitative, quantitative and mixed strategies to thoroughly investigate a phenomenon of interest (Teddlie and Tashakkori 2010: 5).

Mixing of methods is justified at the end when it helps researchers obtain valued outcomes for instance, understanding, description, explanation, prediction, improved practices, improved lives, reduction in inequalities, and social justice (Johnson and Gray 2010, 87, 88). The last four outcomes in Johnson and Gray's thesis correspond closely with the objectives of this study. Shifting from out-of-pocket payments for health care bills (with its catastrophic consequences) to HMI is not only an improved practice, but also leads to an improvement in lives (Bennett 2004, Jakab and Krishnan 2004, Churchill 2006, Polonsky et al. 2009). As stated in the research question above, I hope to get a reliable prediction whether HMI will facilitate or impede the adoption of universal health financing in Cameroon. This transformative orientation is grounded on the reduction of inequalities in health care financing and enhancing social justice, as explained in Chapter 3. Theoretical backing for this advocacy is derived from the economic theory of state intervention, especially, the component on intervention for reasons of social justice, discussed in Chapter 2.1.

4.2.1 Choice of Mixed Methods Design

In the preceding section (4.2), I asked the question: How will mixed methods research, be employed as a methodological strategy in the search for an understanding of the social phenomenon of HMI in Cameroon? The answer to this rests on the choice of mixed methods design chosen for this study. Creswell (2009) identifies six strategies for mixing methods.

The first of these is the *sequential explanatory strategy*. It is characterized by the collection and analysis of quantitative data in the first phase of the research followed by the collection and analysis of qualitative data that builds on the results of the initial quantitative analysis. The mixing of the data occurs when the quantitative results informs the secondary qualitative data collection. Creswell's second strategy for mixing methods is the *sequential exploratory strategy*. Here the first phase entails qualitative data collection and analysis,

followed by a second phase of quantitative data collection and analysis that builds on the results of the qualitative phase.

The *sequential transformative strategy* is the third approach advocated by Creswell. Like the previous two strategies, it is a two-phase project. However, there is the introduction and emphasis on the use of a theoretical lens, for instance gender or race, overlaying the sequential procedure. There is an earlier phase (either qualitative or quantitative) followed by a second phase (quantitative or qualitative) that builds on the earlier phase. The theoretical lens shapes a directional research question aimed at exploring a problem such as inequality, discrimination or injustice. This then creates sensitivity to collecting data from marginalized or underrepresented groups and ends with a call for action. The aim of this theoretical perspective, whether it be a conceptual framework, a specific ideology or advocacy, is more important in guiding the study than the use of methods alone. The purpose of the sequential transformative strategy is to best serve the theoretical perspective of the researcher (Creswell 2009: 211-213). These three strategies of mixing methods by Creswell can be referred to as the *sequential approach*.

The last three strategies constitute the *concurrent approach*. The first of these is the *concurrent triangulation strategy*. Here, the researcher collects both qualitative and quantitative data concurrently and then compares the two databases to determine if there is convergence, differences or some combination. Creswell's fifth strategy for mixing methods is known as the *concurrent embedded strategy*. With this approach both sets of data (qualitative and quantitative) are collected simultaneously. The difference with the concurrent embedded strategy is that it has a primary method that guides the research and a secondary data base that provides a supporting role. Given less priority, the secondary data (quantitative or qualitative) is embedded or nested within the predominant method (qualitative or quantitative). Finally, there is the *concurrent transformative strategy*. It may take on the design features of either a triangular or an embedded approach. In this case the two sets of data are collected at the same time during one data collection phase and may have equal or unequal priority (Creswell 2009: 213-216).

The design chosen for this study is the *concurrent transformative strategy*. Here, the two types of data are collected at the same time during one data collection phase. The mixing of the data will be realized in the interpretation phase of this study, as shown in Figure 4.1. However, Green (2007: 129) argues that designing a mixed methods research study does not involve following a formula or set of prescriptions, but rather is an artful crafting of the kind of mix that will best fulfil the intended purpose for mixing within the context at hand. Creswell's six strategies therefore provide a guiding framework within which I situate the mixing of the qualitative and quantitative data for this study. Even though this research can be said to hinge on the sixth strategy – *concurrent transformative* – it incorporates ideas from the other strategies like the *sequential transformative strategy*. It lays emphasis on a theoretical perspective for mixing both sets of data. In this study, Rawls's theory on social justice and Alford's

concept of repressed interest provide theoretical insights that will be helpful as I explore problems of inequality in Cameroon's health care financing.

I take the liberty to be daring and creative as I mix the data for this research, bearing in mind this is a multi-layered study. The first layer being out-of-pocket payments for health care in Cameroon, the second layer is HMI schemes and the third universalism. This entails making use of the guidelines contained in Creswell's model but also the free hand to venture out of the box. Some scholars like Mishler take the argument a step further, stating that research is more a craft than a slavish adherence to methodological rules. Nobody, he posits, conforms exactly to a standard methodology, each one calls for the researcher to bend the methodology to the peculiarities of the setting (Mishler 1990).

In this guise, therefore, I am incorporating some of the design features from the *triangulation* and *embedded approaches* as discussed above (see 4.2.1). This model has the added advantage of positioning mixed methods research within a transformative framework (Creswell 2009: 216). This research is designed to support the aim of transforming the reality of health care financing in Cameroon. There is need for a seismic shift from 98% of people currently paying for health care, out-of-pocket, at the point of service, to less than 20%. This is achievable, I argue, if more people join the HMI programme. The long-term objective is universal health coverage, as the tax base continues to grow and provide the required resources.

4.2.2 Integrating Method and Theory

The transformative paradigm allows for the inclusion of important contextual factors such as social justice (or lack thereof), power and oppression to be addressed (Mertens et al. 2010: 210). A theoretical perspective is indispensable for a successful *concurrent transformative design* for mixed methods (Green 2007, Creswell 2009). The transformative orientation for this study is anchored on theories of state intervention for reasons of social justice, the social democratic model and Alford's theory of structural interest (see Chapter 2).

Health care financing in Cameroon is the social whole (see Chapter 2). The layers or segments are made up of out-of-pocket consumers of healthcare. Due to the absence of social security provision, they constitute 98% of the population. Empirical data from this segment was conducted using quantitative surveys. I administered 100 questionnaires. The second segment revolves around those directly concerned with HMI. They have been subdivided into members of the scheme, that is, adherents, and stakeholders involved in the set up and management of the programme. I administered 102 quantitative survey questionnaires to adherents. Additionally, using a recorder, I interviewed five stakeholders directly involved in the HMI sector.

The third and final layer in this social whole touches on universal health care finance for Cameroonians. For this, I interviewed two directors as key informants. Both are responsible nationally for the elaboration of HMI policy in particular and social security in general. Using qualitative open-ended

questions, I was able to explore current and long-term state policy on universal health care financing. The interviews were recorded and later transcribed. Though I interviewed just two key informants for this segment of the study, I equally relied on other sources of information like official government policy documents to enrich the data.

As a study rooted in the mixed methods research strategy, the logic of inquiry is both inductive and deductive. Inductively, I will be drawing conclusions from empirical data emanating from interviews with key informants. Preissle (2008: 15) holds that inductive thinking starts with evidence (empirical data) and builds theories, explanations, and interpretations to reflect or represent the evidence. The close relationship between empirical observation and conceptual formulation guides most inductive approaches.

I also make use of the deductive logic of inquiry, even though I do not set out to test theories per se. However, I am testing certain hypotheses, supported by theories such as Alford's theory on structural interest. These hypotheses include the claim that most persons in Cameroon do not enrol in HMI programmes because they rely on relatives to finance their health care bills. Others rely heavily on traditional medicine which is not part of the HMI scheme. These hypotheses are then tested, in a process that has been termed the hypothetico-deductive method (Fox 2008: 430, Shank 2008: 208).

Epistemological Scaffolding

Continuing with the integration of method and theory, I embrace the position that epistemology refers to the nature of knowledge and the most appropriate ways to produce this knowledge (Teddlie and Tashakkori 2010: 4). Dialectical pragmatism as articulated by Johnson (2009) is the philosophical basis for this study. The base word 'pragmatism' emphasizes practical issues of 'methodological appropriateness' (Patton 2002: 72). It has a 'logic of inquiry' that primarily focuses on problem solving and outcomes, allowing one to make use of a myriad of methods (Johnson and Onwuegbuzie 2004). The adjective 'dialectical' emphasizes that mixed methods researchers must carefully listen to, consider and dialogue with qualitative and quantitative perspectives and learn from the natural tensions between these perspectives (Johnson 2009).

In practical terms, dialectical pragmatism is manifested in this study through my navigation between the multiple levels that constitute health financing as a social phenomenon. The quantitative strategy with its post positivist outlook guides my search for explanations concerning out-of-pocket payments. I seek to find out why Cameroonians in large numbers continue to rely on this system of health care financing despite its well documented negative consequences (Atim 1998, Bennett et al. 1998).

Turning to micro insurance, which is the backbone of the study, I employ quantitative and qualitative methods. The former provides an insight into the perceptions members have concerning HMI schemes. Meanwhile, the qualitative approach provides understanding of the management of micro insurance and the challenges or opportunities therein. In all quantitative

interviews, respondents were asked open-ended questions, which provided them with the opportunity to state some lengthy narratives outside the rigidity of structured questions. Here, I am taking full advantage of the tenets of dialectical pragmatism, exploiting the tensions between quantitative and qualitative methods. This was evident when respondents sometimes provided answers to the open-ended questions that contradicted their previous response in the structured interviews.

Universalism in health care financing is the last segment in this multi-level study. For pragmatic reasons, two key informants were interviewed. They provided sufficient data to indicate the likely direction Cameroon's health financing policy will follow in the long term. Problem solving and the search for outcomes is the strength of pragmatism as an epistemic stance (Johnson 2009). Hence, it is applicable in this segment to provide an orientation for Cameroon's long-term health financing, given that micro insurance is considered a short to medium-term approach to health care financing. Finally, dialectical pragmatism as the epistemological choice for this study is very evident in the interpretation and inference phase. It is here that I take advantage of the natural and creative tensions inherent in qualitative and quantitative approaches, as I apply the findings to the phenomenon under investigation.

4.3 Overview of the Empirical Data

The data for this mixed method research was collected in 2011 using the quantitative and qualitative strategies in equal measure. With the quantitative data, I expect to gain an insight into the perception of interviewees with regard to HMI. The quantitative data is equally relied on to provide some explanation for the reluctance of Cameroonians to embrace HMI. In order to achieve this, I make comparisons between HMI members and non-members on certain variables like out-of-pocket payments for health care, use of traditional medicine and others. On the other hand, I relied on the qualitative strategy in order to acquire in-depth understanding from key informants. The very nature of qualitative interviews gives freedom to interviewees. As such, I acquired sufficient data on HMI and universalism in particular and Cameroon's health care financing policy in general. Below, I present a summary table of the quantitative data followed by the qualitative data.

The sample for the quantitative data was drawn from two subgroups that I identified as HMI members and non-members. I then purposefully followed convenience sampling because there was no national data on HMI members from which I could randomly sample respondents. Members and non-members had to reside in a geographical locality having a functional HMI programme. The HMI members had to be up to date with their monthly premium payments, and as such eligible to benefit from the services provided by these community based health insurance schemes. I carried out 202 face-to-face interviews: 102 respondents were members of HMI schemes and 100 were non-members. I

conducted interviews in hospitals with HMI partnership agreements and those with no HMI partnership agreement. I also went to HMI offices in order to interview HMI adherents. These quantitative interviews were conducted in six health districts situated in the North West and South West Regions, two of Cameroon's ten regions (major administrative divisions). Three of the six health districts are in rural areas and the other three in urban settings.

All 202 respondents were interviewed face to face. I had a meeting with the HMI managers and we agreed on a date. Managers invited the HMI members, informing them of the interview. I sometimes stayed from 10 am to 6 pm at certain meeting venues conducting face-to-face interviews as the HMI members trickled in at their convenience. For the non-members, it was fairly easy since they often constitute the larger percentage of the population even in health districts having an HMI scheme. These face-to-face interviews are different from questionnaires mailed to respondents who might refuse to respond, or not answer all the questions. In this light, there was a 100% response rate to the questionnaires. I also made sure answers were provided to all the questions. Table 4.1 shows the total number of HMI members and non-members interviewed and their age distribution.

TABLE 4.1 Summary of quantitative data

	Age of Members					
	Under 20	21–30	31–40	41–50	Over 50	Total
HMI Membership Member	5	24	37	20	16	102
Non Member	14	35	20	15	16	100
Total	19	59	57	35	32	202

In order to ascertain the representativeness of my data, I include the chi square measure to determine whether there are differences in the age distribution of my sample and that of the total population of Cameroon. This is represented in Table 4.2.

TABLE 4.2 Representativeness of age distribution

Age Cohort	Data Distribution		National distribution[1]	
	No.	%	No.	%
Under 20	19	9.4	10,635,399	54.8
21–30	59	29.2	3,363,105	17.3
31–40	57	28.2	2,152,320	11.1
41–50	35	17.3	1,434,093	07.4
51 and above	32	15.8	1,821,183	09.4
Total	202	100	19,406,100	100

[1]Source of national distribution data: Cameroon National Institute of Statistics 2012
Notes: chi2 = 181.654, df = 4, $p < .001$

The chi square test shows that the differences found in the age distribution between my sample and that of the Cameroon national population are statistically significant (chi square = 181.654, df = 4, $p < .001$). In the light of this outcome, the conclusions from this study cannot be generalized to the whole Cameroon HMI reality. However, they can be viewed as indications of the potential trend in financing health care via HMI.

Concerning the qualitative strategy and as depicted on Table 4.3, I interviewed two managers and a board chairperson who are directly responsible for the daily management of HMIs at the community level. They know best the challenges facing these schemes at the grassroots level. Two other interviews were conducted with leaders of NGOs promoting HMI. These five interviewees presented a meso level view point of the challenges in their jurisdiction which often comprise many HMI schemes. Finally, I interviewed two directors with a view to gain a macro level perspective of government policy on HMI and the long-term objective of universal health care financing. These interviews were audio recorded with the express permission of interviewees. They were later transcribed and analysed.

TABLE 4.3 Summary of qualitative data

Key Informants	Role	Interview Type	Objective
2 HMI managers & 1 board chairperson	Responsible for the day to day management of HMI schemes	Answers to open ended questions, recorded and later transcribed	To identify main challenges facing HMI at the community level
2 Coordinators of HMI-promoting NGOs	Sensitize local communities & assist in the set up of HMIs	Answers to open ended questions, recorded and later transcribed	To get an overall picture of HMI in their jurisdiction. Main challenges faced and proposed solutions
2 directors responsible for HMI in the Ministries of Health and Social Security	High level bureaucrats responsible for elaborating HMI policies	Answers to open ended questions, recorded and later transcribed	Reasons for the absence of a legal framework for HMI. Possibilities for universal health care financing in the long term

4.4 Research Design

After presenting the different choices of mixed methods design, I settled for the concurrent transformative strategy for this study (See Chapter 4.2.1). With this design, both sets of data are collected at the same time and the mixing of data is done at the interpretation phases (Creswell 2009). On a practical level and with regard to this study, how is the concurrent transformative design realized? To answer this question, I present in Figure 4.1 below, the various contours to be followed in this design strategy. The intention is to provide a visual and graphic format that will facilitate understanding of the concurrent transformative design at a glance. This is followed by a text explaining the features and the road map embedded in this design strategy.

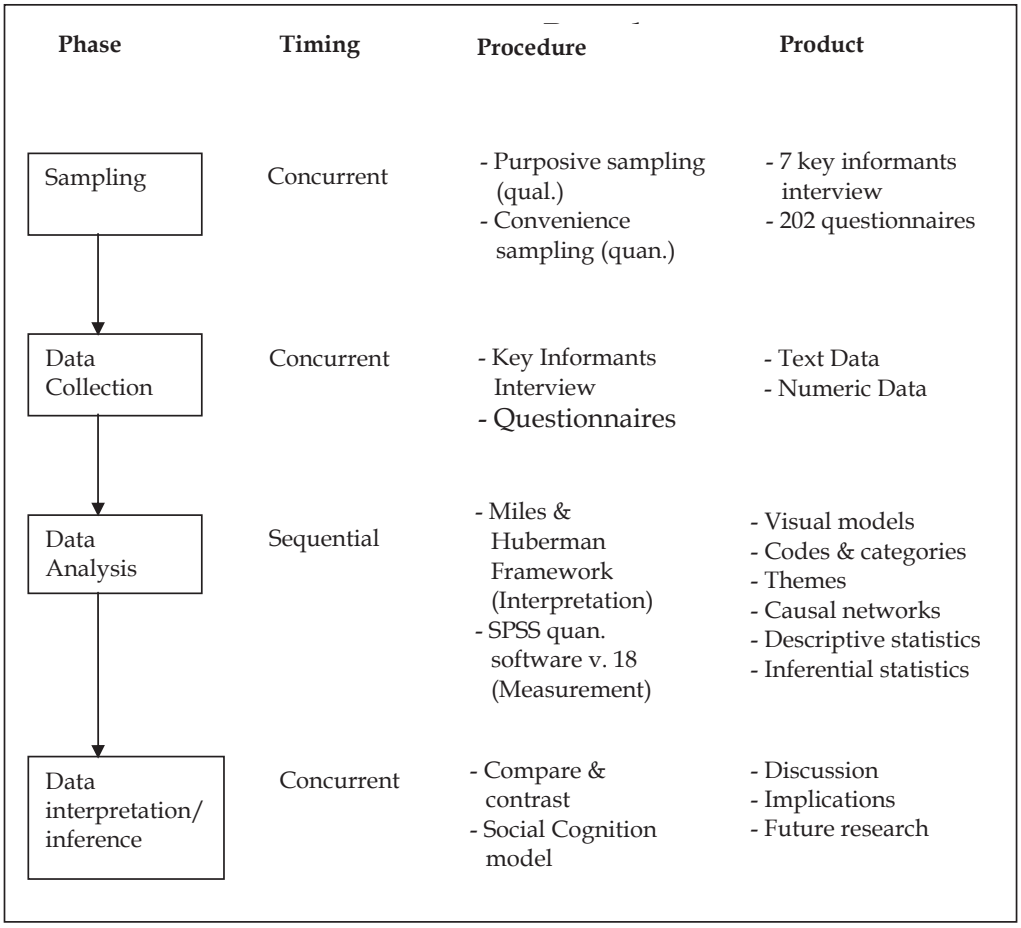

FIGURE 4.1 Concurrent Transformative Design

In the first column in this model (Figure 4.1), I have placed the various phases involved in this mixed methods research. These phases are sampling, data collection, data analysis and data interpretation/inference. I have chosen to combine interpretation and inference. I have placed timing in the second column. Timing is either concurrent (occurring at the same time) or sequential (one following the other) (Creswell 2009: 206). The various procedures applicable at different stages in the research process are presented in the third column, headed Procedure. Finally, the fourth column consists of the end product emanating from each phase.

Sampling was carried out concurrently just before the data collection in Cameroon. Purposive sampling was undertaken and seven key informants were identified. The goal was to sample participants in a strategic way, so that those sampled are relevant to the research questions that are being posed (Bryman 2008: 415). Thereafter, using convenience sampling, I came up with

202 respondents for the quantitative arm of the study. Put together, the population of the regions where the quantitative data was collected is about one million. I interviewed 102 members and 100 non-members of HMI schemes.

A step down, on the second row, is the data collection phase. Like sampling, it was executed concurrently in Cameroon. I used open-ended questions, and follow-up questions when needed to gain a fuller narrative from key informants. These generated rich text data. Meanwhile the quantitative questionnaires were administered, producing sufficient numeric data as well. The logical continuation is the data analysis phase, hence its position on the third row.

Analysis of both qualitative and quantitative data is done separately. Qualitative data is analysed using the Miles and Huberman Framework for Qualitative Data Analysis. This is analysis which is directed at tracing lawful and stable relationships among social phenomena, based on the regularities and sequences that link these phenomena (Miles and Huberman 1994: 4). In order to identify regularities in my data, I coded the raw data into categories, further coding led to themes and concepts. I then proceeded to count the number of times relevant concepts came up in my coding manual. Punch (2005:199) states that for analysis directed at discovering regularities in the data, coding is central. Meanwhile the quantitative data was analysed using SPSS quantitative software version 18.

Finally, the data interpretation/reference phase constitutes the climax of the *concurrent transformative* mixed methods design for this study. This stage is crucial because it is here that the mixing actually takes place. Interpretation of the qualitative and quantitative results (connecting parts) is done at this phase. I will achieve this by comparing and contrasting the findings from the analysis. In order to achieve credibility in inference, I will use social cognition as a model. In this model, the quality of inferences is assessed by examining (a) the process of reaching the results on which they are based, namely design quality and (b) the attributes of the conclusions themselves, that is, interpretive rigour (Teddlie and Tashakkori 2010: 28). This will culminate in a discussion on the overarching phenomenon of health care financing in Cameroon, with a focus on HMI and future research on universalism.

4.5 Limitations of the empirical process

This study has some limitations that are worth highlighting. One of the foremost criticisms of the empirical process of this study relates to the quantitative data being collected mainly in two of Cameroon's ten regions. These are the North West and South Regions which are the two English speaking regions of Cameroon. The other eight regions are French speaking. Only two qualitative interviews – with directors based in Yaoundé, the capital – were conducted outside these two regions. As a result the views expressed by 202 respondents cannot be considered a sample that is representative of the

whole Cameroonian population. Table 4.2 presents the comparison between age distribution in the quantitative sample and the age distribution of the Cameroonian population in 2012. As the chi square test shows ($chi^2 = 181.654$, $df = 4$, $p < .001$) the data collected for this study lacks a sufficient resemblance with the national population level statistics. Therefore, the findings from the quantitative arm of the study cannot be viewed as broad based generalizations of the HMI scenario in Cameroon. However, they can be treated as possible indications of an emerging trend in financing health care via micro insurance.

After the data collection phase and with hindsight, it became obvious that certain questions could have been addressed to both HMI members and non-members. For instance, questions 26 and 27 (see Appendix 1) touching on self-medication and affordability of premiums respectively, which were only addressed to non-members, could have been administered to HMI members as well. Also question 16 (see Appendix 1) on frequency of hospital visits directed at HMI members could have been addressed to non-members equally. Acquiring the views of both groups would have enriched the data without taking anything away from the original intention of testing a particular hypothesis concerning one group or the other.

Another limitation that is worth mentioning has to do with the issue of recall bias. This occurs when respondents have difficulties remembering accurately events that occurred in the past. According to De Leeuw (2005: 244), when information is presented only orally (as with my questionnaires) this demands more memory capacity of the respondents. Certain information is simply not memorized and the longer the recall period, the more likely is recall bias (Smith et al. 2006: 8). In this study, for instance, some respondents may not recall with accuracy their frequency of hospital visits. In other circumstances certain things may be added into the respondent's memory while providing answers to questions. Recall bias may be minimized by relying on the diary method. Here, the respondent is required to make periodic notes as the social phenomenon under investigation unfolds (ibid.). However, this is not feasible with this study which is anchored within a retrospective design framework.

Closely related to recall bias is the question of respondents providing socially desirable responses. With face-to-face interviews, there is a higher level of socially desirable responses, especially with sensitive questions (De Leeuw 2005: 245). This could probably be the case, for instance, when respondents in this study claim they never visit traditional healers. As such, socially desirable responses and recall bias tend to influence the quality of the data. Therefore, the reliability of the information provided needs to be taken with some caution.

These criticisms of the empirical process notwithstanding, the findings from this study point to certain trends with regard to health care financing in Cameroon that cannot be ignored. The strengths of the mixed methods allowed for separate views of qualitative and quantitative approaches providing valuable information in the context of one another. As such, this research contributes to the small but growing literature on HMI in particular and health care financing in Cameroon in general.

5 COUNTRY REALITIES – CAMEROON

5.1 Geography, People and History

Cameroon is located midway between West and Central Africa. Precisely, it is at the north-eastern end of the Gulf of Guinea, where the West African coast makes a right angle, turning southwards near the Equator. It lies between longitudes 8° and 16° east of the Greenwich Meridian and extends from latitude 2° north of the Equator to around 13° north. Cameroon is bordered in the north by Chad, in the west by Nigeria, in the east by the Central African Republic and in the south by Equatorial Guinea, Gabon and Congo. The total surface area is 475,442 sq. km (Tazifor and Tabi 2009: 9). Mount Cameroon (4,069 m), near the coast, is the highest elevation in the country.

FIGURE 5.1 Map of Cameroon

The northern plains - the Sahel region, is semi-arid and hot with seven months of dry season. Meanwhile the central and western highlands are cooler with a shorter dry season. The southern tropical forest is warm with four months of

dry season. Finally, the coastal tropical forest region is equally warm and humid all year round.

Cameroon has a population of 19.4 million. According to government estimates, the population was expected to grow at a rate of 2.12% in 2011. There are about 250 ethnic groups in Cameroon. French and English are the official languages, however, some 270 African languages and dialects are spoken by Cameroonians (http://m.state.gov/mc36882.htm).

Due to the multiplicity and diversity of the climate and people of Cameroon, it is often described as Africa in miniature. The history of the present day population is very diverse (Ngoh 1996). A series of waves of migration can be viewed through the movement of the three major ethnic groups in Cameroon, namely, the Sudanese, the Semi Bantu and the Bantu. In the northern part of Cameroon are the Sudanese ethnic groups. They started their expansion eastward from Senegal in the twelfth century. By the fifteenth century they reached northern Nigeria, whence they penetrated into northern Cameroon (Tazifor and Tabi 2009: 13). The Semi Bantu ethnic groups migrated from northern Nigeria and settled in northern Cameroon. Following Fulani invasions they moved southward to their present location in the West and North West regions of Cameroon. These movements were exacerbated by population explosion and the search for farming and grazing land (ibid., 13). Finally, the Bantu ethnic groups live mainly in the coastal area, the Centre and Eastern Regions of Cameroon. They migrated from the south – Congo and Gabon (Ngoh 1996, Tazifor and Tabi 2009).

The history of Cameroon as a modern state can be traced to the German-Duala Treaty of 12 July 1884. It was a treaty of annexation signed between German trading firms and the coastal chiefs of Duala, Cameroon (Ngoh 1996, Mokake 2008, Tazifor and Tabi 2009). The British and later the French had established missionary outposts and secured trading accords with the coastal chiefs of Cameroon before the Germans. However, Britain in particular showed an uncharacteristic reluctance to annex Cameroon despite numerous pleas and letters from the Duala chiefs (ibid.). At the Berlin West African Conference of 1884–1885 Cameroon was officially recognized as a German colony by the competing colonizing states of Europe. Subsequent bilateral agreements between the European states established the boundaries of Cameroon. One such agreement was the 1913 Anglo-German agreement establishing the western frontiers of Cameroon from Rio del Rey to Lake Chad. A Franco-German agreement demarcated Cameroon's eastern border from River Campo to Lake Chad (Mokake 2008: 19).

German annexation of Cameroon did not last long. In 1916 the Germans were defeated by a joint Anglo-French force in Cameroon following the outbreak of the First World War. In February of same year, talks were held in London between Britain and France for the partition of Cameroon. Britain accepted that France should obtain four-fifths or 143,000 square miles of the territory, while Britain retained one-fifth or 34,000 square miles (Tazifor and Tabi 2009: 78). On 28 June 1919, Germany signed the Treaty of Versailles

following its complete defeat in the First World War. Article 119 compelled Germany to relinquish all its colonies. Consequently, Germany ceded Cameroon to Britain and France. In 1922, Article 22 of the League of Nations confirmed Cameroon as a mandated territory of the League of Nations and its administration conferred on Britain and France (ibid.: 89).

In 1944 France organized the Brazzaville Conference, the principal aim of which was to coordinate the economic and political development of French colonies in Sub-Saharan Africa (Ngoh 1996: 167). African participants at the conference demanded social, economic and political changes. The conference thus set in motion political developments that led to increasingly vociferous demands for independence in French Cameroon after the Second World War. The end of the war meant an end to the League of Nations and gave birth to the United Nations Organization (UNO). Britain and France remained the administering authorities in Cameroon under the supervision of the UNO. The status of Cameroon also changed from a mandate of the League of Nations to a trust territory administered by Britain and France under the supervision of the UN (Tazifor and Tabi 2009: 98)

On 12 March 1959 the UN voted that French Cameroon should become independent on the 1st of January 1960. The situation was a bit complicated for British Cameroon because Britain was administering the trust territory of Cameroon as an integral part of Nigeria (Tazifor and Tabi 2009: 98). The people of British Cameroon were never given the option of autonomy. By UN Resolution 1352 XIV, adopted on 16 October 1959, they were presented with two options, to join either the independent Federation of Nigeria or the independent Republic of Cameroon. The vote held on 11 February 1961 was overwhelmingly in favour of joining the Republic of Cameroon (Ngoh 1996, Mokake 2008, Tazifor and Tabi 2009). British and French Cameroon were thus re-united to form the independent state of Cameroon as it exists today.

5.2 State Capacity and Inequality

An elite of educated bureaucrats and professionals were at the top of the hierarchical chain in most African countries at independence, including Cameroon. These were the individuals who had benefited most from colonial rule, and were set to profit yet again as those most closely associated with the institutions of the post-colonial state (Thomson 2004: 88). These elites soon surrounded themselves with many privileges, amassing great wealth that eventually earned them the appellation 'bureaucratic bourgeoisie' (see Chapter 2.1). There has been little change in this regard since independence because, while there have been multi-party elections in many African countries since the 1990s, these have not led to democratic accountability (Joseph 1999).

In Cameroon, for instance, the situation is so dire such that Kofele-Kale (1987) has calculated that the 'bureaucratic bourgeoisie' constitutes about two per cent of Cameroon's population, yet it grosses one-third of the state's

national income. The result has been the weakening of the state's capacity to enact meaningful social policy reform in the midst of growing social inequality, as Tables 5.1, 5.2 and 5.3 below reveal.

TABLE 5.1 Cameroon Household Income Survey (Source: Statistics Cameroon 2013.)

	Institutional Sector of the Household Head					
	Public	Formal private	non Agric. informal	Agric. informal	Unemployed	Overall
URBAN						
Average income of the household in thousands of CFAF	217.9	212.3	100.1	63.4	80.1	124.8
Average size of the household	4.7	4.2	3.7	4.9	5.7	4.2
Per capita income in thousands of CFAF	46.513	50.870	26.849	12.864	14.124	30.058
RURAL						
Average income of the household in thousands of CFAF	154.9	122.8	80.5	38.1	40.3	55.6
Average size of the household	4.6	4.3	4.2	4.9	5.7	4.8
Per capita income in CFAF	33.388	28.447	19.233	7.705	7.098	11.654
OVERALL						
Average income of the household in thousands of CFAF	196.6	193.1	93.1	39.9	64.0	83.7
Average size of the household	4.7	4.2	3.9	4.9	5.7	4.5
Per capita income in CFAF	42.114	45.919	23.916	8.073	11.271	18.529

According to the figures in Table 5.1 the average household income of a family with the breadwinner employed in the public sector is 217,900 CFAF. Meanwhile, that of a family with the breadwinner employed in the informal sector (not agriculture) is less than half of that, at 100,100 CFAF. The situation is worse when the breadwinner is employed in the agriculture informal sector, amounting to less than a third of the public sector household. The effect of such income inequality is more damaging, because more than 50 per cent of the Cameroonian workforce is employed in the informal sector. The household income inequality is more severe between urban and rural households. As

shown in Table 5.1, the average household income of an urban family is 124,800 CFAF while that of a rural household is 55,600 CFAF.

The ability of the state to elaborate social policy reform addressing inequality is also influenced by the performance of its institutions. Prior levels of institutionalized trust, also referred to as the stock of social capital, are quite crucial. In this light, preconditions of good governance as measured by institutional performance explain why good governance succeeds in the elaboration of social policies (Putnam 1993, Carroll 2004). The performance indicators for Cameroon's institutions presented in Table 5.2 leave a lot to be desired.

TABLE 5.2 Performance of Cameroon's institutions (Source: World Bank 2013)

Indicator	**Value (1–5)**	**Rank/144**
Diversion of public funds	2.2	133
Public trust in politicians	2.1	111
Irregular payments and bribes	2.9	128
Judicial independence	2.5	127
Favouritism in decisions of government officials	2.6	108
Waste in government spending	2.6	108
Transparency of government policy making	4.2	73
Strength of auditing and reporting standards	3.7	124

Among all the indicators, Cameroon fares poorly. This is particularly so with indicators having a direct bearing on corruption. For instance, on the 'diversion of public funds' indicator, Cameroon has a meagre 2.2 value score and is ranked 133 out of 144 countries surveyed. This is followed by the 'irregular payments and bribes' indicator where Cameroon is ranked 128. In a country with overbearing power invested in the president, it is not surprising that judicial independence has a low value of 2.5 and ranked 127 out of 144 countries. Even the 'strength of auditing and reporting standard' – an important tool for accountability – is disappointingly low, placing Cameroon at 124 out of 144 nations. There is therefore little doubt that 'public trust in politicians' is equally low, making Cameroon the 111th country out of 144. It is only in the 'transparency of government policy' that Cameroon finds itself in the upper half of the countries surveyed, in the 73rd position out of 144.

Cameroon can hardly be considered a failed state. However, in order to get a fuller picture of the state's capacity, I included Cameroon's position within the failed state index of 2013. As shown in Table 5.3 this index makes for some interesting reading.

TABLE 5.3 Failed State Index (Source: Fund for Peace 2013)

Indicator	Score/10	Comments
Demographic pressures	8.3	Poor
Refugees and internally displaced persons	7.3	Weak
Group grievance	7.8	Weak
Human flight and brain drain	7.2	Weak
Uneven economic development	7.8	Weak
Poverty and economic decline	6.1	Poor
State legitimacy	8.5	Poor
Public services	8.4	Poor
Human rights and rule of law	8.1	Poor
Security apparatus	8.0	Weak
Factionalized elites	9.2	Poor
External intervention	6.8	Weak

The Fund for Peace conducts the global survey of failed states annually. It ranks each country on a score of one to ten. The closer to one, the better is the state's performance on that indicator, and the closer to ten implies a negative performance. The comments are excellent, good, weak or poor. A glance at Table 5.3 paints a very bleak picture of Cameroon as a state at the brink of failing. Half of the indicators are weak and the other half are worse, that is, poor. Of more worrying concern is the observation that in the past year, Cameroon's indicators experienced mild changes, both for better and for worse. On the whole, the country's score had worsened very slightly (Fund for Peace 2013).

5.3 Economy

Cameroon has an abundance of natural resources, including in the agricultural, mining, forestry and oil and gas sectors. Cameroon is the commercial and economic leader in the Central African sub-region. Gross Domestic Product stands at $25.042 billion for 2010 (IMF 2011). Cameroon's main exports include timber, coffee, tea, cocoa, bananas, rubber, palm oil, cotton, petrol, gas and minerals such as bauxite. The European Union as a bloc is Cameroon's main trading partner, accounting for 45% of total exports and 55.1% of imports, according to the World Bank Report (2012: 12).

Recent growth in the economy (3.8% of GDP for 2011) has been driven by the tertiary sector which accounted for more than half of the estimated growth. This sector benefited from a pick-up in timber related transport and continued strong growth in usage of mobile telephones stemming from a greater use of optic fibres, and in the construction and food processing industries (World Bank 2011). The positive economic outlook has also been driven by the execution of infrastructural programmes and projects to boost productivity in agriculture by providing assistance in the production of key crops (coffee, cocoa, cotton and rice), and access to finance, training and

research. All of these have given Cameroon an encouraging medium-term economic outlook (IMF Report 2011).

TABLE 5.4 Cameroon – Macroeconomic indicators (Source: IMF 2011)

Cameroon: Selected Macroeconomic Indicators, 2009–2016								
	2009	2010	2011	2012	2013	2014	2015	2016
Economic growth and prices								
Real GDP	2.0	3.2	3.8	4.5	4.8	5.0	4.0	4.5
Non oil real GDP	2.9	4.0	4.4	4.0	4.2	4.4	4.5	4.6
Consumer prices	3.0	1.3	2.6	2.5	2.5	2.5	2.5	2.5
Oil export prices (US$/barrel)	58	80	99	96	89	87	86	86
Private investment (% of GDP)	12.4	12.6	13	13.2	13.4	13.6	13.7	13.8

In 2011, the IMF predicted that the GDP of Cameroon would rise continuously to 2014. There would be a slight dip of 1% in 2015, however, this is expected to pick up again the following year, rising from 4.0% to 4.5% in 2016 (IMF 2011). Cameroon is a relatively small oil producer, and its oil production is declining with depleting reserves and aging equipment (World Bank 2011: 4).

Contribution to economic growth is therefore coming mainly from the non-oil sector. From Table 5.4 it is obvious that this contribution has been growing steadily, from 2.9% of GDP in 2009 to 4.4% in 2011. After a small decline of 0.4% in 2012, the non-oil sector's contribution to growth is expected to rise gradually again in 2013 to 4.2% and to reach 4.6% in 2016. Another encouraging indicator of Cameroon's economic viability is the contribution of private investment as a percentage of GDP. From a modest 12.4% in 2009 it rose to 13.2% in 2012 and is projected to rise to 13.8% by 2016 (IMF 2011). See Table 5.4.

However, the benefits of this economic growth have not been equally distributed in all the regions of Cameroon. As such, there are significant disparities in living standards observed across regions of the country. A ranking of relative 'well being' in Cameroon shows wide regional discrepancies. As expected, Douala (the financial capital) and Yaoundé (the political capital) score best, the Far North, North and East regions fare the worst. Particularly striking is the declining access to sanitation and drinking water, as well as the increase in child mortality in some of the regions (World Bank 2011).

In order to improve the delivery of services at the local level, bring services closer to users, give users increased voice and improved choices, and strengthen the accountability of the authorities in delivering these services, the government of Cameroon is relying on decentralization as its principal policy tool (IMF 2011). These goals are achievable because the risks to medium-term economic outlook are broadly balanced. These include, on the down side, the uncertain pace and strength of the global recovery, and a vulnerable banking sector that may generate fiscal liabilities and affect the economy. On a positive

note, the growth of the tertiary sector (telecommunications), and a faster and more effective implementation of the new large public infrastructure projects, would generate non-oil sector growth, higher than projected under the baseline (IMF 2011).

At this juncture, before proceeding I feel the urge to justify the heavy reliance on IMF, World Bank and WHO reports for data on Cameroon's profile. The absence of population based data in particular and socioeconomic data in general on Africa has been decried often (Arhin-Tenkorang 2004: 165, Samson 2009: 4). Cameroon is no exception to this scarcity of current data. In this study, the choice is between some grey literature on Cameroon, which might be partisan and/or not covering the entire country, or relying on IMF, World Bank and WHO reports/publications. The decision is for the latter for obvious reasons – first, since the economic crisis of the 1990s, these institutions continue to play important roles in the elaboration of economic and social policies in Cameroon. Secondly, they have the resources (human and financial) to conduct regular and nationwide surveys on the socio-economic life of member states. Nevertheless, where local sources are available, I make use of them, even if they are not the most recent. This is supplemented by some reliable online sources.

Continuing with the profiling of Cameroon, the country needs to improve its business climate in order to attract both domestic and foreign investment. These will create jobs and generate sufficient tax revenue for other development projects. Unfortunately, Cameroon is currently classified 161 out of 183 countries surveyed by the World Bank in the annual 'Doing Business Index' (World Bank 2012). Even though Cameroon improved four places from 165th in 2011, it still leaves a lot to be desired, as Table 5.5 reveals.

TABLE 5.5 Doing Business in Cameroon (Source: World Bank 2012)

Doing Business in Cameroon		
Topic Rankings	DB 2011 Rank	DB 2012 Rank
Starting a Business	131	128
Dealing with Construction Permits	89	92
Getting Electricity	65	66
Registering Property	157	154
Getting Credit	139	98
Protecting Investors	120	122
Paying Taxes	169	171
Trading Across Borders	156	155
Enforcing Contracts	174	174
Resolving Insolvency	148	147

Cameroon might have improved four places on the Doing Business scale in 2012. Nevertheless, a closer look reveals that it regressed in four of the ten variables considered for this classification. For instance, in granting construction permits Cameroon dropped from the 89th position in 2011 to 92 in 2012. It fared equally poorly in the all-important sector of energy, from 65 in 2011 to 66 in 2012. If investors are to risk their money they must feel protected,

yet Cameroon also regressed in this crucial variable in 2012 from 120 the previous year to 122 out of 183 countries. The same is true with paying taxes, from the 169th position the previous year to 171st in 2012 (see Table 5.5). Therefore, Cameroon needs to do a lot to improve the business climate if it is to attract investment, boost productivity and create employment.

However, the entrepreneurial situation in Cameroon is not all gloom and doom. For instance, with the all-important variable of 'starting a business' Cameroon is doing better than the sub-Saharan average in all but one of the four indicators, as shown in Table 5.6.

TABLE 5.6 Starting a business in Cameroon (Source: World Bank 2012).

Starting a Business			
Indicator	Cameroon	Sub-Sahara Africa	OECD
Procedure (number)	5	8	5
Time (days)	15	37	12
Cost (% of income/capita)	45.5	81.2	4.7

The number of procedures required to start a business in Cameroon is below the Sub-Saharan average and similar to OECD countries. This is equally the case with the time taken, which is 15 days, below the Sub-Saharan average of 37 days and getting close to the OECD average of 12 days. The cost of starting a business may be cheaper in Cameroon than the Sub-Saharan average, but it is nevertheless exceedingly high at 45.5% of income per capita, compared with 4.7% in OECD countries (see Table 5.6). Private investment is the engine of growth and subsequent employment (Mbaku 2007: 299). Therefore, if Cameroon wants to attract private investment into the country, it needs to significantly bring down the cost of starting a business and make it closer to the OECD levels.

5.4 Institutional Framework of the Health Sector in Cameroon

Cameroon has a pluralistic health care system because it is characterized by multiple sources of financing and health care providers. The main sources of financing are the government, public enterprises, foreign aid donors, private enterprises, households, religious missions and NGOs. On the other hand, health providers are government health facilities, public enterprise health clinics, health facilities of religious missions and NGOs, private clinics, pharmacies, drug retailers and traditional doctors (Ntangsi 1998).

According to Cameroon's National Institute of Statistics (2010), the population of the country is 19.4 million, with an annual population growth rate of 2.6%. Cameroon has 1031 government operated health facilities which include 1 teaching hospital, 2 referral hospitals, 3 central hospitals, 8 regional

hospitals, 38 divisional hospitals, 132 district hospitals and 847 health centres (Ntangsi 1998). These are manned by a medical staff of 14,292 (Cameroon – Ministry of Public Health 1997: 7). The bulk of non-profit facilities are operated by Christian (Roman Catholic and Protestant) health services. The Catholic Church operates 179 facilities (including 8 hospitals) with a staff of 1,315 and Protestant organizations own 122 health facilities (including 24 hospitals) with a staff of 2,633. There are more than 200 private for-profit facilities (Cameroon – Ministry of Public Health 1997) and a few thousand traditional healers. About half of Cameroonians have access to essential drugs. This is considered a low rate of access by WHO standards. There are 2.55 hospital beds per 1000 people (Cameroon Health Stats, NationMaster: http://www.nationmaster.com/country-info/profiles/Cameroon/Health . Accessed 28 June 2013). Concerning the health workforce, Cameroon lags behind (especially physicians) even when compared with the African average (Table 5.7).

TABLE 5.7 Cameroon – Health workforce. (Source: WHO 2011)

Health Workforce (per 10,000 Population)		
	Cameroon	African Average
Physicians	1.9	2.3
Nurses & Midwives	16.0	10.9

From the figures in Table 5.7 it is evident that with 16.0 nurses and midwives per 10,000 persons, Cameroon's average is higher than the African average of 10.9. However, the challenge is for Cameroon to increase its number of physicians at least to reach the African average of 2.3 doctors per 10,000 people.

At this juncture, I wish to present a health profile of Cameroon based on some selected health indicators for 2009.

TABLE 5.8 Cameroon – Mortality and burden of disease (Source: WHO 2011)

Mortality and Burden of Disease		Cameroon	African Average	Global Average
Life Expectancy at birth (years)	Male	51	52	66
	Female	51	56	71
	Both Sexes	51	54	68
Adult mortality rate (per 1000 adults 15–59 years)		413	383	176
Under 5 mortality rate (per 1000 live births)		154	127	60
Maternal mortality ratio (per 100,000 live births)		600	620	260
Prevalence of HIV (per 1000 adults 15–49 years)		53	47	8
Prevalence of tuberculosis (per 100,000 population)		191	471	201

Cameroon's health indicators on mortality and burden of disease fare poorly in comparison to the global average. The rare exception is the (relatively low) prevalence of tuberculosis (Table 5.8). Unfortunately, Cameroon also falls below the regional (African) average on four of the six indicators. These include life expectancy at birth, where the African average for both sexes is 54 years while

that for Cameroon is 51 years. The situation is same with adult mortality rate (per 1000 adults aged 15–59 years). While the African average is 383 deaths, Cameroon's death rate is a staggering 413. On the third indicator, which is under-5 mortality rate (per 1000 live births) Cameroon registers 154 deaths while the African average is 127 deaths. Even the HIV/AIDS pandemic has hit Cameroon harder than the African average. The country has a prevalence of HIV of 53 (per 1000 adults aged 15–49) compared with the African average of 47 (see Table 5.8).

Cameroon fares better than the African average only on two of the indicators in Table 5.8. For instance, on maternal mortality ratio (per 100,000 live births) Cameroon incurs 600 deaths while the African average is 620. Finally on the prevalence of tuberculosis (per 100,000 population) Cameroon registers 191 cases while the African average is 471. On this last indicator, Cameroon's efforts are worth emulating because it even outperforms the global average. Nevertheless, these health indicators point to the fact that Cameroon still has a lot of catching up to do in the provision of equitable and quality health care to its citizenry.

A closer look at Cameroon's health expenditure will demonstrate the importance the state attaches to improving the provision of health care. The health expenditure orientation is crucial because it directly affects the supply side as well as the demand side of health financing (Ensor 2003). In order to have a meaningful perspective of the direction this health expenditure is taking, Table 5.9 presents some figures on Cameroon's health expenditure for fifteen years from 1995 to 2009.

From the figures in Table 5.9, it is evident that for this fifteen-year period, there was a significant increase in the total expenditure on health (TEH) as a percentage of GDP. Nevertheless, these increments were, at best, episodic. In 1995 TEH was a meagre 3.9% of GDP. However, this rose significantly to 5.1% of GDP in 2003. It then dropped to 4.8% the following year, 2004, stabilizing until 2008 when it started climbing again to reach a peak of 5.6% of GDP in 2009. If the growth rate witnessed in the last three years (2007–2009) were to be maintained, then Cameroon could be on course to meeting the Abuja commitment of allocating 15% of government budget to health sooner rather than later.

TABLE 5.9 Cameroon – National Expenditure on Health 1995–2009 (Source: WHO 2011)

Health Expenditure Ratios	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total Expenditure on Health (TEH) as % of GDP	3.9	5.0	4.4	4.3	4.3	4.6	4.8	5.0	5.1	4.8	4.9	4.8	4.9	5.3	5.6
External Resources on Health as % of TEH	4.6	2.8	3.1	3.3	2.3	4.1	4.8	5.8	6.5	6.4	5.5	5.6	5.9	5.5	8.1
General Government Expenditure on Health (GGEH) as % of TEH	23.2	13.7	17.0	14.6	16.2	22.0	25.3	27.8	28.1	25.4	25.2	25.0	24.7	22.7	27.9
Private Expenditure on Health (PEH) as % of TEH	76.8	86.3	83.0	85.4	83.8	78.0	74.1	72.2	71.9	74.6	74.8	75.0	75.3	77.3	72.1

Interestingly, external resources on health as a percentage of TEH seem to follow the pattern set by TEH as a percentage of GDP. It started with a bang, accounting for 4.6% of TEH in 1995. The following year, it dropped to 2.8% of TEH rising and falling until 2000 when it started increasing again from 4.1% to 6.5% of TEH in 2003. After a noticeable drop in 2005, external resources on health as a percentage of TEH rose significantly to account for 8.1% of TEH in 2009. External resources therefore, continue to play a major role in Cameroon's health care financing.

Among the four variables chosen for this analysis of Cameroon's health expenditure, the General Government Expenditure on Health (GGEH) as a percentage of TEH is the most erratic. From 1995 with a 23.2% of TEH, GGEH fluctuated for four years, dropping to a minimum of 14.6% in 1998. It then witnessed its longest period of consistent growth (1999–2003) with a peak of 28.1% of TEH in 2003. This was followed by a four-year downward trend, only to start rising in 2008 to reach a mere 27.9% in 2009. Such an unpredictable nature of government spending on health does not augur well for long-term planning in such a strategic sector as health.

From Table 5.9, it is clear that private expenditure on health constitutes a sizeable percentage of TEH. The gap between the general government expenditure on health (GGEH) as a percentage of TEH and private expenditure on health (PEH) as a percentage of TEH is overwhelmingly wide. In 2009, for instance, and notwithstanding the slight increase, GGEH stood at 27.9% while PEH accounted for up to 72.1% of total expenditure on health. There is little wonder that more than 94% of Cameroonians rely on out-of-pocket payments at the point of service to finance health care.

The government's limited expenditure on health is further compounded by the regional inequality as highlighted by the 'relative well being' study of the World Bank (2011) mentioned in section 5.2. The WHO also decries the consequences of these inequities on health in its 2011 annual report. A look at two indicators brings out these inequities vividly (see Tables 5.10 and 5.11).

TABLE 5.10 Cameroon – Inequities in health service utilization (Source: WHO 2011)

Inequities in Health Service Utilization				
Indicators	Rural	Urban	Wealthiest 20%	Poorest 20%
% of births attended by skilled health personnel	44	84	29	95
% of measles immunization in 1-year-olds	58	73	52	83

A manifestation of the consequences of inequality in government expenditure on health is evident when one examines the percentage of births attended by skilled health personnel and the percentage of measles immunization in one-year-olds. On both indicators there is an overwhelming inequity against the rural population. As shown on Table 5.10, the situation is more pathetic when comparing the poorest 20% and the wealthiest 20%, with the latter benefiting from this inequity in health utilization. This is also reflected in the mortality rate of children under five (See Table 5.11).

TABLE 5.11 Cameroon – Inequities in infant mortality (Source: WHO 2011)

Inequities in Mortality				
Under-5 mortality rate	Rural	Urban	Poorest 20%	Richest 20%
Deaths per 1000 live births	169	119	189	88

As a result of unequal health expenditure between rural and urban areas, a higher infant mortality rate obtains in rural areas. The reality is worse when these rates are compared between the poorest 20% and the richest 20% (see Table 5.11). These findings have been corroborated by UNICEF. In particular, the provinces of Adamawa, East, North and Far North, with a combined population of about 4 million, is home to some 85,000 refugees from the neighbouring Central African Republic. This has put a lot of strain on the existing health institutions. To add salt to the wound, Cameroon in May 2010 experienced the worst cholera outbreak in the country for 40 years (UNICEF 2011).

In Northern Cameroon, malnutrition is widespread. The acute malnutrition rate of 14.5% is close to the emergency threshold of 15%. This is due primarily to a lack of access to age-appropriate foods and feeding practices, essential health services and safe water and hygiene practices (Government of Cameroon 2011). Social security provision could address these social and regional inequalities in Cameroon. It is argued that successful social security policies can be applied in the alleviation of poverty, redistribution of income and fostering social cohesion. They have equally been successful in the promotion of economic efficiency, protection against risk, compensation and effecting behavioural change (Walker 2004: 29). If the state in Cameroon incorporates HMI as an active arm of social security by providing subventions, it might attract more adherents.

5.5 Social Security Provision in Cameroon

The state of social security in Cameroon is summed up by a finding contained in a study undertaken by the Ministry of Public Health in 2005. It stated bluntly

that 'there is no such thing as social security in Cameroon because of the absence of a universal welfare regime' (Government of Cameroon 2005: 28). The report mentions Decree No. 2000/692 of 13 September 2000 providing health insurance for workers of the public sector. This health insurance is reduced to 60% when it concerns the wives or children of the public sector employee. Unfortunately, five years later, this law had yet to come into effect (ibid.: 28).

According to this report, another social category that has some social insurance benefits comprises workers of the private sector. These, by virtue of contributions made to the National Social Insurance Fund (NSIF) by their employers, have the following benefits:

- Family allowances
- Old age pensions
- Compensation for invalidity and death
- Compensation for work related accidents and occupational diseases.

Consequently, public sector employees, workers of the informal sector, the unemployed and handicapped persons who are non-pensioners, do not benefit from any form of collective health insurance. Even the situation regarding occupational diseases, supposedly covered by the NSIF, is pathetic. The Cameroon legislature makes an ambiguous distinction between occupational diseases and diseases connected with employment. It defines occupational diseases vaguely as any disease arising as a result of certain work practices. Cameroon, like most African countries, has chosen a system based on a list of more than 90 occupational diseases eligible for compensation (ILO 2010a). Unfortunately, statistics from NSIF indicate that only three cases of occupational diseases have been accepted in Cameroon over the past two decades. This may be due to the fact that the list of occupational diseases is not adapted to the working environment. Secondly, the system for the diagnosis of pathologies is insufficient or inappropriate (Bowen 2007).

However, the legislation also recognizes as occupational diseases any cases accepted as such by the Committee for Health and Safety at Work. This applies to cases which are considered as being of an occupational nature because they seem to be connected with employment, but which are not included in the lists. In these cases the above-mentioned Committee is responsible for assessing the cause and effect relationship between the disease and the tasks usually performed by the victim. It then recommends whether or not the disease should be considered as 'occupational'. Strange as it may seem, this committee that is supposed to meet annually to ascertain what constitutes an occupational disease in Cameroon, in 2007, had not met for four years (Bowen 2007).

The dire straits of social security in Cameroon is epitomized by the selected ratios for social security expenditure on health presented in Table 5.12

TABLE 5.12 Cameroon National Expenditure on Health (Source: WHO 2011)

Ratio of Social Security Expenditures on Health	2007	2008	2009
Social security funds as % of GGEH	2.6	3.3	4.7
Private insurance as % of PEH	0	0	0
Out-of-pocket expenditure as % of PEH	94.5	95.1	94.9

Less than 5% of social security funds as a percentage of GGEH is earmarked for health and with zero coming from private insurance, it is not surprising that out-of-pocket expenditure as a percentage of PEH is as high as 94.9 in Cameroon.

In order to show the existing gap and the long way that needs to be travelled for Cameroon to achieve universal coverage, I present as a comparison the scenario in an OECD country. Health care in Finland is mainly based on public financing and service provision. About 85% of total health care expenditure is financed through the public sector: 75% from taxes and tax expenditures, and 10% from sickness insurance payments. The remaining 15% is financed by direct payments from households, including user charges for public services, non-subsidized medicine and co-payments for private sector medical and dental treatment (Klavus and Häkkinen 1998: 141).

HMI is increasingly seen as a short to medium-term strategy to achieve universal health coverage by low income countries. The challenges and opportunities of such a policy will constitute the bulk of the subsequent chapters of this study, as I present the data, analysis and findings from my empirical field work in Cameroon.

6 DEMOGRAPHIC OUTCOME FROM QUANTITATIVE DATA

As stated in Chapter 4, this study is rooted in the mixed methods research strategy, employing both quantitative and qualitative research procedures in equal measure. In this chapter, I present the demographic outcome from the quantitative data collected from my field visit in Cameroon. The next chapter (Chapter 7) consists of the analysis of the quantitative data presented here. Aliaga and Gunderson (2000) define quantitative research as - Explaining phenomena by collecting numerical data that are analysed using mathematically based methods (in particular statistics). However, the phenomena that I look at, health care financing in Cameroon via micro insurance, does not occur naturally in quantitative form. Nevertheless, most data that do not naturally appear in quantitative form can be collected in a quantitative way. This is achieved by designing research instruments aimed specifically at converting phenomena that do not naturally exist in quantitative form into quantitative data, which can then be analysed statistically (Muijs 2011: 2).

A questionnaire of 27 variables was the instrument used to convert the phenomena in my research into quantitative data (see appendix for questionnaire). These variables can be broadly divided into three sub headings. The first six questions constitute the demographic findings of gender, age, marital status, educational level, religious inclinations and private insurance coverage. The second segment of the questionnaire (questions 7 to 20), were addressed to members belonging to a HMI scheme. Questions 21 to 27 make up the last segment and were addressed to non-members of HMIs residing where a functional HMI exists.

6.1 Respondents' Demographic Data

The demographic information collected with the aid of the questionnaire is aimed at providing a glimpse at the background of the respondents involved in this study. As such, I sought information on gender, age, marital status, highest level of education and religious inclinations. Taken on their own, the data collected on these variables seem to provide little useful information with regard to the research questions. However, when considered alongside the 'HMI membership' variable, one begins to see their emerging significance to the study. Table 6.1 contains a description of the data in percentages and absolute numbers (N).

TABLE 6.1 Data characteristics by HMI membership, % (N)

	Member	Non-member	Total
Gender1			
-male	44.1 (45)	49.0 (49)	46.5 (94)
-female	55.9 (57)	51.0 (51)	53.5 (108)
	100 (102)	100 (100)	100 (202)
Age2			
20 or less	4.9 (5)	14.0 (14)	9.4 (19)
21–30	23.5 (24)	35.0 (35)	29.2 (59)
31–40	36.3 (37)	20.0 (20)	28.2 (57)
41–50	19.6 (20)	15.0 (15)	17.3 (35)
51 or more	15.7 (16)	16.0 (16)	15.9 (32)
	100 (102)	100 (100)	100 (202)
Marital status3			
Single	32.4 (33)	21.0 (21)	26.7 (54)
In a relationship	4.9 (5)	27.0(27)	15.4 (32)
Married	52.0 (53)	35.0 (35)	43.6(88)
Divorced	1.9 (2)	9.0 (9)	5.5 (11)
Widowed	8.8 (9)	8.0 (8)	8.4 (17)
	100 (102)	100 (100)	100 (202)
Educational level4	3.0 (3)	1.0 (1)	1.9 (4)
Primary school	22.5 (23)	21.0 (21)	21.7 (44)

Secondary school	37.3 (38)	39.0 (39)	38.0 (77)
Apprenticeship & Trade course	10.8 (11)	13.0 (13)	11.8 (24)
University	26.4 (27)	26.0 (26)	26.2 (53)
	100 (102)	100 (100)	100 (202)
Religious inclinations5			
Catholic	59.8(61)	42.0 (42)	51.0 (103)
Protestant	29.4(30)	40.0 (40)	35.0(70)
Pentecostal	8.8 (9)	11.0 (11)	10.0 (20)
Muslim	1.9 (2)	6.0 (6)	3.0 (8)
African traditional religion	0.0 (0)	1.0 (1)	0.5 (1)
	100 (102)	100 (100)	100 (202)

NOTES: 1) chi2=.484, df=1, p=.487, 2) chi2=12.080, df=4, p=.017, 3) chi2=27.182, df=5, p=.000, 4) chi2=2.862, df=7, p=.897, 5) chi2=8.114, df=4, p=.087.

It is important to state here, I am reading the figures in the tables by column. This is due to the fact that, my main aim is to compare the two groups, members and non-members as such, reading the tables by column is a deliberate choice. When I read row-wise, I will tend to lose the main focus that is, the comparison of HMI members and non-members. Reading the tables by column also allows me to control the effect of group size, which in reality is not 50-50.

Gender

From Table 6.1 it emerges that 55.9% of HMI members are female and 44.1% male. Meanwhile, among non-members, there is almost no gender difference. However, the chi square test shows that the difference between females and males in terms of HMI membership is statistically not significant (chi square = .484, df = 1, p = .487).

Age

The age distribution of the respondents is presented in groups. This is due to the fact that some people are not keen to divulge exact personal details such as their age. One way of neutralizing the impact of such questioning is to present respondents with age bands (Bryman 2008: 208). As shown in Table 6.1, the age distribution of the respondents is presented in five bands as follows: 20 or less, 21–30, 31–40, 41–50 and 51 or more years.

From Table 6.1, the 20 or less age band constitutes 9.4% of respondents. Amongst HMI members, 4.9% belong to this category, while amongst non members the figure is 14%. This reveals a substantial difference in HMI membership within this age group. Some of the respondents stated that they

would have liked to join an HMI programme but were precluded by the requirement of family membership. The age group of 21–30 is the largest age band for this study, making up 29.2% of all respondents: 23.5% of HMI members come from this cohort and 35% of non members. Like the youngest age band, a higher percentage of respondents within this group are not HMI members.

The third age band is made up of people between the ages of 31 and 40. They make up 28.2% of the respondents. Interestingly, a higher share of HMI members, 36.3%, belong to this age category when compared with non-members, of whom only 20.0% fall into this age band. This can be partially explained by the fact that most members of this age group are married and family heads. They readily meet the criterion of family enrolment with a minimum of four family members. A sensitization campaign to enlist members into the HMI should target members of this age band, as they are most likely to join the scheme.

Table 6.1 indicates that the fourth age band, made of people aged 41–50, constitutes 17.3% of the respondents. A slightly higher percentage of HMI members – 19.6%, compared with 15% of non-members – belong to this age cohort. As with the third group, most of the respondents here are family heads. These are people who are aware of the importance of health insurance for family members. The last age group consists of persons aged 51 years or more. All of these are most certainly family heads and account for 15.9% of all respondents. This older age group provides 15.7% of HMI members and 16% of non-members, thereby revealing almost no difference in HMI membership within this age group. The chi square test shows that the differences in the age cohorts and HMI membership are statistically significant (chi square = 12.080, df = 4, p = .017).

Marital Status

Marital status as a demographic variable was included in the questionnaire because all the HMIs require family membership. I therefore deemed it necessary to have an understanding of the filial relationship of members and non-members involved in the study. It was also important to ascertain whether the marital status of respondents had any bearing on HMI membership. This variable, together with that of age, can highlight the main target groups on which to focus when undertaking sensitization for more members into HMIs.

As shown in Table 6.1, single persons account for 26.7% of the respondents. The findings indicate a marked difference in HMI membership for this group of respondents: 32.4% of HMI members are single persons compared with 21% of the non-members. People living in a relationship make up 15.4% of respondents. Like the preceding group they too reveal a substantial difference in HMI membership, though reversing the trend. People living in a relationship, account for a mere 4.9% of HMI members but 27% of non-members.

Married persons form the third and largest group in the marital status variable, making up 43.6% of the respondents. They account for 52% of HMI members and 35% of non-members, thereby showing a marked difference in

favour of HMI membership. Divorced individuals constitute 5.5% of the respondents. They make up 9% of non HMI members and only 1.9% of HMI members. Finally, 8.4% of respondents were widows or widowers forming 8.8% of HMI members and an equal 8% of non-members. The chi square test for marital status and HMI membership shows the differences found are also statistically significant (chi square = 27.182, df = 5, p = <.001).

Highest Level of Education

Only 1.9% of the respondents questioned had never been to school. They make up 1% of non-members and 3% of HMI members, indicating a noteworthy difference given their small number within the sample size. Persons who have attended primary school constitute 21.7% of the respondents. This category accounts for 21.0% of non HMI members and 22.5% of HMI members, thus showing no significant difference. Those who have been to secondary school constitute the largest group, accounting for 38.0% of all respondents. Like the preceding category they too manifest no difference in HMI membership making up 39.0% of non members and 37.3% of HMI members.

People who have had professional apprenticeship or attended a trade course – that is, vocational training – make up 11.8% of respondents. This cohort provides 13% of non HMI members and 10.8% of HMI members. There is therefore, not much of a difference here as well. Those who have acquired university education make up 26.2% of respondents for this study. This cohort provides 26.0% of non-HMI members and 26.4% of HMI members thus revealing no difference. With most of the categories showing no major differences in HMI membership, it is not surprising that the chi square test for level of education and HMI membership show the differences found are statistically not significant (chi square = 2.862, df = 7, p = .897).

Religion

The importance of people's religious inclinations in choosing whether or not to join a HMI scheme is not immediately obvious. However, the religious context has often contributed in explaining the development of the welfare state. This is the case with Christian democracy in Central European regimes (Kersbergen 1994) or Protestantism in the Nordic social democratic model (Kangas and Palme 2005). In a thought provoking article, 'Old Wine in New Bottles: Impacts of Colonization, Modernization and Institutions on the Timing of Social Insurance in Africa', Kangas (2007b) underscores the importance of religion in the enactment of social policy. His findings show that of the three competing religious beliefs in Africa – namely Christianity, Islam and African traditional belief systems – Islamic countries were the most advanced in implementing social legislation.

Armed with this religious indicator from social welfare literature, I was interested in discovering the religious inclination of respondents and their perception of HMI as measured by membership figures in these schemes. The respondents of this study were mainly living in the southern part of Cameroon, which is overwhelmingly Christian, hence the low representation of Muslims and followers of traditional religion. Also, my principal interest with this religious variable is the Catholic and Protestant divide. This is due to the fact that they are the dominant religious belief systems in the region studied.

According to the figures in Table 6.1, Catholics make up 51.0% of the respondents, 42.0% of non HMI members and 59.8% of HMI members. This reveals a difference in HMI membership for Catholics, with a slight majority of them belonging to an HMI scheme. On the other hand, Protestants constitute 35.0% of the respondents for this study, 40.0% of the non HMI members and 29.0% of HMI members. This denotes a difference in the HMI membership criterion for Protestants. However, unlike the Catholics, the difference weighs significantly in favour of non HMI membership for Protestant respondents.

Pentecostals are a rising force in the religious circles in Cameroon. They make up 10.0% of the respondents, with 11.0% of non HMI members and 8.8% of HMI members. This does not reveal any major difference. Muslims constitute 3.0% of the respondents, 6.0% of non HMI members and 1.9% of HMI members. This reveals some difference in HMI membership. The dwindling effect of African traditional religion was evident in my study where just one respondent (0.5%) professed to practise African traditional religion. Unsurprisingly, this individual is not a member of any HMI scheme. The chi square test for religious beliefs and HMI membership proves the differences found are statistically speaking not quite significant (chi square = 8.114, df = 4, p = .087) but can be treated as indicative of differences.

Private Insurance Coverage

This study is strongly rooted in understanding the MHI programme in Cameroon. I therefore deemed it necessary to investigate the level of private health insurance coverage within the target population. Such an interest was further enhanced by the findings presented in Table 5.10 on Cameroon's national health expenditure, which shows that private health insurance as a percentage of private expenditure on health was zero. The findings from my respondents corroborate the above observation on the role of private health insurance in Cameroon.

Only one out of 202 respondents for this study had private health insurance coverage, 0.5% of the sample. This is hardly surprising, considering the high cost of monthly premiums for private health insurance in Cameroon. The average cost of private health insurance is about 15$ per month per person, in a country where a majority of the inhabitants live on an average of 1$ per day. This makes

HMI all the more attractive. The data collected from members of HMIs and non members will facilitate this understanding. I now present the outcome of the quantitative data, first for HMI members and later the outcome from non-members.

6.2 Descriptive Results for HMI Members

Those referred to here as members of HMI schemes are those respondents who are currently registered with an HMI programme and up to date with their monthly premium payments, and hence eligible to benefit from the services provided by these community based health insurance schemes. I surveyed 102 of such respondents for this study. As members of HMIs, they can provide useful data that will contribute to understanding the modus operandi of HMIs in Cameroon. Members are also privy to useful information that can provide answers to the main research question: Why have Cameroonians not embraced HMI with enthusiasm despite the benefits therein? To achieve this, I will test certain hypotheses with the expectation that they will shed more light on the main research question.

In Table 6.2 below, I present the descriptive results from the analysis of data emanating from HMI members on eight variables. These variables are: (1) Consistency in HMI membership, (2) Source of information on HMI, (3) Availability of information on HMI, (4) Respect of HMI contracts by health care providers, (5) HMI membership and out-of-pocket payments, (6) Frequency of hospital visits, (7) Reliance on traditional medicine, and (8) Reliance on kinship.

TABLE 6.2 Descriptive results for HMI members

	Frequency	%
Consistency in HMI membership1		
Inconsistent	15	14.7
Consistent	87	85.3
	102	100
Source of Information2		
Promoter	37	36.3
Health Unit	25	24.5
Friend, Neighbour or Family	11	10.8
Media	1	1.0
Social Meetings	8	7.8
Church/Mosque	16	15.7
Other	4	3.9
	102	100
Availability of information on HMI3		
Too little	7	6.8
Little	26	25.5
About right	22	21.6
Much	36	35.3
Too much	11	10.8
	102	100
Respect of HMI contracts by health care providers4		
Always	74	72.5
Not Always	28	27.5
	102	100
HMI membership and out-of-pocket payments5		
Always	5	4.8
A couple of times	12	11.8
Once in a while	52	51.0
Never	33	32.4
	102	100
Frequency of hospital visits6		
More often	38	37.3
No difference	45	44.1
Less often	19	18.6
	102	100
Reliance on traditional medicine7		
Never	72	70.6
Once in a while	28	27.4
Depends	0	0.0
A couple of times	2	2.0
	102	100
Reliance on kinship8		
Always	2	2.0
A couple of times	9	8.8
Depends	1	1.0
Once in a while	55	53.9
Never	35	34.3
	102	100

Consistency in HMI Membership

Consistency here refers to uninterrupted HMI membership. After joining the HMI, some members at one point or another suspend their membership for one reason or another. Meanwhile, other members have never discontinued their membership. The latter group is deemed for the purpose of this study the consistent HMI members. In order to measure the level of consistency in HMI group membership, I asked respondents whether they have either suspended their membership or been suspended from the scheme any time since becoming a member.

The answers indicate that just 14.7% (15 out of 102) as shown on Table 6.2 have been inconsistent since registration. Meanwhile 87 respondents have never interrupted their membership since joining the scheme giving a high membership consistency score of 85.3%. This augurs well for the growth and sustainability of these HMI programmes.

Source of Information on HMI

As stated above, HMI is a relatively new health care financing medium. In order for the target population to be reached, there is need for sensitization and awareness campaigns to be undertaken by all stakeholders. That is the reason why the variable on the source of information was included in the questionnaire. It is hoped that this variable will identify the most effective channels of communication that will carry the message to the intended beneficiaries. Seven indicators constituted building blocks for the variable on the source of HMI information: HMI promoter, hospital/health centre, friend neighbour or family member, radio or newspaper, social meetings, church or mosque and finally 'other', for instance, school. Respondents were required to tick a box corresponding to one of the indicators above, which was the source of information leading to HMI membership. The frequency and percentage of their responses are presented in Table 6.2 above

It is hardly surprising that HMI scheme promoters are the most effective means of recruiting members into HMIs. This is their primary function, mainly, to make known the existence of HMI in communities where there are operational or intend to operate: 36.3% of the respondents who are HMI members got the information from promoters. These are mostly NGOs that champion the cause of community health financing for the poor. Hospitals and health care units are the second most important source of information, reported by 24.5% of respondents. Given the importance most Cameroonians attach to religion, it is logical that churches and mosques come third as a vital source of HMI information: 15.7% of respondents got information on HMI from churches and mosques.

Unfortunately, the public media, especially radio, has not been fully incorporated into sensitization efforts to inform citizens about the necessity to

join an HMI scheme. As a result, only 1.0% of the 102 HMI members in my research got the information from the public media. Though most persons in rural areas may be illiterate, hence unable to read newspapers, almost everyone listens to the radio. The state has effectively used this medium to sensitize Cameroonians about the dangers of other health hazards like HIV/AIDS. It will, therefore, be very beneficial for HMI membership if the state steps in to sensitize people via this medium. More awareness equally has to be spread in social meetings. Almost all Cameroonians belong to one social meeting group or another, popularly called 'Njangi'. Surprisingly, only 7.8% of my respondents got information on HMI from these social meetings. The public media and social meetings are channels of information that should be targeted more by HMI promoters and the state to recruit new members into HMI programmes.

Availability of Information on HMI

Closely related to the variable on source of information is that on the availability of information on HMI. My intention is to get the perception of members on the volume of information available to them. To achieve this, they were asked to indicate on a scale of five, how much information on HMI they think is available to them, ranging from too little, little, about right, much and too much. This is one of the variables whose findings will be compared with that of non-members in the discussion phase of this study. Meanwhile, the results on the availability of information by members are presented on Table 6.2.

A majority of the respondents agree that there is 'much' information out there on HMI, scoring 35.3%. The second group with a positive view of this variable consists of those who think the available information is just about right, they make up 21.6%. The over positive view of too much information is held by 10.8% of respondents. These three groups can be collectively called 'positive respondents': cumulatively, they constitute 67.7%. This is a sizeable percentage of respondents who think the available information is at least sufficient. Not surprising, only 6.9% of HMI members think the available information is too little. However, the view of the 25.5% who hold that the available information is 'little' cannot be ignored if HMI coverage is to be extended to the wider population with no health insurance.

Health Care Providers and Respect of HMI Contracts

Health care providers are indispensible for the successful functioning of HMI. After agreeing to create a community based health insurance scheme, the promoters sign a working contract with a willing health care provider in the vicinity. This is usually a public health facility or quite often a mission (Catholic or Protestant) run health care unit. The extent to which these health care providers respect the terms of the contract signed with each HMI determines to a

large extent the success or failure of that scheme. That is why I asked HMI respondents whether or not health care providers do honour the terms of contracts signed with the HMIs. The results are presented in Table 6.2.

Respondents were asked the question, whether health providers always respect the terms of the contract each time they consult or they do not always honour the contract. An overwhelming 72.5% (74 out of 102) stated that hospitals always honour the terms of the contract. Just 27.5% (28 out of 102) respondents reported that health care providers do not always honour the terms of contracts they sign with HMIs. The findings paint a favourable picture of the working relationship between health care providers and HMI programmes in Cameroon.

Health Micro Insurance Membership and Out-of-Pocket Payments

The out-of-pocket payments variable is one of the variables with which comparisons will be made between the responses of members and non-members later. In the meantime, I present the results from the questionnaire provided by members only, as contained in Table 6.2 above.

On a Likert scale of four items – Always, A couple of times, Once in a while and Never – HMI members were required to indicate that which best describes how often they still rely on out-of-pocket payments. The findings reveal that just 4.9% (5 out of 102) respondents still rely on out-of-pocket payments always, and just 11.8% (12 out of 102) of respondents make out-of-pocket payments 'a couple of times'. Astonishingly, 51% (52 out of 102) HMI members still rely on out-of-pocket payments once in a while. This figure takes the cumulative percentage of those who use out-of-pocket payments at one time or another to 67.6%. This high percentage of occasional to frequent reliance on out-of-pocket payments by HMI members may be due to the fact that no scheme in this study provides 100% coverage for all medical expenses. Nevertheless, an encouraging 32.4% (33 out of 102) respondents say they never use out-of-pocket payments for health care since joining the HMI programme.

Frequency of Hospital Visits

According to Bennett et al. (2004: 5), having to pay even small fees when seeking care can create a barrier to health care. By removing this financial barrier at the time of need, HMI schemes make people more predisposed to seek health care services. In order to test this hypothesis, I included the variable on the frequency of hospital visits by HMI members.

Respondents were asked to choose from three items which indicate their frequency of hospital visits since they joined the HMI programme: More often, No difference and Less often. As seen on Table 6.2 above, 37.3% (38 out of 102) respondents report that they visit the hospital more often presently, and 44.1%

(45 out of 102) report that there is no difference in frequency between their current hospital visits and prior to them becoming HMI members. Finally, 18.6% (19 out of 102) report that they make fewer hospital visits now than was previously the case. This may be because, among other reasons, they now seek health care at an earlier stage, thereby avoiding complications necessitating further treatment. On the other hand, it could also be an issue of recall bias. According to De Leeuw (2004: 244), when information is presented only aurally (as with my questionnaires) this demands more memory capacity of the respondents. In this vein, some respondents may not recall with accuracy their frequency of hospital visits, for instance.

Members' Reliance on Traditional Medicine

Also known as alternative medicine, the use of African traditional medicine is quite common in Cameroon, as in other African countries (WHO 2002a: 9). I intend to compare the results from this variable between members and non-members. At moment though, I am presenting the results from HMI members only.

Respondents were required to indicate which of four items best describes the frequency with which they seek medical care from traditional healers since joining the HMI scheme. The options were: Never, Once in a while, Depends and A couple of times. 'A couple of times' suggests more frequent visits than 'once in a while'. The results, presented in Table 6.2 show some surprising findings; 70.6% (72 out of 102) respondents claim they have never been to a traditional healer since becoming HMI members. This figure can imply three things. The first is that HMI membership meets the health care needs of this group to a large extent. Secondly, it may be an indication of the changing attitude of Cameroonians toward African traditional medicine. Third, this may be an instance of respondents providing socially desirable responses (see Chapter 4.4). This is more evident where visiting a traditional healer is considered a sensitive issue.

Respondents who have sought health care from traditional healers once in a while constitute 27.4% (28 out of 102) respondents. No respondent chose the item on the scale 'Depends'. This may be due to the ambiguity embedded in this item. For instance, respondents may think choosing this item will necessitate further explanation. However, consistent with the trend observed in the first two items, only 2% (2 out of 102) persons claim to have been to the traditional healer for health care 'a couple of times'. In order to arrive at a valid conclusion on the importance of traditional medicine, it will be necessary to make a comparison with non-members' frequency of seeking traditional healing.

Members' Dependence on Kinship

In Cameroon, the notion of 'family' goes beyond the nuclear and includes the extended family. Therefore, it is culturally expected that better-off family members will extend a helping hand to other family members when they are in need. As such, I am using this variable to get an indication of the extent to which HMI members still depend on relatives to foot their medical bills. Like the previous variable, I will be making comparisons of the findings from members and non-members on the dependence on kinship below (in Chapter 7 'Analysis of quantitative data'). Meanwhile, the results for HMI members are presented in Table 6.2.

These respondents were asked to choose one of five items on a Likert scale, which indicates best their dependence on relatives to pay their health care bills. Table 6.2 figures show that only 2.0% (2 out of 102) respondents always depend on kinship for the payment of health care bills. 'A couple of times' amount to 8.8% (9 out of 102) HMI members. Just one member selected 'Depends', representing just 1%.

However, 53.9% (55 out of 102) respondents, state that they rely on relatives to pay their medical bills 'once in a while'. This takes the total percentage to 65.7% of respondents who depend on kinship for medical bills assistance even though they belong to an HMI scheme. Nevertheless, 34.3% (35 out of 102) respondents indicate that they have never relied on relatives for the payment of medical expenses since joining the HMI programme.

Preferred HMI Services

One variable that is not included in Table 6.2 but which I find quite useful, deals with the health services HMI members prefer from health care providers. The reason for including this variable is to find out the most beneficial and, conversely, the least appreciated services offered by HMIs. This will enable HMI stakeholders to allocate more resources towards those services members find to be most beneficial. Like any other insurance programme, a HMI scheme is only as good as the product and services it offers to the members (Radermacher et al. 2006: 72). All the HMIs included in this study provide similar services. These services are: outpatient consultation, admission to hospital, surgery, prenatal consultation and delivery. I added evacuation abroad as this is currently being contemplated by some bigger HMIs. Members were asked to rank three of the services most beneficial to them in the order of first, second and third. In other words, respondents had the chance to provide answers to three categories, which explains why there are 306 responses (3 x 102).

TABLE 6.3 Most beneficial services[1]

Services[1]		Responses	
		N	Percent
	Outpatient	93	30.4
	Admission	78	25.5
	Surgical	65	21.2
	Pre-natal	17	5.6
	Delivery	40	13.1
	Evacuation	13	4.2
Total		306	100.0

Notes: **Outpatient:** involves consultations only, patients are prescribed medication to buy and administer at home, or visit the hospital in the daytime for treatment without spending the night.
Admissions: After consultations, patients are admitted in hospital to spend more than a day.
Surgical: Patients undergo a surgical intervention to treat an illness.
Pre-natal: Medical consultation for pregnant women before delivery.
Delivery: Either normal delivery or via caesarian section, i.e. surgical intervention.
Evacuation: Sending patients out of Cameroon, usually to developed countries, for treatment.

The findings reveal that 30.4% respondents prefer outpatient care as shown on Table 6.3. This is because the HMI covers 75% of outpatient medical bills for a maximum of 30$ three times a year. Admissions come in second place with 25.5% of respondents considering it as most beneficial. As stated in Chapter 3.1.1, the HMI pays 75% of admissions bills for a maximum of 60$ three times in a year – little wonder that respondents find it quite beneficial.

Surgical interventions come in third place as a service of choice. Respondents chose it 65 times giving it 21.2%. With the HMI paying 75% of surgery bills up to a maximum of 240$, surgery appears to be a good service too, therefore, deserves the scores it has. The limitation of once a year does not appear to deter this beneficial outlook of surgery, especially if one considers that very few persons require surgery more than once a year.

Delivery is chosen 40 times as being beneficial, with 13.1% of responses. The HMIs pay 75% of delivery bills to the maximum of 50$ once a year. This seemingly low response rate may be explained by the fact that a number of respondents were unmarried males, widows or women past childbearing age. In the same vein, pre-natal consultations were mentioned just 17 times as being beneficial. This may be due to the fact that pre-natal consultations fall within the

ambit of outpatient consultations. The meagre 4.2% response rate for evacuation is hardly surprising because hardly any HMI provides this service. Evacuations are too expensive to be covered by any community based HMI scheme. One evacuation would be enough to deplete the funds of the common pool.

From the HMI members' data, certain trends can already be discerned thus far. At the level of information, there is the need to make more use of the public media with its wider reach for sensitization on the advantages of HMI. Another surprising observation is that HMI members still finance health care via out-of-pocket payments to a reasonable extent. This may be due to the fact that no HMI scheme provides 100% coverage of health care costs. As would probably be expected, the number of HMI adherents making use of traditional medicine is modest. This is also the case with members' reliance on kinship to pay medical bills. Adherents believe the most beneficial services in order of importance are outpatient care, hospital admission and surgery. I will now proceed to present the data from non HMI members.

6.3 Descriptive Results for Non-Members

Low coverage remains a major challenge facing HMI schemes in Cameroon in particular and Africa in general. For instance, the Bambouantou (a local HMI scheme) in Cameroon covers less than a quarter of the community (Ekman 2004). In one of the earliest community health financing programmes in Tanzania, only 2.8% of the target population was covered (Chee et al. 2002) and 6% in the Maliando scheme in Guinea (Criel and Waelkens 2003). In order to understand the challenges inhibiting people from joining HMI schemes despite the numerous benefits, I interviewed 100 respondents. They had to reside in communities with a functional HMI scheme. Some of the results will be compared with those of HMI members below in Chapter 7. For instance, the results from the variables on the availability of information, reliance on kinship, out-of-pocket payments and others, will be compared between members and non-members. Before the analysis phase, I proceed with the results of data collected from non-members summarized in Table 6.4.

TABLE 6.4 Descriptive results for non-members

	Frequency/Percent
Availability of Information1	
Too little	37
Little	43
About right	8
Much	10
Too much	2
	100
Frequency of falling ill2	
Often	9
Sometimes	33
Rarely	58
	100
Out-of-Pocket Payments3	
Always	3
A couple of times	56
Once in a while	13
Never	28
	100
Reliance on kinship4	
Always	37
A couple of times	24
Depends	2
Once in a while	18
Never	19
	100
Reliance on traditional medicine5	
Never	68
Once in a while	25
Depends	5
A couple of times	2
	100
Self medication6	
Always	3
A couple of times	20
Depends	2
Once in a while	63
Never	12
	100
Affordability of HMI premium7	
Agree strongly	36
Agree	55
Neither agree nor disagree	3
Disagree	0
Disagree strongly	1
Don't know	5
	100

Notes: The column for frequency and percentage have been merged because I surveyed 100 respondents, hence the figures for frequency and percentage are the same.

Availability of Information on HMI

HMI is a fairly recent health care financing instrument in Cameroon. According to an official document on HMI published by the government of Cameroon, the first HMIs were identified in Cameroon in 2000 (Government of Cameroon 2006). Therefore, if such a novel health financing tool is to be embraced by the population, a lot of sensitization and information campaigns need to be undertaken by HMI promoters. With the 'availability of information' variable, I intend to find out how much information on HMI non-members possess. The findings are presented on Table 6.4.

The respondents were presented with a Likert-scale questionnaire of five items and asked to choose the one most applicable to them. These items indicated the amount of information they perceived to have on HMI: Too little, Little, About right, Much and Too much. As shown in Table 6.4 above, 37% of the respondents perceived the amount of information they have as too little. A further 43% hold that the available information is 'little'. Together, these two options reveal that 80% of the respondents felt the information on HMI is either too little or little.

If these findings are considered a fair representation of the population in general, then a large proportion of the target population are unaware of the existence of a HMI programme in their locality. In order to improve coverage by the scheme, a lot needs to be done in spreading the advantages of joining the HMI programme. So far, this responsibility for sensitization has been left to the NGOs promoting the schemes. Government needs to take an active part, as is currently the case with HIV/AIDS prevention. The state has substantial resources at its disposal, such as radio and television, and a plethora of health personnel working even in the most remote parts of Cameroon. These human and material resources can be used to great effect. All that is needed is for the state to refocus its health information policy to place more emphasis on HMI as a worthwhile health financing opportunity.

Frequency of Illness

The variable of frequency of illness is meant to test the hypothesis that people who are hardly ever ill are unlikely to join a health insurance scheme. Non HMI members were then asked to tick one of three indicators aimed at measuring the frequency with which they become ill: Often, Sometimes and Rarely. The findings are included in Table 6.4.

From the results, only 9% of the respondents claim they are often ill. Like most individuals, 33% non HMI members indicate that they sometimes become ill. Why none of these finds it necessary to join the HMI programme is the object of further investigation as this study proceeds. The majority (58%) claim they rarely become ill. At first sight, this appears to confirm the hypothesis that such

persons do not need to join a health insurance scheme. However, the situation becomes murky when one considers the percentages of respondents who are either ill often (9), or sometimes (33). Cumulatively, they constitute 42%. The obvious question then, becomes why is it that none of these 42% find it beneficial to invest in a health insurance policy, even with the moderate premiums offered by HMIs? The answer seems to rest somewhere else and I hope to find out as I continue to test other hypotheses.

Non-Members and Out-of-Pocket Payments

With this variable I am testing the hypothesis that people are not willing to enrol in a health insurance scheme because they prefer to make out-of-pocket payments for medical bills. Respondents were asked to select from a four-item Likert scale that which best describes their frequency of out-of-pocket payments. The results presented in Table 6.4 make for some interesting reading.

Just 3% claim they always pay for medical bills out-of-pocket. This is surprising giving the fact that they neither belong to the HMI nor own a private health insurance policy (See Section 6.1: Respondents' demographic data). However, 56% report that they rely on out-of-pocket payment for health care bills a couple of times. Together with those who use out-of-pocket always, it gives a combined percentage of 59%. Meanwhile 13% of non-members respondents rely on out-of-pocket payments for health care once in a while. Therefore, a majority (72%) of non-members make use of out-of-pocket payments in varying degrees

Nevertheless, it is intriguing to find that 28% say they never pay for health care out-of-pocket. This is interesting because they do not belong to a HMI scheme, yet never use out-of- pocket. The question then is: How do they finance their health care? Perhaps they rely on relatives, or make extensive use of the availability of traditional medicine. The findings on out-of-pocket payments by non-members will be compared with that of members in the analysis chapter. This will give a clearer picture on the implications of the use of out-of-pocket payments by both groups of respondents.

Non-Members' Dependence on Kinship

With the challenge of low coverage, common in most HMI programmes, I am testing the hypothesis that dependence on kinship to pay for health care adversely affects HMI membership. As stated earlier, the obligation of family solidarity requires successful family members to lend a hand in times of need. And what other times of need can surpass periods of sickness? I argue that such family obligations have led otherwise capable individuals to depend continuously on others to foot their health care bills. To test the veracity of this

hypothesis, I introduced the variable on non HMI members' dependence on relatives for health care financing.

In order to measure this dependence on kinship, respondents were asked to choose from a scale of items that which represents the level of dependence on relatives to pay for their health care bills when they are ill: Always, A couple of times, Depends, Once in a while and Never. The results are presented in Table 6.4.

It is not surprising that a high percentage – 37% – of non HMI members always rely on relatives to pay their health care bills. An additional 24% depend on kinship for medical bills a couple of times. This gives a cumulative 61% who depend on relatives for medical expenses on a fairly regular basis. Of the 2% who chose 'Depends', further probing revealed they were housewives, whose husbands took care of their medical expenses as part of their matrimonial responsibilities. As shown on Table 6.4 above, 18% of the respondents rely on relatives to foot medical bills once in a while.

Just 19% of non-members declare that they never depend on family members to pay for their health care costs. Therefore, an overwhelming 81% of non HMI members who participated in this survey depend on kinship to a greater or lesser extend for health care financing. A comparison will be made between these findings and those obtained from members of HMI on the same variable. A significant difference will validate the hypothesis that dependence on relatives contributes in limiting HMI coverage. Meanwhile, the search for other contributing causes continues.

Non-Members' Use of Traditional Medicine

The use of traditional medicine, as stated earlier, is common in Cameroon as in most African countries. I am testing the hypothesis that this may be the reason why most people are reticent to enrol in HMI schemes. It might be a possible explanation given the fact that HMIs do not work with traditional healers. To test this hypothesis, non HMI members were asked to choose from a Likert scale the item that represents their dependence on traditional medicine. Table 6.4 contains a summary of their responses.

Table 6.4 reveals that 68% of the respondents claim they never go to the traditional healer when they are ill. Such an overwhelming response is a clear rejection of the hypothesis on traditional medicine and its negative influence on HMI membership. As with HMI members, it can also be viewed as respondents providing socially desirable responses where traditional medicine is looked-down upon. However, 25% of the respondents visit traditional healers in times of illness once in a while. Of the 5% who answered 'Depends', on further probing they revealed that certain illnesses are better handled by traditional healers. These illnesses, they reveal are of mysterious origins like witchcraft. Just 2% of the respondents reported using traditional medicine a couple of times.

Cumulatively, a minority 32% of non HMI members visit traditional healers, sparingly, when they are ill. Therefore, the reason for poor HMI coverage lies elsewhere.

Self Medication

Self medication is the practice whereby people purchase medication over the counter without the prescription of a health care professional. The negative consequences of such a practice are beyond the scope of this thesis. With this variable, I intend to determine the percentage of non HMI respondents who indulge in self medication. In a study carried out in Cameroon, Van Der Geest (1987), found that the practice of self medication was not only widespread in Cameroon, but was actually growing. Is this still the reality today? To find out, non HMI respondents were asked to indicate which of five items on a Likert scale shows the regularity with which they self medicate. This, it is hoped, can provide a partial explanation concerning the reticence to join an HMI despite its inherent advantages. The results are included in Table 6.4.

The findings appear to confirm the trend of increasing reliance on self medication in Cameroon. Even though only 3% use self medication always, 20% rely on this form of treatment a couple of times. Of the 2% who chose 'it depends', in a follow-up probe, they stated that if their present illness has a previous prescription from a health professional, they proceed to buy the same drugs over the counter. Continuing the self medication trend, 63% of respondents claim that they indulge in self medication once in a while. Just 12% state they never engage in self prescription of drugs for their illnesses. Therefore, 88% respondents practice self medication to varying degrees. With such a high percentage of respondents accessing health care via self medication, it is not so surprising that they are hesitant to join an HMI. They tend to justify such reticence by asking the rhetorical question, why pay for health insurance when I can purchase drugs easily over the counter? Addressing the widespread availability of ambulatory treatment will curb such high reliance on self medication and its negative consequences on the population.

I did not put the question on self medication to HMI members because I hypothesized that this was one among other reasons why non-members do not belong to HMI schemes. Nevertheless, acquiring the views of both groups would have enriched the data without taking anything away from the original intention of testing this hypothesis.

Affordability of HMI Premiums

The affordable level of HMI premiums is often mentioned as one of its main advantages (Arhin-Tenkorang 1995, Eklund and Stavem 1996). In Cameroon, the average HMI premium costs $1 per month per individual. Meanwhile, private

health insurance costs 15$ per month per individual. Nevertheless, during informal discussions, I have often heard non HMI members say the reason they are not members is due to the lack of finance. In a bid to test how far this assertion was affecting HMI membership, I included the variable on the affordability of HMI premiums. Respondents were presented with the statement: The amount charged for HMI premiums is affordable. They were required to indicate from a five-item Likert scale, that which captures best their perception of the affordability of HMI premiums. The results from the questionnaire administered to 100 non HMI respondents are presented on Table 6.4.

Interestingly, 36% of those interviewed agreed strongly that the premium for HMI was quite affordable. A further 55% simply agree that it is affordable. This gives an astonishingly cumulative 91% who either agree or agree strongly that HMI premiums are affordable. None of the respondents 'disagree' and only 1% 'disagrees strongly' with this claim. If the figures from the sample are a reflection of the population within the study area (around one million people) then the argument of lack of finance as justification of not joining by some non HMI members is not tenable. As such, the search for the reasons of the reticence to join HMIs will continue.

In the meantime, these findings from non-members of HMI schemes make for interesting reading. It is clear that the information on HMI is wholly insufficient, as a large majority (80%) of the respondents state the information is either too little or little. A majority of non members appear to justify their non membership by the fact that they are rarely ill. Concerning the variable on out-of-pocket payments for health care, it is not surprising to find 59% of respondents rely on this health care financing regime. It is a similar situation with non members' reliance on kinship to finance health care cost. Here, the vast majority of respondents (81%) rely on kinship to a greater or lesser extent. One of the major surprises emerging from the findings on non-members of HMI is the fact that 68% of the respondents 'never' make use of traditional medicine. Equally astonishing is the high numbers (91%) who either agree strongly or agree that HMI premiums are affordable, yet they are not HMI members. Finally, the high percentage of non-members making use of self medication is to be expected – 88%, to varying degrees. After presenting the data outcome from HMI members and non-members, I will take the next step of analysing further these quantitative data findings in the following chapter.

7 ANALYSIS OF QUANTITATIVE DATA

In this chapter, I continue with the analysis of the quantitative data introduced in the preceding chapter. However, not all of the data presented in Chapter 6 will be analysed here. For instance, the demographic data has served its purpose in providing the necessary information on the relevant characteristics of respondents. SPSS for Windows is the principal software used in analysing the quantitative data. While in Chapter 6, I used descriptive statistics to present the preliminary findings, here I will employ inferential statistics like statistical significance where applicable. This will be the case especially in instances where I make use of cross-tabulation in conducting bivariate analysis comparing two groups – members and non-members of HMIs.

According to Shank (2008: 208), the deductive syllogistic approach has often played a major role in quantitative research studies. In its purest form it takes the following process – at the start, there is a theory followed by a hypothesis deduced from the theory, then data collection to test the hypothesis, findings, confirmation or rejection of hypothesis and revision of the theory (Bryman 2008: 10). However, he goes further to state that when this deductive approach, which is usually associated with quantitative research, is put into operation it often does not follow the sequence outlined above. Generally, its broad contours may be discernible but often there are departures from it (ibid.: 10 & 11). This study is no exception to these deviations. While analysing the quantitative data, I make use of the social policy approach and collective resource mobilization theories presented in Chapter 2 to enrich the analyses. In the process, some hypotheses will be confirmed or rejected as the empirical scrutiny requires.

7.1 Importance of Information

The importance of information in raising awareness concerning a novel social phenomenon such as HMI cannot be overemphasized. Increasingly, in the face of the critical health crisis that Africa is experiencing, it is imperative that a massive mobilization campaign be launched to meet the challenge (Monekosso and Martin 2008: 55). However, the reality in Cameroon seems to suggest the contrary as far as HMI is concerned. In this study, I wish to determine the relationship between the availability of information on HMI and HMI membership.

In order to achieve this, I included two variables in the research that hinge on information. The first, dealing with the source of HMI information, was directed toward HMI members. It is a foundation to the main variable on availability of information. The findings are presented in Table 6.2 with comments on its distribution in the preceding chapter.

The second variable deals with the amount of information available. The question to conceptualize it was addressed to both members and non-members of HMI schemes. In a bivariate analysis comparing members and non-members' responses, I intend to find out the effect of availability of information on HMI membership. To achieve this I carried out cross-tabulation with chi square and phi tests. Chi square test is based on not just the actual values but also the expected values. This helps to determine whether there are differences between the actual (observed) values and the expected values on the responses provided by members and non-members on the availability of information.

TABLE 7.1 Availability of information and HMI membership cross-tabulation, % (N)

	Member	Non-member	Total
Available information on HMI			
Too little	6.8 (7)	37.0 (37)	21.8 (44)
Little	25.5 (26)	43.0 (43)	34.2 (69)
About right	21.6 (22)	8.0 (8)	14.8 (30)
Much	35.3 (36)	10.0 (10)	22.8 (46)
Too much	10.8 (11)	2.0 (2)	6.4 (13)
Total	100 (102)	100 (100)	100 (202)

Notes: $chi^2 = 52{,}088$, df = 4, $p < .001$, phi = .508

A look at Table 7.1 shows that only 6.8% of HMI members think the amount of information on HMI is too little, while 37% of non-members hold this view. This

reveals a significant difference in the perception of both groups on this item in the scale. The situation is similar for the second item on the scale, 'little.' While 25.5% of members indicate that the available information on HMI is 'little', 43% of non-members hold this view, thereby manifesting a marked difference between members and non-members on this item as well.

It is not surprising that a higher percentage (21.6%) of HMI members, against a meagre 8% of non-members, think the available information on HMI is about right. The trend continues with 35.5% of members holding the view that 'much' information is available on HMI, with a mere 10% of non-members sharing the same opinion. Finally, 10.8% of members hold that the amount of information on HMI is too much as against 2% of non-members. The last three items on the scale show that HMI members have a more optimistic view as to the level of HMI information than non-members. The chi square test shows that the differences found in the perception of available information and HMI membership are statistically significant (chi square = 52,088, df = 4, $p < .001$).

It is necessary to determine how strong the relationship between information and HMI membership is. The previous procedures have proved the existence of this relationship. I therefore need to look at the strength of this relationship, also known as effect size. The effect size for the chi square test is called phi. The effect size measure varies between 0, implying no relationship, and 1, meaning perfect relationship. As such, the closer to 1, the stronger is the relationship Muijs (2011: 110). In this case, phi = .508. This tells us that the relationship between information and HMI membership is moderate.

From the analysis thus far, it is evident that information plays an important role in raising awareness. If more people are to join the HMI schemes then a lot needs to be done on the information and sensitization fronts. Unfortunately, the state of Cameroon, with the largest means to achieve this, is lagging behind. The mass media – radio, television and newspapers – is the means by which the fewest of the 102 HMI members (1.0%) got information about the scheme, as shown on Table 6.2

The use of public media by the state for HMI sensitization can be justified with the theory of state intervention for social justice, whereby the primary aim of institutions (private and public) is social justice (Rawls 1972). If HMI is seen as promoting equity in health care financing, then the use of state media to advertise the merits of HMI can be justified on grounds of social justice. The state intervention for social justice argument is further strengthened by the fact that HMI is considered an inclusive health insurance plan, unlike private insurance which excludes high risk cases and the poor via cost (Churchill 2006: 22).

State intervention for reasons of efficiency is another theoretical argument the government of Cameroon can advance to justify its intervention. According to the invisible hand theorem, for there to be a perfect market equilibrium three conditions must be fulfilled, one being perfect information. This condition focuses on the extent to which economic agents are well informed (Barr 2004: 72,

73). As shown in Table 7.1, however, a sizeable number of non HMI members interviewed (compared with HMI members) felt that the available information on HMI is too little. At this juncture, the state can justify its intervention, at least on the level of information and awareness, on the need to achieve efficiency within the health care financing milieu.

7.2 The Trap of Out-of-Pocket Payments

Out-of-pocket payments for health care occur when consumers pay for health care at the point of service. This is in contrast with other prepaid health care financing arrangements like private health insurance, state financed social security or, as in this study, HMI. Out-of-pocket payments for health care often lead to catastrophic consequences (Gottret et al. 2008:13). When people are ill and have no money, they are forced to sell meagre family assets or borrow at high cost. Delays in seeking medical care sometimes lead to otherwise avoidable deaths. As a result, poverty and vulnerability reinforce each other in an escalating downward spiral (Churchill 2006: 12). With this variable, I intend to test the hypothesis that the more people subscribe to HMI the less likely they are to continue with out-of-pocket payments for health care. Table 7.2 is the output from a cross-tabulation analysis of the responses of members and non-members on out-of-pocket payments.

TABLE 7.2 Out-of-pocket payment and HMI membership cross-tabulation, % (N)

	Member	Non-member	Total
Out-of-Pocket Payment			
Always	4.9 (5)	3.0 (3)	4.0 (8)
A couple of times	11.7 (12)	56.0 (56)	33.7 (68)
Once in a while	51.0 (52)	13.0 (13)	32.1 (65)
Never	32.4 (33)	28.0 (28)	30.2 (61)
Total	100 (102)	100 (100)	100 (202)

Notes: $chi^2 = 94,370$, df = 4, $p < .001$, phi = .684

The chi square test proves that the differences found in the use of out-of-pocket payments and HMI membership are statistically significant (chi square = 94,370, df = 4, p <.001). The phi test shows that the relationship between these two

variables is strong (phi .684). What these two tests do not reveal is the direction of the difference between HMI members and non-members. Is the difference in favour of members or non-members? Both HMI members and non-members continue to use out-of-pocket payments to finance health care, however, members do so less frequently. This is supported by the fact that 'just' one third (32.4%) never pay from their pocket. This is not very much more than non-members (28.0%). The situation is similar with the item 'always', where one would expect a significant difference in favour of non-members, yet the slight difference tilts toward HMI members. This shows that, while there is a significant difference, the relationship between out-of-pocket payment and HMI membership is a complex one.

From the analysis above, it is clear that, contrary to my hypothesis, the fact that people are HMI members does not necessarily imply they are less likely to continue with out-of-pocket payments for health care. This justifies the heading 'The trap of out-of-pocket payments' for this variable. Incidentally, it seems to find some backing from Alford's theory of structural interest in general and the repressed interest in particular. According to Alford (1979) repressed interests are held by the community and in Alford's time and place these were the poor and uninsured, as in Cameroon today. Alford's theory holds that repressed interests are heterogeneous with respect to their health needs, ability to pay and ability to organize their health needs into effective demands. Most importantly, the theory concludes that the nature of institutions guarantees that repressed interests will not be served unless extraordinary political energies are mobilized (ibid.: 14). Alford's theory with the empirical evidence seems to suggest that HMI alone is not sufficient to free Cameroonians from the trap of out-of-pocket payments for health care.

7.3 Changing Attitudes towards Traditional Medicine Usage

I am interested in investigating whether there is a difference between members and non-members in their use of traditional medicine. In other words, are non-members of HMIs more likely to rely on traditional medicine for health care than members? To answer this question, I proceeded to undertake a cross-tabulation analysis of the data collected from members and non-members on the traditional medicine variable. The findings are presented in Table 7.3.

TABLE 7.3 Traditional medicine and HMI membership cross-tabulation, % (N)

	Member	Non-member	Total
Reliance on traditional medicine			
Never	70.5 (72)	68.0 (68)	69.3 (140)
Once in a while	27.5 (28)	25.0 (25)	26.2 (53)
Depends	0.0 (0)	5.0 (5)	2.5 (5)
A couple of times	2.0 (2)	2.0 (2)	2.0 (4)
Total	100 (102)	100 (100)	100 (202)

Notes: phi = .161, chi^2 not used because 50% of the cells have expected counts less than 5: the minimum should be 20%.

Of HMI members, 70.5% say they never use traditional medicine while an almost similar percentage of non-members (68%) hold the same view. These figures show no worthy difference on this item. Concerning the occasional use ('once in a while') the situation is no different. Here 27.5% of members and 25% of non-members use traditional medicine once in a while. As with the previous measure, the difference is insignificant. None of the members claim 'it depends', while 5% of non-members state likewise. Finally, for those who use traditional medicine 'a couple of times', there is perfect parity between members and non-members each having a score of 2%. In this analysis it is impossible to rely on the chi square test because 50% of the cells have expected counts less than 5. As a rule-of-thumb the minimum should be 20% (Muijs 2011: 109).

Nevertheless, a close look at the figures in Table 7.3 show that, though there might be differences between HMI members' and non-members' use of traditional medicine, this difference is minute. Even with these slight differences it is not obvious where the differences lie. Little wonder, the phi test score of .161 shows that the relationship between HMI membership and the use of traditional medicine is very weak.

Based on these analyses, it can be concluded that whether a person is an HMI member or not has little or no bearing on their use of traditional medicine. The findings shown on Table 7.3 appear to present an indication that attitudes toward traditional medicine usage might be changing among Cameroonians.

7.4 Reliance on Kinship

In Cameroon, it is customary to rely on better-off members of one's (extended) family to provide support in times of need. One such moment of need is in times

of ill health. According to the national values approach, the cultural and ideological conditions inherited from each country's past affect the ease with which reformers outside the government can build popular support for proposed new policies (Skocpol 1992: 17). HMI is an example of such a new policy, referred to by Skocpol. Building popular support for HMI necessarily has to pass through massive enrolment into the programme.

In this light, I hypothesize that reliance on kinship for health care financing is a limiting factor on people becoming HMI members. The aim is to determine whether there is any relationship between HMI membership and reliance on kinship to foot medical bills. The figures are shown in Table 7.4.

TABLE 7.4 Reliance on kinship and HMI membership cross-tabulation, % (N)

	Member	Non-member	Total
Reliance on kinship			
Always	2.0 (2)	37.0 (37)	19.3 (39)
A couple of times	8.8 (9)	24.0 (24)	16.3 (33)
Depends	1.0 (1)	2.0 (2)	1.5 (3)
Once in a while	53.9 (55)	18.0 (18)	36.1 (73)
Never	34.3 (35)	19.0 (19)	26.7 (54)
Total	100 (102)	100 (100)	100 (202)

Notes: $chi^2 = 62, 042$, df = 4, p <.001, phi = .554

In total, 19.3% of all 202 respondents 'always' rely on kinship for health care financing. Out of the 102 HMI members, just 2% rely on kinship always while 37% of non-members depend on kinship always. This vast difference between members and non-members for this item on the scale is hardly surprising. The situation for the next item is no different, with 8.8% of members and 24% of non-members stating that they rely on kinship for the payment of medical bills 'a couple of times'. Like the previous respondents there is a substantial difference in the response of members and non-members, in favour of non-members. According to the hypothesis stated above, these differences are expected for the two items on the scale.

However, the situation becomes more complex with those who rely on kinship 'once in a while', with 53.9% of members against 18% non-members. The difference here is quite significant in favour of members. Nevertheless, it is not such as to outweigh the other differences that have swayed in favour of non-members, especially if one considers the all important item on the scale – 'never'. Here, as expected, a larger proportion of HMI members never rely on kinship to foot medical bills (34.3%), compared with 19% of non-members. The chi square

test shows that the differences are statistically significant (chi square = 62,042, df = 4, p <.001). The phi test score of .554 for this variable reveals that the relationship between reliance on kinship for health care financing and HMI membership is moderate.

Therefore, one can safely state that the hypothesis that reliance on kinship for health care financing is a limiting factor on people becoming members of HMI schemes receives support from the data. The findings and confirmation of the hypothesis equally lend credence to the national values approach. This approach insists on the importance of recognizing people's customary practices and historical past in efforts to enact new social policy like HMI in Cameroon.

So far, I have attempted an analysis of the quantitative data relevant to this study. In the process of analysing the quantitative data, I have been guided by the deductive syllogistic approach which often provides a road map for quantitative data analysis. Even though I have not adhered to the sequence set by the purest form of this approach, I have nevertheless followed its broad contours. For instance, the economic theory of state intervention, especially intervention for reasons of social justice, informed to a large degree the analysis of the variable on the importance of information. I found it interesting that the deductive syllogistic approach in conjunction with the empirical findings sometimes led to the rejection of a hypothesis. This is the case with Alford's theory of structural interest and in particular the repressed interest. It confirmed the empirical findings nullifying the hypothesis that HMI members were less likely to make use of out-of-pocket payments for health care than were non-members.

8 PRESENTATION AND ANALYSIS OF QUALITATIVE DATA

As stated in Chapter 4.2, this study is rooted in a mixed methods approach employing quantitative and qualitative research strategies in equal measure. It is therefore fitting that, after presenting and analysing the quantitative data in the two preceding chapters, presentation and analysis of the qualitative data is the logical next step. Lockyer (2008: 706) states that some of the reasons for making use of qualitative method are the need to identify, analyse and understand patterns of behaviour and social processes. Employing the qualitative strategy in this study, I have identified the principal stakeholders involved in the HMI sector in Cameroon. In conjunction with the quantitative data, the qualitative data when analysed will provide understanding concerning the reticence of Cameroonians to embrace HMI despite its advantages. Finally, qualitative data will shed more light on the process of making HMI widely available, as well as the move to universal health coverage for Cameroonians.

8.1 Presentation of Qualitative Data

Unlike quantitative data, qualitative data are non-numerical but have the added advantage of possessing many sources, both verbal and nonverbal (Schreiber 2008: 185). I therefore took advantage of the numerous sources offered by qualitative data to collect data from interviewees with competences at different levels within the HMI structure. Table 8.1 below is a summary of the number of interviewees at each level and their areas of competence.

TABLE 8.1 Qualitative data interviewees

Levels	Number of Interviewees	Area of competence
Macro	Two Directors Ministry of Public Health Ministry of Labour and Social Security	National territory of Cameroon
Meso	Five respondents 2 HMI managers 2 Coordinators of NGOs promoting HMI schemes 1 HMI Board chairperson	For HMI managers, the HMI members concerned in the Northwest Region. For NGO coordinators, the Northwest Region. For HMI Board chairperson, the HMI concern
Micro	202 interviewees	Represent personal views, drawn from the Northwest and Southwest Regions (two of Cameroon's former ten Provinces)

At the macro, that is, the national, level I interviewed two directors. These were the director in charge of HMI in the Ministry of Public Health and the director in charge of HMI in the Ministry of Labour and Social Security. Stepping one rung down to the meso level, I interviewed five individuals directly involved in the set up and functioning of HMIs. Two were managers of HMI schemes, two were coordinators of NGOs promoting HMI, and one was the chair of the board of an HMI. This group of interviewees represents the managerial personnel of HMI schemes. The respondents for the macro and meso level interviews were purposefully sampled for key informant interviews. The main contribution of key informants lies in their knowledge and understanding of events, relationships and meanings at the community level. They appear to be particularly well informed about the subject matter under study (Wolcott 1988: 195, Schensul 2008: 524).

As far as the micro level respondents are concerned, I took advantage of the mixed methods approach adopted for this study to glean some qualitative data from the quantitative questionnaires. This is in line with the epistemological choice for this research, which is guided by dialectical pragmatism, as explained in Chapter 4.2.2. It follows a 'logic of inquiry' that primarily focuses on problem solving, with the researcher maintaining a constant dialogue with qualitative and

quantitative perspectives. With the 202 individuals – members and non-members of HMIs – whom I interviewed, I included three open-ended questions. These interviewees were free to provide lengthy responses as they saw fit in the tradition of qualitative interviews. I will proceed to present the qualitative data collected from the three levels depicted in Table 8.1.

8.1.1 Macro Level

As mentioned above, I interviewed two persons who are responsible for the elaboration of a national policy on HMI in Cameroon. These directors of HMI in the Ministry of Public Health and the Ministry of Labour and Social Security, respectively, represent macro level interviewees. The directors interviewed are considered macro level because their jurisdiction or areas of competence covers the national territory of Cameroon. As such, they are differentiated from HMI managers working in one region, the North West Region, which I term meso level. Macro level interviewees are equally distinguished from the grassroots respondents at the micro level who are members and non-members of HMI schemes.

Given the overwhelming empirical evidence on the importance of a legal framework for HMI, I had two main concerns for these bureaucrats. The first issue had to do with the current state of efforts to enact a legal framework for HMI. The second was aimed at addressing the all important question whether or not the pursuit of HMI will enhance or impede the move to universalism. Unsurprisingly, before addressing these two concerns, both bureaucrats, in separate interviews, reiterated the importance of a legal framework for HMI. They maintained that this was hampering to a large extent efforts to get Cameroonians enrolled into the programme. At this juncture in both interviews, I asked about the reasons for the delay in enacting this law, if its advantages were so obvious. As if reading from the same script, though interviewed at separate times and places, both interviewees stated that the law was elaborated some time ago and was just waiting to be enacted. This is how one of them stated the point:

> The law on social security has been elaborated two years ago. It went to parliament and came back for modification. It has been modified and previewed by the Prime Minister. This law is presently at the presidency for possible review and onward transmission to parliament for adoption into law.

The state bureaucrats may have done their part in drafting the legal framework for HMI. Nevertheless, they remain powerless to see its implementation, as the response from one of the directors reveals:

> We as technicians have done all that has to be done, we are now just waiting for hierarchy with decision making power to enact the law on health insurance.

I turned next to the crucial question: whether the pursuit of a legal framework for HMI will enhance or hinder the move to universalism. I report sections of the response pattern to this question from the two interviewees below. I will refer to them as 'interview 1' and 'interview 2' respectively.

Interview 1

> The main problem is the absence of a political will to enact a legal framework on HMI into law. There is a long term goal to make social security available to all Cameroonians and residents. Presently under 3% of the population is covered by health social security in Cameroon.

Interview 2

> We are working with the Ministry of Labour and Social Security. In the law we have to adopt this notion of universalism within the framework of Cameroon's social protection. The first step is to adopt the first two pillars, that is, health insurance and unemployment benefits, into our social protection framework. It is a matter of political will for this to become law.

These data from macro level interviewees will be analysed and discussed later. Meanwhile I will present the interviews conducted at the meso level.

8.1.2 Meso Level

Meso level key informants were chosen for their in-depth knowledge of HMI. They are mostly managers of support services (NGOs) at the fore in starting HMI in communities and providing 'expert' managerial advice. All four managers and one board chairperson interviewed were from the North West Region of Cameroon. These were; the coordinator of the North West Special Fund for Health, the coordinator of SAILD (an NGO) for the Northwest Region, the manager of the Nforya HMI and the manager of the Kumbo HMI. To cap the interview of managers at the meso level, I interviewed the board chairperson of one of the most successful HMI schemes, the Kumbo HMI. These meso level interviewees constitute the core of the qualitative empirical investigation for this study.

Current State of HMI Activities

In order to set the ball rolling for the interviews, I asked respondents to 'paint a picture' of the present state of HMI in their jurisdiction. All interviewees were unanimous that when the HMI programme started in 2004 many persons were joining the scheme. There was much initial enthusiasm; this was confirmed by official government documents for the national territory. A survey of HMI in Cameroon revealed an increase from 37 HMI schemes in 2003 to 101 in 2006

(Government of Cameroon 2006: 16). After a while, this initial enthusiasm began to wane, according to my interviewees. One of them put it succinctly:

> You know, it is a voluntary scheme, people come and join as they wish. However, there is a misconception concerning the schemes. A majority do not know the concept of HMI, especially the idea of solidarity. They think the HMI is a place to solve their problems. Once the ill health is resolved, they go away and wait for another health challenge before coming to renew their contribution. It is unfortunate.

This view was commonly held by all the meso level interviewees, giving the impression that it was a widespread challenge affecting many HMI schemes. The manager of one of the most successful HMI schemes decried the situation, stating that:

> There are people, once they pay and do not benefit, it becomes very difficult to come and renew. No matter how much you sensitize the person, it will be as if he or she wasted his or her money. People want that, if they pay they must benefit.

In the light of Hechter's theory of solidarity (see Chapter 2.2), these observations by the meso level interviewees indicate a major challenge to HMI in Cameroon. Hechter's theory of solidarity argues that group solidarity is only as strong as the extent to which members comply with their corporate obligations to contribute to the group's joint goods (Hechter 1987). The joint good here is the common HMI pool to prefinance health care for members. Hechter's theory of solidarity contains two conditions for strong group solidarity: the extensiveness of a group's obligations and the rate of members' compliance with these obligations. When HMI members fail to pay their premiums, as mentioned by the interviewees, none of these conditions is met. Such actions weaken the group solidarity and threaten the HMI scheme.

Lack of Resources or Attitudinal Indifference

I was also interested to find out from my meso level key informants whether poverty on the part of citizens was an issue affecting the growth of HMI. Without exception, all five managers denied the fact that the lack of money was the reason why people were not joining the HMI schemes despite its advantages. They averred it was an attitudinal problem. One of the managers who believes the issue at stake is not simply the lack of money puts it picturesquely, saying:

> Most often people say 'oh poverty' but I don't think it is. It's an attitude or mentality problem. For instance, many people will drink two or more bottles of beer per day at 1$ per bottle, even offer some to friends without complaining about the cost. Calculate such an individual's expenditure per month or per year for beer. How much? It is a matter of mentality. People need to realize that they have to save for their health. A woman, for instance, will prefer to save money to buy the most expensive dress or a pair of shoes but will not use just one tenth to pay for future health care. So it is a question of mentality.

Another manager who has been instrumental in setting up many HMI schemes argued thus:

> The main problem is ignorance. I don't think it is finance. The people are not so poor as not to be able to pay the contribution. What is the contribution – less than 1$ per month. We do a lot of studies before setting the schemes. We study the local economy before we set up an HMI scheme.

The views expressed by these interviewees raise the issue of bounded or limited rationality articulated by the rational choice approach and organizational theory as both attempt to explain institutional theories of politics (see Chapter 2.1). According to the rational choice approach, people usually do what they believe is likely to have the best overall outcome. Actions are valued and chosen not for themselves but as a more or less efficient means to a further end (Elster 1989: 22). Consequently, alcohol consumption while socializing and the purchase of luxury goods may provide more satisfaction to individuals as a means furthering their perceived ends than health insurance.

A slightly different explanation is advanced by organizational theory which starts from a recognition of the limits of human cognition. Immergut (1992: 20) states that this approach emphasizes the ways in which techniques for processing information compensate for these limitations. Accordingly, standard operating procedures decide what kinds of information should be used to make decisions. Immergut claims this type of 'bounded rationality' restricts choice by ordering information. In tandem with this theory, therefore, the bounded rationality of most Cameroonians has ordered their choice of joining an HMI at the bottom of their spending priorities. A closer look at the average household income of Cameroonians (see Table 5.1) lends credence to the view that poverty is not the main reason for the lukewarm attitude of Cameroonians towards HMI.

Meso Level Challenges to HMI Expansion

After getting a fair picture of the HMI schemes in the various communities, I now delved into specific questions. I asked my interviewees what were the major challenges facing the HMI initiatives. Their responses varied depending on the areas where each operates, yet some common themes could be discerned across their responses. It is important to state that the challenges presented below are by no means exhaustive as these are challenges emanating from meso level respondents only. The challenges include; resistance to prepayments for health care, absence of a legal framework, adverse selection, moral hazard and rivalry between promoters.

Resistance to Making Prepayments

Regarding the resistance to prepayments for health care, one of the managers stated that:

> The situation fluctuates a lot, there are some schemes when you are starting, the people are very enthusiastic and welcoming. But when it is time to pay the premiums it becomes a problem.

Decrying the continuing resistance to prepayments, the manager of the North West Special Fund for Health asked the rhetorical question:

> *Why* is it that [in] Bamenda Health District, with more than 300,000, inhabitants only [just] over 2000 persons are enrolled into an HMI scheme? For the past three years, however, we tried to find out if our products were attractive to the people. The findings reveal that the products are attractive. We are of course aware that it is a new initiative, so we are still doing more action research. People prefer out-of-pocket payment which is more expensive and detrimental to the family.

One of the members of a struggling HMI in a rural setting reiterated the reticence for health care prepayment, saying, as the previous interviewees:

> The main problem is contribution. We have registered members who do not pay their contributions. For instance, we have 200-plus adherents but only 50 are regular contributors who are up to date with their monthly premium. They expect us to be running behind them to [make them] pay their premiums. You know with our people it is not easy but we are doing all we can to make them realize the benefits of HMI.

No Legal Framework for HMI

The absence of a legal framework governing the HMI programme in Cameroon also featured prominently in the response of the key informants. All of them stated it was making their job of promoting HMI extremely difficult. Potential adherents were sceptical with regard to the legitimacy of HMI schemes. According to one of the managers:

> The absence of a legal framework was a major impediment to the development of the HMI. Most people doubt the legality [and] hence competence of the schemes. They think people are coming to dupe them. No legal papers backing the schemes, only promises.

One meso level interviewee even predicted the demise of the HMI if a legal framework is not enacted sooner rather than later:

> One of the main challenges threatening the survival of the HMI is the absence of a legal framework. People look at the HMI with a lot of scepticism, they don't believe it is something valuable. If the legal framework is there, the HMI will survive sustainably. But if the situation continues like this, the managers and the delegates undertaking the sensitization will get tired and give up.

Considering the importance respondents attached to the legal framework, I asked what was really meant by a legal framework, and what are the advantages of having one? From the various responses, it emerged that it is a full-fledged law to be enacted by parliament and promulgated by the president. This law will recognize HMI, also called Mutual Health Organization (MHO) or Community Based Health Insurance (CBHI), as a legitimate health care financing scheme in Cameroon.

Interviewees mentioned a series of advantages linked with the enactment of a legal framework regulating HMI in Cameroon. Top on the list of advantages was the fact that it will provide legitimacy to the schemes, thereby dispelling the scepticism of would-be adherents. The legal framework will ensure the provision of subsidies to make up for the micro nature of premiums. Other advantages mentioned include the use of public media for sensitization, capacity building for HMI managers and the possibility of making HMI compulsory.

Widespread Adverse Selection

Adverse selection was raised by the managers as one of the major obstacles inhibiting the smooth functioning of HMI schemes. The problem of adverse selection was so severe that one interviewee maintained it could affect the very survival of the HMI scheme:

> The future of the HMI is at stake with the challenges we are facing especially the issue of adverse selection. It looks like people who are registered in the HMI are people who are often sick.

Moral Hazard

Closely linked to, though different from, the problem of adverse selection is that of moral hazard. I asked my interviewees to explain how moral hazard is manifested in the HMI milieu. One of the respondents explained the occurrence of the phenomenon as follows:

> At a certain point we realized that there was so much abuse. People just took advantage of belonging to the HMI to consult. For instance, when a person is programmed for surgery, he or she rushes to register into the HMI. That is why we pushed the waiting period for surgery to nine months and delivery to one year. As such, if a woman is pregnant before joining the HMI she cannot benefit.

Another form of moral hazard common to HMI in Cameroon is outright collusion between patients and health care providers. Respondents claim that often health care providers inflate hospital bills for patients who belong to an HMI. Whether patients then proceed to share in the proceeds of this collusion could not be proven. An interviewee made the following observation:

> In some instances a surgery of 30,000 cfa may be priced at 300,000 cfa. It appears as if the health units look at the HMI as a lucrative source to finance their establishments, to the extent that they push people to consult because they are members of the HMI.

Competing Interests of HMI Promoters

In order to conclude the discussion with meso level interviewees on challenges facing HMI in Cameroon, I asked about the relationships between fellow promoters. The interviewees were unanimous that it was marked by petty rivalry bordering on superficial tensions. This is how one of the key informants describes the situation:

> Most promoters when they were getting into this initiative (HMI), they thought there was money in it. So there was some kind of negative competition. Some of us who started the scheme, we knew what it was all about, we understood the concept. Those who came later thought government was giving some money or that the contributions were entering into our pockets.

Another interviewee was more blunt as to the extent of rivalry between HMI promoting stakeholders stating that:

> Everybody is fighting for his or herself, so at times there are conflicts. You cannot avoid some tension.

Opportunities for HMI Expansion

After exhausting the challenges that were plaguing the HMI programme, I asked the meso level interviewees for the opportunities available to the scheme. The generous benefit package offered by the HMI compared to the premiums emerged among the interviewees as the principal advantage of the scheme. They backed this argument with official documents like brochures of their organization showing details of the benefits accruing to adherents.

Interviewees were unanimous in highlighting the support they receive from international NGOs and multinational bodies. They were keen to state that these international bodies did not contribute to the HMI's financial pool which is entirely made of members' premiums. Support from international bodies is directed to HMI promoting partners like SAILD, the North West Special Fund for Health and others. This support is in the form of training, technical inputs and funds to carry sensitization and set up and monitor new HMIs. This is how one HMI promoter puts it:

> They (international bodies) support us financially in the setting up of HMI schemes. We in turn support schemes with equipment like computers, furniture in the beginning because these are real needs, management tools, for example, documents and membership cards, thanks to GTZ. Without GTZ we could do nothing financially.

A revolving contributory scheme commonly called 'Njangi' was often mentioned by meso level interviewees as a veritable opportunity for HMI growth in Cameroon. One of the interviewees presented the opportunity offered by the 'Njangi' in glowing terms in the following words:

> Actually, the njangi is even the easiest way that we try to educate the members about HMI. We explain that, rather than assisting a member with a tablet of soap or fruits when s/he is ill, it is preferable to use the aid/sinking fund, augment it a bit and pay 3,500f cfa per year for each member and benefit from a bigger package, that is, a year's health insurance coverage.

In response to a question concerning the reasons behind the success of one of the HMI schemes, the manager attributed this to the important role played by opinion leaders. This is how the respondent puts it:

> The HMI receives a lot of support from opinion leaders, especially the mayor and the Fon (tribal king). They are completely implicated in the project. They are enrolled into the programme with their wives and children. Therefore, when they talk about HMI, people listen and the message goes through municipal and traditional councilors who reside in all the quarters. That is why the Kumbo HMI is considered one of the best in Cameroon. Since its creation in 2004 it has [enrolled] 25,000 members.

I wanted to pursue the issue of the influence of opinion leaders further. As such, I posed the question to the manager of an HMI scheme that was struggling to attract adherents. I asked the manager if her organization had explored the possibility of working with some opinion leaders in the community. This is what she had to say:

> We went to the Fon (tribal king) but he simply told us 'go ahead'. Neither he nor members of the royal family are HMI members. When we came back, we tried to organize the quarter heads. But for them to join and pay their contributions has not been easy. Some even say they are not sick.

This is the data collected from meso level key informants. I will now proceed to present the data emanating from grassroots interviewees, hereafter called micro level interviewees because they are at the base of the three tier structure.

8.1.3 Micro Level

'Grassroots' respondents in this study refer to individuals living in communities with a functioning HMI programme, both members and non-members of the HMI scheme. In this chapter, I make substantial use of dialectical pragmatism as the epistemological road map for this research. As stated in Chapter 4.2.2, dialectical pragmatism allows the mixed methods researcher to listen to, consider and dialogue with qualitative and quantitative perspectives with a logic of inquiry primarily focused on problem solving. In order to achieve this, I took

advantage of the 202 questionnaires administered to this group for quantitative data, to glean some qualitative data. In this light, grassroots respondents were asked to state in their own words what they think could be done to attract more adherents into the HMI programme. An additional question was addressed to members only, on the issue of consistency in HMI membership.

I will begin with the response to the first question concerning strategies to attract more members into the HMI. Extensive sensitization was overwhelmingly mentioned as one activity that will increase HMI membership. These respondents were of the opinion that the current level of information on HMI was not sufficiently persuasive to cause many Cameroonians to enrol into the scheme. One of the respondents stated the need for sensitization as follows:

> The HMI should make more publicity about its services. They should place adverts in newspapers, radio and on the television non-stop because it is a new idea to the community members.

Coming right after sensitization and ranking almost equally in importance is the role of HMI promoters. Most interviewees called for promoters to be recruited and deployed to the field. These promoters, they argued, should always be available to attend to HMI members and potential members. An interviewee stated that:

> Promoters should visit social groups to sensitize [their members]. They should even embark on door to door visits. Sometimes our local promoter is not available to validate our right to HMI benefits before treatment or attend to would-be members.

These two interviewees highlight the crucial role information has to play in the success of HMI. According to the economic theory of state intervention, specifically intervention for reasons of efficiency (see Chapter 2.1), the state can intervene to enhance efficiency in the provision of some services where there is the absence of perfect information, among others. Perfect information entails knowledge about the quality of the product, about the price and about the future (Barr 2004: 75). This is a far cry from the reality of HMI in Cameroon, going by the views expressed in the anecdotes. Consequently, the state with more resources, including information, can intervene in this sector in order to achieve greater economic efficiency.

Individual membership was advanced frequently by respondents as a reform that would attract more members into the HMI programme. It will be recalled that almost all the HMI schemes involved in this study accept only family membership with a minimum of four persons (see Chapter 3.1.1). Some interviewees mentioned the fact that they were living independently, not yet married and would like to join the scheme, however, the requirement of family registration was an exclusionary clause preventing them.

The modality of reimbursement was raised as one of the challenges limiting the expansion of HMI in Cameroon. As stated in Chapter 3.1.1, a vast majority of

HMI schemes in Cameroon provide 75% coverage for members' health care costs. Most of the schemes require co-payments of 25% from members when they are ill. However, a number of other HMI programmes require the members to pay the complete bill, to be reimbursed 75% later. This was very unpopular among members and this is how one of them expressed his point of view:

> Members should pay only the percentage required from them, that is, 25% when ill, not the entire bill to be reimbursed later. What then is the benefit of the HMI scheme if I have to look for the total amount of my treatment when I am ill only to be reimbursed later? My contributions should be used when I need it most, that is when I am ill, not after treatment.

I now present the response from the question that was addressed to HMI members only. They were asked whether they have had to discontinue their membership at any point since joining the HMI scheme and if so, for what reason? Out of 102 HMI members (see Table 6.2) just 15 stated that they have lapsed at least once since joining a HMI scheme. This demonstrates a very high consistency level of 85.3% and a mere 14.7% inconsistency level among HMI members. Nevertheless, if HMI is to achieve its goal of bridging the health care financing gap in Cameroon, then the reasons that caused this 14.7% inconsistency level have to be investigated in order to attain even higher consistency levels for HMI members.

Top of the list of reasons that pushed HMI members to temporarily suspend their membership was 'there was no reason'. Some of them were honest enough to say it was simply negligence. Only two of the fifteen respondents gave the simplistic excuse of 'lack of finance'. This goes to confirm the argument expressed at the start of this study, that the lack of finance was an easy excuse for Cameroonian's nonchalance in embracing HMI.

The important role of HMI managers also came to the fore as reason for inconsistency in membership. Respondents stated that often the managers of HMI schemes were hardly in their offices when they were needed either to take payments of premiums or to process members' claims, and this had led to them suspending their membership. The attitude of managers may be explained by the lack of financial motivation. This is due to the fact that the micro nature of premiums cannot guarantee high wages for managers.

Another frequently mentioned reason for inconsistent HMI membership was the fact that the adherent moved out of the region where his or her HMI scheme is located. With such movement, they could neither transfer their contributory obligations nor beneficial privileges to the new destination, even if it had a functioning HMI programme.

The exclusion of certain illnesses from HMI coverage is another one of the major reasons why some HMI members opted out of the programme temporarily. This is how one respondent puts it:

> I am HIV positive and at that time HIV cases were not assisted but now it is no longer the case. That is why I renewed my membership.

Qualitative data for this study came from multiple sources that could be subdivided into key informants and grassroots respondents. The key informants are found in the macro and meso levels as presented in this study. These have specialized knowledge on HMI in particular and health care financing in Cameroon in general. On the other hand, the grassroots interviewees are found at the community level, where HMIs operate. They make up the micro level respondents, completing the three tier structure adopted for the qualitative empirical arm of this study. In the following section, I engage in the analysis and presentation of the findings of the qualitative data.

8.2 Salient Findings from Qualitative Data Analysis

After presenting the qualitative data within the three tier structure of macro, meso and micro, I do not intend to follow the same pattern for the findings. These results are rather divided into thematic sub-chapters drawn across the board from the three levels where applicable. However, before delving into the important findings of the qualitative arm of this study, it is worthwhile to discuss the qualitative data analysis strategy employed. Analytic induction is the broad qualitative data analysis strategy for this study. However, it is not used here in its original conception, as an approach to qualitative data analysis in which the researcher seeks universal explanation of social phenomena (Bryman 2008: 539). Rather, I use analytic induction as identified in modern times, which refers to the systematic examination of similarities and differences occurring in cases, in order to develop categories and concepts (Hammersley and Atkinson 1995, Punch 2005).

According to Punch (2005: 197), analytic induction shares common features with two approaches to qualitative data analysis: the Miles and Huberman Framework for Qualitative Data Analysis and Grounded Theory Analysis. For this study, I make use to a large extent of the Miles and Huberman Framework. According to the authors of this framework, 'social phenomena exist not only in the mind but also in the objective world – and… some lawful and reasonably stable relationships are to be found among them. The lawfulness comes from the regularities and sequences that link together phenomena. From these patterns, we can derive constructs that underlie individual and social life.' (Miles and Huberman 1994: 4).

In order to arrive at these constructs, the Miles and Huberman framework presents three concurrent and interwoven components for the qualitative data analysis process. These operations are: coding (data reduction), memoing (data display) and drawing and displaying conclusions (Miles and Huberman 1994,

Punch 2005). After transcribing the recorded interviews for this study, I proceeded with coding. There are a plethora of coding methods available of which I chose three methods. The first is 'in vivo' coding. It entails using a word or phrase as used by the participants themselves. The second coding method is descriptive coding (a noun or phrase that is an indication of the topic). Finally, I made use of the values coding approach. It involves attributing codes to the data that reflect participants' values, attitudes and beliefs, representing their perspectives or world view (Saldana 2009: 70, 74 & 89). With a successful coding procedure, memoing was not much of an issue.

I simply went through my coding manual and identified codes that could be raised to higher levels of analysis such as concepts or themes. In some instances like in vivo coding, there was no change from the code to the memo. For instance, if interviewees kept mentioning legal framework as a need, the expression of such strong feelings captured in a conceptual phrase was maintained. The drawing and verification of conclusions was preceded by a consistent search for regularities and differences observed. I actually counted the number of times a concept or theme appears in my manual. This gave me an insight into the frequency or regularity of each social construct. In most instances, I could discern emerging patterns in the codes and memos. The findings from these analyses are presented below.

8.2.1 Opportunities for HMI Growth

HMI may be a fairly new prepayment modality for health care in Cameroon. However, there are a number of opportunities militating in favour of its expansion. Some of these opportunities emerging from the data include the following:

Generous Health Care Benefit Package

The generous health care benefit package offered by the HMI to members emerged as one of the opportunities that augur well for the scheme in Cameroon. A comparison of the premium and benefits reveals an overwhelming advantage in favour of the benefits. After the payment of a registration fee of 1,000 FCFA and premium of 3,500 FCFA each, for at least four family members, the HMI pays:

- 75% of outpatient bills up to a maximum of 15,000f cfa up to three times a year
- 75% of hospitalization bills up to a maximum of 30,000f cfa up to three times a year
- 75% of delivery bills up to a maximum of 25,000f cfa once per year
- 75% of surgery bills up to a maximum of 60,000f cfa for planned surgery and 120,000f cfa emergency surgery once per year.

With such a generous health benefit package, the HMI is bound to attract more members in the near future as the concept is embraced by Cameroonians. However, this will be possible only if some of the weaknesses like over utilization are minimized.

Current International Good Will

Presently, there is enormous international good will for addressing social security concerns for the vulnerable after the disastrous IMF policies of the 1980s. The Social Protection Floor Initiative launched in 2009 is one such international concern for inclusive health care security (see Chapter 3.4). HMI promoters made repeated reference to the invaluable inputs from international partners. This was supported by official documents listing international NGOs at the fore of promoting HMI in Cameroon. Amongst those mentioned are ILO, UNESCO, the Belgian CTB, the African Development Bank (ADB) and the German GTZ (Government of Cameroon 2005).

These international organizations find in Cameroon a good number of local NGOs with whom they can work. The local NGOs are well informed on HMI issues and willing to champion the cause of HMI and an equitable health care financing approach. In the absence of any financial support from government, financial and technical input from international donors is a veritable opportunity for HMI in Cameroon. However, this international good will should not weaken the need for the state of Cameroon to hasten the enactment of a legal framework that includes state subsidies before donor fatigue sets in.

The Njangi

The njangi is an economic activity which is very popular amongst Cameroonians of all levels of social standing. This is a kind of revolving contributory scheme. Members come together and contribute an agreed sum periodically, which is handed to a member to enable him or her realize a project needing financial capital that could not be raised individually or through the banks. These njangis exist in almost all occupations, and communities, in villages as well as cities, even among Cameroonians in the Diaspora. Such original 'savings schemes' can serve as veritable spring boards for HMI in Cameroon.

If the national values approach (see Chapter 2.2) is anything to go by, then HMI promoters can tap into this long tradition of njangi in Cameroon to attract potential members. According to the national values approach, the cultural and ideological conditions within a country either facilitate or delay actions to promote social security, in this case HMI. Challenges will abound in the beginning, as njangi members will be reluctant to part with their hard earned money in order to pay for a future contingency of ill health. Nevertheless, once

Cameroonians embrace the notion of HMI, the njangi will offer a golden opportunity to recruit new adherents.

Influential Role of Opinion Leaders

In Cameroon, traditional, religious and political leaders of high moral standing are considered as opinion leaders. Such persons' points of view are often listened to by the citizens of the communities in which they reside. The Kumbo HMI, considered one of the most successful in Cameroon, has exploited the opportunity offered by opinion leaders to utmost effect. The traditional ruler, who is the tribal king, together with his wives and children are HMI members. The mayor representing political authority is equally an HMI member with his household. Promoters use these opinion leaders to point to the importance of the HMI. What these opinion leaders offer can be compared to 'superstar power' in high income countries when celebrities endorse a product.

Though not conclusive, this case indicates that there is a relation between the role of opinion leaders and HMI membership. The Kumbo HMI has rallied and made use of local opinion leaders to become one of the most successful HMI schemes in Cameroon. If other schemes can learn from this, identify and implicate some opinion leaders of high moral standing, then HMI membership can be improved. The role of opinion leaders, therefore, is an opportunity to be tapped into by HMI promoters in Cameroon.

These are some of the principal opportunities that militate in favour of HMI growth in Cameroon. However, all is not bright and sunny, as some challenges exist to be addressed if HMI expansion is to reach the threshold set by the state (Government of Cameroon 2006).

8.2.2 Challenges Inhibiting HMI Expansion

Like any other social process, HMI in Cameroon has a series of challenges to surmount in order to be successful. From the qualitative data, a number of these challenges came to the fore. I am highlighting the prominent ones that need to be addressed for HMI to attain its desired goal of minimizing inequality in health care finance in Cameroon.

Concept of Solidarity Misconstrued

Considering the small amount paid as premium ($1 per month) and the huge benefit package (see Chapter 3.1.1) the concept of solidarity has to be completely embedded in the psyche of potential members. The concept of solidarity entails that one pays the premium but does not necessarily benefit unless and until one is genuinely ill. As such, the other adherents who are genuinely ill can be taken care of by the HMI. According to Hechter's theory of solidarity (see Chapter 2.2), group solidarity is only as strong as the extent to which members are willing to comply with their corporate obligations to contribute to the group's joint goods.

Such compliance with HMI obligations entails payment of premiums as well as benefiting only when one is genuinely ill, as opposed to benefiting simply because one is an HMI member. Promoters and other stakeholders have an uphill task in convincing potential adherents to embrace this concept of solidarity, if the schemes are to be sustainable.

At the moment, each HMI member believes that when he or she pays the premium for a calendar year then he or she must benefit, irrespective of the severity of the illness and in total disregard of the concept of solidarity. This is hardly surprising because the idea of insurance in general and health insurance in particular is a concept fairly new to Cameroonians. Prepayments for health care without a corresponding consumption of health care services are seen as unnecessary expenditure. However, this has to change with the concept of solidarity fully imbibed into the psyche of HMI members as the principal strength of HMI given the micro nature of premiums.

Resistance to Embrace HMI: More than an Issue of Poverty

From the data, there is repeated mention of the fact that the HMI is a relatively new programme in Cameroon. A survey carried out by Bennett et al. (1998), revealed an early history of HMI particularly in West Africa. In Cameroon, meanwhile, the first HMIs were identified in 2000 (Government of Cameroon 2006). As stated above (Chapter 8.1) the HMI schemes involved in this study were established as recently as 2004. Accordingly, this fairly recent history of HMI in Cameroon means the whole concept of HMI is pretty new. Getting potential adherents to grasp the notion of prepayments for health care cost remains a daunting task. This will entail massive and sustained sensitization, needing huge resources which HMI promoters currently do not have and cannot raise from the small fees charged for premiums.

The situation becomes even trickier when existing members fail to renew their premiums regularly. This affects the growth rate that was witnessed in the early years. Even the experience of potential members coming in contact with members who are withdrawing is hardly encouraging, leading to a generalized reluctance to join the schemes in areas where they exist. The notion of making prepayments in anticipation of future medical bills is a novelty in most African countries in general and Cameroon in particular. Most persons who have been relying on out-of-pocket payments do not see the necessity to depart from that practice. As a result, reluctance to embrace HMI appears to be an attitudinal problem rather than an issue of poverty. The anecdote about Cameroonians' preference for luxury goods and alcohol consumption rather than making prepayments for health care was widely repeated.

Nevertheless, to dismiss the poverty claims of non HMI members as a factor limiting HMI membership would be premature. A study carried out in Burundi found that approximately 27% of households gave 'financial inability' to purchase a CAM Card (premium) as one of the main reasons for non-

membership. But in a dramatic twist, the same study revealed that non-CAM patients referred from health centres to higher level facilities often purchased cards prior to, or on arrival at, the referral centre. By so doing, they manipulate the scheme to reduce their financial barriers to expensive health care without prior participation as members (Arhin-Tenkorang 2004: 174).

Such actions bring to light the problem of free riding inherent in Hechter's theory of solidarity (see Chapter 2.2). It presupposes that even though the members have agreed to honour their obligations, each will do better by ignoring them when it is expedient to do so. As such, poverty levels may, to a lesser extent, have an impact on HMI membership. However, it is not an important reason for non-membership because, when pushed (i.e. referred for treatment), most non-CAM holders purchase the card. In order to prevent such manipulation and abuse, the HMI schemes in Cameroon have instituted waiting periods for new members: three months for outpatient care, nine months for surgery, and one year for delivery.

The Absence of a Legal Framework

In the absence of a legal framework the HMI scheme in Cameroon is operating in a legal vacuum. From the macro through the meso and micro levels, interviewees expressed the need for a legal framework to regulate the HMI sector in Cameroon. As an enacted law, the legal framework will provide HMI with the legitimacy to perform the triple role assigned to all health care financing regimes, namely collecting revenue, pooling risks and purchasing goods and services (Gottret and Schieber 2006).

Among the many advantages that come along with a legal framework is the fact that the state will have to provide subsidies to make up for the micro nature of premiums. The small nature of premiums – 1$ per month – compared with the numerous services available to adherents cannot sustain the HMI schemes. Government support will ensure sustainability and equity in the scheme (Jakab and Krishnan 2004). If the legal framework is so important, why has it not been enacted into law? From the interviews it emerged that bureaucratic inertia coupled with the lack of a political will to enact a legal framework for HMI was to blame.

The administrative pendulum, swinging back and forth between the legislature and executive body in Cameroon, is holding back the legal framework on HMI. This can be better understood in the light of the institutional theories of politics (see Chapter 2.1). The theory argues that, if societal groups are the agents for social reform, their effectiveness as a political voice depends on the political landscape (institutions) in which they must perform. The most important feature of this terrain is shaped by the constitutional design of the state. According to the Constitution of Cameroon, promulgated in 1990, Cameroon is a unitary state with total and absolute control of all governance structures in the hands of the president (Mbaku 2007: 54). One of the consequences of such concentration of

powers is that all important decisions must be approved by the president. The presidency subsequently becomes a scapegoat, genuinely or otherwise, for bureaucratic inertia.

According to Maioni (1998: 20), the institutional theory of politics reveals four features of state structure that affect social policy outcomes. However, I will limit this discussion to two of these features which elucidate the challenges of enacting a legal framework for HMI in Cameroon. The first feature is the role of autonomous state bureaucrats. The state bureaucrats may have done their part in drafting the legal framework for HMI. Nevertheless, they remain powerless to see its implementation.

The state bureaucrats can hardly be described as autonomous. They are appointed by the all-powerful president, hence they cannot liaise with other civil society actors to force the arm of the government to legislate in favour of a law governing HMI. The second feature of state structure of concern to this study is the design of political institutions. As stated earlier, the design of political institutions as typified by the Constitution is highly centralized, with little power delegated to other arms of government. Political parties cannot work with other stakeholders in the HMI sector to propose a private member's bill enacting a legal framework for the programme. The result of all these is administrative inertia with regard to official government policy on a legal framework for HMI.

Administrative or bureaucratic inertia, as used here, refers to the inability of bureaucrats to be proactive concerning the enactment of social policy reform in Cameroon. Korpi and Shalev (1980: 307) provide an explanation for such bureaucratic inability to enact social reform by the power resource approach. According to this approach, where the difference in power resources between the parties is great, the weaker party is unable to carry out successful action. In the case of Cameroon, the all powerful president has the power, yet hinders social reform, while the bureaucrats are willing to enact such reform but lack the power. The situation is similar to early twentieth-century social security reform in Finland. The 1916 elections gave an absolute majority to the SDP who proposed progressive social legislation that was often thwarted by the all powerful Russian czar (Kangas 2007a: 251)

Adverse Selection and Moral Hazard: Two Sides of the Same Problem

Due to the specialized knowledge of key informants, they came up with concepts like adverse selection and moral hazard that did not need any coding or memoing. As such these concepts are cited in vivo from the data as major challenges inhibiting the growth of HMI in Cameroon.

According to Radermacher et al. (2006: 68) adverse selection occurs when the risk profile of the group insured is worse than what would be expected in the general population. On the other hand, moral hazard takes place when people with insurance use more services than they would if they did not have insurance coverage. Adverse selection and moral hazard are considered both sides of the

same coin because they are both major causes of inefficiencies in the functioning of health insurance schemes with consequences for financial viability (Arrow 1963, Pauly 1963, Lohr et al. 1986). The occurrence of adverse selection within the HMI milieu in Cameroon is captured vividly by this observation from one of the interviewees.

> A lot of adverse selection occurs within the HMI. When you go through the list of those who have benefited, it looks like every member is a patient.

In a sustainable HMI programme, the best case scenario will be for the health profile of HMI members to be at least the same or better than the general population. From the excerpt above it is obvious that the health profile of HMI members is worse than the general population. They are people within the populace who stay healthy throughout a given year unlike members of the HMI going by observation of this interviewee.

Moral hazard refers to situations in which the expected loss is affected by the presence and extent of the insurance. According to Pauly (2006: 32), moral hazard in health insurance can take two forms. The presence of insurance coverage may give rise to actions affecting an individual's probability of illness. This form of moral hazard is synonymous with the example mentioned by one of the interviewees in which 'people just take advantage of belonging to the HMI to seek treatment' (see Chapter 8.1.2). The second form of moral hazard is when the presence of insurance may also affect the amount and cost of care, once illness has occurred. It describes succinctly the example given by another interviewee, where the cost of surgery increased tenfold from 30,000 cfa to 300,000 cfa because of HMI coverage (see Chapter 8.1.2).

Extending the waiting period can limit to an extent the first instance of moral hazard. However, care must be taken not to make the waiting period so long as to deter potential adherents. Concerning the second case of moral hazard, it can be minimized by establishing an official tariff for medical procedures that is strictly monitored by all stakeholders.

The effect of adverse selection and moral hazard is the same, both lead to excessive expenditure by the HMI, resulting in widening of the compliance gap. This occurs when the actual contribution falls short of the expected amount (Dror 2001: 273). Considering the small amounts paid as premiums, if left unchecked, adverse selection and moral hazard will lead to widening of the compliance gap. Little wonder that most interviewees spoke of the shortage of funds to pay for members' medical bills as potentially fatal to the HMI initiative in Cameroon.

Rivalry between Promoters

From the interviews it emerged that there is some rivalry among HMI promoters that could have a negative impact on the expansion of HMI programmes. This is surprising because, as a non-profit venture, promoters would advance the cause

of HMI more through cooperation than competition. It later became clearer, from follow-up questions that, this rivalry arises from the fact that HMI promoters rely on funding from international donors. In the case of the North West Region of Cameroon, for instance, the German Agency for Technical Cooperation (GTZ) is the main funding body for HMI activities. In the absence of any government subsidy, promoters in the regions (except the Catholic-run BEPHA) depend exclusively on international donors to finance their HMI promotion activities. As such, there are bound to be rivalries not only in attracting new adherents but also for funding opportunities.

Collectively, as the main pressure group in pursuit of state recognition and support of HMI, promoters need to minimize their rivalries and present a united front. According to the institutional theory of politics (see Chapter 2.1), the mechanisms by which social pressures are transmitted to political decision-makers are crucial (Immergut 1992: 19). Therefore, in order to be more effective, HMI promoters need to close ranks as they advance their cause. Despite these challenges, all is not gloom and doom with HMI in Cameroon. On the contrary, these obstacles to HMI constitute a platform from which to elaborate and implement social reform on HMI in particular and health care financing in general.

8.2.3 Rethinking Policy on a Legal Framework for HMI

A legal framework to regulate the activities of HMI in Cameroon was overwhelmingly expressed as a condition sine qua non for the sustainability of the scheme. One of the most obvious drawbacks of the absence of a legal framework is that it leaves policyholders unprotected against opportunistic behaviour. This makes the long-term viability of HMI uncertain (Wiedmaier-Pfister and Chatterjee 2006: 491).

Decisions on public policy, particularly in the context of social matters, are essentially political. As such, the extent of a government's commitment to its social objectives is important in determining whether and how it should become involved in HMI. A national policy framework should define the role of micro insurers in the larger context as well as the particular roles of the government and other stakeholders (Trommershäuser et al: 2006: 509). A number of social policy concerns emerge from the empirical findings that need to be incorporated in the legal framework. These concerns include among others portability of entitlements, and minimum wages for HMI workers. It was clearly reiterated during the interviews that most of these HMI policy reforms will be possible only with substantial state subventions.

Portability of Entitlement

Portability of entitlement, as used here, refers to the possibility to pay premiums to one HMI scheme and receive health care in a facility, or a district, other than

that with which the HMI scheme has contracted. The non portability of entitlement is one of the main criticisms often levelled against HMI. According to Ron (2008: 12), the main components of HMI, such as contribution levels and collection mechanisms, as well as benefits, vary from scheme to scheme, making mergers and portability of entitlement very difficult. One of the main difficulties facing HMI members was the fact that once they travel out of their health district, they cannot use their HMI policy in the new destination.

Non portability of claims was causing HMI members to contemplate dropping out of the scheme. The reticence of viable HMI schemes to implement portability of entitlements can be understood in the light of micro premiums and the absence of reinsurance to act as back up when funds become limited. A legal framework will harmonize the different HMI schemes, thereby facilitating portability of claims. Besides state subvention to strengthen the pool, government can establish a stabilization fund to play the role of reinsurance (Dror and Wiechers 2006: 525).

Motivating Promoters to Undertake Sensitization and Education

The interviewees were of the opinion that the current level of sensitization and education could be improved significantly. This response is hardly surprising when we look at Table 6.2. There, one observes that, of the seven sources of information for HMI activity, public media was a source of information for only 1% of HMI members. Meanwhile, in a developing country like Cameroon, public media especially radio, is widely relied on, both in rural and urban areas, for useful information. With recognition coming from the legal framework, HMI schemes will be able to advertise on public media for free.

Promoters/managers were identified as playing a crucial role in improving HMI membership. Health insurance is a relatively new health financing concept in most African countries in general and Cameroon in particular. As such, education and sensitization are activities that should be ongoing and vigorously pursued, if new members are to be recruited into the scheme. Cohen and Sebstad (2006: 41, 42) state that, for many low-income households, insurance is seen as the province of the rich, there is a reluctance to pay in advance for services one may not receive. They continue, arguing that, in some cultures, it is not always socially acceptable to bet on negative events, as any focus on illness and death is seen as wishing for bad luck. Promoter/managers are charged with the responsibility of overcoming such long-held belief systems. Unfortunately, these promoters lack the financial motivation to carry this important role. This is due to the fact that most of them work on a voluntary basis or are paid less than the minimum wage. A legal framework for HMI can guarantee at least the payment of the minimum wage to promoters, with the incentive of bonus payment for each new member joining the HMI.

Individual Membership

Opening the HMI programme to individual membership was frequently advanced as a reform that would attract new members. Currently all the community-based health insurance schemes in this study practise group membership, of four members minimum per household. The Catholic based scheme (BEPHA) and schemes managed by enterprises are currently the only ones accepting individual membership because they can deduct the premium at source. This is done when parents of students are paying for tuition for the Catholic scheme and salaries of employees at enterprises with a HMI. However, for a majority of the HMI schemes which are community based, only group membership is accepted and this is perceived as an exclusionary clause by some potential adherents. The problem is that individual membership poses numerous challenges which group membership seeks to minimize.

According to Wipf et al. (2006: 152), individual micro insurance membership is possible, but requires a high participation rate among the potential target market to attain desirable financial results. They aver that individual insurance can cost more than twice as much as group coverage because of higher sales, underwriting, administration and claims costs. It is therefore understandable when HMI schemes, struggling for sustainability, are reluctant to embrace individual membership. The legal framework can ensure HMI schemes offer individual membership as an inclusionary gesture to enhance equity in health care financing.

Modality of Reimbursement

Two types of reimbursement are practised by the HMI schemes involved in this research. In one, the HMI pays 75% of members' health care cost, requiring 25% co-payments from members at the point of service. In the other modality, members are required to pay the complete cost at the point of service and will be reimbursed 75% later. This second arrangement was very unpopular with members. I equally find this reimbursement arrangement intriguing. It defeats the very purpose of the HMI programme, which is aimed at encouraging members to seek quality health care as soon as they need it. If HMI members have to look for finance when they become ill, just like non-members, it only reinforces the cycle of poverty and ill health and more poverty, characteristic of the out-of-pocket payment method (Xu et al. 2007).

It was apparent during my field trip that schemes with the second reimbursement model were struggling, compared with schemes where members paid only 25% of the health care cost at the point of service. If schemes are to attract new members, then they need to revise their reimbursement policy to that practised by most HMI. This implies paying 75% to health providers and expecting members to pay only 25%, as stipulated in the contract. Members of such schemes expect the legal framework to do away with 100% payment at

point of service for subsequent 75% reimbursement, in favour of 25% payment by adherents at the point of service.

8.2.4 The Possibility of Universal Health Care Financing

One of the specific research questions for this study seeks to determine whether the pursuit of a legal framework for HMI will enhance or hinder the move to universalism. In order to answer this question, I will begin by replicating the interviews reported in section 8.1.1. This is intended to facilitate understanding of the analysis used, which is different from the Miles and Huberman framework relied on thus far.

Here, I employ conversational analysis techniques, in an attempt to draw meaning from the dialogue I had with the two macro level interviewees on the issue. The reason I am using the conversational analysis approach is because the responses had some linguistic undertones in relation to the question that are worth examining.

Interview 1

> The main problem is the absence of a political will to enact a legal framework on HMI into law. There is a long term goal to make social security available to all Cameroonians and residents. Presently under 3% of the population is covered by health social security in Cameroon.

Interview 2

> We are working with the Ministry of Labour and Social Security. In the law we have to adopt this notion of universalism within the framework of Cameroon's social protections. The first step is to adopt the first two pillars, that is, health insurance and unemployment benefits, into our social protection framework. It is a matter of political will for this to become law.

In order to engage in a conversation analysis of this talk, it is important to start from the question that led to the responses above. I asked my interviewees: Will a legal framework on health micro insurance facilitate or hinder the long-term move to universal health care in Cameroon? In 'interview 1' the respondent, after blaming the lack of a political will for the delay in enacting a legal framework for HMI, switches seamlessly to the concept of 'social security'. This interviewee states that there is a long-term goal to make social security available to Cameroonians and residents. In the case of 'interview 2' the respondent admits that universalism will be part of the HMI legal framework. As with interview 1, she says this will be 'within the framework of Cameroon's social protection'.

My focus is how both respondents expand the concept of universalism explicit in the question, to the broader issue of 'social security and social protection' in their response.

An important element in conversation analysis is the argument that the meaning of words is contextually grounded. According to Heritage (1987), this means we must seek to understand what someone says in terms of the talk that has preceded it and that talk is viewed as exhibiting patterned sequences. From the two interview extracts, it is clear that the pursuit of a legal framework for HMI is likely to enhance the long-term goal of universal health care provision in Cameroon. Of particular interest is the fact that both interviewees take this, a step further. At this juncture, the contextual demand of conversation analysis becomes evident. The first respondent works in the Ministry of Labour and Social Security and the second in the Ministry of Public Health, both are macro level bureaucrats responsible for HMI policy in Cameroon.

These respondents, therefore, equate or substitute universalism with social security and social protection, concepts that were not mentioned in my question. This is in line with the second feature of conversation analysis, known as reflexivity. It means that spoken words are constitutive of the social world in which they are located. Talk is not a 'mere' representation of the social world and does much more than just stand for something else as to be considered to constitute part of that social reality (Bryman 2008: 494). 'Interview 2' opens up this social world even further, talking of the first step being the adoption of the first two pillars – health insurance and unemployment benefits – into Cameroon's social protection framework.

Conversation analysis emphasizes fine-grained detail, including length of pauses, prolongation of sounds and others. Heritage (1987: 258) warns that such details of interaction cannot be ignored as insignificant without damaging the prospects for coherent and effective analysis. Listening to the recorded interviews for the purpose of this analysis, I noticed the absence of any such pause in both interviews. Just as I transcribe the interviews above, they were almost spoken in one breath in a prose-like rendition. I interpret this as a reflection of the continuous flow each respondent envisaged from a legal framework on HMI to universalism in health care.

From the conversation analysis above, one can safely state that the pursuit of a legal framework for HMI is likely going to facilitate the eventual adaption of universal health care in Cameroon. However, this must be taken with a pinch of salt given the 'absence of a political will' mentioned by both respondents to legislate for HMI. This notwithstanding, the research question had to do with whether the one (HMI legal framework) will inhibit or enhance the other (universal health care provision). The findings from the data weigh in favour of the latter view, namely that legislating for HMI will strengthen the long-term goal of universalism in Cameroon.

In this chapter, I have sought to enhance the mixed methods orientation of this study by presenting and analysing the qualitative data. The findings from these qualitative data reveal that opportunities abound militating for the growth of HMI. It was equally clear that some challenges exist to be addressed for HMI

to reach its full potential in Cameroon. A legal framework for HMI emerged as a near panacea for most health care financing challenges. Interestingly, the legal framework was shown to have a potentially positive effect on the long-term goal of universal health care provision. In the following chapter, I combine the quantitative and qualitative findings for an enriched discussion on HMI and Cameroon's long-term vision for universalism.

9 DISCUSSION AND CONCLUSION

In this study, I have explored the various contours of health care financing undertaken by Cameroonians as they attempt to access quality health care. As a single entity, health care financing in Cameroon has nevertheless been investigated as a social whole with three connected layers (Figure 1.1). This multi-layered approach of the social whole has unraveled a complex maze of processes and relationships that are essential for understanding the challenges and opportunities embedded in each of the health care financing choices. This may be out-of-pocket payment, HMI or the long-term policy orientation of universal health care coverage.

The mixed methods strategy is the deliberate methodological choice for this study. I make equal use of quantitative and qualitative data. These are supplemented with secondary data in the form of official documents. The researcher's own informed observation further enriched the data. Dialectical pragmatism as advocated by Johnson (2009) provides the epistemic pathway for this study of health care financing in Cameroon. The mixed methods strategy and the epistemological orientation allow me to exploit the natural tensions between the quantitative and qualitative perspectives. The end result is expected to be a fuller and richer interpretation of the findings of the study with supporting or contrasting arguments from relevant theories.

The discussion on the findings will follow the structure of the three tier layers in Figure 1.1. As such, the first segment will consist of the findings concerning out-of-pocket payments, followed by the all important HMI results and, last but not the least, the long-term goal of universalism. Thereafter, I will present suggestions for further research in this area of health care financing in Cameroon.

9.1 Out-of-Pocket Payments: Old Habits Die Hard

More than 90% of Cameroonians rely on out-of-pocket payments to finance health care. This health care financing regime is therefore deep rooted in the population. Weaning Cameroonians off out-of-pocket health care financing is fairly daunting as some of the findings presented here reveal.

9.1.1 Attitudinal Limitations Wrapped in Financial Deficiency

Often, in informal settings, one gets the response 'lack of finance' to explain the lack of enthusiasm for joining an HMI programme. This reason may find some support in the literature, where it is claimed that sometimes even modest sums like 1$ per month may be too much for the poorest people to pay as premium for health insurance (Criel and Waelkens 2003, Bennett et al. 2004). While this may be true in a limited number of cases, overwhelming empirical evidence from this study seem to suggest otherwise. In response to a question on the affordable nature of premiums, an astonishing 91% of non-members agreed or agreed strongly that HMI premiums were affordable (see Table 6.4). What then accounts for the nonchalance in joining HMI schemes? This is due in part to the attitude of most Cameroonians who simply do not consider making prepayments for future health care costs as a priority. The anecdote by one interviewee presented in Chapter 8.1, suggesting that Cameroonians are prepared to spend money on bottles of beer or a new dress but will not pay health insurance premiums, is very telling. Such observations were widely recorded from managers of HMI programmes. They all point to the fact that citizens' reluctance to embrace HMI is a problem of attitude presented as a financial challenge.

Such reasoning is strengthened by the findings from defaulting members. Most of the HMI members who have been inconsistent in their membership said there was 'no reason' for their defaulting. Others admitted it was due to their own negligence. However, all defaulters made a promise to restart their HMI membership and stay consistent with annual premium payments. Whether this is achieved is beyond the scope of this present research. The attitudinal limitation of Cameroonians toward joining HMI is partially explained by the 'bounded rationality' concept of institutional theories of politics (see Chapters 2.1 and 8.1.2). It starts with a recognition of the limits of human cognition. According to this approach, standard operating procedures decide what kinds of information should be used to make decisions. Immergut (1992: 20) claims this type of 'bounded rationality' restricts choice by ordering information. Going by this theory, therefore, the bounded rationality of most Cameroonians has ordered their choice of joining an HMI at the bottom of their priorities.

The attitude of most Cameroonians towards prepayments for health care leaves a lot to be desired. A majority of people who are well educated, including the relatively wealthy middle class in the communities studied, do not possess any form of insurance for health care. Only one person from a total of 202 interviewees for this research had private health insurance coverage (see Chapter 6.1). This is hardly surprising, given the comparatively exorbitant premium of 15$ per month for private health insurance, against 1$ per month for HMI. Consequently, the argument of financial deficiency as a barrier for HMI membership is hardly tenable, especially in the light of the average household expenditure of Cameroonians (see Table 5.1)

Alford's theory of structural interest in health care (see Chapter 2.1) presents another perspective. The repressed interest articulated in Alford's theory is held by the community. In Alford's time and place these were the poor and uninsured, as in present day Cameroon. According to Alford's theory, the nature of institutions guarantees that the repressed interest will not be served unless extraordinary political energies are mobilized. However, in the case of Cameroon, HMI presents an opportunity for the repressed interests to access equitable quality health care. Unfortunately, the attitude of the target population has been largely nonchalant, necessitating the extraordinary political energies advocated by Alford's theory. It equally reaffirms the essentially passive nature of community interest within the structural constraints of health care in general and health care financing in particular.

9.1.2 Relentless Sensitization

HMI is a relatively new health care financing option in Cameroon. As such, a vast majority of potential beneficiaries are unaware of its modus operandi and advantages. The need for sensitization and awareness creation is therefore huge. As depicted in Table 7.1 there is a significant difference in the perception of HMI members and non-members concerning the availability of information on HMI. While members think there is 'much' available information, the majority of non-members claim it is insufficient. This is the group that should be targeted with relentless sensitization and information on the benefits of joining the HMI programme. Even HMI members, when asked what could be done to make the scheme more appealing, mostly mentioned continuous sensitization. Managers promoting and/or in charge of HMI schemes state that they have undertaken numerous sensitization campaigns and think they have exhausted all avenues. The challenge may not be the lack of sensitization effort but the strategies and choice of information channels.

Promoters of HMI schemes and health facilities, like hospitals and health centres, constitute the principal source of information on HMI (see Table 6.2). More than 60% of HMI members state that they first heard of the HMI programme from promoters or while visiting a health facility. The important role

of the HMI promoters was highlighted in the qualitative data as well. Regular members argued for more promoters if HMI was to make inroads in Cameroon. Unfortunately, because of the micro nature of premiums, promoters often work on very meagre salaries. They consider their job as supplementary to their principal livelihood. As a result, some of them were hardly to be found in their offices when they were needed for registration or payment of claims. Defaulting members say the irregular presence of the HMI promoter is one reason for their inconsistent membership. The most effective form of sensitization can be provided by members benefitting from HMI prepayments. Defaulting members, on the other hand, equally have a negative multiplier effect in desensitizing potential adherents.

The preceding discussion reveals that information asymmetry is a major obstacle in HMI expansion in Cameroon. In this light, the economic theory of state intervention argues that, in the absence of perfect information in the provision of goods and services, the state can intervene in its provision for reasons of efficiency (see Chapter 2.1). Perfect information requires knowledge about the quality of the product, about the price and about the future (Barr 2004). Empirical evidence from this study reveals that these requirements are hardly met by HMI members and even less so by non-members. In such a scenario, and based on the economic theory of state intervention for efficiency reasons, Goodin (1988: 241) says that where the state possesses better information on what people want and how to get it, then a case can be made for 'the superior efficiency of non-market, state-directed allocations'.

Considering the importance of promoters in the process of HMI implementation and success, their status, and especially their financial remuneration, needs to be improved. This will provide the incentive to undertake the demanding task of sensitizing a reticent public about prepayments for health contingencies that may never occur. For instance, in response to an inquiry on the frequency of falling ill, 58% of respondents stated they are rarely ill, 33% said sometimes and only 9% claimed they are often ill (see Table 6.4). In order to widen the HMI pool, such respondents and other potential adherents need to be educated on the merits of modest prepayments for health care.

However, this will require relentless and concerted sensitization by promoters and other HMI stakeholders including the state. Writing on the early development of social insurance in the Nordic states which could be compared to present day Cameroon, Kangas and Palme (2005: 21) claim state intervention was based on what they call 'mobilization from below'. For instance, sickness cash benefits and unemployment insurance were first organized in the form of voluntary, independent insurance funds (like present day HMI in Cameroon) and eventually subsidized by the state. One may therefore conclude that intervention by the state via grassroots mobilization for reasons of efficiency finds support both in theory and in early examples of successful welfare programmes as in Nordic countries.

9.1.3 The Mitigating Hold of Kinship, Self Medication and Traditional Medicine

The slow rate of HMI penetration into Cameroon's health care financing structure can be attributed to some contributing factors. These include among others; strong kinship ties, self medication and traditional (alternative) medicine. In varying degrees, these have a mitigating effect on the way potential adherents respond to HMI – a novel and equitable health care financing regime. While kinship and self medication appear to have a diluting effect on the willingness to join the HMI programme, traditional medicine seems to have less of a hold on the people.

Kinship ties are quite strong in Africa in general and Cameroon in particular. Society frowns on successful individuals who are perceived to be unwilling to offer a helping hand to family members in need. This has created situations where certain individuals tend to shift some responsibilities, like prepayments for health care, down their list of priorities. This is done with the benign expectation that, when the health situation becomes critical, family members will intervene. There is sufficient evidence that a reasonable amount of the remittances sent home by emigrant workers to family members is meant to cover health care expenditure (Adams 2011, Ebeke 2012). With the guarantee of such assistance from kinship in times of illness, potential adherents are hesitant to make prepayments for health care. The consequence of such reliance on kinship for health care expenses is in tandem with the national values approach (see Chapter 2.2). This theory argues that the cultural and ideological conditions inherited from each country's past either facilitate or delay governmental actions to promote social security (Skocpol 1992: 16).

Self medication, also known as auto medication, is another factor inhibiting potential adherents from joining the HMI programme in Cameroon. As shown on Table 6.4, 88% of the respondents attest to the practice of auto medication in varying degrees. This is substantiated by the head of the drug unit of the North West Special Fund for Health (NWSFH). He states that 25% to 60% of the population may be users of non prescription drugs during any specific period (NWSFH 2009: 26). Due to the wide availability of over-the-counter drugs in Cameroon, individuals find it convenient to self-medicate. They simply purchase medication without a physician's prescription over the counter when they are ill. For this reason, they often do not consider it worthwhile to make prepayments for health care in HMI schemes.

While the hypothesis that kinship and self-medication have a mitigating effect on HMI membership is confirmed, traditional medicine presents an intriguing finding. I hypothesized that the wide availability of traditional healers and alternative medicine was a factor limiting adherence to HMI. However, the study led to a different conclusion. A cross-tabulation analysis presented in Table 7.3 reveals no significant relationship between the use of traditional medicine

and HMI membership. The findings show that traditional medicine, like other cultural practices in Cameroon, was dwindling with modernization and globalization. People give the impression that someone who is perceived as relying on traditional medicine is not 'modern'. Sometimes, people associate traditional medicine with witchcraft and its negative connotations.

The declining influence of traditional medicine was not limited to urban settings. Surprisingly, the trend was equally evident in rural areas and villages. The situation of traditional medicine is further compromised by the widespread prevalence of charlatans among the genuine practitioners. However, this finding may also be a result of respondents providing socially desirable responses. De Leeuw (2005: 245) argues that, with face-to-face interviews, there is a higher level of socially desirable responses especially with sensitive questions. The use of traditional medicine may be considered a sensitive issue. As such, respondents provided answers that are socially desirable. Nevertheless, the findings can be viewed as a pointer to the trend of declining reliance on traditional medicine in Cameroon.

These findings so far concern the first layer of this study which, as shown in Figure 1.1, consists of non HMI members who rely on out-of-pocket payments for health care. I will proceed to present the findings from the second segment, dealing with HMI adherents. Here, I will continue with the attempt to provide answers to the main research question – Why have Cameroonians not embraced HMI with enthusiasm despite the benefits therein?

9.2 Challenges and Opportunities for Health Micro Insurance in Cameroon

In an attempt to increase HMI coverage, a number of challenges need to be addressed. However, all is not gloom and doom within the HMI sector in Cameroon as many opportunities abound that can be built on to improve HMI coverage.

9.2.1 Group versus Individual Membership

A vast majority of the HMI schemes covered in this study require group or family membership with a minimum of four persons. The greater the number of adherents in any insurance programme the more sustainable the scheme. This view finds credence in Hechter's theory of solidarity (see Chapter 2.2). According to this theory, group solidarity is enhanced to the extent that members comply with the obligation to contribute to the joint goods of the scheme. The common goods here refer to the pooling of financial resources (premium), for future health care cost. Group size is therefore of fundamental interest to insurance in

general and HMI in particular, hence the requirement of group membership. However, some respondents argued for individual membership in order to make the HMI inclusive. They cited the case of unmarried individuals still to have children and living independently from their parents.

There are, nevertheless, few HMI schemes that accept individual membership. These include enterprise-based HMI for their members – families or individuals, and the Catholic owned HMI (BEPHA) for students in Catholic colleges. Both schemes are not strictly voluntary, because premiums are deducted at source. In the case of enterprises, premiums are debited when making salary payments and, for students, when parents pay their tuition fees. As such, they circumvent the high administrative and claims cost associated with individual membership. The reasonable size of the student population and the compulsory nature of the BEPHA and enterprise schemes meet the requirements of Hechter's theory of solidarity. This makes them sustainable with individual membership.

However, the situation is more problematic with community based health insurance where membership is voluntary. Even with the paupers' scheme supported by municipal authorities, individual membership is not encouraged. In a pilot programme, two municipalities within the Bamenda urban council decided to pay the registration and premiums of 44 vulnerable households comprising of 161 members. Each vulnerable household was required to have a minimum of four members. While such financial support from municipal authorities is new in Cameroon, it has a long history in high income countries. Jensen and Lolle (2013: 350) state that, in most European countries, welfare services are under regional or municipal authority, and in some countries local authorities have considerable autonomy with respect to determining the quality and quantity of these services.

One reason for the preference for group membership may be due to the African concept of extended family. Vulnerable family members like the old or widowed are seldom allowed to live on their own. With the exception of adolescents leaving the family 'nest' after coming of age, all others live as a closely knit family unit, including extended family members in need. Another reason is the micro nature of premiums compared with the benefit package. In this light therefore, individual membership of HMI schemes is possible only with compulsory health insurance or with substantial state subsidy in the future.

9.2.2 Modalities of Reimbursement and Preferred Services

HMI schemes in Cameroon undertake two types of reimbursement (see Chapter 8.3). A vast majority of HMI schemes require patients to pay 25% of their medical bills at the point of service while the programme pays the remaining 75%. With the second reimbursement modality, the patient pays the totality of the medical bill for the HMI and is reimbursed 75% later. This second arrangement was very

unpopular with adherents, who complained that it defeats the very notion of prepayments in order to avoid catastrophic consequences of out-of-pocket payments at the point of service. Delays in reimbursing 75% of members' health care costs was another complain levied against this mode of reimbursement. After paying the complete medical expenses, adherents were made to wait for unnecessarily long periods before receiving 75% reimbursement.

I raised these issues with the managers of the HMI schemes concerned. They stated that the HMI programme is still in its infancy, consequently such feedback is taken seriously, as they seek to make HMI more attractive. According to the institutional theory of politics, one of the four features of state structure that affect social policy outcomes is the feedback effect of past politics. This HMI manager can therefore take advantage of the feedback effect embedded in the institutional theory of politics, to reform the modality of reimbursement in order to attract more members.

Any insurance in general and HMI in particular, can only be as good as the products it offers to policy holders. That is why adherents were asked to rank their first three preferences among the services covered by the HMI. As shown in Table 6.3, outpatient care emerged as the service most preferred by beneficiaries. Admissions and surgical interventions were ranked second and third respectively. According to Radermacher et al. (2006: 73), health insurance policy holders prefer high probability, low-cost events while insurance providers prefer rare, high-cost events. An example of a high probability, low-cost event preferred by the insured is outpatient medical treatment. It is therefore not surprising that it appears as the service respondents in this study most want to benefit from. Services like admissions and surgery, on the other hand, are products with low probability but high cost, which insurance providers prefer. The reason they prefer these services is their low probability of occurrence. With the high cost involved in the provision of these services, if they were to occur frequently, they would deplete the common pool, making the scheme unsustainable. The appearance of these two products in the upper echelons of beneficiaries' preferences presents a major challenge to HMI managers.

From the above, it is obvious that paying the complete medical cost at the point of service, only to be reimbursed 75% later, does not augur well for HMI adherence. Such a reimbursement modality needs to be reformed and replaced by the direct payment of 75% of members' medical costs to the health care providers. According to the rational choice approach (see Chapter 2.1), when faced with several courses of action, people usually do what they believe is likely to have the best overall outcome. Actions (reforms) are valued and chosen not for themselves but as an efficient means to a further end (Elster 1989: 22). Concerning the preferred services, any HMI wishing to attract more adherents should be ready to cover outpatient medical treatment, admission, surgery and delivery in that order.

9.2.3 Consumer Moral Hazard or Increased Utilization – A Fine Line

Consumer moral hazard occurs when the insured use more services than they would if they did not have coverage. The expected loss is, therefore, affected by the presence and extent of the insurance (Pauly 2006: 32). This is different from provider moral hazard. According to Barr (2004: 261), it arises through third party payment problems. In health care it arises for two reasons: (a) the insurer is largely divorced from the decisions of doctor and patient, and (b) the doctor is paid a fee for the service (ibid.). As such, attempts by the doctor to maximize profits due to the presence of insurance coverage are considered provider moral hazard. However, the focus here is on consumer moral hazard and the fine distinction that exist with the concept of increased utilization. The principal reason for advocating HMI is to avoid catastrophic health care costs incurred by the vulnerable. The danger often takes the form of delays in seeking health care, due to the absence of prepayment arrangements, thus leading to complications and even deaths (Arhin-Tenkorang 2004, Palmer et al. 2004). The problem then arises when HMI members begin to seek early medical care upon becoming ill, and are accused of perpetuating consumer moral hazard.

In order to test the veracity of this criticism levied at HMI members, I included a variable in this study to identify their frequency of hospital visits. Table 6.2 shows that 62.7% of HMI members indicated there is no difference in the frequency of their present hospital visits and prior to joining the HMI scheme. In fact, 18.6% said they now make fewer visits to the hospital than was previously the case. Surprising as this may appear, it may be explained by the fact that delays in seeking health care have been eliminated, thus leading to a general improvement in the health of the insured. However, this explanation cannot be completely taken at face value due to the issue of recall bias (see Chapter 4.4). Consequently, some respondents may not recall with accuracy the frequency of their hospital visits.

Nevertheless, this finding may be viewed as a possible indication that consumer moral hazard is not yet a major problem within the HMI sector in Cameroon. Even if the data had revealed a higher frequency of hospital visits, it would simply be a confirmation of the evidence that HMI membership leads to higher utilization of modern health care services (Criel and Kegels 1997, Atim 1999, Musau 1999). It is therefore clear that only a fine but distinguishable line exists between consumer moral hazard and increased utilization by HMI members.

In this study, it emerged that HMI membership does not necessarily lead to any significant increase in health care utilization. However, 37.3% of HMI members reported that since joining the scheme they currently make more visits to the hospital than was previously the case. The question then arises whether this is an instance of consumer moral hazard or proof of higher utilization of modern health care encouraged by the HMI programme. I argue that it is the

latter (increased utilization). If out-of-pocket payment is a hindrance to accessing quality health care, then insurance coverage should logically lead to increased use of health care services. The challenge, though, is the extent of this increase in utilization of health care services. It should not reach the tipping point of what Barr (2004) refers to as 'over-consumption' which is borne out of the incentive to consume all health care that yields any private benefits. When this threshold is breached, it can be labelled consumer moral hazard, otherwise it is a scenario of increased utilization of health care services.

9.2.4 Addressing Portability through Enhanced Networking

Wide variations exist in the main components of HMI, such as contribution levels, collection mechanism and benefits. This makes the portability of claims very difficult to achieve. The situation is further complicated by the fact that each HMI signs a contract with a unique health care provider. In such circumstances, the insured can only visit a particular health facility and no other in case of ill health. Most respondents cited this as a major factor hampering the growth of the HMI in Cameroon. Some stated that they travel a lot for business purposes and would like to take advantage of their insurance coverage to visit a health facility anywhere within Cameroon.

These concerns could be addressed with better networking arrangements between HMI promoters. However, the reality of this relationship reveals the existence of rivalries between the HMI promoters operating in Cameroon. In the absence of public subventions, and due to the micro nature of premiums, promoters compete for available funding from international NGOs as well as new adherents. Such rivalry amongst promoters can only be detrimental to the expansion of HMI in Cameroon. HMI promoters can be likened to the challenging interest in Alford's theory of structural interest. According to Alford, internal and external social pressures and resulting shifts in structures will give rise to 'challenging interests', seeking to establish themselves as the new legitimacy. In advocating for HMI as an equitable alternative to out-of-pocket payments, promoters are positioning themselves as 'challengers' of the existing health care financing status quo. In order to be effective in this new role, they need to present a united front.

In an attempt to address these rivalries, promoters created a national platform of HMI promoters in Cameroon. The effect of this platform as a networking instrument for promoters is still to be felt. Nevertheless, they have taken the noteworthy step of decentralization, creating regional platforms of promoters. The regional platforms will work to establish trust for an improved rapport among local HMI promoters. Thereafter, they can start to harmonize identified discrepancies in the main components of partner HMIs. Such a move will eliminate the economic inefficiencies that the absence of portability engenders.

According to the economic theory of state intervention, the state may intervene in activities such as education and health care for reasons of efficiency (see Chapter 2.1). Such intervention can either be through direct production of the goods/services by the state or through financial allocations (Barr 2004). An important concept of this theory is productive efficiency, which demands that the activity should be organized to obtain maximum output from given inputs. Concerning HMI, the input that needs to be organized (harmonized) will include contribution levels and collection mechanisms. The output to be maximized from this harmonization process is the benefit package. The state, therefore, can facilitate this by intervening in the HMI programme in Cameroon. It can provide logistics and technical/legal support to the platform of HMI promoters. These will provide the enabling environment for enhanced networking, thus facilitating efforts to address portability concerns.

9.2.5 A Legal Framework for Health Micro Insurance and the Possibility of Unfulfilled Expectations

The first HMI schemes were identified in Cameroon in the year 2000. Since then, the schemes have been operating in a legal vacuum, because of the absence of a legal framework regulating the sector. There is little wonder the clamour for a legal framework runs across the board for every informed respondent in this study. So high are the expectations of Cameroonians that the legal framework is presented almost as a panacea for all the challenges of HMI. The legitimacy that a legal framework entails was of primordial interest to HMI stakeholders. Since its inception, HMI promoters have been carrying out their activities without a legal document to justify their existence. They are therefore met with a lot of scepticism from potential adherents during sensitization meetings. The legitimacy that a legal framework will give to HMI is highly cherished by all stakeholders involved.

Subsidies to HMI schemes is another advantage associated with a legal framework (McIntyre et al. 2005: 30). Due to the small amount of premiums, HMI schemes cover only a limited range of illnesses. Certain health challenges deemed to be long term, like diabetes and high blood pressure, are excluded. With the government subsidy that a legal framework will bring, these illnesses and others can be covered. Subsidies will also cover administrative costs and provide a minimum wage for HMI promoters. Presently, promoters are working almost on a voluntary basis, despite the crucial role they play in the process of extending HMI in Cameroon. Making HMI compulsory is another possibility ascribed to a legal framework. Such a view has precedents in other countries like Rwanda, Ghana and Chile that have followed this path (WHO 2010c: 7, Bitrán and Urcullo 2008: 100, Chankova et al. 2008: 266). When HMI is made compulsory by the legal framework, paupers and other vulnerable groups will be covered.

The economic theory of state intervention provides justification for the enactment of a legal framework on HMI for reasons of social justice. Rawls (1972) argues that the primary aim of institutions is social justice. Social and economic inequalities are to be arranged so that they are to the greatest benefit of the least advantaged. In support of the social justice dimension of state intervention, Immergut (1992: 44) contends that government subsidies to voluntary mutual aid societies comprise the most limited form of intervention. This is due to the fact that it is mostly restricted to reducing the cost of membership, thereby enlarging the risk pool to include those who would otherwise be excluded. A legal framework for HMI with all the advantages mentioned above would address the inequalities associated with out-of-pocket payments. However, there is need for caution concerning the expectations that a legal framework will entail.

A legal framework will certainly not be a panacea for all challenges of HMI. One such challenge is the size of the expected government subsidy. How large will such subsidies be, given the current budgetary constraints faced by many nations? The issue of fictitious bills by health care providers, or hoarding of drugs in some public hospital pharmacies, needs to be addressed. There is the need for improved financial management as HMI expands. According to the World Health Report (WHO 2010c), Rwanda's HMI scheme is facing financial management challenges as it expands to cover 80% of the population. In this light, the expectations of the legal framework for Cameroon's HMI programme need to be tuned down.

Nevertheless, the programme will definitely improve with a legal framework, as proven in other countries. Without the legal framework and given the current rate of adhesion, meeting the government's target of 40% coverage by 2015 will be difficult. Unfortunately, the capacity of the state to enact meaningful social reform in Cameroon is considered weak (see Tables 5.2 and 5.3). Therefore, the wait for a legal framework regulating HMI in Cameroon might be a little longer. I will now present the conclusions from the findings concerning the third and last segment of this multi-layered study – universalism (see Figure 1.1).

9.3 Universalism: A Long-Term Health Care Financing Policy in the Making

HMI is not an end in its self. It is a short to medium-term health care financing objective, with universalism as the long term goal. In this study, the steps for an inclusive health care financing programme in Cameroon move from out-of-pocket payment via HMI to universal coverage. Callahan and Wasunna (2006: 87) define universal coverage as a system of health care that provides everyone with full access to adequate care, whether through direct taxation, mandatory employer-employee, or affordable private insurance or some combination of

these. In Cameroon, attaining universal coverage requires a major paradigm shift in health financing policy design and implementation.

According to the World Health Report (WHO 2008: 25), the fundamental steps a country can take to promote health equity is to move towards universal coverage. It entails health financing policies concerned with pooling pre-paid contributions collected on the basis of ability to pay. The funds are to be used to ensure that services are available, accessible and produce quality care for those who need them, without exposing them to the risk of catastrophic expenditure. Low income countries like Cameroon often face the issue of a low tax base from which to finance state funded pre-paid contributions (McIntyre et al. 2005). However, it is not only a question of limited financial resources. Equally important is the absence of political will. This came up prominently during the empirical field work for this study. This is not surprising because universal health coverage has generally been struggled for and won by social movements, not spontaneously bestowed by political leaders (WHO 2008: 25).

In Cameroon, HMI is championed by local and international NGOs like the ILO, GTZ and others. These can hardly be said to constitute social movements. When these movements arise spontaneously in Cameroon, it is often to clamour for political freedoms and/or bread-and-butter issues like the food riots of 2008. Social protection is hardly ever on the agenda. In the absence of pressure from social movements, political leaders will always find reasons to postpone debates on universalism. Institutional theories of politics argue that the mechanisms by which social pressures are transmitted to political decision-makers are crucial (Immergut 1992: 19).

For the time being, promoters of HMIs can concentrate their resources on making the schemes attract more members. If the schemes are large and members are sensitized, they can eventually play the role of social movements, putting pressure on political leaders to legislate for universal coverage. According to Carin et al. (2005), many countries have experimented with voluntary health insurance schemes like the HMI. Such schemes, they argue, are no substitute for universal coverage, but they can become important building blocks of universalism. Therefore, rather than acting as a hindrance to universalism, HMI presents a springboard for the elaboration of a long-term policy on universalism in Cameroon.

While designing a universal health coverage policy, Cameroon can be guided by the Social Democratic Model. It is particularly committed to comprehensive risk coverage, generous benefit level and egalitarianism (Korpi 1983, Esping-Andersen 1990). The example of the Nordic Social Democratic model can serve as a blueprint for Cameroon. It may not follow exactly the same contours as the Nordic countries, with a tripolar class structure of industrialist, labour and peasantry who had political representation (Kangas and Palme 2005). However, as the tax base in Cameroon improves, it can take advantage of the

nascent civil society to draft a policy on universal coverage based on the Social Democratic Model.

Carroll (2005: 83) suggests another route to universalism, stating that voluntary state subsidized insurance funds (HMI in Cameroon) have historically constituted vital schools of democracy in the Nordic countries, particularly for those previously excluded from these voluntary programmes. As such, Carroll argues, if embedded in a broader network of corporatist institutions, voluntary subsidized insurance institutions may constitute sites where bridging social capital can be generated. Therefore, the social capital nested in the cultural practice of rotatory aid funds in Cameroon holds huge potential for inclusive social policy reform that may lead to universalism.

9.4 Suggestions for Further Research

The multi-layer approach has been applied in this study to provide an understanding of the relationships and structures embedded in the reality of Cameroon's health care financing. Out-of-pocket payments served as the background to the all important HMI programme. The challenges and opportunities offered by HMI were investigated in conjunction with the role it can play in moving towards universal coverage for Cameroonians. There is overwhelming evidence that HMI minimizes catastrophic health care cost (Atim 1999; Jakab and Krishnan 2001, Jütting 2004). Nevertheless, it has not generated the enthusiasm one would expect. How can greater interest in HMI be generated using novel or existing approaches?

One such approach that could be studied is the mutual aid associations, commonly known as 'njangi' in Cameroon. This is an age-old practice of most African countries in general and Cameroon in particular. It is so entrenched in Cameroonians' psyche that they even practice it in the Diaspora. The njangi is an untapped reservoir of bonding social capital waiting to be exploited for HMI. Bourdieu's social capital approach will provide a theoretical framework for such a study. Social capital consists of resources based on connections and group membership (Bourdieu 1987: 4).

In the mutual aid associations, members jointly contribute money which is handed to one member. This is done repeatedly, until all the members have benefitted. It provides each member with a kind of 'loan' for business or other uses, which otherwise cannot be raised from the regular banks demanding collateral security. How then can this resource mobilization dynamic be channelled to strengthen participation in prepayments for health in Cameroon? This and other questions on the workings of the njangi can form the basis for further research on Cameroon's health care financing opportunities.

HMI is definitely a transitional phase to universal coverage. What precisely will be HMI's contribution toward universalism, will this contribution be positive or negative? What strategies will be put in place to overcome the bureaucratic inertia so prevalent in Cameroon's administrative structure? These questions could be investigated in future. The path dependence framework can provide the theoretical wherewithal to find answers for these questions. In its basic form, the path dependence theory stresses the importance of past events for future action, or more precisely of foregoing decisions for current and future decision making (Schreyögg and Sydow 2010: 4). According to this theory, therefore, decisions are conceived as historically conditioned – bygones are rarely bygones (Teece et al. 1997: 522). Will any future policy on universal health coverage be influenced by the current struggles to legislate for HMI? The path dependence theory may be used to guide any future study in search of answers.

As a health care financing mechanism, HMI has a relatively short history in Cameroon. The concept of prepayments for health care in general is fairly recent and policy formulations are ongoing. It is therefore a domain of social science where a lot still has to be researched. For instance, it will be interesting to study the possibility of combining HMI with micro finance. Considering that both are micro in scale, they can be jointly proposed as a two-in-one socio-economic policy package for improved livelihood in Cameroon.

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APPENDIX 1: QUESTIONNAIRE

Please, kindly provide answers to this questionnaire intended to collect data for a PhD research on Health Micro Insurance.

1) Sex: □ 1. Male
□ 2. Female

2) Age: □ Under 20
□ 21 to 30
□ 31 to 40
□ 41 to 50
□ Over 50 yrs

3) What is your marital status?
□ 1. single
□ 2. in a steady relationship (boyfriend/girlfriend)
□ 3. married
□ 4. divorced
□ 5. widowed

4) What is the highest level of education that you have attained (please tick the highest level)
□ 1. Primary school
□ 2. Secondary school
□ 3. Apprenticeship or trade course
□ 4. University

5) What are your religious inclinations
□ 1. Catholic
□ 2. Protestant
□ 3. Pentacostal
□ 4. Muslim
□ 5. Traditional African religion

6) Do you have a private health insurance coverage (not HMO)?
□ 1. Yes
□ 2. No

Answer the questions below if you are a member of an MHO. Non-members should skip to question 21.

7) When did you join the MHO (year) …….. & name of MHO ...…….

8) Since joining has there been any time when you have suspended your membership or been suspended from the MHO?

□ 1. yes
□ 2. no

9) If yes to question (8) state why…….....
……

10) How or where did you learn of the existence of the MHO programme

□ 1. MHO promoter
□ 2. hospital/health centre
□ 3. friend, neighbour, family member
□ 4. radio, newspaper
□ 5. social meeting
□ 6. church or mosque
□ 7. other …….

11) How much information do you have on the MHO in your health district?

□ 1. Too little
□ 2. Little
□ 3. About right
□ 4. Much
□ 5. Too much

12) Among the services listed below, choose the 3 most beneficial that the MHO must include in contracts with hospitals? (rank from 1st to 3rd)

---- out patient consultation
---- admissions
---- surgical interventions
---- pre-natal consultations
---- delivery
---- evacuation

13) Do hospitals honour the terms of the contract with the MHO?

□ 1. Always
□ 2. Not Always

14) Since joining the MHO the health of my household has improved

□ 1. Agree strongly
□ 2. Agree

□ 3. Neither agree nor disagree
□ 4. Disagree
□ 5. Strongly disagree

15) When I am ill I make use of out-of-pocket payments
□ 1. Always
□ 2. A couple of times
□ 3. Once in a while
□ 4. Never

16) Would you say that since joining the MHO you now go to hospital more often when you become ill than was previously the case?
□ 1. More often
□ 2. No difference
□ 3. Less often

17) When I am ill I go to the traditional healer
□ 1. Never
□ 2. Once in a while
□ 3. Depends
□ 4. A couple of times

18) When I am ill my relatives assist in the payment of my medical bills
□ 1. Always
□ 2. A couple of times
□ 3. Depends
□ 4. Once in a while
□ 5. Never

19) Tell me the number that shows how much satisfaction you get from the MHO
□ 1. A very great deal
□ 2. A great deal
□ 3. A fair amount
□ 4. Very little
□ 5. None
□ 6. Don't know

20) What do you think can be done to make the MHO more effective in meeting the health needs of members of your community?.....
…….
…….

Answer the following questions if you are not a member of any MHO

21) How much information do you have on the MHO in your health district?
- □ 1. Too little
- □ 2. Little
- □ 3. About right
- □ 4. Much
- □ 5. Too much

22) Which of these describes best how often you become ill?
- □ 1. Often
- □ 2. Sometimes
- □ 3. Rarely

23) When I am ill, I make use of out-of-pocket payments
- □ 1. Always
- □ 2. A couple of times
- □ 3. Once in a while
- □ 4. Never

24) When I am ill my relatives assist in the payment of my medical bills
- □ 1. Always
- □ 2. A couple of times
- □ 3. Depends
- □ 4. Once in a while
- □ 5. Never

25) When I am ill, I go to the traditional healer
- □ 1. Never
- □ 2. Once in a while
- □ 3. Depends
- □ 3. A couple of times

26) When I am ill I buy medicine over the counter or from a mobile drug seller
- □ 1. Always
- □ 2. A couple of times
- □ 3. Depends (explain)
- □ 4. Once in a while
- □ 5. Never

27) The amount charged for MHO premiums is affordable
- □ 1. Agree strongly
- □ 2. Agree
- □ 3. Neither agree nor disagree

□ 4. Disagree
□ 5. Disagree strongly
□ 6. Don't know

28) Any Comments:

29) Place: