Accessibility of health services in West Africa: the case of Ivory Coast

KOUDOU ZOHORE OLIVIER & GUEI SOSTHENE AUGUSTE GREGOIRE
Ph.D. students in Economics & Master degree in Economics
University of Cocody-Abidjan (Côte d’Ivoire) BP V 43 Abidjan
ozohore@yahoo.fr & stenauguste@yahoo.fr
ABSTRACT:

In this paper we use the results of the Integrated Core Survey for Poverty Assessment in Ivory Coast (EIBEP, 2002-2003) carried out by the Ivorian Government and the World Bank to study how populations, particularly the poor have access to health care. Despite considerable improvement in health supply following the application of the *Bamako Initiative* (1987) and the increasing development of mutual insurance, we show that many obstacles persist: institutional dysfunction, poor quality of services, clientelism in health Centers… Removing these barriers will help support actual health policy and help the development of the reforms. A sustained commitment of the Ivory Coast state is suggested to consolidate the hospital infrastructure and promote a good functioning of the National health system.

**Keyword:** Health, finance, micro-insurance, population, State

RÉSUMÉ :


**Mots clés :** santé, financement, micro-assurance, population, Etat
Introduction

The access to health services refers generally to the compatibility between the cost and the quality of health services on the one hand, and the purchasing power of populations on the other hand. In Ivory Coast, this access remains restrictive, particularly for low-income people engaged in less profitable economic activities. It is also restrictive for people living in the rural areas (51.2% in 2008 against 53.2% in 2005, according to the World Bank (2008) where, apart from a few posts and health centers specialized in providing "primary health care" the hospitals are almost non-existent or at least are located in dozens of kilometers from these places.

Ivory Coast has adopted the *Bamako Initiative* (BI) since it was set up in 1987. This initiative aims at collecting from users of health services, additional resources to finance the access to primary health care, to improve the efficiency of health structures and the quality of services. In return of this contribution, the management of these healthcare units is delegated to communities.

The advantages of such a policy are numerous. As far as the public authorities are concerned, it allows providing to health structures additional resources in order to guarantee the quality of services (quality of reception, availability of drugs, skilled labor, etc.), in order to meet basis community health needs. Another advantage is that it enables the efficient use of public expenditure on health, by channeling the financial resources "where welfare benefits are most important" (Audibert et al., 2004). The Hospital Reform Framework Document developed by the Ivorian Ministry of Public Health (2008) considers public health expenditure per capita and per year to $8 against the 13 USD standards established by the World Health (WHO). This expenditure is 3.5 USD in Guinea, 5 USD in Ghana and 9 USD in Mali (WHO, 2006). As for the users, however, the involvement of communities in the management of health facilities can help, in particular, improve their functioning and the regulation methods of the National Health System in general. The right to inspect and control guaranteed to users by the Bamako initiative is therefore intended to bring public and private returns investment in health structures. It should ensure an effective functioning of health structures, by providing quality services to users, whether they are customers or prospects (Audibert et al., 2003).
In Ivory Coast, although the Bamako Initiative helped expand national health coverage, many obstacles still constrain populations’ access to health care, particularly the poor. Indeed, basic health needs remain unsatisfied and people are reluctant to pay for poor quality health services. These factors lead people to avoid going in hospitals and in other care units (Audibert et al., 2004), and by the same token intensify informal health practices (traditional medicines, self-medication, etc.) which happened to be risky. In addition, the mixed results arising from the policies of decentralization and devolution of the health system announces the "end of cost recovery and primary health care model" in force for a decade (Comolet, 2000). The development of Institutional reforms which improve the operational quality of the hospital structures is therefore necessary to meet users’ satisfaction, the productivity of investment and the productive capital of medical structures (Rodrick, 2005).

Furthermore, the promotion of private health services by the authorities did not help reach the expected access rate of populations to health care. In fact, the free-market economics and the deregulation measures would lead to unequal access to basic social services (Baumann, 2005). People living on the poverty line do not have access to good quality health care. Also, the political crisis the country is experiencing led to the deterioration of basic social services and the development of selective private services. According to Rodrick, this situation calls for some institutional reforms that will combine private incentives and social objectives in order to develop a qualified private health sector.

Furthermore, despite their progressive development, the health insurance systems (microinsurance, mutual of informal sector workers) of sub-Saharan African countries participate marginally to health financing and particularly hospitalizations (World Bank, 2008). In Ivory Coast, out of a population of nearly 20 millions, only 1.22% benefits from health insurance services, according to that institution. These figures are 4.29% in Mali, 0.12% in Burkina Faso and 2.87 in Senegal for a population respectively estimated at 11.6%; 12.1 and 10.2 million inhabitants, (World Bank, 2005). Faced with this situation, initiatives are being taken by populations, development partners, NGOs to help the poor to overcome the obstacles (financial problems in particular) which impede the access to health care (ILO-STEP, 2002, Zett, 2005).
This paper aims firstly at the identification of barriers that trammel the whole population to have access to appropriate health care, and secondly put forward solutions to overcome them in order to offer people, particularly the poor better living conditions. With that end in view, we will study first of all the functioning of the health system in Ivory Coast. This step will help us understand the setting up of health facilities with regard to users dwelling places. The second part of the work analyzes the relevance of health policies implemented based on the geographical distribution of health infrastructures. In the third part, we show the importance of developing an affordable system of health risk coverage for the poor to improve access to quality health services and promote the development of health infrastructures nationwide. The fourth and final section suggests some solutions to reform the health system and make medical offices a place of ‘horizontal solidarity’ based on 'mutual assistance” (Goujon, Boisat, 2005).

1. Health supply structures

Ivory Coast has a less efficient health system. This weakness is closely linked to the very structure its economy: rent economy dominated by the primary sector with exports essentially based on raw materials and a developing informal economy with low value added incomes. Agriculture and fisheries practiced by the majority of the population (more than 59% of the population in 2009 according to ADB), do not account for more than 27% of GDP. The agricultural sector employs 2/3 of the labor force and provides in addition to the agribusiness sector 40% of export earnings. As for mining, this sector is less exploited in Ivory Coast (PRSP, 2009).

In spite of its agricultural potential, one Ivorian out of two lives on less than 1 USD per day. Ivory Coast then happens to be one of the poorest countries in the world with a poverty rate in rural areas estimated to 62.5% in 2008 against 49% 2002. In 2008, according to the IMF (2008), the GDP per capita was 1053 USD; the inflation rate was more than 3% and the economic growth rate 2.9%. Regarding birth indicators, the maternal mortality rate for one hundred thousand births was 543 in 2005 (PRSP, 2009). Between 1995 and 1998, these statistics were respectively 590, 580 and 600 per one hundred thousand births in Niger, Mali and Guinea (ADB, 2004). The results of "primary health care" policy implemented by the Ivorian authorities to improve access to care across the population remain however below expectations. This bad
result is the consequence of the socio-political crisis the country is going through. Sala-I-Martin and Subramanian (2003) drew an analogy between the abundance of natural resources and rents and the poor performance of institutions specialized in the supply of health care. For, it does not encourage institutions productivity and investment in important sectors like the Health sector. Moreover, according to these authors, these sectors are subject to political consciousness of leaders and to the price of exported raw materials. Easterly and Levine (2003), however, argue that the "poor" quality of the institutions led to the inadequate use of factors and therefore raised dissatisfaction among the users of the services produced.

It is worth recalling that the Ivorian health system is the result of the reforms carried out by public authorities in 1988. These reforms were inspired by the Bamako initiative. They rely on administrative division to extend the mapping of health units and raise to the best the population’s interest in using them. National health institutions are divided between the sixteen major administrative regions which are themselves divided into 50 Departments and 229 sub prefectures and 2 health districts.

In 2007, the Public health infrastructures consisted of 1,591 first contact health facilities with 27 CSUCOM and 20 FSUCOM, 77 first reference health institutions and 9 second reference health institutions with 4 teaching hospitals and 5 specialized national institutes. The Private sector has 813 hospitals, 175 health centers and medical offices, 113 dental practices, 75 clinics and 11 polyclinics. In addition, we have 653 dispensaries and 21 laboratories.

This organization which focuses on health districts (Walter et al. 2005) comprises three main levels:

- The first level includes districts or prefectural hospitals, health centres and health stations. Health centres are fully community-based structures, managed by communities for rural development (CRD) or by the municipalities. According to the statistics provided by the Ministry of health in 1998, 1591 health centre were operational. For rural areas that do not have the size of a commune, the authorities have created health posts. In total, 402 health posts were functioning in 2008, according to the same statistics. Health centres and posts offer a "minimum package of activities" (PMA) such as ambulatory care, prevention (vaccination, prenatal care, etc.) or childbirth. They are hierarchically
- Articulated to the 50 districts (including Abidjan and Yamoussoukro) or secondary care hospitals (MSP, 2001), specialized in providing comprehensive care.

- The second level consists of regional hospitals. These hospitals (9 in total excluding those in the district of Abidjan) provide first aids. These institutions are the first resort of districts in case of situations beyond their competence (secondary health care).

- The third level consists of national hospitals. Ivory Coast has four national hospitals located in Abidjan and Bouaké. These institutions serve as teaching hospitals specialized in various fields. They are the ultimate resort in providing health care. Beside these national hospitals, there are many clinics and surgeries people go to for primary health care.

This distribution of care units is like a pyramid with a broad base, consisting of health centres and health posts. According to the Ministry of public health (2008) it is meant to guarantee fair access to health care for the whole population. It allows access to primary health services to a large number of Ivorian. In fact, the rate of population having access to these benefits increased to 32% from 1985-1989 and 80% from 1992-1996 (ADB, 2004). Similarly, this health policy based on the development of primary health care has helped improving prevention among populations. The vaccination rate of populations against some epidemics has much improved, according to the African Development Bank. It is the case of tuberculosis, 71% in 2002 against 50% in 1990; measles, 61% in 2002 against 25% in 1990 and diphtheria, and 58% in 2002 against 20% in 1990. However, these performances are lower than those of countries in the sub region of West African such as Senegal and Gambia where access rates to health care were from 1992 to 1996 respectively of 90% and 93%, against 40% and 90% from 1985 to 1989 according to ADB. Also, these performances are stained by the hospital equipment rate which is very low in Ivory Coast (4 bed for 1 000 people) compared to its neighboring countries, while the users of health services contribute to about 30% of hospitals budget (Comolet, 2000).

National hospitals management involves now, in addition to public administration, community groups participating in health care financing. Therefore, we have two entities consisting on the one side of the public administration which champions public utility, and on the other side the
community which defends the community solidarity. The downtrend of government subsidies to hospitals and the financial autonomy granted to them to behave on the market like any business enterprise by supplying services in order to cover a part of their expenses. Goujon and Poisat (2005) argue in this case that the hospital is the synthesis of the following three entities: market, public service and community solidarity. The common ground for these three entities is closely linked to the level of economic development. It expands in a situation of economic slump – increasing as a result the poverty rate - and conversely, shrinks in the case of economic growth and poverty reduction. In the current social and economic context, characterized by a strong need of health care, budgetary constraints at the level of national health system and a decrease in populations income (the poverty rate rose from 32.8% in 2000 to 49.8% in 2008, according to the World Bank) and health institutions can be perceived as full-fledged development agents. From this last point, the national health strategy should be revised in order to take the health policy into account in the development of poverty reduction policies.

2. The State and the regulation of health services

The regulations of health services primarily involve providing access to health care for all the social classes and improve the effectiveness of care. The health policy implemented in Ivory Coast until 1987 was based on free health care in public health institutions. Theoretically, this policy shows the government endeavor to help users, but in practice it happens to be socially unjust. In fact, free health care does not guarantee medical care covering (drugs and examination) to populations. It is charged and performed by private institutions (Roodenbeke, 2003). The privatization of this coverage (insurance) coupled with the bad functioning of health services constitute a barrier for all the social classes and the underprivileged are the poor. The development of a system of redistribution base solely on taxation is sometimes hailed as the best way to grant people equal access to health care (Atkinson et Stiglitz, 1976). This policy is intended to restrict government intervention in the health sector and to improve its impact. As for the issues concerning the efficiency of health care, they are left to the market which would allow an optimal adjustment of supply and demand should it function properly (Atkinson and Stiglitz, 1976). This adjustment is so optimal that willingness to share health risks is manifested and important among users (prospects). However, it requires beforehand making people aware of the dangers of such a choice and a firm intention to share them before their occurrence.
The implementation of tax redistribution policy to grant people equal access to health care works perfectly in a well structured economy with formal economic activities. In other words, if this policy helped improve the health coverage in developed countries like in France where the rate of individuals without health coverage decreased from 24% to 0.7% between 1960 and 1991 according to Henri and Rochet (1999), on the contrary, in developing countries such as Ivory Coast characterized by an informal economy, the implementation of the tax redistribution policy is likely to fail. Many reasons can be put forward to back up this assertion.

- First, the economy of Ivory Coast is 60% dominated by informal activities according to the World Bank. As a result, it is difficult for the State to identify tax households and collect taxes. The implementation of the tax redistribution policy to increase equal access to health care will be impossible in this case given the small amount of tax revenues. According to the African Development Bank (ADB) between 2000 and 2008, the GDP per capita has fluctuated from 1750 to 1526.2 USD; while the Gross domestic saving (11.9% of GDP in 2006 against 17.5% between 2000 and 2005) is less than half the African average (26.3% of GDP in 2006 for all African countries against 21.3% between 2000 and 2005). Moreover, the health coverage rate is likely to decrease because of the scope of the sociopolitical crisis the country is going through.

- Secondly, the above mentioned facts show that if the implementation of reforms helped increase access to health care in Ivory Coast, however, people are not offered equal treatment. In fact, the household survey carried out on the geographic distribution of health facilities provides much information on this issue (appendix 1). In this table (appendix 1) we study the average distance between populations and health facilities ranked according to the services they offer. For convenience, we classified the distances under three intervals: [0-1 km], [1-5 km], [5-plus infinity km]. For each of these intervals we have urban and rural areas.

Asked about the last health facility they went to during the four last weeks, people living at less than 1km far from health facilities in urban areas mention the health centre first (27%), then prefectural hospital or municipal medical centre (20%). But, people living in rural areas go first to health posts (25%), then to health centres (15%). We can notice from this survey that despite
the proximity of health facilities, 52% of people living in rural areas prefer home care against 20% of people living in urban areas.

In the interval [1-5 km, the results are slightly different from the first one. Even if 27% of people living in urban areas claim to go first to the health centre, we noticed that the prefectural hospital or the communal medical centre and the regional hospital or the teaching hospital have been used respectively by 26% and 22% of the interviewees. Furthermore, 70% of consultations in rural areas occurred in health posts (30%) and in other health centers (40%). The decrease of home consultations (30% for urban areas and 16% for rural areas) in favor of the above mentioned health institutions can be explained by the seriousness of the disease, which exceed the scope of traditional remedies or go beyond the competence of the local health facilities. The health facilities used the most beyond 5km far from people dwelling places in town are the regional hospital or the teaching hospital (48%), the health centre (14%) and clinics (12%). Whereas in rural areas, people go first to health centres (37%), followed by the prefectural or the communal hospital (18%) and the health posts (16%).

Since 1998, the geographic expansion of health infrastructures in Ivory Coast is noticeable. This policy consisting in creating specific health services to meet local populations’ needs helped improve the welfare of many people formerly constrained to use alternative means of treatment. However, it is worth noticing that there is much to achieve in order to reach the average threshold of “acceptability” of inequality among population as far as health care is concerned. In fact, people living in urban areas with a relatively high socioeconomic standing are privileged by the proximity of districts, regional and national hospitals providing various and quality services. As for people in rural areas (62% of the total population in 2008), they only have health posts located in hamlets and health centres specialized in providing first aid. This disparity in the access to health care and more qualified health facilities between different geographical areas with different social classes has a negative impact on the health of the whole population. It happens to be unfair for people living in rural areas and generally to the poor and to some extent to users who go to health offices in urban areas. Moreover, the fact that those users cannot

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1 The health risk coverage in developed countries is about 100% whereas in Ivory Coast, less than 2% of the population are insured (World Bank, 2005)
change the situation to receive at least health care in proportion to their income can constitute further reason for them to choose alternative health mechanisms or go to traditional healers.

Asked about why they did not use modern health services during the four last months, 95% of people interviewed in rural areas point at the feature distance against 5% of people in urban areas. The problems of infrastructure and equipment are frowned upon by users of urban areas (58 %) as well as those in rural areas (42 %). Other important reasons have been put forward namely the quality of services (52% of villagers versus 42% of city-dwellers), the cost of access to care (43 % of villagers versus 57 % of city-dwellers). Finally, other more important reasons have been indicated such as “not sick” (58% of people in rural areas versus 42% of those in urban areas), “not necessary” (56 % of people in rural areas versus 44 % of those in urban areas), “other miscellaneous reasons” (41 % of people in rural areas versus 59 % of those in urban areas), etc. (see figure 1). These results, with some slight differences are the same as those got from previous studies. The World Bank (1993) and kaendi (1994) argue that the level of the health infrastructures and the way they function determine the use of modern health services. Lule and Ssembatya (1995) realized that in the district of Mangochi (Malawi), only 25% of women (out of 390 women who accepted to be the subject of the survey) gave birth in the health center of Nankumba, whereas 90% of them wanted it. This gap is justified not only by the deficiency of health facilities but also they are located at tens of kilometers far from their dwelling places.

The problem of financial resources was also claimed as one of the reasons hampering the access to health services. In fact, the implementation of the policy consisting in all individuals contributing in the hospital charges caused many people (particularly the poor) in sub-Saharan Africa to refrain from going to health centres. Many empirical studies came to confirm this fact namely those conducted by Wyss and Nandjinger (1995) and Ndhlovu (1994) for respectively the case of Thad and Kenya and Meuwisen (2002) for the case of Niger. These studies show that cost sharing was discriminatory especially for low-income people because the demand for health care is proportionate to the level of income. The demand is important when the income level is high.
However, this idea is strongly contradicted by other studies which maintain that users’ contribution to health care costs is not relevant to explain why only few people go to health centres. Audibert and Mathonnat (2000) show that in Mauritania this policy rather turned out to support the development of a widespread vaccination programs (the elasticity between the consultations per capita- health care costs ratios being 0.81%). As for Chawla and Ellis (2000) who studied the case of Niger, the negative impact of health care costs on the use of health services is not statistically applicable. Finally, Touré (2002) tell us, in his study on the demand in health care in Mali that when there is a quality health service, the care costs do not impact negatively on their use. In other words, people are ready to pay for the health care provided the service is of good quality. The empirical study conducted by Mariko (2003) on the “access to health care and quality” in Mali comes to confirm that conclusion. According to him, by doubling the charges of health care delivery, the attendance rate falls only to 0.8% for clinics and 1.8% for hospitals. From this observation he suggests that health authorities raise the charges in order to improve the quality and functioning of services which can influence people’s decision in using health care facilities.

In the case of Ivory Coast, the lack of good quality health care is revealed by the household survey carried out by EIBEP. It happens that in an “extremely poor” country like Ivory Coast where every second person lives under the threshold of poverty the quality of health services can
motivate people’s choice in using modern health facilities. Whether they live in rural or urban areas, about 50% of users are not satisfied with the quality of care provided in hospitals and health centres. This can explain that despite their acute disease some people (56% and 44% of people surveyed respectively in urban and rural areas) resort to other means of treatment instead of using modern health services. On this point, we share the measures recommended by Mariko for the case of Mali on the fact that a good reception, the availability of drugs for first aid in hospitals and the cuts in drug costs can promote the use of care units by populations. These measures may to some extent compensate for the gap in tax redistribution and given that they directly affect the offer, they can reinforce the effectiveness in the functioning of health institutions and the increase the quality of services provided. These measures are also supported by Comolet (2000) who campaign for a reform of the drug supply system in Guinea in order to “gain in profitability and continuity”. Finally, Audibert et al. (2004) also argue that the quality of services provided by health care units explains their level of use by populations. However, in addition to quality, these authors identify two important determinants: the financial and sociocultural factors. Other factors such as the economic development, cultural and social behaviors, the environment or even education determine the health status of populations (Evans et al., 1996).

Modern health care costs (previously mentioned) said to be too high by the surveyed population reveals that the financial factor remains above all a major determinant for access to health care. We disagree on this point with Mariko, who advocates instead a strategy based the pharmaceutical policy (availability of drugs in hospitals, affordable and accessible generic drug for everybody etc.). One of the major points we can sort out of this study is that health care costs are said to be expensive by about 45% of Ivorian people (those in rural areas as well as those in urban areas). This financial issue therefore discriminate patients according to their level of income (Buor, 2004; Audibert et al.) and compels us to search alternative mechanisms to overcome these problems and by the same token enable access to health care to the whole population.

3. **Insurance as a mean for accessibility to quality health care**

By regarding Health as an ideal objective and not a marketable “good” we can easily understand why the intensity of demand of care and the level of exposure of populations to diseases remain
proportional (Beresniak et al., 2001). In fact, Ivory Coast, like many developing countries is the
den of many diseases including endemic diseases (malaria, respiratory infections, diarrheal
diseases etc.) which require important financial resources in order to be eradicated. But apart
from external operating subsidies (51% of hospital budgets in 2003 against 20% in 1999) all the
other hospital resources are falling: pricing revenues (20% in 2003 against 25% in 1999),
government grant (29% in 2003 against 50% in 1999), and other resources (0% in 2003 against
5% in 1999) (MSP, 2004). This reduction of hospital financial resources leads necessarily to the
drop of health supply which in its turn results in the decrease of the demand of health care
according to Beresniak et al. One of the immediate consequences of this situation is populations
turning away from hospitals and therefore a gradual degradation of their health. A study
conducted by the Ministry of health in association with the German Cooperation Fund (GTZ) in
1991, revealed that in the prefecture of Sipilou and of Guitry, many farmer are obliged to sell at
least an animal, mortgage their producer goods or their crops in cases of emergency. According
to the same study, between 25 and 50% of households surveyed said that they resort at last some
days after to health facilities because of financial reasons.

In addition, the malfunction of national health facilities combined with the lack of effectiveness
in the communication system, namely the care pricing system do not promote the use of modern
health care facilities. According to the World Bank, a study in 2000 reveals important differences
between the official rate and the current rate applied by practitioner in Ivory Coast. The variance
is 6 times for medicine, 15.5 times for maternity and about 30 times for traumatology. It is also
regrettable to find out that there is not any control system to enforce compliance with the
established rules and the regular functioning of hospitals.

To solve these problems of access to health services and ensure a regular and effective funding
of health supply, the development of a coverage system against the risk of disease is one of the
best solutions. It involves a rational reorganization of the balance between supply and demand of
health care by the establishment of an insurance system allowing people to pre-pay care costs.

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2 We assume that resorting to traditional doctors or self-medication can be dangerous in the long run.
The health insurance system is a form of solidarity between citizens in the health field whereby the “healthy” bear the costs for the “sick persons”. It helps reduce the options of demand of any possible health care into one: the hospital. Because once the premium is set, variances in income among users of health services (the insured) have little effect on the demand for care directed to modern health structures. This is also the case of the variation of services fees for health care supply. This system consists in introducing a third-party sponsor in the health system to act as a go-between between the care suppliers (hospitals and related structures) on the one side, and the people who need that care on the other side (the population). This new relation thus created is comparable to a relationship between the insurer (representing people in need and defender of the insured interests: clients, partner, affiliated, etc.) and the care providers represented by the hospital and related structures (Henriet and Rochet, 1999). In this new configuration, it is the responsibility of the insurer (the representative) to convey the needs of the insured (principals) to care providers (agents) while making sure they are actually taken into account. It has the advantage of improving the production of health services as far as the supply is concerned (sustained contribution to supply funding, improvement of services income, etc.) and as for the demand, it helps increase the consumption of care in optimal conditions.

Populations, especially the poorest, without the necessary means (financial and acquaintances) unable to claim for quality health services to the supplier– for transaction and supervision costs reasons – it is then the principal (the insurer) who take the responsibility for this task in the agency relationship. It is his responsibility (the insurer) to set up a monitoring system of services provided to its members and a profit-sharing scheme in order to deter the opportunistic behavior of the agent. The agent (the hospital) under supervision is compelled to perform well to be trusted by the principal (motivation cost). In this new system, we can hope maintain or increase users’ confidence in health facilities and as a result give them incentive to take out health insurance.

Institutionalized social welfare systems are still restrictive in Ivory Coast. Beside some civil servants, private sector actors and dealers operating in the informal sector, only few households

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3 If the disease the insured is suffering from is covered by the insurance.

4 It means that hospitals are granted autonomy by public authorities, for a free competition between services providers. In the case of Ivory Coast, public hospitals are financially autonomous, but they can’t recruit their staff.
receive social coverage. The World Bank estimates at less than seven hundred thousand the total number of beneficiaries of health insurance system out of a population of about 20 million inhabitants. That is 3.73%. This proportion, to recall figures, is of 4.29% in Mali; 5.09% in Congo (DRC) and 0.12% in Burkina Faso. For the case of Guinea, this percentage represents the marginal number of people who can afford health services without being compelled to make choices between different social needs that can sometimes lead to their impoverishment. It also tells us about the extent of mutual assistance and solidarity practices for access to care, particularly in a society where there is a lack of symmetry between the information on care cost and difficult socioeconomic conditions.

The advent and development of the microinsurance, namely mutual insurance companies (from 1991) certainly helped improve access to health care to many poor families. The study carried out in Ivory Coast for the Inventory of African health insurance systems in 2003-2004 reports that there are 64 mutual insurances in Ivory Coast and has more than one hundred thousand members. These mutual insurances cover all the country and have different forms (credit unions or mutual insurance with large cover). Their objective is to promote the socioeconomic participation of economically fragile households. The microinsurance happens then to be an alternative institution of social welfare to the other established insurance institutions whose access is reserved to the well-off and to the current health policies which gives little chances to the poor. It gives its members better access to quality health care, a more rigorous management of care structures, promotes the welfare of its members and their social integration (Develtere et al., 2004).

However, all the social classes cannot afford all the financial requirements to be member of these organizations. The development of the health microinsurance aims at expanding the financial risks to individuals who do not have access to the “standard” health insurance system. But it should be noticed that if people have to pay a premium as a prerequisite to be covered, it means as a matter of fact that it is restrictive to the poor (they experience financial difficulties before being members). This fact as a consequence put at stake the spread of care to the whole population. Moreover, the guarantee of a compensation (or the payment of care costs) of microinsurance organizations remains essentially limited to small risks; hospitalization costs,
difficult deliveries or complicated surgeries are sometimes excluded. In other words, serious health risk coverage is very limited. Many reasons can explain this fact:

The contributions paid by members are not sufficient enough to allow mutual insurance companies to bear the costs for this category of care. This also explains the low financial endowment of these institutions and their fragility.

Secondly, there are not enough members to enable solidarity among the sick persons and the healthy persons to work properly. Roodenbele (2003) thinks that an average threshold of members is required for the development of the microinsurance institutions and to meet their goals efficiently with few expenses5.

The third point is concerned with the difficulties experienced by the mutual insurances to ensure their members quality health services. This last point influences members’ commitment and determines the organization’s future. In fact, mutual assurances must provide their members with quality health services in accordance to the stipulations of the contract. However, mutual insurance companies sometimes find it difficult to abide by the contract not only because they don’t have the necessary financial resources to control the quality of care provided to their members but also because of their size, they cannot lobby to alter the functioning of the National health system. To overcome these difficulties, some Ivorian mutual insurance companies (such as the general mutual insurance of civil servants and state agents of Ivory Coast– MUGEFCI) pay premiums and other forms of incentives to public health care institutions, to each sick members of the mutual who is treated. But if these structures functioned properly, these premiums could have been used to strengthen their finances and thus improve the level of health risks coverage of their members. As a consequence, they are obliged to bear the costs of the dysfunctions of the health system. The conclusion we can draw from this analysis is that it is the poor who bear the costs of the dysfunctions of the public health structures. This situation is not meant to encourage membership and the development of micro health institutions weakened by member deficiency.

5 The government decided in June to charge no fees for women who give birth by caesarean because many of them died for lack of financial resources. But there is still much to do to enable access to health care.
Finally, if the coverage rate clearly increased nationwide during the last decades (access rate 80% between 1992 and 1996 against 32% between 1987 and 1989 according to the ADB), we can notice however that this improvement was carried out at the expense of social equity and the quality of care. The services provided by health institutions don’t meet populations’ need. In fact, the development of small size health care businesses, in accordance to the decentralization policy initiated by the authorities, goes along with softening the Government control power over these businesses. It is obvious that the role played by the Ivorian Government in health development remains ambiguous because there is an endeavor to make the hospital a public utility but at the same time let the population assume its funding.

4. How to improve access to quality financial services in Ivory Coast?

The minimum package activity system initiated within the framework of “primary health care” policy consider in principle that all the populations from all the regions need that primary health care at a given time. This policy follows a new global health strategy initiated by the WHO and taken up during the conference held in Bamako in 1987. That is why we notice the rapid growth of health posts and health centres across the country, even in some areas where health needs outweigh the level of primary health care. In other words, the geographic distribution of health facilities does not take into account the specificity and diversity of populations’ immediate and future needs as far as health care is concerned. Many regions in Ivory Coast are known to be the den of endemic diseases- onchocercosis in the regions of Taabo, Sakassou and Béoumie; trypanosomiasis in the regions of Daloa, etc. In these regions there should be specialized hospitals instead of primary health care clinics to meet comprehensive health needs of local populations. This would probably help save more money and manpower as these health posts and centres are run essentially by nurses and doctors who refuse to settle in these areas. A revision of the hospital distribution strategy would bring satisfaction to people’s health care needs and thus lead them to make the right choice.

Furthermore, the quality of human resources of hospitals, their optimal utilization and their number play an important role in providing quality health care. In his work on Ivorian primary care system, Comolet (2000) condemns the existence of a “sector deficit” of health staff “to the advantage of hospitals and a geographical deficit for the benefit of large cities” namely Abidjan,
Yamoussoukro and Bouaké. This situation is linked to the bad distribution of health staff nationwide and their professional qualifications. This situation also restricts access to health centres (Atai-Okei, 1994). According to an inventory survey of the mutual insurance in Ivory Coast in 2000, the region of Abidjan with 15.27 of the total population has more than 50% of midwives, 48% of physicists; whereas the other regions with 60% of total population have respectively 9% of doctors, 13% of midwives and 7% of physicists. This imbalance in the distribution of health staff naturally raise the problem of equity of the health system questioned in the survey carried out by EIBEP (2002-2003). Considerable efforts need to be done to balance the distribution of health staff nationwide but also increase their number which is below the standards established by the WHO.

The improvement of access to health care can also be possible by the establishment of a comprehensible, uniform and appropriate pricing system. This system should be understandable to help populations understand the conditions of access to health care and put an end to the informal pricing that stain the image of public hospitals and the health system in general. It should be uniform to avoid financial barriers that can lead people to chose a given health facility at the expense of others (in a given area). It must be adapted for social justice reasons and to alleviate the exclusion of the underprivileged from health care scheme. A flat rate pricing set according to people’s socioeconomic status in order to pay in part the care costs could be suitable to contribute to the running costs of health structures. This contribution that could be nominal for the underprivileged aims at empowering users of health services and put them in a contributory framework where they can integrate and stand in the society. However, to be implemented effectively, this policy requires transparency in hospital management and a sustainable financial support of the State and development partners for the smooth running of hospitals. Since 2001, expenses related to the operation of hospitals keep growing without any readjustment of the rates and the financial backing of the State. These two situations led to the worsening of the financial situation of health institutions in Ivory Coast (Walter et al., 2005). In return of the contribution brought by populations, they should be provided with quality health services. This situation determines users’ confidence in health institutions on the one hand and populations’ confidence in insurance companies on the other hand. Also, it can lead people to give up hazardous health practices in favor of appropriate modern health care.
The status of mutual insurance companies must also be clarified. Since 1991, the Government is doing its best to promote mutual insurance companies and formalize relations between mutual insurance companies and health institutions. The 110 existing microinsurance institutions either deal with the formal sector (particularly the public sector) or with the informal sector (village mutual). Indeed, the Government encourages the establishment of mutual insurance companies but they are managed essentially by their founders (NGOs, development partners, GTZ, CIDR, UNICEF, WHO etc.). This situation of dependency restricts their initiatives and then limits their growth. A regional grouping (or first at the level of the prefecture) of these institutions would increase their finances; then, they will be able to deal with the social security cover of their members, face up new challenges and take an active part in the ongoing reform of the ailing health system (Comolet, 2000). It would also help develop their relationship with the established insurance companies. Finally, a clearly defined status of the mutual insurance companies and their supervisory authority would help develop their activities and make better the relationship they entertain with health institutions and other development agents. Local micro-insurance institutions are swinging between the Ministry of Social Affairs, women and children welfare (MASPFA) and the Ministry of Public Health. This lack of clarity of status entails some consequences on their operating conditions and the expansion of their activities.

**Conclusion**

If the improvement of the population’s health status in Ivory Coast allows the development of a national production potential able to satisfy needs for manpower for subsequent investments, according to Roodenbeke (2003), many studies run in developing countries revealed that the health status of populations in these regions is affected by external factors to health such as environment, education, social integration… It means that the improvement of health level in a developing country like Ivory Coast is also dependent of the performance achieved in these sectors. Baumann (2005) argues in this regard that the causes of the difficulties people in poor countries are experiencing could be found in the nature of policies implemented in these countries. It is therefore important to develop policies likely to act on the vulnerability of the poor, said the author. It involves the establishment of regulatory authorities entrusted with developing strategies to make public services accessible including fundamental social services.
such as health and education likely to alleviate progressively poverty and socio-economic vulnerability.

The supply of health services in Ivory Coast outweighs the demand according to the health economics statistics. The first reason is the malfunctioning of the national health system. In fact, in spite of the efforts made to improve the access to health care to all the population, the Ivorian health system is still impenetrable: poor communication, lack of transparency in health care pricing, nursing staff clientelism… this malfunction tends to transfer unfairly health facilities operating costs to populations (and now to mutual insurance companies which act as legal representatives of populations). A second reason worth noticing is the mismanagement of hospitals and the lack of clarity of their status. National health facilities are shared between public services and part government-owned services. Also the commitment of the authorities remains vague. The hospital self-financing policy promoted by public authorities is therefore in contrast with the State’s hold on the management of these hospitals.

Promoting a corporate culture in the functioning of health care facilities to combat clientelism, corruption and provide people with quality health care would surely raise social welfare level and expand health risk coverage to the underprivileged. It will tighten relationships between populations and microinsurance institutions as well and encourage health care needs. It will also help alleviate poverty by a significant improvement of life expectancy at birth which is 53 years old, according to the WHO. However, the success of this policy is subordinate to the revision of the current institutional approach which restricts agents’ choice between “modern” or “traditional” health services. It will consist in the establishment of health institutions nationwide and explain to users (actual or prospects) how they work so that their contribution to the costs would be used actually in a solidarity perspective for everybody’s satisfaction.

Ultimately, public health policies should strike a balance between the promotion of private health care services and the expansion of basic health services. Merchandising the supply of health services is in contradiction with the decrease of populations’ income level and the national economic crisis which is intensifying led to the exclusion of many people from health services particularly the low-income populations. The decentralization policy initiated by the Government indeed empowered district, prefectures and even rural development committees but it did not
provide them with financial resources. However, to avoid low costs of health services and income in the long run, labor productivity and social welfare, the State should abide by its principles and see to the good quality of health institutions (Rodrick, 2005).

**Bibliography**


