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2ND SURVEY ON THE MONITORING OF PUBLIC EXPENDITURES AND THE LEVEL OF RECIPIENTS' SATISFACTION IN THE EDUCATION AND HEALTH SECTORS IN CAMEROON

(PETS2)

RESULTS SUMMARY REPORT

Health component

December 2010

1- PRESENTATION NOTE

What is a survey on the monitoring of public expenditures?

A survey on the public expenditure circuit "budget tracking (also called PETS), is a statistical audit (and not accounting) which aims at evaluating the traceability of public expenditure in certain targeted sectors. The traceability of public expenditures follows the pattern of the flow of public funds and material resources from the Government and other donors, through the administrative hierarchy right up to the official entitled to order payment in health units, providers of health services.

A survey on the monitoring of public expenditure "budget tracking (also called PETS[1]), is a statistical audit (and not accounting).

PETS2 enables to have information for the appreciation of public finance management in priority sectors considered. It helps to answer a few questions:

(i) Do public funds and material resources get to their destinations?
(ii) Which are the levels of fund leakages?
(iii) What is the percentage of managers who lose resources in the expenditure circuit?
(iv) To whom are the resources lost destined?
(v) What is the satisfaction level of beneficiaries of services rendered?

Given the importance of the governance component in the government's current policy, and the place of results based management in the new financial regime, it was recommended that such a survey be conducted periodically, with lighter data collection tools.

[1] ***Public Expenditure Tracking Survey***

2- TRACEABILITY OF PUBLIC EXPENDITURE

Budgetary preparation

In 2009, one official out of three of the regional delegation declared having participated in his budget preparation. Regarding the health units, managers of CMA and CSI are the least involved in the preparation of their budgets (26% and 31% respectively). Whatever the area of implantation and the type of budget considered, at most one manager of structure out of four is informed on the budgetary allocation before the arrival of resources.

The feeling of being involved in the elaboration of the budget remains low for actors of the health sector. Only 31% and 26% of managers of CSI and CMA respectively believe they are involved.

Table 1 : Percentage of officials having been associated in the preparation of the budget in 2009

Type of structure	Level of the structure	Urban	Rural	Total
Decentralized services	DRSP	66.7	-	66.7
	SSD	54.3	-	54.3
Health units	HD	69.6	26.7	52.6
	CMA	22.2	30.8	25.8
	CSI	28.2	32.7	30.9

Source : NIS/PETS2, 2010

The availability of budgetary information

Budgetary information is less fluid as we move away from central services. 81% of HD directors have provided detailed information on their operating budget, as against 71% and 62% for CMA and CSI respectively.

Regarding the intermediary decentralized health services, we note that 88.9% of regional delegates have provided detailed information on their operating budgets, as against 71.4% for investment budget. For the investment budget, the situation seems more deplorable in District Health Services (SSD), where, nearly 56% of managers are unaware on the amount of their investment budgets.

As regards to health units, as one moves from a higher category to a lower category, managers have less information on the operating budget as well as the investment budget. In addition, given that a greater part of the investment in health units is managed at a higher level, information on the investment budget is less available at the level of these managers.

Table 2 : Proportion of managers of health structures having available information on their budgets in 2009

	Structure	Operating			Investment		
		Collected	Finance act	Collected and finance act	Collected	Projects log book	Collected and Projects log book
Decentralized services	DRSP	88.9	100.0	88.9	71.4	100.0	71.4
	SSD	97.0	100.0	91.0	27.3	44.4	12.1
Health units	HD	80.8	100.0	80.8	73.1	57.9	42.3
	CMA	70.8	71.4	41.7	66.7	14.3	8.3
	CSI	62.3	80.3	59.0	54.1	9.8	3.3

Source : NIS/PETS2, 2010

The managers of public resources

There exist an inadequacy between resources received and those inscribed in the finance act/ projects log book.

Apart from the CSI, at least half of the managers of other health structures reported that the amount of resources received from the administration did not correspond to that inscribed in the finance act and/or in the projects log book of health units.

Table 3 : Proportion of officials entitled to order payment who declared having received from the administration in 2009, an amount of resources corresponding that inscribed in the finance act

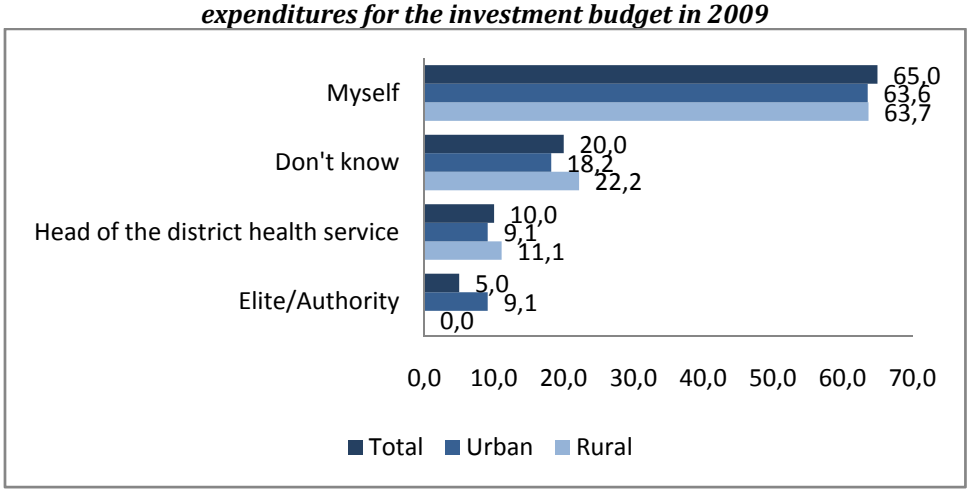
Type of structure	Level	Urban	Rural	Total
Decentralized services	DRSP	55.6	-	55.6
	SSD	54.3	-	54.3
Health units	HD	56.0	-	56.0
	CMA	70.0	40.0	55.0
	CSI	35.0	39.5	37.9

Source : NIS/PETS2, 2010

The authorizations of expenditures of one structure out of three are withdrawn by persons other than the appointed managers.

In health units, nearly 4 managers out of 10 declared that they did not personally withdrew the authorisations of expenditures destined to their structures. Apart from district hospitals, this proportion is higher in the urban area as compared to the rural area. In addition, 20% of managers are unaware on the quality of the person who withdrew their authorizations of expenditures.

Figure 1: Proportion of health units according to the quality of the person who withdrew the authorizations of expenditures for the investment budget in 2009



Source : INS/PETS2, 2010

The time limit for budgetary execution

The reduction in time limit for the execution of public expenditures remains a challenge. In 2009, the budget has been executed by the officials entitled to order payment over 2.5 months after the beginning of each semester.

The authorizations of expenditures of the first semester 2009 for the operating budget were withdrawn in late February by the SDI and in mid March by the health units. Those of the second semester were withdrawn in mid September whatever the structure.

Once the authorizations are withdrawn, the officials entitled to order payment in the health units spend more than half a month to execute those with the highest amount. In return, managers of decentralized services take much time (two folds the time taken in the FSs). An analysis by semester shows that the gaps are less pronounced in the second semester than in the first. This could be justified by the fact that, the preparation of some expenditures for the second semester is anticipated by the officials entitled to order payment, just at the beginning of reception of the first authorizations of expenditures of the financial year.

Figure2:*Average time elapsed between the withdrawal of the operating authorizations of expenditures and the execution (in months)*

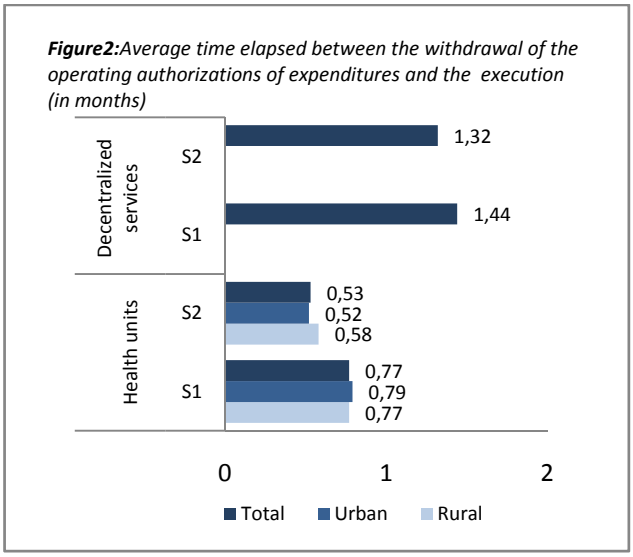
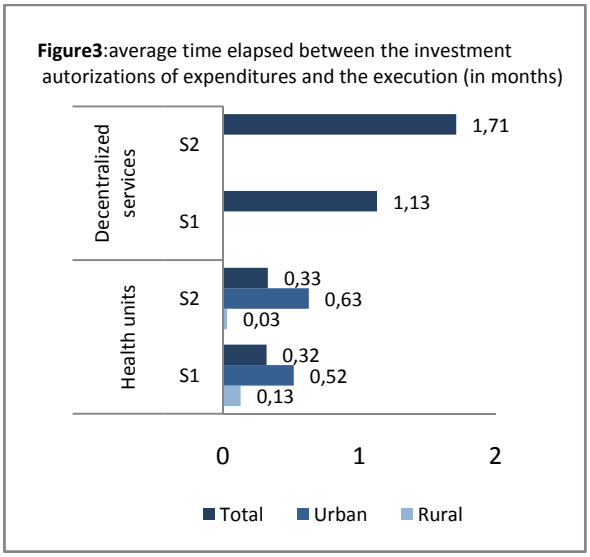


Figure3:average time elapsed between the investment autorizations of expenditures and the execution (in months)



For the investment budget, the first authorizations of expenditures executed are those with the highest amount. They were executed about 10 days after withdrawal for the health units and after more than a month for the intermediary decentralized health services. We equally note that for health units, the execution time limits are much more reduced in the rural area than in the urban area.

The execution rate of the budget

With the exception of the health units in the South region and decentralized services of the South-West region, the execution rate of the operating budget approaches 100% in general. On the contrary, the execution rate of the investment budget still remains low throughout the country. As we move from a lower level to a higher level, the execution rate of the investment budget increases significantly. For health units for example, it varies from 50% for CSI to 60% for CMA and 90% for HD.

If the execution rate of the operating budget is satisfactory, that of the investment remains very low because it's about 60% at the national level.

Losses of resources recorded in the expenditure circuit

Regardless of the budgetary line and due to the multiplicity of interveners in the expenditure circuit, a greater proportion of budgetary resources is lost by decentralized services during budget execution. Overall, the most affected lines are "*purchase of current equipment*" and "*purchase of supplies*".

A greater proportion of budgetary resources, that is say 35 to 40% is lost to take care of various interveners identified as elements of the expenditure circuit or unidentified (actors of political life).

For the majority of health unit established in the rural area, the fact that the withdrawal of their authorizations of expenditures is sometimes done by an authority of the locality (an elected person, an elite or an administrative authority), it may worth a compensation. Both in the urban and rural areas, the budgetary lines the most subjected to losses of resources for health units are respectively *"purchases of drugs", "office supplies" and "hardware equipment"*.

Table 4 : Percentage of resources declared lost by managers of decentralized health services to take care of the interveners in the expenditure circuit

	Hierarchies and administrative authorities	Finance services	Stores accounting	Contract commission	Representatives of the work master
Purchase of supplies	19.9	23.3	10.5	4.0	42.3
Purchase of current materials	7.0	48.0	4.0	7.7	33.2
Purchase of small materials	18.7	41.1	6.2	9.7	24.2
Fuel and lubricants	18.3	28.3	7.0	8.4	38.0
Maintenance and repair of vehicles	21.2	35.5	5.9	0.0	37.5
Mission allowances	7.0	35.1	4.2	0.0	53.8

Source : NIS/PET2, 2010

Table 5 : Percentage of health unit managers having lost resources to take care of interveners in the expenditure circuit according to the area of establishment

	Hierarchies and administrative authorities	Finance services	Stores accounting	Contract commission	Representatives of the work master
Purchase of drugs	32.0	9.7	18.8	27.2	12.4
Office supplies	37.8	11.0	4.4	29.7	17.1
Hardware equipment	40.4	10.2	3.2	1.0	45.1
Office maintenance	27.9	9.0	3.3	45.5	14.2
Fuel	69.9	5.4	0.9	0.1	23.6
Staff bonuses	35.4	1.4	1.4	57.4	4.4

Source : NIS/PET2, 2010

In 2009, managers of health units and of intermediary decentralized health services have virtually experienced the same difficulties in the execution of their operating and investment budgets..

Budgetary execution is still surrounded with several difficulties ...

In order of importance, the difficulties noted include:

- ✓ *Insufficiency and inadequacy of credits;*
- ✓ *Administrative slowness;*
- ✓ *Worries in the payment;*
- ✓ *Delay in the reception of the cartons.*

The appreciation of the functioning of contract commissions

As regards to the deliberations of commissions, 7 out of 10 managers believe that they correspond to their expectations. This proportion is higher in the urban area (90.9%) than in the rural area (50%). The main reasons given by unsatisfied managers are: Opacity in the granting of contracts (25%), disorder in the granting of contracts (18.5%) and favouritism (18.5%).

Managers of the sector deplore the most: Opacity in the granting of contract (25%), disorder in the granting of contract (18.5%) and favouritism (18.5%).

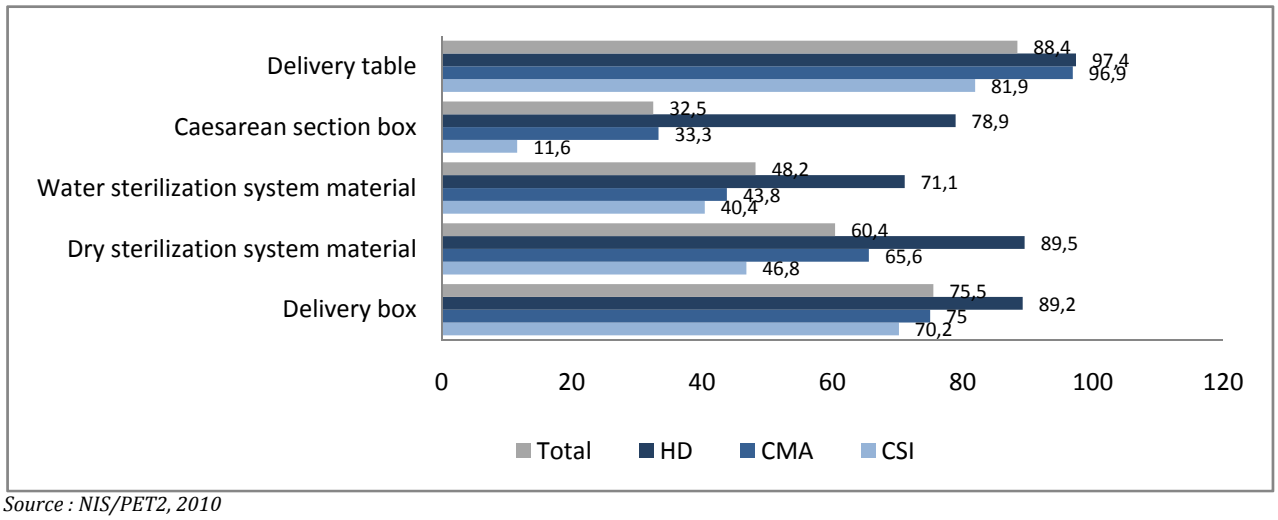
Among these managers, just over 2 out of 5 believe they should play a more important role such as giving their view points on the awaited results and the suppliers to be retained.

3- PROVISION AND DEMAND OF HEALTH SERVICES

Availability of infrastructures and basic equipment

The proportion of FSs with basic medical equipment (*delivery box, material for dry and water sterilization system*) decreases as we move from a higher category to a lower category. FSs located in the urban area are better equipped than those located in the rural area. From 2004 to 2010, the proportion of FSs with basic equipment has increased. However, it is noted that the proportion of CMA and CSI without caesarean section box is still very high.

Figure 4: Percentage of health units with some medical equipment



Source : NIS/PET2, 2010

Seven health units out of ten have access to electrical energy network. This access to electrical energy network is higher in the urban area. In the rural area, one FS out of two is connected to AES-Sonel network. As expected, the access to electricity decreases as we move from a higher to a lower category health unit. Overall, managers of FS deplore power cuts, whose duration vary from 11 to 16 hours. The damages caused by these power cuts in 2009 have led to losses estimated at millions of CFA francs for some health units. To remedy this situation, 50% of health units resorted to alternatives sources like solar energy and generators (78.9% for HD, 43.8% and 33.3% for CMA and CSI respectively).

The findings of this study reveal that only 46.8% of health units have access to running water. It should be noted that one health unit out of 5 gets water supply from a sinking well, almost the same value from harnessed springs and wells and about 15% elsewhere (rivers, non harnessed springs ...). In the rural area, only 2 out of 10 health units have access to water, as against 7 out of 10 in the urban area. Running water supply is also rare as one moves from HD to CSI.

Three health units out of ten have no energy source for lighting, and two out of four have no harnessed water source.

Table 6 : Percentage of health units with basic services

	Electricity	Running water	Medical laboratory	Mortuary	Consultation room	Operation room	Pro-pharmacy
Category of health units							
HD	94.7	83.8	97.4	47.4	100.0	92.1	92.1
CMA	87.5	51.6	93.8	6.3	100.0	43.8	96.9
CSI	54.3	30.0	69.1	1.1	95.7	17.0	94.7
Area of establishment							
Urban	90.0	70.9	95.0	17.5	97.5	52.5	92.5
Rural	50.6	21.8	66.3	8.4	97.6	26.5	96.4
Total	**70.1**	**46.8**	**80.5**	**12.8**	**97.6**	**39.6**	**94.5**

Source : NIS/PET2, 2010

Medical coverage

At the peripheral level, the health system accounts on average for 2 medical doctors per HD and 1 per CMA.

Overall, patients more consult nurses, the number of medical doctors being very low.

In 2010, basic health units have an average size of 24 persons among which 20 permanents and 4 temporaries. For the permanent personnel, the average number stands at 14 for the public and 35 for the private. The personnel number varies depending on the status and category of the FS. Regarding the temporary personnel, the average number per health unit stands at 4 for the public and 3 for the private.

Regarding the medical and paramedical personnel of health units, medical coverage by specialized doctors stands on average at about 2 for a HD, almost 1 for a CMA and virtually zero for an CSI. The coverage by general practitioners is almost identical to that of specialized doctors for HD, but two folds for CMA and CSI. A reduced number of CSI, likewise private clinics and consulting rooms have general practitioners or specialized doctors working part time. Regarding non specialized nurses, this coverage stands at 27 for a HD, 10 for a CMA and 3 for an CSI. In addition, one can note that in the CSI, we almost do not have radiology technicians.

Six patients out of ten have not met a medical doctor during a consultation. The majority address themselves to a chief nurse. Patients consult medical doctors more in private health units. As such, nearly 5 out of 10 patients met a medical doctor in a private health unit and only 3 out of 10 in a public health unit. Consultation by a doctor is essentially an urban phenomenon while that of a chief nurse remains a rural phenomenon.

Availability of essential drugs in FSs

Stock run out of essential drugs is a reality in FSs. It is more observed in the CSI. FSs are more in shortage of coartem, amodiaquine (tb) + artesunate and cotrimoxazole (tb)

Concerning the duration of stock run out, it varies from 3 to 19 days. Coartem represents the product that experienced more shortages and for a long duration in health units (19 days on average), contrary to quinine for which the shortage lasts at most 3 days. Seven drugs out of thirteen are more often unavailable in public health units than in the private ones. Meanwhile nine of these drugs are more often unavailable in the rural and urban areas.

Attendance of FSs and patients' profiles

In 2009, three patients out of four visited a public health unit. According to the area of establishment, about two patients out of three (69.0%) resorted to a health unit located in the urban area.

Concerning the attendance of basic health units, the study reveals that in 2009, three out of four patients visited a public health unit. This reflects the magnitude of the provision and geographical coverage in public health infrastructures. According to the area of establishment, 69% of patients resorted to a health unit located in the urban area. Patients more often visit HD in the urban area (33.0%) and CSI in the rural area (31.1%). Moreover, women visit health units more than men. Indeed, among 10 patients received in health units during the last three months preceding the survey, about 7 are women. Regarding the socio-economic group of patients, qualified employees are the most numerous to visit HD, meanwhile we more often find executives in the CMA and apprentices in the CSI.

The results also show that health units have received on average 12 patients per day, of which 2 were hospitalized. Health units with a higher technical plateau are on average more visited than others. In fact, the HD have thus received an average of 22 patients per day. This average stands at 8 for the CMA and 6 for the CSI.

Determinants of the choice of a health unit

From patients interviewed, 35% choose a FS because of proximity, 28% for quality services and 25% for recommendation by a practitioner.

The cost of health care seems to allow patients indifferent. In fact, overall, 67.1% of patients judged the level of expenditure incurred sufficient/normal. However, 6.5% of patients believe that the fees paid were very excessive. The average expenditure per person for a consultation stands at 1 381 CFA F, thus representing 1 840 CFA F in the HD, 1 252 CFA F in the CMA and 1 097 CFA F in the CSI.

As regards to the appreciation made on the quality of services received by beneficiaries, the findings show that about 9 patients out of 10 are satisfied with the quality of consultation and consider it good and complete.

Following the area of establishment, the judgment is more favourable for health units in the rural area (92%) than those in the urban area (89%). Following the status of the health unit, the quality of consultation is better appreciated in private health units (94%) than in public ones (89%) and for the category of the health unit, despite the fact that the consultation in the CMA lasts longer, the competence is thus ensured (94%).

Beneficiaries' satisfaction

The poor and the less educated patients are the most numerous to be satisfied with the health provision

The poor persons are more satisfied with health service provisions (81%) than the non-poor (80%). This can be explained by the fact that the non-poor persons are more demanding when it comes to health, while the poor persons are content with the bare minimum. The analysis is similar regarding the education level, since a person with a high education level is better placed to appreciate the imperfections of the health system. Thus, persons who come from a household whose head has no education level are more satisfied with health service provisions (81,9%) than those whose head has the primary school level (80,6%) and secondary level or more (78,9%).

4- CONCLUSION AND RECOMMENDATIONS

The reforms in the public finance management and the improvement of health provision in Cameroon, through the recruitment of health personnel, the creation of FSs and the raising of the technical plateau, have helped to improve the quality of services. However, many problems still exist regarding the response to the population's demand.

These problems are related to the lack of traceability of public expenditure, which results in insufficient budgetary information, long time-limit in budget execution, the dependency of the different interveners of the expenditure chain, leading to loss of resources and dissatisfaction of beneficiaries due to insufficient sanitation and health coverage, the equipment of FSs and to poor hospital governance..

To improve the provision of health services, the following recommendations are made for implementation:

On the expenditure circuit

- Involving more the officials of decentralized services and dialogue structures in budget preparation;

- Decentralize the technical structure of budget preparation;
- Take into account the real needs expressed by health units;
- Allow managers of structures to define their priorities;
- Create a Planning - Programming - Budgeting - Monitoring committee (PPBS) in the MINSANTE;
- Decentralizing as much as possible the management of the PIB;
- Revise the role of financial controls and administrative authorities in the expenditure circuit ;
- Systematically make available to the public (through dialogue structures such as management committees) information on budgetary resources and their uses;
- Make available the manual of budgetary and accounting procedures and facilitate its acquisition and its use to officials;
- Establish an archiving system of budgetary documents;
- Improve the time-limit of transmission of authorizations of expenditures;
- Increase the decision power of officials entitled to order payment within local contract commissions;
- Sufficiently fill out technical specifications to exclude adventurer service providers;
- Consider the financial and technical capacities of bidders in the granting of contracts;
- Establish a mechanism to appropriate the "Budget tracking" exercise in the Ministry of Public Health.

In relation to the level of beneficiaries' satisfaction

- Adequately equip health units;
- Improve the quality of health service provision especially in the rural and inaccessible areas;
- Promote modern methods of waste disposal, while respecting environmental protection;
- Ensure access to drinking water to all FSs;
- Ensure access to electricity to all FSs;
- Make available essential drugs, vaccines and consumables as well as laboratory tests at all levels of the health system, especially in rural areas and area with difficult access;
- Make available and motivate the qualified personnel in the FS especially in rural areas and areas with difficult access;
- Clearly define an orientation system of patients' in health units;
- Improve the quality of equipment of health units to meet the demand and intensify the fight against some priority diseases such as malaria.