Determinant of the Willingness to Pay of the rural household head in the Community health care financing in Cameroon

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Abstract: The main objective of the study is, on the one hand, to assess the poor heads of households' Willingness To Pay (WTP) of their fees for in the community healthcare financing membership in Cameroon and on the other hand, to identify the determining factors of such membership. Based on survey data, we used the Contingent Valuation Method (CVM). As a matter of fact, findings show that heads of households agree to pay an average amount of CFA F 6,893 per year for their possible participation in the community healthcare funding system. On the other hand, findings reveal that the educational factor positively affects the agreed amount heads of households should pay. Indeed, it appears that heads of households with a high level of education are more willing to pay a larger sum to participate in the community healthcare financing compared to those with no level of education. Similarly, their state of morbidity positively affects this amount. In fact, this reflects the fact that heads of households who reported poor health within the last three months prior to the survey period are willing to pay more for their participation in the community healthcare funding system than those in good health.

Keywords: Poor household, Community health care Financing, Willingness To Pay.
JEL Classification: D11; I12

INTRODUCTION

According to Atal an al. (2020), Community healthcare financing provides better access to modern health care for low-income people. However, this system has quite limited protection due to the low income the community receives. Moreover, the protection it can provide is, most often, limited by the small size of the beneficiaries. Waelkens et Criel (2004) also showed that effective coverage within a community limited to about 10% of the target population on average. There are several reasons why many people choose not to participate.

The main reason is the fact that many households do not understand the need and the community funding system. For Hsiao (2001), because membership is voluntary, people tend to adhere to a community scheme if they expect benefits to outweigh costs and if the community has a high level of social cohesion.

Bennett et al. (1998), while relying on an analysis in developing countries, found that very few systems were capable of reaching the poorest. Preker et al. (2004) also agree that the poor do not have access to such schemes and attribute the phenomenon mainly to lack of financial accessibility. The direct consequence of this is that they divert from formal health facilities to informal ones.

Indeed, some studies that have also highlighted the WTP approach in African countries emerged with authors such as Asenso-Okyere et al. (1997) who use it in rural Ghana to estimate the amount that the population would be willing to pay for community health insurance and in this perspective, one can refer to the studies carried out by Dong et al (2003); Binam et al (2005); Asgary et al (2003).

Willingness to pay is of paramount interest as it seeks to assess the usefulness of community participation in monetary terms. The economic theory states that the maximum amount an individual agrees to disburse for a good or service is WTP. However, it differs across income groups; this is why its review provides information on the contributory capacities of households that leads to the assessment of the optimal WTP that would contribute to reducing inequalities in access to these systems by populations and thus improving their accessibility to modern healthcare services.

The case of Cameroon is quite illustrative. Indeed, the (ECAM4, 2014) report, shows that at the national level, almost 6 out of 10 households consider themselves as being poor or very poor. Also, the percentage of households that declare themselves poor or very poor is higher than that of households classified as objectively poor. According to an analysis of the populations living conditions, poverty remains a rural phenomenon. Indeed, 55% of poor households live in rural areas, as opposed to 12.2% in urban areas. Despite the fact that people live mainly in semi-urban and rural areas (65%), these rates reflect the fact that poverty remains mainly a rural phenomenon. We can therefore understood why the rate of attendance is as high as 70.9% for the informal sector and so low for formal health facilities.

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This low attendance recorded informal health facilities shows how often poverty stops a significant segment of the population from receiving quality healthcare services. As a result, a report of the Macroeconomics and Health Commission suggested an increase of the amount communities should pay for the demand for healthcare services (WHO, 2001). This is likely to involve the integration of the poor into these systems. So it is from this angle that we sought to know how much poor households are able to pay to participate in such a system. In other words, can Willingness To Pay (WTP) be a determining factor in the accession of poor heads of households to Community Healthcare Funding in Cameroon? What are the determinants?

The objective of the study is, on the one hand, to assess poor heads of households' willingness to pay (WTP) for their membership in Community Healthcare Funding in Cameroon and, on the other hand, to identify its determinants.

1. LITERATURE REVIEW

Several studies have attempted to provide solutions to the thorny problem of financing healthcare services for the poor (Asgary et al., 2004 etc.). It is in this respect that it we found out that community healthcare funding, regardless of its form constitutes a special tool to the solvency of the demand for health care.

1.1. Community Healthcare Funding and Healthcare Demand Solvency

Theoretically, the study draws on the unified healthcare demand model to question the factors that affect individuals' use of healthcare services, including community-based healthcare funding. This healthcare demand model which was developed by Grossman (1972) and Rosenzweig and Schultz (1982), focuses on health production based primarily on individuals' utility maximization behaviour. The simplifying assumption postulated in this model is that each individual gives equal preference to healthcare services and other goods. From this hypothesis follows the observation that the behaviors related to the demand for healthcare are identical.

Indeed, the solvency of the healthcare demand of poor households via the community healthcare funding system protects them from the fungibility of the limited means in their possession and thereby ensures a good level of health capital. However, in a context of generalized poverty that characterizes African countries, it is not often easy for populations to use health insurance systems as they are less developed; in addition, poor households do not have access to them because of the deductible which is often too high (Peterson and Obileye, 2002).

From the above perspective, some studies have established the relationship between household poverty and access to healthcare services in developing countries (Akin et al., 1987; 1995; 1999; Orubuloye et al., 1997; Whitehead et al., 2001; Asgary et al., 2004). From these studies, it emerges that collecting the Willingness To Pay (WTP) of poor households, in order to remove this barrier to access to health insurance systems and in particular, community healthcare funding systems can be an interesting way of finding solutions to the problems of inaccessibility by the poor to basic healthcare services and the fight against poverty; these two factors being the guarantee for the contribution of these systems of community healthcare funding to the demand for healthcare. However, reviewing this process first requires an analysis of the WTP, consistent with a neo-classically inspired welfare economics.

1.2. The Neo-classical Approach to Willingness To Pay (WTP)

The Neo-classical theory of the welfare economy incorporates consumer preference as the preferred instrument in determining the WTP. In line with this, the estimatable monetary value for obtaining a good or service will depend on the preference or expected utility of that good. With regard to healthcare goods and services, the Willingness To Pay (WTP)[2] or Willingness To Accept (WTA) of individuals or households often refers, as some authors such as Bala et al., (1999); Hanemann (1991) and Johannesson(1996), said, to the so-called "contingent valuation" method most often used in the theory of welfare economics especially when it comes to the change in prices or analysis of the change in quantities of goods, Maler (1974); Haneman (1991).

In addition, the research carried out by Bala et al., (1999), which is based on the theory of consumers' demand, examined the maximum amount that an individual would be willing to pay in return for the health risk due to Health capital instability. Thus, the amount that individuals are supposed to pay can be considered as the sum distributed among certain households and communities. This led to the correlation between the WTP of households and that of individuals in the sense that the WTP of households would be the sum of the WTP of each individual who is member of the household.

2. METHODOLOGY

2.1 Analysis Model

The economic theory offers a variety of methods that aim at determining the optimal amount of a public good that should be produced (Stiglitz, 2000). These are, on the one hand, indirect methods and, on the other hand, direct methods.

Indirect methods are based on the observation of individual actions. They therefore consist in inferring utilities from observed behaviours.

As for the direct methods based on individual statements, these involve interviewing individuals by means of a questionnaire. It is therefore a technique implemented when individual behaviours are difficult to observe. This method, which serves as the basis for contingent valuation, assumes that individuals would have, prior to the survey, a perfectly determined value deep in them. However, some parameters which theoretically should not affect survey responses have in practice an influence on contingent valuation survey responses, so there would be a violation of the theoretical model prediction. So, should this theory be violated, it would then be presence case of bias (Flachaire and Hollard, 2005). For example, recent developments in behavioural economics propose to account for these biases that affect individual decisions (Camerer et al.2003). However, it is necessary to revisit the main principles of contingent valuation and the main biases.

In view of the discussions on the choice of the method of assessing the optimal Willingness To Pay, we chose the double closed-ended question for its efficiency gain, as compared to simple closed-ended questions because for the latter, the WTP obtained are generally higher due to the "Yea-Saying2" phenomenon.

In the double closed-ended question method, we preferred using the Interval Regression Model to analyze answers to these questions and thereby calculate the WTP of households.

Indeed, in many contingent valuation surveys, a high percentage of respondents express a WTP equal to 0 for the good or service in question. Integrating this into the analysis results in selection biases. The proposed model used to correct selection bias is that of Heckman.

The model takes into account the fact that the value provided by an individual during an interview is the result of two potentially correlated stochastic processes: on the one hand, the respondent gives a value to the program in question from a discrete choice model; in the case study, it is the decision to participate in the system or not and, on the other hand, whether or not to disclose the amount to be paid for this participation (reservation price) according to another choice model.

D_i will therefore be considered as the dichotomous variable such that: $D_i = \begin{cases} 1 \\ 0 \end{cases}$, indicating whether the respondent i gives credit to the service of the system by deciding to participate in the system or not. It is assumed that latent variable CAP_i^* 3 measuring the WTP of an individual is determined by a set of explanatory variables X_i / $CAP_i^* = x_i\beta + \sigma\mu_i$.

Similarly, it is assumed that the decision to reveal one's WTP or not is determined by the sign of the latent variable D_i^* / $D_i^* = z_i\gamma + \varepsilon_i$ resulting from our questionnaire "In view of the definition of the mutual and the products it offers to these members, would you like to participate?" where z_i is the set of variables explaining the decision to participate conditioning the will to reveal or not the true WTP of the respondent; with:

$$D_i = \begin{cases} 1 & si & D_i^* \geq 0 \\ 0 & si & non \end{cases}$$

Combining these two decisions, it is clear that the true WTP can only be observed if the respondent decides to value the system by deciding to participate. It can then result in:

$$D_i^* = z_i\gamma + \varepsilon_i \qquad avec \quad D_i = \begin{cases} 1 & si \ D_i^* \geq 0 \\ 0 & si \ non \end{cases}$$

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[2] "Yes-Saying" is the state of an individual answering "yes" to the amount proposed to him in order to please the interviewer, when his real WTP is less than this amount.

This latent variable is not observable ; it is apprehended by the questionnaire of the survey: "How Much Are you willing to pay per year and in Cfa to join the health mutual

$$CAP_i^* = x_i\beta + \sigma\mu_i \quad avec \quad CAP_i = \begin{cases} CAP_i^* & si \ D_i=1 \\ 0 & si \ D_i=0 \end{cases}$$

Therefore, the amount revealed CAP_i by the respondent when they decide to participate is obtained each time:

$$\ln CAP_i = \begin{cases} X_i\beta + \delta u_i & si \ D_1=1 \\ pas \ d'observation & si \ D_i=0 \end{cases} \quad (1)$$

and the participation equation is represented as follows:

$$D_i = \begin{cases} 1 & si \ Z_i\gamma + \varepsilon_i \geq 0 \\ 0 & si \ Z_i\gamma + \varepsilon_i \leq 0 \end{cases} \quad (2)$$

Thus referring to equation (1) and (2), the revelation of the WTP is observed whenever the participation variable is equal to the unit. μ_i and ε_i are the error terms that, when joined in a simultaneous equation, represent the cumulative density function $F[\mu_i, \varepsilon_i]$, with zero mean, variance equal to 1 with the correlation. $Corr(\mu_i, \varepsilon_i) = \rho$. In the case where $\rho = 0$ that is to say, in the absence of a problem of selection bias, the parameters of equations (1) and (2) can be estimated separately. However, when $\rho \neq 0$, these two processes cannot be separated6. In this case, one can estimate the CAP logarithm provided that the variable participation is equal to the unit; thus the expression is obtained as follows:

$$E(\ln CAP_i / D_i = 1) = x_i\beta + \rho\sigma\lambda(z_i\gamma) \quad (3)$$

$$\lambda(z_i\gamma) = \frac{\varphi(z_i\gamma)}{\phi(z_i\gamma)}$$

Where $\lambda(z_i\gamma) = \frac{\varphi(z_i\gamma)}{\phi(z_i\gamma)}$ is the inverse of the Mills ratio; φ et ϕ are respectively the density and the distribution function of the standard normal variables.

In agreement with Strezzera et al, (2003b) and Calia and Strezzera (2001), equation (3) can be estimated simultaneously by the Heckman two-step procedure or by estimating the maximum likelihood in order to correct the problem of the presence of selection bias.

Based on equation (3), which estimates the average Willingness To Pay of respondents based solely on the declaration of those who agreed to participate, it is possible, according to Strezzera et al (2003a), to estimate the median and mean according to the following formulations:

$$M\acute{e}diane = \exp(x_i\beta) \quad et \quad la \ Moyenne = E(CAP_i) = \exp(x_i\beta + \delta^2/2) \quad (4)$$

2.2. Data Source

The data used in this study come from a survey funded under the BILL and MELINA GATE Foundation "Microinsurance-EUDN" Program and the International Labour Office (ILO), carried out in Cameroon in April 2010 in collaboration with experts from the National Institute of Statistics (INS) of Cameroon.

The scope of the survey was limited to two rural areas in the Far-North Region (Mokong) and the Centre Region (Sa'a), and to one urban area in the North-West Region (Bamenda). Indeed, these three above-mentioned regions are those in which the percentage of the poor would be the highest compared to other regions of Cameroon7. In addition, based on the mapping works carried out as part of the Third General Census of Population and Housing (RGPH, 2005), 21 clusters were randomly drawn from the comprehensive list of clusters provided.

The survey included a sample of 420 households, or 1,823 individuals. Thus, the data provide information on the socio-economic and cultural characteristics of the surveyed population such as education level, age, gender, religion, household size, income. Other information such as the choice of participation of the respondent in the micro-health insurance, the Willingness To Pay (WTP) depending on whether he is a head of household or an individual are included. All these information will be useful for the estimation of the model and also for the analysis of descriptive statistics.

3. Analysis and Discussion of Findings

This section addresses the description of the variables selected and leads to two complementary approaches, one which is statistical and the other econometric.

3.1. Description of model variables

Table 1 below describes the variables selected from the model.

Table 1 : Description of analysis variables

VARIABLES	DEFINITION	DESCRIPTION
Gender	Variable of gender which takes the value 1 if it is a male and 0 if not	Dichotomous
Education	Level of education achieved by the person surveyed who takes the values: 1= no level; 2 = primary; 3= secondary 1st cycle; 4= high school and 5= higher education	Categorical
EntenMS	Knowledge about the existence of the Health Mutual in the community taking value: 1= yes and 0= no	Dichotomous
Contingent Offer	Bidirectional offer of consent to pay amounts: a) 16000 b) 18000 c) 20000 d) 14000 e) 12000 f) 10000	Categorical
Participation	Variable indicating whether the respondent agrees to pay to join the HM 1 if yes and 0 if no	Dichotomous
MttWTP	The maximum amount the respondent agrees to pay to join the HM	Continuous
Age	Age of respondent in past year	Continuous
Taillem	Size of the household	Continuous
MorbStat	Indicates whether the respondent experienced a morbid event in the last three months prior to the survey	Categorical
Socioeconomic activity	Respondent's activity group	Categorical
Distance	Distance that separates the respondent's place of residence from the nearest health facility	Categorical

Source : Author

The treatment of these variables offers results shown in the tables below that are important to analyze from a statistical and an econometric perspective.

3.2. Statistical Approach
This approach is based primarily on the characteristics of heads of households.

Indeed, the descriptive statistics of the variables selected from the model and contained in Table 20 below, show that 79% of heads of households in the sample are men of the age group of 20-95 years whose average age is 43 years.

In addition, there is a relatively small percentage of non-residents in the survey localities. And with regard to the level of attendance at health facilities, among the 49% of heads of households who reported their state of morbidity during the last three months before the survey period, 38% used modern health facilities whose average cost of expenditure per head of household amounts to CFA F11,525.

Also, there is an average of 5 people per household and 73% of heads of households declare their intention to participate in the community healthcare funding system. Table below illustrates all of the observations mentioned above-.

Table 2: Descriptive statistics of the characteristics of the head of household

Variable	Obs	Mean	Std. Dev.	Min	Max
Gender	282	.7943262	.4049117	0	1
Age	282	43.82979	14.84605	20	95
Loresidence	282	.9787234	.1445614	0	1
MorbidState	282	.4964539	.5008763	0	1
ConsulStruc	282	.3829787	.4869774	0	1
Cost cons	282	11526.21	23673.96	0	99998
Distance	282	1.457447	.7545576	1	3
Decision	282	.7304965	.4444907	0	1
Size hshld	282	5.560284	4.190939	1	30

Source: Author, findings obtained from Stata

However, in Table 35 in the Appendix, the level of education in the sample shows that 35% of heads of households attained the primary level, 29% the secondary level and only 9% the higher education level. And with regard to the level of declared income, 48% of heads of households place it in the range of CFA F23,500 to 50,000.

From the analysis of the statistical aspects of these results, it appears that 79% of the sample of heads of households are men. Indeed, we observed the average age at in the group of heads of households is 43 years. In addition, heads of households spend an average of CFA F11,525 per morbid event.

Based on these statistical analyses, it is therefore necessary to focus on the analysis aspects according to the econometric approach.

3.2.   Econometric Approach

The tables below show the results relating to the participation of heads of households   using the probit model. Indeed, these results reveal factors that influence the probability of respondents to declare their Willingness To Pay (WTP). However, these factors, while influencing the possibility of WTP responses, do not necessarily inform the amount reported. Its main advantage is therefore to inform about the selection bias introduced by the different respondents (Mc Clelland et al., 1993).

In addition, these factors also represent the influence of respondents'' participation or not in the community healthcare funding system.

3.2.1. Determinants of the participation of heads of households

Factors that influence the participation of heads of households in the community healthcare funding system include residence status, age, education level and household size.

With regard to the locality of residence, it appears that the rural area has a negative influence on the probability of heads of households participating in the community healthcare funding system, since those residing in rural areas have a reduced probability of participation of 17% compared to those in urban areas at the threshold of 10%.

With regard to the age factor, it appears that it positively influences the probability of participation of heads of households in the community healthcare funding system. Indeed, the older heads of households are, the high the probability of participation is, for instance, 0.36%, as compared to heads of households aged 20 years.

With regard to the level of education, it appears that the level of education of the head of household has a positive influence on the decision to participate in the community healthcare funding system. Indeed, heads of households with a level of Education have a probability of more than 4.6% of participation compared to uneducated ones.

In addition, household size has a positive influence on the decision to participate of heads of households. Indeed, the number of people in the household increases the probability of participation of heads of households by 1.7% compared to single-person households. Table3 below illustrates all of the above-mentioned observations.

Table 3 :   Equation of participation of heads of households

```
Probit model with sample selection              Number of obs =     282
                                                Censored obs   =     75
                                                Uncensored obs =     207
                                                Wald chi2(6)   =     3.99
Log likelihood = -240.6221             Prob > chi2  =    0.0000
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Variables	Heckman à 2-Etapes Coef.	Std. Err.	z	P>z	[95%	Conf. Interval]
Region	-.171744	.1040197	-1.65	0.099	-.375619	.0321309
Gender	.1709216	.2064247	0.83	0.408	-.2336633	.5755066
Age	.003628	.0061674	0.59	0.056	.0157158	.0084599
Mar.Stat.	-.075502	.0894925	-0.84	0.399	-.2509041	.0999
Education	.0464836	.0703033	0.66	0.008	.1842754	.0913083
Religion	-.0712994	.0730641	-0.98	0.329	-.2145024	.0719036
Activity	.3156001	.2482204	1.27	0.004	-.170903	.8021032
Morb.State	-.0173613	.1839971	-0.09	0.025	-.377989	.3432664
Householdsize	.0731508	.1211889	0.60	0.046	-.1643751	.3106766
_cons	1.240861	.5735089	2.16	0.030	.1168041	2.364918

Source: Author; survey data, STATA

In view of the observations contained in the table above, the following observations should be noted:

As concerns heads of households, it appears that household size positively influences the probability of the head of household's participation in the community healthcare funding system. Indeed, the larger the household size, the greater the likelihood of the head of household to participate. In addition, the educational factor promotes the possibility of participation; however, it should be noted that the residence status of heads of households negatively influences their decision to participate. For example, those living in rural areas have a lower probability of participation in the system compared to urban dwellers.

Now, let us examine results of the equation for assessing the Willingness To Pay of heads of households.

3.2.2. Head of households WTP valuation analysis

The variables in the equation that impact the Willingness To Pay of heads of households as shown by the results of the estimates in the table below:

a) Analysis by status of heads of households

Considering Table 24 below, it appears that statistically, age negatively and significantly affects the Willingness To Pay of heads of households.

Indeed, as shown by Grossman (1972) and Kenkel (1994) on Life-cycle theory, older people with low health capital have low contributory capacity compared to younger people.

Income, on the other hand, positively and significantly affects the WTP, as shown by statistics; thus, the upper the monthly income bracket, the greater is the contributory capacity of heads of households.

With regard to distance, it appears that the distance covered by the head of household, from his place of residence to the nearest health facility, negatively affects the of their WTP.

In addition, household size positively and significantly affects the contributory capacity of heads of households, as shown by statistics. This reflects the fact that a head of household is willing to pay a higher amount as their household size grows.

Moreover, on the basis of Table 24 below, it appears that the estimated coefficient of the Inverse Mills o ratio of (IRM) ($\lambda = 0,23$) is significant, which led to the admission of Heckman's procedure in relation to other existing estimation methods. Indeed, the fact that the level of correlation of the error terms of the two equations is equal to zero ($\rho = 0$), reflects the absence of selection bias. Because from every indication, the estimate of the average WTP based solely on the observation only of those who responded positively to the idea of participating in the community healthcare funding system may prove incorrect if there are in this sample people who protest the WTP. To compensate for this, Calia and Strezzera., (2001) proposed the use of Heckman's two-step procedure as applied.

Table 4: Equation characterizing the Willingness To Pay using 2-Step Heckman

```
Heckman selection      model -- two-step estimates     Number of obs=     282
(Regression model      with sample selection)          Censored obs   =     75
                                                        Uncensored obs=     207
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                                             Wald chi2(12)          =      16.35
                                             Prob > chi2            =     0.0000
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	Coef.	Std. Err.	z	P>z	[95%	Conf. Interval]
Gender	-.1485772	.310972	-0.48	0.633	-.7580711	.4609166
Age	-.000604	.0068213	-0.09	0.009	-.0139735	.0127655
Revenue	.0688278	.1048536	0.66	0.000	-.1366815	.2743372
Morb	.0598878	.2117596	0.28	0.777	-.3551533	.474929
Distance	-.2595709	.1536025	-1.69	0.091	-.0414844	.5606262
Househld size	.0332427	.0311885	1.07	0.000	-.0278856	.094371
_cons	.0350796	.6289188	0.06	0.956	-1.197579	1.267738

Mills						
Lambda	0.229918	0.307979	0.75	0.006	-0.598328	
0.608926						

Rho	0.010060		
Sigma	0.526512		
Lambda	0.229918	0.307979	

Source: Author, findings obtained from survey data, STATA

In view of the above, it is clear that the educational factor is one of the major determinants of the WTP. In addition, age negatively affects the contributory capacity of heads of households. Another highlight of the observation is that the number of dependents of heads of households positively affects the WTP. This shows that in a more populated household, the head of the family reports a higher contributory capacity than in a one-person household.

Thus, from the determination of the factors having a definite influence on the WTP of heads of households, it becomes important to dwell on the estimate of this WTP.

b) Estimating the Willingness To Pay

The table below presents result of the average and median estimates of the WTP of heads of households.

Table 5: Estimate of the median and average Willingness To Pay

WTP* per head of household			
Method	**Observation**	**Median**	**Mean**
2-Step Heckman	282	10000	6893

Source : Author
- In Franc CFA

The following observations are made with regard to the WTP per head of household, the result of the estimate shows that on average, each head of household consents to disburse a sum of CFA F6,893 per year for his participation in the community healthcare funding system. In addition, the median per head of household is CFA F10,000.

Indeed, findings of the Third Cameroon Household Survey ECAM3 show that on average, a Cameroon household spends per year for its healthcare close to CFA F12,775. In addition, this amount varies according to the place of residence; for example, households in urban areas spend on average CFA F22,715 while those in rural areas spend on average CFA F8,512.

Indeed, any contribution to community healthcare funding aimed at integrating a large number of people in general and the poor in particular, must be below CFA F 6,893.

4. CONCLUSION

The objective of the study was to assess the capacity of poor households to contribute and join the community healthcare funding system in order to improve the equity of such a system to the poorest. For that purpose, we evaluated the WTP of households on the one hand, and on the other hand, identified factors determining this WTP.

As a matter of fact, the estimated value of Willingness To Pay of heads of households amounts to CFA F6,893. This amount actually reflects the average value of the amount that each head of household pays per year for their participation in the community healthcare funding system.

Regarding individual characteristics of heads of households, we observed that the educational factor positively affects their Willingness To Pay. This is because heads of households with a high level of education are more willing to pay a larger sum for their participation than those who are uneducated. Similarly, the state of morbidity positively affects this amount. In reality, this reflects the fact that individuals who reported poor health in the last three months prior to the survey period agree to pay a higher amount for their participation in the community healthcare funding system, compared to those in good health.

Ultimately, in order to ensure equity in the contributory capacity of those who are excluded from community healthcare funding for healthcare demand, the annual contribution amount must not exceed the above values, regardless of the status of people and their place of residence. Indeed, it appears that the average annual amount spent per household for healthcare in Cameroon, according to ECAM3 amounts to CFA F12,775. Thus, individuals will be more encouraged to participate in the community healthcare funding system whenever the annual contribution does not exceed the value of CFA F6,893 that our results offer. The above-mentioned value approximates the yearly amount of CFA F 7,230 that should target more people excluded from such a system in a context of generalized poverty characterizing Cameroon households.

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