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MAPS CÔTE D'IVOIRE: PRIVATE SECTOR DESCRIPTION

Volume III: Private Sector Provision of Health Services

FINAL REPORT

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A. INTRODUCTION

Health care in developing countries tends to be a luxury good, in the sense that the elasticity of demand for health care with respect to income is usually greater than one. Thus, an increase in income produces a proportionally greater increase in the demand for health care, while a decrease in income leads to a proportionally greater fall in demand.^{1/} In its first twenty years of independence, Côte d'Ivoire experienced strong, export-led growth that resulted in rising per capita income and increased demand for health care. By the early 1980s, declining world market prices for key export crops, coupled with appreciation of the real effective exchange rate, stalled growth and eroded competitiveness, while profligate borrowing and inappropriate investment undermined the foundation for future growth. In the absence of exchange rate movement and other policy reforms to restore competitiveness, formal sector employment and real per capita income declined by more than a third in the past decade. In recent years, global recession has deepened this economic crisis, and the decline in incomes has led to a marked reduction in demand for private sector health services in Côte d'Ivoire. It has also shifted demand toward lower cost services, particularly toward public sector services that have been supplied at no monetary cost to the client.^{2/}

Currently the Ivorian market for health care is characterized by: a) high-priced, high quality private sector physicians' care for the privileged classes; b) low-priced private sector care provided by nurses, which is perceived by the public as being of low quality; and, c) low-priced care offered by the public sector and some non-governmental organizations. In most areas of the country, there is a wide gap in service provision between high-priced private facilities and public facilities which impose no monetary cost. The economic crisis has increased demand for public services at a time when budgetary constraints prohibit a significant expansion in the supply of these services. Prices are not used to ration care in these facilities; rather, it is the opportunity cost of time -- i.e., queuing and geographic proximity -- which ration care. Public facilities are swamped with customers, but are inadequately staffed and supplied to handle this demand. The quality of care in the public sector has suffered, and nearly 300 *dispensaires* and *maternités* in rural areas are inoperative due to lack of public resources. This financial squeeze has led to: a) a review of cost recovery policy in the public sector, to ease the budget constraint and discourage overuse of public facilities; and, b) reconsideration of the role of the private sector in health care provision.

^{1/} Gertler, P. and van der Gaag, J., in The Willingness to Pay for Medical Care: Evidence from Two Developing Countries review various estimates of income elasticity of demand for health care in developing countries.

^{2/} User fees have been in effect for public sector hospital services since the 1970s. Government intends to impose modest user fees (well below marginal cost) for primary and secondary care, beginning in 1993.

B. THE ROLE OF THE PRIVATE SECTOR

Governments intervene in the market for health care for a number of reasons. Health care tends to be viewed as a basic right of individuals, making equitable access to care socially and politically desirable. Health care, particularly preventive care, also has positive externalities that warrant public investment. Finally, poor health is unpredictable, making health care outlays uncertain for households. Economic efficiency can be enhanced by reducing this financial risk through some type of insurance -- with the least sophisticated form of insurance often being government provision of low- or no-cost health services to the public at large, financed out of general tax revenues. However, governments in most developing countries cannot -- and need not -- provide low-cost services to everyone, particularly when the tax base is narrow and tax collection weak. User fees are one way to ease the financial burden on the public sector, but demand can also be shifted to the private sector, if affordable services are available to those with some ability to pay. Often, middle-income households are willing to trade off higher monetary costs for shorter waiting times and better quality care in the private sector, as is the case among the well-to-do.

There is little recent data on the willingness to pay for medical care in Côte d'Ivoire. Gertler and van der Gaag have examined this question -- as it pertained to the imposition of user fees in the public sector -- on the basis of 1985 health expenditure data (Annex I).^{3/} Their findings are informative with respect to the potential for private sector health services, as well:

1. Overall, demand for health care was fairly inelastic with respect to price for the upper half of the income distribution. Therefore, imposing fees for services would have a relatively small negative impact on the quantity of services demanded by consumers at higher income levels. This indicates considerable potential for revenue generation through user fees (or, by extension, considerable potential to support private sector health services);
2. Price elasticity of demand was higher at lower income levels. Simulations indicated that user fees to cover half or full marginal costs would have a significant negative impact on utilization of services by the poorest segments of society;
3. Simulations to examine the economic impact of extending health care to isolated rural areas found that extension would be welfare enhancing for consumers only if service provision were highly subsidized. Clinics or health posts in rural areas would not be financially viable unless heavily subsidized.

Thus, the Ivorian government has an important role to play in ensuring highly subsidized care for the poorest segments of society, especially in rural areas. One should not expect, nor

^{3/} Gertler and van der Gaag, *op. cit.*

encourage, an unsubsidized private sector to establish health facilities in isolated rural areas. While community contributions and user fees in these areas are feasible and desirable, service provision will need to be subsidized by the state or other entities (e.g. NGOs, religious groups) for years to come. To achieve both equity objectives and efficient financing of health services, price discrimination based on income level is needed within the public sector, and -- as would be expected -- between the public sector and the private sector. The policy environment should encourage financially viable private sector health services in primary and secondary urban centers in order to shift demand into the private sector, unclog public facilities and free up public resources for the task of providing subsidized care for the very poor in urban and, especially, rural areas.

The objective of this report is to identify constraints to the provision of affordable private sector health care in urban areas. It begins with an overview of the policy environment for private sector services, then identifies major constraints and recommends policy reforms and pilot activities that USAID could support in order to promote affordable private sector health care delivery.

C. THE POLICY ENVIRONMENT FOR PRIVATE SECTOR HEALTH SERVICES

Aggregate data on private sector health services in Côte d'Ivoire are scant. What little data are available are based on licensing by the *Ministère de la Santé et de la Protection Sociale* (MSPS), or on membership in professional societies. All doctors, dentists and pharmacists in the public and private sectors are obligatory members of their respective *Ordres professionnels*, each with its own code of ethics. Neither nurses nor midwives have an *Ordre professionnel*, but each has a *Syndicat national* for private sector practitioners, as do doctors, dentists and pharmacists. MSPS and *Syndicat* estimates differ, but indicate approximately 160-170 doctors, 100 dentists (95 in Abidjan) and 320-340 pharmacists (170 in Abidjan) in the private sector.^{4/} Neither Government nor the *Syndicats* could estimate the number of nurses or midwives operating in the private sector. In contrast, the public sector employed (as of June, 1991) 739 doctors, 163 dentists, 92 pharmacists, approximately 4000 nurses and 1545 midwives.

Beyond its role in the initial licensing of private practitioners, government's regulation of private sector health services is modest, and its ability to enforce regulations is weak. Notwithstanding, both the government and the various professional societies demonstrate a proclivity for greater "organization" of the private sector, to prevent quackery and protect professional incomes. In 1991, the MSPS convened a working group, representing government and the various *Ordres professionnels* and *Syndicats*, to study the relationship between public and

^{4/} Figures provided by the *Ministère de la Santé et de la Protection Sociale, Direction des Etablissements Sanitaires et Sociaux*.

private sector health and social services.^{5/} Among the preliminary findings and recommendations made by the Working Group *vis à vis* the private sector were:

1. the need to establish a regulatory framework for all health professions, including norms for qualification, membership in the *Ordre professionnel* and nationality, as well as sanctions for failure to comply with norms;
2. the need to develop *Ordres professionnels* and codes of ethics for nurses, midwives and medical technicians;
3. the need to define the services authorized for each profession;
4. the need to elaborate and/or revise the requirements for establishing, operating, buying or selling medical facilities, including the enforcement of minimum standards for infrastructure, equipment, sanitary procedures, safety, staffing and academic qualifications;
5. the need to classify medical services and establish fee structures -- fees that would serve as "floor prices" below which price competition would be viewed as "*concurrence déloyale*", and be sanctioned by the profession. Reduced fees --also determined by the profession -- would be acceptable as "*tarifs sociaux*" for those with limited incomes, as well as for mutual protection/insurance groups.

To date, the government has taken no action on these preliminary recommendations. While there is a need for a regulatory framework and well-defined qualifications for licensing, standards for facilities and equipment should not be exaggerated with the intent of limiting access to the profession. Nor should the government indulge its fear of market competition by accepting the *Syndicats'* administered pricing policies. Such administered prices have been, in effect in some of the professions, making market prices "sticky downward". However, maintaining these prices in the face of continued economic malaise and declining purchasing power has been difficult, and more and more professionals are negotiating group rates and other "discount" prices. The situation differs for each profession, and will be examined in greater detail in the pages that follow.

The discussion below is based on interviews carried out over a two-week period in November, 1992 in Abidjan, Bouaké, Korhogo and a number of villages in surrounding areas. During that period, interviews and sample surveys were conducted at approximately half a dozen clinics and *cabinets médicaux*, a dozen pharmacies, 30 infirmaries and several traditional healers and medicinal plant dealers (Annex II). In addition, a sample survey on utilization of public and private health facilities was carried out among approximately 50 consumers in these urban areas

^{5/} *La Commission de Travail Chargée de l'Etude des Relations entre le Secteur Public et le Secteur Privé de la Santé et de la Protection Sociale.*

(Annex III). Given the small size and non-representative nature of the samples involved, the following observations cannot be considered definitive, and should be interpreted with caution.

1. Physicians' Services

Physicians' services in the private sector are mostly provided through large polyclinics and clinics, or smaller *cabinets médicaux*. All clinics and *cabinets* visited were operating below capacity, and typically had experienced a 20-35 percent reduction in activity during the past three years -- often despite diversification into a broader array of services. The economic crisis, declining purchasing power and a shrinking expatriate community were cited as reasons for the downturn in demand. The facilities visited were owned by private sector physicians, but tended to employ civil service physicians on a part-time basis, particularly for specializations. In 1984, the government authorized civil service physicians to spend two afternoons a week (eight hours) in private practice, as a means of supplementing their incomes, although MSPS officials continue to express misgivings about this policy. Reportedly, licenses to establish private clinics have also been granted to active military and civil service physicians, despite restrictions prohibiting this practice.

Licenses to establish private clinics or *cabinets* are granted to individuals who: (a) possess a diploma as a doctor of medicine; (b) are not military, civil servants or otherwise salaried; (c) are Ivorian or naturalized citizens of Côte d'Ivoire; and (d) meet facility and equipment standards during a site visit by the MSPS. A license is granted automatically, free of charge, if these conditions are met. The licensing process was not viewed as a constraint by the physicians interviewed (all of whom were Ivorian). A physician from a neighboring country -- a long-time resident of Côte d'Ivoire, currently employed in the public sector -- found the citizenship requirement to be an insurmountable obstacle to private practice. Government is also considering allowing the *Syndicat* to play a larger role in the licensing process for physicians, possibly including the establishment of placement rules for clinics to avoid geographic competition -- a practice currently employed by the *Syndicat des Pharmaciens privés* to limit competition in the pharmaceutical market. Such policies favor the profession at the expense of Ivorian consumers, and should be discouraged.

Private clinics and *cabinets* are subject to the same taxes as other formal sector service industries, including profit tax (BIC/BNC), value-added tax on services (TVS), municipal tax (patente), property tax, payroll tax (ITS) and the employers' social security contribution (CE). This burden on the formal sector is high, but is unlikely to be reduced as the formal sector tax base narrows. In addition, medical equipment and supplies are subject to standard import duties, although drugs are exempt from all import taxes.

The fee structure for physicians' services is established by the *Syndicat* and approved by Government. Fees were last amended in 1984, when a consultation with a generalist was set at CFAF 10,000 (US\$ 38.46), for a specialist, at CFAF 12,000 (US\$ 46.15) and for a medical professor, at CFAF 15,000 (US\$ 57.69). With a median monthly household income of around CFAF 45,000 (US\$ 173.08), it is clear that health care at this price is only available to the

highest income groups in Côte d'Ivoire.^{6/} Nonetheless, declining incomes in recent years have barred upward adjustment of fees, reducing the demand for medical care at these prices, and placing downward pressure on market prices. Indeed, the *de facto* situation is more flexible than the administered prices suggest, with some physicians negotiating discount rates for employer-provided insurance groups and/or adopting a sliding scale for individual clients. Neither the Government nor the *Syndicat* oppose the principle of reduced rates for bulk provision of services. However, they believe such rates should be established in a uniform and orderly fashion rather than through market forces -- to avoid "*concurrence déloyale*" among physicians. A commonly expressed belief is that by enforcing administered prices, one separates qualified physicians from "quacks" who routinely undercut these prices. However, Government should not confuse administered pricing with quality control, which is best assured through licensing and periodic inspection. Administered prices merely give quacks greater scope to charge higher fees.

In the large polyclinics, it is not uncommon for physicians to take home 60 percent of their consultation fees, with the remaining 40 percent covering clinic costs. In smaller *cabinets médicaux*, take home pay is generally a smaller share of consultation fees. All the physicians interviewed had been in private practice for many years, but agreed that starting up a clinic or *cabinet* today would be more difficult as a result of the economic climate. Banks are not lending to physicians due both to illiquidity in the banking system, and to uncertainties about the demand for private health care. Thus, the limited purchasing power of the general public and the lack of start-up capital are the two major constraints facing young physicians in the private sector. Government is preoccupied with this problem: due to budgetary constraints and changes in staffing norms in public facilities, the government no longer inducts all graduating physicians into the civil service. In 1991, only 50 percent of graduating physicians joined the public sector. At that time, nearly 2000 medical students were in training to become doctors, although the projected civil service intake in the 1991-2000 period was expected to be less than 800 physicians.^{7/} Government is now considering how it might offer incentives to young physicians to set up private practice, particularly in secondary cities and rural areas.

2. Infirmaries and Midwife Services

The survey team visited 28 private infirmaries in various *quartiers* of Abidjan, Bouaké and Korhogo. Health facilities were identified by posted signs, and through discussions with residents. This method may have created a bias against those health care providers operating clandestinely, i.e. without a Government-issued license. Ultimately, it also failed to identify private sector midwives, most of whom are assumed to be retired or active civil servants

^{6/} *Programme de Valorisation des Ressources Humaines: Planification-Programmation-Budgetisation dans le Secteur de la Santé, Ministère de la Santé et de la Protection Sociale, June 1991, p. 52*

^{7/} *Programme de Valorisation des Ressources Humaines: Planification-Programmation-Budgetisation dans le Secteur de la Santé, Ministère de la Santé et de la Protection Sociale, June 1991, pp. 34-35.*

operating out of their homes. An alternative strategy for contacting midwives will be necessary during future missions.

Most health care consumers expressed a lack of confidence in *infirmiers privés* for diagnosis and treatment beyond minor injuries and recurring illnesses such as malaria and diarrheal disease. A common pattern of use described by consumers is to go to public sector facilities for an initial diagnosis and drug prescription (a time-consuming process due to queuing), then to a private pharmacy to fill the prescription and, finally, to an infirmary for injection of the prescribed drugs. Injections are among the most frequently performed services at private infirmaries. Infirmary staff surveyed agreed unanimously that malaria was the most commonly treated illness, followed by both diarrheal diseases and sexually-transmitted diseases (STD) other than AIDS. Treatment of injuries was the next most frequent service provided, followed -- at a much lower frequency -- by treatment of respiratory infections and measles. Little preventive care was provided by infirmaries. None offered vaccinations, and only a few offered prenatal visits. None offered family planning services beyond advising on the use of condoms; most advised condom use to prevent STDs, but only a few sold condoms directly. All staff were aware of the threat of HIV/AIDS (as were most health care consumers), but none had knowingly treated patients who were HIV positive or had AIDS. The apparently high incidence of other STDs suggests a high potential for HIV transmission through sexual contact within the client population, while the heavy reliance on injectable drugs also increases the risk of HIV transmission through use of unsterilized syringes.

Licenses for private infirmaries or midwife services -- like licenses for physicians -- are granted at no cost to individuals who: (a) possess a diploma as an *Infirmier Diplômé de l'Etat*, *Infirmier Breveté* or *Sage Femme*; (b) are not military, civil servants or otherwise salaried; (c) are Ivorian or naturalized citizens of Côte d'Ivoire; and (d) meet facility and equipment standards during a site visit by the MSPS. The majority of infirmaries surveyed were owned by retired civil service nurses, although a number were owned (in violation of the licensing criteria) by civil service physicians or nurses still actively employed in the public sector. According to staff surveyed, the median time required to obtain a license was more than six months -- considerably longer than that reported by physicians for clinics and *cabinets médicaux*. MSPS officials claim that the delay results only from incomplete dossiers filed by the applicants. All infirmaries visited claimed to be licensed, although this could not always be verified, and it should be recognized that duplication and forgery of licenses are not uncommon.

For much of the time, the staff on duty in many infirmaries consists of nurses or nursing assistants who have neither diplomas nor formal training. In some cases, the licensed doctor or nurse who owns the infirmary makes only one or two visits each week. Indeed, for two infirmaries visited in Bouaké, the owners reside in Abidjan, requiring a three-hour trip to supervise operations. One-quarter of the infirmaries surveyed had no full-time nurse on staff, only nursing assistants with limited academic and on-the-job training. For those with full-time nurses on staff, only one-half of the nurses had diplomas. Thus, the skill level of the full-time staff at infirmaries varies considerably, and undoubtedly serves to undermine public confidence in infirmary care. Nearly half the infirmaries visited also claimed to have a public sector

physician on staff one or two afternoons a week, offering consultations at prices well below private clinic fees. However, no physicians were present during the interviews.

Start-up capital for 17 of the 28 infirmaries came out of the owners' personal savings. Six relied on loans from family and friends, while only one reported borrowing from an informal sector moneylender. Three attempted to secure bank loans, but only one succeeded. In three infirmaries, staff surveyed were unsure how the owner had financed start-up costs. Likewise, staff in some facilities could not comment on taxation. In five infirmaries, however, taxes had never been paid, despite apparent licensing of these facilities. Eighteen infirmaries reported tax payments; most of these paid the *patente*, or annual municipal tax, of CFAF 60,000. A few facilities mentioned other taxes, notably income and property taxes, but none mentioned other business taxes which normally apply to formal sector health services.

The *Syndicat des Infirmiers Privés Autorisés* establishes fixed fees for a list of particular services, rather than for general consultations with private nurses. For example, the fee for an injection is CFAF 400 (US\$ 1.54), and for bandaging a new wound, it is CFAF 1,000 (US\$ 3.84). Fees were last reviewed and approved by Government in 1989. However, enforcement of these administered prices is negligible, and while many infirmaries apply them in principle, the continuing economic crisis has made flexible pricing the rule. Comparing fee structures among infirmaries is difficult: consultation fees are not routinely separated from drug charges or other services. For those with an established consultation fee, the average amount paid per visit in the past year was consistently reported as being below the established fee, pointing to liberal use of a sliding scale for those in financial difficulty. For the 28 infirmaries surveyed, the average estimated amount paid was CFAF 1,150 (US\$ 4.42) per visit. This figure includes some minor drug charges, particularly for relatively low-cost antimalarial drugs. Fees for particular services could run up to CFAF 6,000-7,000, particularly for consultations with part-time physicians. This is still considerably less than the CFAF 10,000-15,000 routinely charged at private clinics.

Most clients pay cash for infirmary services, although many infirmaries extend short-term credit (several weeks to several months) on an informal basis to familiar clients. Ten of the 28 infirmaries reported having some clients who are reimbursed for medical expenses by employment-related or private insurance. However, clients are scarce. Despite facilities which remain open, in many cases, 24 hours a day, the average number of clients seen per day is only six or seven, some of which seek only an injection of drugs prescribed and purchased elsewhere. The vast majority of facilities reported that the number of clients had declined relative to last year, a drop which was overwhelmingly attributed to the deepening economic crisis and rising unemployment (several also mentioned the proximity of "free" public facilities as a factor in reducing demand for private sector services). Thus, a lack of consumer purchasing power was viewed as the primary constraint to private sector infirmary services.

Responding to the recessionary climate, infirmaries have been obliged to negotiate reduced fees for their services, although the cost of purchasing drugs has not declined. Many *infirmiers* believe that an adequate drug supply is essential to attract clients, and feel squeezed

by rising drug prices and falling revenues. Indeed, when asked whether gross revenues had been sufficient to cover operating costs in the past three months, three-quarters of those interviewed said no. Detailed analysis of financial records was not possible to confirm this figure. Based on the survey of health service utilization by consumers, one can conclude that a lack of consumer confidence in the quality of services obtained in private infirmaries may also be undermining demand.

3. The Pharmaceutical Industry

Most drugs are imported into Côte d'Ivoire, with the exception of several basic drugs (notably aspirin and nivaquine) which are produced domestically by the mixed-capital enterprise CIPHARM. The domestic market for these drugs is protected through import restrictions. Imports of other drugs totaled CFAF 34.8 billion in 1991, 88 percent of which came from France. However, these drugs were supplied by hundreds of different firms, many of which are the French subsidiaries of multinational companies from around the world. Importers tend to import from France because: (a) brand-name drugs are less expensive in France due to Government regulation of profits; (b) transport links are well-established; and (c) exchange rate risk and other foreign currency difficulties are minimized. A major disadvantage of this French supply link for Ivorian consumers is that generic drugs are not marketed in France, and, hence, are rarely found in Côte d'Ivoire.

Although its market share has fallen from around 40 percent five years ago to just 20 percent today, the public sector remains an important importer of drugs. The *Pharmacie de la Santé Publique* (PSP) imports on the basis of international competitive bidding. It then distributes drugs to the *Bases de Secteur de Santé Rural* (BSSR), which sell to public sector pharmacies and health facilities with an eight percent mark-up. These pharmacies and facilities then sell to the public with a ten percent mark-up over the BSSR price. Public sector cost recovery on drugs and medical supplies is relatively new, having been adopted in the past few years after the collapse of the subsidized distribution system. The Government is now committed to increasing the share of generic drugs in the public system in coming years.

High profits in the private sector, and budget constraints in the public sector have shifted eighty percent of the drug market into the private sector in recent years. Importing is carried out largely by two licensed wholesalers, GOMPCI and LABOREX, although several large pharmacies in Abidjan have also been authorized to do their own importing. Both GOMPCI and LABOREX are private enterprises. GOMPCI was entirely Ivorian-owned until 1991, when a French drug company took a 49 percent interest in the company. LABOREX is majority French-owned. Authorization to import and distribute drugs is issued to wholesalers who: (a) have licensed pharmacists to oversee operations; (b) have at least 51 percent of their shares owned by pharmacists; and (c) will market more than one brand of drugs. Thus, the many multinational drug companies (e.g. Pfizer, Ciba-Geigy) with marketing representatives in Abidjan are not authorized to distribute their own products in the domestic market. They market their products to GOMPCI and LABOREX, which then import the drugs directly from the multinationals in France or elsewhere.

Marketing representatives of several drug companies contacted by the mission insisted that the option of distributing their own products was entirely unappealing, given the high cost structure of a distribution network in the Franc Zone. Personnel and energy costs were deemed too costly in the Franc Zone to make individual distribution networks -- or more than about three or four grouped networks -- worthwhile. Thus, liberalizing the import and distribution of drugs is unlikely to induce considerable entry into the market given the size of the market and the current macroeconomic framework. However, competition for market share in the private sector will increase as of 1993, with entry in the market of a third authorized wholesaler, PHARMACOM. This competition will be of little benefit to the Ivorian consumer, given the fixed pricing policies currently in place in the pharmaceutical market.

As with other medical professionals, the criteria for obtaining a retail pharmacy license include: (a) having a diploma as a pharmacist; (b) being Ivorian or a naturalized citizen; and (c) not being salaried elsewhere, including the military and civil service. As in the other medical professions, those not holding an Ivorian passport cannot own a pharmacy. Unlike other medical professions, pharmacy licenses are granted by a *Commission d'Enregistrement* consisting of Government, the *Syndicat des Pharmaciens Privés* and other representatives of the profession. The *Commission* strictly controls the location of new pharmacies, with applicants indicating their top three choices for location in their dossiers. In the past, when all pharmacists trained in Côte d'Ivoire were obliged to enter the civil service for at least two years, preference in awarding locations for private pharmacies was given based on seniority in the civil service. Now that civil service is no longer obligatory, and 10-20 pharmacists per year are not being inducted into the civil service, this policy is under review.

The *Commission*, with Government approval, is also responsible for pricing policy with respect to drugs. All drugs brought into the country are exempt from import taxes (*droits de douane, droit fiscal, TVA and taxe statistique*), although medical supplies such as bandages and syringes are fully taxed. The *Commission* has established fixed percentage (i.e. ad valorem) mark-ups for wholesalers and retailers, at 18 percent and 37 percent, respectively. However, the actual mark-up between the *prix de cession* (the price at which wholesalers sell drugs to retail pharmacists) and the *prix de vente* (retail price) is 59 percent--not the authorized 37 percent--according to billing statements sent to pharmacists. Neither pharmacists, pharmaceutical importers nor the Ministry of Health could explain this discrepancy between stated policy and actual practice. An authorized price list is available for all drugs, and uniform pricing is enforced throughout the country. Consumers lose the benefits of price competition, although very remote areas may benefit from pan-territorial pricing through cross-subsidization of their transport costs. However, application of a single, fixed percentage mark-up for all drugs creates a powerful incentive for wholesalers and retailers to market more expensive products. Why should a pharmacist take a 37 percent mark-up on a generic or other low-cost drug for CFAF 800 when he can take a 37 percent mark-up on a specialty drug for CFAF 3,000? One marketing representative for a multinational drug company claims his firm abandoned plans to market oral rehydration salts (ORS) -- an inexpensive and effective treatment for diarrheal disease -- through pharmacies, because the incentive structure created by pricing policy favors the sale of high-priced anti-diarrheal drugs. Policy reform is needed to

reduce drug prices through (a) enhanced price competition in the market; and (b) incentives to offer low-cost alternatives, including generic drugs.

Expenditures on drugs are typically the most expensive aspect of health care for households in Côte d'Ivoire. Household expenditure data from 1985 indicate that the average household spent CFAF 31,183 on health services, 81 percent of which was for pharmaceutical products, mostly drugs. Spending on pharmaceutical products declines as a share of health expenditures as income rises, although the absolute value increases steadily. Not only are drugs expensive, but they appear to be overprescribed, as well. Interviews with pharmacists revealed that the average prescription is for three or four different drugs, often to treat the same condition. Customers spend on average anywhere from CFAF 2,000 to 4,000 (US\$ 7.69-15.38) per pharmacy visit.

Every pharmacy visited in Abidjan, Bouaké and Korhogo had a steady stream of customers, and a staff of 6-12 employees on duty at any given time. Business is down, however. The number of customers per day in most pharmacies was estimated at around 100 to 150, but had been as high as 250 per day several years ago.^{8/} As a result of fewer customers and more selective purchasing, turnover has dropped in the past few years from as much as CFAF 900,000 (US\$ 3,462) per day to as little as CFAF 150,000-200,000 (US\$ 577-769) per day. Again, the decline is attributed to rising unemployment and reduced purchasing power. Some demand for treatment has shifted to lower cost alternatives: medicinal plants and other traditional remedies, as well as smuggled pharmaceutical products from neighboring countries which are sold in the markets, often one tablet at a time. As with all informal sector products, smuggled drugs offer no opportunity for quality control by either government or the pharmaceutical industry.

Despite the decline in activity, pharmaceuticals remain a profitable business. Until recently, banks were eager to provide start-up capital for pharmacies, attracted by the relatively inelastic demand for drugs and the assured profit margins. According to one financial advisor, it was not uncommon for a pharmacy to benefit from CFAF 30-40 million in bank financing. However, many pharmacists were guilty -- as one observer remarked -- "of confusing their gross revenues with their profits", investing in elaborate buildings for their professional and personal use, and failing to reimburse both suppliers and the banking community. For several dozen pharmacies, financial management deteriorated to the point where the wholesale supplier, GOMPCI, was obliged to temporarily assume control, until arrears to the supplier were repayed. Nearly a dozen of these pharmacies remain under GOMPCI management, and the banking community has grown leery of extending credit to new pharmacies.

^{8/} The number of pharmacies increased only marginally in the 1989-92 period.

4. Traditional Medicine

Some health care consumers expressed confidence in practitioners of natural medicine (*tradipraticiens*), traditional healers (*guerisseurs*) and herbalists, and were willing to pay for these services at prices which sometimes equaled or exceeded the cost of "modern" medicine. Traditional medicine in Côte d'Ivoire encompasses a broad array of providers, services and prices. The following individuals were interviewed during the mission, and serve to highlight this diversity:

- a. a traditional healer at the market in Korhogo: The traditional remedies displayed at this stall were plant- and mineral-based. Most were priced at CFAF 100 to 200 (US\$ 0.38-0.77) for a large spoonful. Malaria, diarrheal disease and general aches and pains were the most frequently treated conditions. Also for sale were a variety of *gris-gris* (CFAF 100 and up) to protect children from illness, and hasten teething, walking and other developmental skills. The healer estimated that he had an average of 25-30 customers per day in recent weeks, down from last year due to the deepening economic crisis.
- b. an herbalist in a medicinal plant store in Bouaké: The store was commercially licensed, and was well appointed with glass display cabinets and metal racks for packaged remedies. The plant preparations and packages were imported from France, although packaging was done in Côte d'Ivoire. Most of the remedies sold for CFAF 1,500 (US\$ 5.77) per package. Treatments were available for virtually all common diseases, with malaria, hemorrhoids and ulcers being the most frequently treated conditions. The herbalist contracts with a local physician for diagnoses, at a cost of CFAF 5,000 (US\$ 19.23) per consultation. Currently, the store receives an average of five customers per day, a figure which has declined relative to last year, despite a publicity campaign.
- c. a practitioner of natural medicine in his office in Abidjan: The Government does not require *tradipraticiens* to obtain a medical license. However, like many of the *infirmiers privés*, this practitioner pays yearly municipal taxes. His office is staffed with a nurse and a nursing assistant, neither of which has a diploma. Two licensed physicians are also on contract on a part-time basis for diagnoses. The most frequently treated conditions are malaria, STDs, hemorrhoids and sterility. The initial consultation fee is CFAF 2,500 (US\$ 9.62) -- with a reduced rate of CFAF 1,000 for those in difficulty -- but the total cost depends on the services and treatments provided. Costs range from CFAF 1,000 to 8,000 (US\$ 3.85-30.80) for consultation with the nurse, and from CFAF 12,000 to 25,000 (US\$ 46.15-96.15) for consultation with the *tradipraticien*. The average number of clients per day is five, down significantly from last year.

It is clear from these examples that there are providers of traditional medicine at all levels of the health care market. The village healers and herbalists with stalls in the local markets offer the most affordable treatment -- often as little as CFAF 100 -- and generate the most business in a depressed economy. Some *tradipraticiens* offer services at prices which rival the largest polyclinics in Abidjan, although they, too, are facing reduced demand at these prices. Nonetheless, many consumers -- daunted by the high cost of private physicians and specialty drugs, impatient with the overcrowding of public facilities and lacking confidence in the diagnostic skills of *infirmiers privés* -- turn to low- or mid-priced traditional medicine for most of their primary health care. Often they turn to a practitioner with roots in the same village; this is true even of Malians and Burkinabè who have been living in the Côte d'Ivoire for many years.

D. RECOMMENDATIONS TO PROMOTE PRIVATE SECTOR HEALTH SERVICES

Based on the overview provided above, this section focuses on the key constraints to private sector health services, and outlines recommended measures to alleviate them. (The reader is encouraged to review MAPS Volume V: Private Sector Strategy Recommendations, where these options are delineated in greater detail.) The discussion is limited to preventive and curative medical care, although the important preventive role of sanitary services such as clean water supply and garbage collection is fully recognized. The constraints to private sector provision of these sanitary services is addressed in Volume II of this report. The recommendations outlined below pertain to medical care, and serve four major objectives: a) enhancing the purchasing power of health care consumers; b) promoting private sector physicians' services; c) increasing utilization of private infirmaries; and d) reducing the cost of drugs.

1. Enhancing the Purchasing Power of Health Care Consumers

A lack of consumer purchasing power was unanimously identified by health personnel as the primary constraint to private sector health care provision. In fact, it was usually the only constraint mentioned spontaneously by providers, with issues of licensing, taxation and government regulation being of only marginal concern. A reduction in clientele at all levels of private sector care bears witness to their concern. Thus, to promote private sector health services, one must enhance the purchasing power of health care consumers, both by mobilizing additional resources for care, and by reducing the cost of care. One means of doing this is through the development of health insurance mechanisms linked to managed care. This would be one way to make private sector care more affordable for a larger segment of the population, freeing up public sector resources for subsidized care of the poor.

1.1 Health Insurance and Managed Care Concepts

Health insurance has been described as a "health care risk-spreading mechanism".^{9/} The sharing of risk is fundamental: people pay a premium to avoid financial risk -- the financial cost of illness or injury which may not happen. Illness and injury are events which are unpredictable for individuals, but are relatively predictable for large numbers of individuals. Thus, insurance schemes rely on a large risk pool to ensure financial viability. Premiums are based on the probability of an event occurring multiplied by the average cost of treatment for that event. It is financially easier to insure against rare events with severe financial consequences for individuals (i.e., catastrophic loss). People are sufficiently risk averse to protect themselves against this loss (creating a large risk pool), and the insurer can keep premiums low and still make a profit. For these reasons, it is usually advised that developing countries with low income levels and limited managerial capacity begin with insurance against catastrophic loss, usually in the form of coverage for hospitalization only. However, existing schemes in developing countries have experimented with a wide range of service coverage, including ambulatory care and pharmaceutical products.

A distinction must be made between insurance plans, which enhance purchasing power through risk-sharing, and prepayment plans, which have no risk-sharing aspect. Under a prepayment plan, enrollees pay in advance for an agreed quantity of services. They have the right to obtain services worth as much as they paid in. Under an insurance scheme, the sick have the right to obtain services worth more than what they paid in. Insurance schemes are, therefore, redistributive from the well to the sick. They enhance purchasing power specifically for those who need it. Both insurance schemes and prepayment plans also reduce the cost of services, by negotiating reduced rates for the bulk provision of services to members.

Insurance plans can be indirect, i.e. the insurer is not the service provider (third party payor systems), or direct, i.e. the insurer is the service provider (health maintenance organizations). Depending on the design of the plan, insurance schemes can fall prey to several problems that reduce their efficiency and threaten their financial viability. First, adverse selection occurs when those individuals who are at greater risk of illness join the insurance scheme in larger proportions than they are found in the general population. Thus, the risk pool is "sicker" than expected, and total costs are higher than expected based on the probability of illness in the general population. Insurance schemes can minimize adverse selection through: a) compulsory membership (i.e. government-mandated participation); b) family enrollment (entire families must participate); and/or, c) group enrollment (entire group must participate) based on employment or other group membership (such as agricultural cooperatives or informal credit associations in developing countries).

^{9/} Vogel, Ronald, "Health Insurance in Sub-Saharan Africa: a Survey and Analysis", PRE Working Paper #476, World Bank, August, 1990.

Second, moral hazard is the term used when insurance plans create incentives for overconsumption of health services (the marginal cost of the services for the insurer exceeds the marginal value to the insured individual). Solutions to the problem include: a) establishment of deductibles; b) use of a copayment system (the insured individual pays a percentage of the service cost); and c) use of a referral system (primary physician must refer individuals for specialized services and hospitalization).

A third problem faced by many insurance plans is that provider payment systems sometimes create incentives for overprovision of services, leading to escalating costs. Full cost reimbursement, fee-for-service and flat fee daily hospitalization rates provide incentives for excessive services and lengthy hospital stays. Fees based on diagnostic categories, or use of diminishing daily rates, are two proposed solutions. However, the preferred solution for insurers, particularly for ambulatory care, is payment on a capitation basis. Under a capitation system, providers are paid a negotiated monthly sum for each registered individual, whether or not he/she uses the services available. Thus, it is in the interest of providers to reduce costs through rational use of services. The simplicity of the system reduces administrative costs and paperwork. Insurers prefer this solution because the cost to the insurer is highly predictable, with financial risk being transferred to the provider. Health maintenance organizations (HMOs), where the insurer is also the service provider, operate on a capitation basis.

HMOs are, by definition, based on: (a) prepayment for services; (b) a capitation fee system; and, (c) assumption of financial risk by the service provider. Beyond these elements, the organizational structure can vary, including staff models (with health personnel on salary), prepaid group practice (PGPs) and independent provider associations (IPAs). The terms of coverage and payment can also vary considerably. In the United States, which has the most extensive experience with HMOs, it has been found that staff models and PGPs have reduced health care costs by 10-40 percent relative to conventional private insurance, while IPAs have generated smaller cost savings.^{10/} Cost savings resulted mostly from a reduction in the quantity of services used, not from lower unit costs for services. This can be attributed to incentives for providers to rationalize use of services, and to reliance on a system of primary physician referral for specialized services and hospitalization. The U.S. experience with HMOs has led a number of middle-income developing countries to experiment with development of HMOs as one form of health insurance.

1.2 Developing Country Experience with Health Insurance and HMOs

Broadly speaking, one can include direct government or employer provision of health services as a form of health insurance, or risk-sharing mechanism. In this case, the financial risk is assumed by government and employers, with funds supplied by taxpayers, employers and employees. However, it is more practical to discuss insurance in a narrower sense, as a formal pool of funds, held by a third party or a service provider, used to pay the health care costs of

^{10/} Tollman, S., Schopper, D. and Torres, A., "Health Maintenance Organizations in Developing Countries: What Can We Expect?", Health Policy and Planning, 5(2):149-160, 1990.

members of the pool. This can include public sector schemes, such as social security funds or civil service funds, as well as employer-provided insurance, private for-profit insurance and non-profit mutual associations.

Generally, between 5 and 15 percent of the total population in developing countries participates in some form of risk-sharing for health care.^{11/} All but one to three percent of this is usually public sector or employment-provided insurance. In a review of health insurance in 23 countries in Sub-Saharan Africa, Vogel found that coverage ranged from less than one percent of the population in 16 countries to a high of 11.4 percent in Kenya.^{12/} Private insurance peaked at 4.6 percent coverage in Zimbabwe. In Kenya, much of the coverage consists of compulsory enrollment in the National Hospital Insurance Fund (NHIF), a public sector insurance scheme which covers hospitalization costs for more than two million formal sector employees. In addition, there are 60,000 voluntary enrollees in private group health policies, particularly to cover ambulatory care. Private sector insurance predominates in Zimbabwe, and is organized under the National Association of Medical Aid Societies (NAMAS), an umbrella organization similar to the U.S. Blue Cross/Blue Shield system. NAMAS had 384,000 enrollees as of 1987, for coverage of ambulatory care and hospitalization in both government-subsidized hospitals and unsubsidized private hospitals and clinics. Premiums are progressive to income.

Vogel finds that most insurance schemes in Sub-Saharan Africa benefit government employees, and to a lesser extent, formal sector wage-earners. Many schemes are highly inefficient, having fallen victim to the cost-escalating problems described above. Private, for-profit insurance is extremely expensive, making it available only to the wealthiest members of society. One scheme which appears to have avoided many of these pitfalls is the Bwamanda Rural Health Zone (BRHZ) in Zaire.^{13/} The BRHZ consists of a hierarchy of health centers and a referral hospital, founded with the help of Belgian missionaries, and funded through user fees (the largest source of revenue) and subsidies from church groups, donors and the government (35-50 percent of revenues). The insurance plan was established in 1985 by the provider, making BRHZ a sort of non-profit HMO (although they see non-insured patients, too). The insurance plan covers hospitalization (including deliveries), as well as ambulatory surgery and -- since 1988 -- chronic illness care at primary health centers. Other ambulatory care and pharmaceutical products are not covered. By not including most ambulatory care, they have kept premiums low (subsidies also allow the hospital to reduce its fees, thereby lowering insurance payments). In 1989, the annual premium was Z 125 (US\$ 0.35) per person. Costs are controlled through flat rate service payments, a strict referral system from primary health centers, 20 percent copayments and a family enrollment policy. By 1989, the BRHZ insurance

^{11/} *ibid.*

^{12/} Vogel, R., *op. cit.*

^{13/} Shepard, D., Vian, T., and Kleinau, E., "Health Insurance in Zaire", PRE Working Paper #489, World Bank, August 1990.

plan had more than 80,000 members, representing more than 60 percent of the total population in the health zone. This was accomplished in a population that is 90 percent farmers, with a median household income of only US\$ 58 per annum and an average household size of seven.

Comparison of admission rates for various service categories indicates that the insured population is making greater use of the health services than uninsured individuals. Financial statements for the insurance plan indicate that yearly revenues (premiums) more than covered yearly expenses in the 1987-89 period. Satisfaction with the plan has sparked interest among the insured in raising premiums by 60 percent to cover ambulatory care. It remains to be seen whether this would be feasible. Other rural and urban insurance schemes in Zaire have covered ambulatory care exclusively, but have had greater financial difficulties, despite substantially higher premiums. The Bokoro Rural Health Zone, for example, had an annual premium of Z 1200 (US\$ 3.36) per person in 1989 -- or ten times that of Bwamanda. St. Alphonse, an urban insurance scheme, charges only Z 300 (US\$ 0.85) per person per annum, but requires enrollees to pay Z 500 (US\$ 1.40) per episode of illness.

The success of the Bwamanda Rural Health Zone insurance plan is not unqualified, and was aided by: (a) a well-established hierarchy of facilities with a good referral system; (b) a long history of financing through user fees; and (c) subsidization of hospital services, which lowered fees and, therefore, premiums. Nonetheless, it might be possible for Côte d'Ivoire to develop insurance schemes along these lines in the private sector. One option would be to develop non-profit mutual associations for indirect insurance coverage, with care provided through negotiated contracts with private clinics and hospitals. Alternatively, direct insurance plans could be developed, with care provided by HMOs. A number of initiatives of this type are already underway in the private sector, several of which will be examined briefly below.

1.3 Health Insurance and Managed Care in Côte d'Ivoire

Private insurance companies offer health insurance in Côte d'Ivoire at premiums which range from around CFAF 200,000 to CFAF 350,000 (US\$ 769-1,346) per person per annum, amounts which equal or exceed the country's per capita income. Thus, it is only available to the wealthy, or to the relatively well-off who share the cost of the insurance with their formal sector employer. In fact, most private health insurance policies in Côte d'Ivoire are employment-related group policies. Insurance payment is largely on a cost reimbursement basis, creating incentives for overprovision of services. Some policies require no copayment, creating incentives for overconsumption of services. Coverage is comprehensive, and the insured are entitled to seek care at any licensed facility -- a flexibility that leads to considerable fraud by non-enrolled friends and family.

A number of private sector initiatives are underway to reduce the cost of care and enhance consumer purchasing power through the organization of non-profit mutual associations (*mutuelles de risque*) in urban areas. The mission examined two such initiatives begun in the past few years, key components of which are summarized here:

- a. ***Mutuelle d'Assurance Familiale (MAF)***: After an initial membership fee of CFAF 10,000 (US\$ 38.46), up to six family members are offered comprehensive coverage (ambulatory care, drugs, hospitalization) at a family premium of CFAF 70,200 (US\$ 270) per annum for care in public facilities only; CFAF 106,200 (US\$ 408) for private clinic care and public hospitalization; and CFAF 166,200 (US\$ 639) for private clinic and hospital care. MAF has negotiated reductions in fees for members at specified private clinics (e.g. CFAF 4,000 for consultation with a physician, instead of CFAF 10,000). Members pay their own bills, then MAF reimburses 70 or 80 percent, depending on the service. MAF currently has approximately 4,000 members, many through group enrollments. MAF is underwritten by a private insurance company.

- b. ***Mutuelle du Centre (MC)***: Comprehensive care (ambulatory care, drugs, hospitalization) is offered through a contracted private clinic at a family premium equal to 3.0 percent of salary. Initially, three months of premiums must be paid in before insurance payments begin. Thus far, MC has negotiated an exclusive contract with just one clinic, reducing the price of a consultation with a physician to just CFAF 1,000. Negotiations with pharmacies have also led to 10-15 percent reductions on drug prices for members. MC, which is newly founded, has a current membership of 400, although recent agreements with three group enrollments will raise membership to 10,000 in 1993. MC reimburses the clinic directly, but members pay a 20 or 30 percent copayment depending on the service.

A couple points are worth highlighting. First, these non-profit insurance plans have successfully negotiated significantly reduced rates for private sector services, although payment is still on a cost reimbursement basis, rather than on a capitation basis. At this early stage in their development, these mutual funds are relying on negotiated contracts with providers, although the director of MC has a long-run vision of organizing an HMO through the mutual association, including establishment of an associated pharmacy. Second, the premiums for these mutual associations are a fraction of those charged by the insurance industry. The cost of private care for a family of six would be CFAF 166,200 under MAF, but more than CFAF 1.0 million through a private insurance company. This raises the most fundamental question: can these mutual associations deliver on their obligations, given their comprehensive coverage? Are they financially viable based on these premiums? Given the broad scope and short duration of the mission, it was not possible to analyze the actuarial base from which these premiums are derived, or assess the financial viability of the present schemes. Such a task would be of highest priority if USAID were to support pilot initiatives in this area.

1.4 USAID Support for Mutual Associations and Managed Care

By supporting pilot mutual associations and managed care schemes, USAID would be identifying ways to increase the purchasing power of health care consumers in Côte d'Ivoire, making private sector care affordable for a broader segment of the population. This would ease

the burden on public facilities, allowing them to focus more resources on highly subsidized care for the poor. It should be pointed out that USAID could directly subsidize health care in the private sector -- preferably through non-profit providers such as NGOs -- just as it does in the public sector through existing projects. This could reduce the out-of-pocket costs of private sector care in targeted areas (poor neighborhoods, for example), making it affordable for a broader segment of the population. Unlike health insurance, such direct subsidization of care is obviously not a way to make private care more affordable on a self-sustaining basis, but it reaches more of the poor. It may be justified, in particular, for non-profit facilities that also mobilize resources through health insurance and reduce costs through managed care. Such was the case for the Bwamanda Rural Health Zone in Zaire, where the referral hospital remains subsidized by churches, donors and government.

Whether or not USAID opts for direct subsidization of private health care, the agency should support pilot initiatives to develop financially viable non-profit insurance plans, and to reduce costs through managed care. These initiatives would create self-sustaining mechanisms for making private sector care more affordable. In an initial phase, USAID could provide the following types of support for mutual associations and private clinics and hospitals interested in insurance plans and managed care:

- a. training in basic insurance and managed care concepts, as well as in development and financial management of risk pools;
- b. technical assistance for specialized skills, such as managing risk pools and setting up appropriate information and financial accounting systems;
- c. exchange visits within Côte d'Ivoire, and to other developing countries with successful mutual associations and/or HMOs;
- d. educational/promotional materials to sensitize the public to the benefits of mutual associations and managed care;
- e. assistance in establishment of pharmacies linked to mutual associations, and supply of essential generic drugs for start-up of revolving fund.

2. Promoting Private Sector Physicians' Services

Faced with hiring limits in the civil service, Government is now considering various measures to encourage young physicians to establish private practices in secondary cities and rural areas. One idea suggested by government is to provide physicians -- who generally have difficulty obtaining credit from the banking community -- with interest-free loans for investment and working capital. The source of financing for such a plan has yet to be determined. However, providing start-up capital to young physicians without ensuring sufficient demand for their product would lead to private practices that are financially unsustainable. A better option

is to address the question of why physicians are considered a poor credit risk by the banking community, and identify ways to enhance their creditworthiness.

Banks are not lending to physicians because of the uncertainty of their revenue streams, which is a function of the weak demand for private sector health services. Thus, private practice would be more attractive to the banking community (and to physicians) if: (a) the purchasing power of health care consumers were increased; and (b) a steady revenue stream were assured. This analysis points to the benefits of health insurance schemes that increase the purchasing power of the sick, and managed care arrangements that reduce costs for consumers while ensuring a steady client base for physicians. Indeed, under a capitation payment system -- whether through an HMO or a negotiated contract with a group practice -- variation in monthly revenue is minimized, depending only on changes in enrollment (i.e., the size of the client base). Government should encourage the establishment of non-profit mutual associations which, through contractual arrangements, can stimulate the formation of group practices or the expansion of existing practices to include young physicians entering the market. If physicians can be assured of a steady client base which is covered by insurance, they will have a more certain revenue stream -- and are likely to be an attractive risk for the banking community. USAID could play an important supporting role in the establishment of mutual associations linked to group practices, and this would serve as a sustainable means of drawing physicians into the private sector.

3. Increasing Utilization of Private Infirmaries

Private infirmaries are underutilized as a result of the general reduction in purchasing power, a perception that the quality of treatment is not very high and the availability of the same drugs at private pharmacies for the same price. Consumers rely on private nurses for injection of drugs, as well as diagnosis and treatment of common illnesses -- particularly malaria, diarrheal disease and STDs. To increase utilization of private infirmaries, USAID should build on these existing areas of demand, but provide: (a) training to improve the quality of treatment; (b) training and information/education/communications (IEC) materials to enhance nurses' role as educators; and (c) low-cost treatments and supplies not currently offered at pharmacies. Interventions could focus on four areas of high demand:

- a. **STDs, including AIDS:** The survey of utilization of health facilities by consumers indicated that while most people have heard of AIDS through radio and television, very few could identify a local source of information and counseling. At the same time, the frequency of STD treatment at infirmaries indicates little behavior change to prevent HIV transmission. Because people, particularly men, appear to turn readily to private nurses (most of whom are male) for treatment of STDs, these nurses are in a good position to serve as educators on prevention of AIDS and other STDs. Private midwives can also serve as educators for women. It is recommended that USAID provide training and simple IEC materials to private nurses and midwives, perhaps through NGOs that are working in family planning and AIDS prevention. Infirmaries could also

be encouraged to sell condoms, although low-cost condoms are now available at neighborhood stores, bars and restaurants as a result of social marketing campaigns supported by USAID. Another way to help prevent HIV transmission would be for USAID to directly support the marketing of disposable syringes through private infirmaries, where people can purchase them prior to injection of drugs. USAID could also urge Government to exempt all syringes from import duties, and launch a media campaign to counter the popular notion that injectible drugs are more effective than oral alternatives.

- b. Family planning: Demographic surveys have found that many women in Côte d'Ivoire who don't use a family planning method don't want more children, or wish to wait several years before their next child. Thus, there is considerable unmet demand for family planning. Currently, the *Association Ivoirienne du Bien-être Familial* (AIBEF), an NGO with considerable support from USAID, is the main supplier of subsidized contraceptives in urban areas, through its clinics and the Government's *Centres Sociaux*. AIBEF currently relies on volunteer physicians and midwives from the civil service for examinations and prescriptions. This network of subsidized contraceptives could be expanded to include private nurses and midwives, with appropriate training and certification as family planning providers. While it is debatable whether women would accept physical examinations by male nurses -- particularly in infirmaries which sometimes lack privacy -- these infirmaries could still serve as resupply points for oral and injectible contraceptives, the two most popular methods (along with condoms).
- c. Diarrheal disease: Currently, most *infirmiers* prescribe the same high-priced drugs as private pharmacies for treatment of diarrheal disease. USAID could provide low-cost ORS packets, as well as training and IEC materials, to be marketed through private infirmaries. As parents tend to bring children to neighborhood infirmaries at an early stage in the illness, ORS therapy would begin before serious dehydration occurs -- the point at which many parents bring children to public hospitals and health centers.
- d. Malaria: Prevention and treatment of malaria is currently complicated by the rise of chloroquine-resistant strains which respond only to higher-priced specialty drugs. Infirmaries could play a greater role in prevention, however, through marketing of insecticide-treated mosquito nets or other anti-mosquito products.

Through these interventions, USAID would make private infirmaries more attractive to health care consumers, not just by improving the quality of treatment for common illnesses, but also by marketing low-cost treatments and products through infirmaries that are either unavailable or more expensive at private pharmacies. These products would include ORS packets, treated mosquito nets, condoms and other contraceptives. For example, a cycle of pills

at a private infirmary could be sold at the AIBEF price of CFAF 100 (plus a reasonable mark-up), far below prevailing pharmacy prices of around CFAF 1,000. In supporting training aimed at midwives, nurses or nursing assistants, USAID would have to determine the minimum qualifications (e.g., academic credentials, work experience) necessary to participate in training activities.

4. Reducing the Cost of Drugs

The pharmaceutical market in Côte d'Ivoire is the least competitive of the private health care markets. There are significant barriers to entry at both the importing/wholesale level and the retail level, while industry and government effectively collaborate to enforce fixed wholesale and retail prices. A fixed, ad valorem mark-up (18 percent of cost at the wholesale level, 37 percent at the retail level) creates incentives to market the most expensive products. Finally, unlike health services, the public sector pharmaceutical network has not provided an alternative to the private sector in recent years, as public drug supplies dwindled. To reduce the cost of drugs in Côte d'Ivoire, policy reforms are needed which reduce barriers to entry, introduce price competition, and shift incentives in favor of low-cost drugs, including generic drugs.

4.1 Reducing Barriers to Market Entry

For importing and wholesale distribution of drugs, the criteria for government authorization of enterprises need to be revised. While the need for licensed staff pharmacists to oversee operations is justified, the requirement that 51 percent of shares in the enterprise be held by Ivorian pharmacists serves only the pharmaceutical industry itself. It is well-advised to eliminate this barrier to entry, although given the small size of the Ivorian market and the high cost structure in the Franc Zone, easier access may not lead to market entry by competing wholesale distributors. The wholesale market may well remain an oligopoly of two -- soon to be three -- importers/distributors. This has important implications for pricing policy (below). At the retail level, pharmacy licenses should be granted on the basis of: (a) qualified pharmacists to oversee operations; and (b) appropriate facilities and equipment for the storage and dispensing of drugs. If these conditions are met, neither Government nor industry ought to have a deciding voice in determining the merit of an additional pharmacy or its geographic location. These are decisions best left to the market, rather than an industry intent on avoiding competition.

4.2 Liberalizing Prices

With around 300 retail pharmacies already in operation in urban areas, price liberalization at the retail level should engender price competition to enhance market share. Consumers would benefit from lower prices, while marketing incentives for pharmacists would shift in favor of lower-cost drugs with high volume potential and higher profit margins than expensive specialty drugs. Liberalization of retail prices may even lead to extension of the pharmacy network into more remote areas, with higher transport costs. Despite the potential consumer benefits, price liberalization is likely to face opposition from the Government, which fears price "gouging" in

an unregulated environment (and takes its cue from the regulated markets of Europe), as well as from the industry, which faces reduced profits. At the wholesale level, with its oligopolistic structure, it is possible -- perhaps even probable -- that price liberalization would lead not to price competition but to collusion to maintain or augment profit margins. To prevent this, Government may wish to maintain a ceiling on mark-up margins at the wholesale level. If fixed, *ad valorem* margins or fixed ceilings are maintained at the wholesale or retail level, a system of regressive margins (higher margins on lower cost products, lower margins on higher cost products) should be adopted to shift incentives toward lower cost drugs. This type of incentive structure is currently in effect in France. In the absence of more far-reaching reforms, adjustment of fixed margins to favor lower cost drugs would be one step in the right direction.

4.3 Introducing Generic Drugs

A marketing representative for a major multinational drug company indicated that he was advising his firm to introduce its own line of generic products into Côte d'Ivoire in coming years. As a matter of both social responsibility and business sense, declining consumer purchasing power necessitates a shift toward lower cost products with higher volume potential. However, most private pharmacists and pharmacy staff interviewed had never heard of generic drugs, and none were identified in the pharmacies visited. Introduction of generic drugs through a financially viable network of public sector pharmacies -- an effort which is now underway -- may provide added incentive for private wholesalers to explore generic options. Any support that USAID can provide for this public sector effort is likely to have a positive impact on the private pharmaceutical industry, as well. In addition, USAID support for private mutual associations, group practices and/or HMOs could include assistance in establishing associated pharmacies. USAID could supply essential generic drugs to be marketed through these pharmacies to mutual association or HMO members -- creating an additional impetus for commercial pharmacies to offer these low-cost alternatives. Media efforts to increase awareness of generic alternatives among pharmacists and the general public may create demand, and stimulate a supply response from private wholesalers. Pharmacists would also have to obtain the legal right to substitute generic drugs for higher-priced brands.

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Enquête sur les Formations Sanitaires dans le Secteur Privé

1. Ville dans laquelle se trouve cette formation sanitaire _____
2. Quartier dans lequel se trouve cette formation sanitaire _____
3. Cette formation sanitaire est un(e):
Hôpital _____ Combien de lits? _____
Clinique _____
Infirmierie _____
Maternité _____
Autres (à spécifier) _____
4. Cette formation sanitaire, fait-elle partie du Ministère de la Santé ou d'un autre organisme public?
oui _____ non _____
5. Est-ce que vous offrez ici les:
Soins pour:
Vaccinations _____ paludisme _____
Visites prénatales _____ diarrhée _____
Accouchements _____ grippe _____
Planning familial _____ infections respiratoires _____
Protection contre les MST _____ MST _____
Education sanitaire et rougeole _____
nutritionnelle _____ yeux _____
6. Quels sont les trois services utilisés le plus souvent par vos clients?
Soins pour:
Vaccinations _____ paludisme _____
Visites prénatales _____ diarrhée _____
Accouchements _____ grippe _____
Planning familial _____ infections respiratoires _____
Protection contre les MST _____ MST _____
Education sanitaire et rougeole _____
nutritionnelle _____ yeux _____
Autres (à spécifier) _____

12. Comment est-ce que vous attirez la clientèle?

Publicité _____
Réputation dans la communauté _____
Contrats avec les employeurs _____
Envoyés par d'autres services médicaux _____

13. Avez-vous des difficultés à trouver de la clientèle? _____ Si oui, quel est le problème, à votre avis?

Clients n'ont pas d'argent pour les services de santé _____
Clients ne veulent pas des services offerts _____
Manque de médicaments à vendre aux clients _____
Manque de capital pour acheter des médicaments, des équipements, etc. _____
Manque d'autorisation officielle _____
Restrictions et règlements imposés par le gouvernement _____
Autres (à spécifier) _____

14. Quelles sont vos heures de travail? _____

15. Quel est le tarif normal pour une consultation? _____ FCFA

16. Avez-vous un tarif réduit pour ceux qui sont en difficulté financière? _____ Si oui, quel est le tarif réduit pour une consultation? _____ FCFA

17. Est-ce que vous utilisez un système flexible/variable de tarification selon la situation financière du client? _____

18. Parmi tous vos clients, quel est le tarif moyen pour une consultation? _____ FCFA

19. La plupart de vos clients vous paient:

Immédiatement, de leurs propres ressources _____
Par assurance _____
Par employeur _____
Par crédit _____

20. Avez-vous des clients couverts par l'assurance médicale? _____

21. Est-ce que vous vendez des médicaments aux clients? _____

22. Où est-ce que vous vous approvisionnez en médicaments?
Pharmacie privée _____
Pharmacie publique _____
Grossiste privé _____
Autres (a specifier) _____
23. Est-ce qu'il vous arrive de ne pas trouver les médicaments nécessaires? _____
24. Est-ce qu'il vous arrive de ne pas avoir suffisamment d'argent pour acheter des médicaments?

25. Au cours des trois derniers mois, est-ce que vos recettes étaient suffisantes a couvrir vos frais de fonctionnement?
26. Le financement initial pour cette formation sanitaire était:
De vos propres ressources _____
D'un pret bancaire _____
D'un pret de la famille, des amis _____
D'un pret d'un usurier _____
Autres (à specifier) _____
27. Vous avez essayé d'avoir un prêt bancaire? _____
28. Au début, est-ce qu'il a fallu enregistrer vos services? _____
29. Il a fallu combien de temps pour vous enregistrer?
Moins d'un mois _____
1-3 mois _____
3-6 mois _____
Plus de 6 mois _____
30. Combien l'enregistrement vous a-t'il couté? _____ **FCFA**
31. Le gouvernement vous demande-t-il de payer des impôts? _____
32. Quelles sortes d'impôts faut-il payer? _____
33. Quel est le montant total des impôts que vous avez payé l'année passée? _____
_____ **FCFA**

JE VOUS REMERCIE POUR VOTRE PARTICIPATION A LA REALISATION DE CETTE ETUDE.

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Enquête sur l'Utilisation des Services de Santé

1. Ville de l'enquête: _____ Quartier: _____

2. Statistiques de base sur l'individu et le ménage:

Quartier de résidence: _____ Nationalité: _____

Sexe: M / F Age: _____

Profession: _____ Chef du ménage: oui / non

Nombre de personnes au ménage: _____ Nombre d'enfants de moins de 16 ans: _____

=====

3. Quand vous êtes malade, où est-ce que vous allez dans un premier temps pour les soins de santé?

Hôpital public (H1, H2, CHR ou CHU) _____

Centre de santé urbain (public) _____

Centre de PMI (public) _____

Pharmacie publique _____

Hôpital privé _____

Clinique privée _____

Infirmierie privée _____

Pharmacie privée _____

Guerrisseur traditionnel _____

4. Pourquoi est-ce que vous y allez?

Vous connaissez bien le personnel _____

C'est tout près _____

C'est peu cher/le moins cher _____

Heures de travail me conviennent _____

Services sont de bonne qualité _____

Soins de santé sont efficaces _____

Médicaments sont disponibles _____

Autres (à spécifier) _____

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5. Le medecin/infirmier/pharmacien qui vous soigne est-il diplômé de l'Etat?

Oui _____

Non _____

Vous ne savez pas/n'êtes pas sûr _____

6. Vous avez payé combien pour la consultation la dernière fois que vous y êtes allé?

_____ FCEFA

7. Vous avez payé combien pour les médicaments la dernière fois que vous y êtes allé?

_____ FCEFA

8. Comment est-ce que vous avez pris connaissance de ce service?

Mentionné par des amis/des membres de la famille _____

La publicité (les affiches, la radio, etc.) _____

Mentionné par votre employeur _____

Réputation dans la communauté _____

Autres (à spécifier) _____

9. Au cours de la dernière année, vous et les membres de votre ménage est-ce que vous êtes allés à d'autres endroits pour vous soigner? _____ Lesquels?

Hôpital public (H1, H2, CHR ou CHU) _____

Centre de santé urbain (public) _____

Centre de PMI (public) _____

Pharmacie publique _____

Hôpital privé _____

Clinique privée _____

Infirmierie privée _____

Pharmacie privée _____

Guerrisseur traditionnel _____

10. En moyenne, vous et les membres de votre ménage, vous utilisez des services de santé:

Une fois par semaine _____

Deux fois par mois _____

Une fois par mois _____

Six fois par an _____

Quatre fois par an _____

Deux fois par an ou moins _____

11. Au cours de la dernière mois, combien de fois avez vous et les membres de votre ménage utilisés des services de santé? _____

12. Comment est-ce que vous payez pour les soins de santé?

Vous ne payez pas _____

De vos propres ressources _____

Par crédit _____

Par assurance médicale _____

Par employeur _____

Autres (à spécifier) _____

13. Ou est-ce qu'on peut aller pour vacciner les enfants? _____
_____ Vous ne savez pas _____

14. Ou est-ce qu'on peut aller pour se renseigner sur le planning familial? _____
_____ Vous ne savez pas _____

15. Ou est-ce qu'on peut aller pour se renseigner sur le SIDA? _____
_____ Vous ne savez pas _____

JE VOUS REMERCIE POUR VOTRE PARTICIPATION A LA REALISATION DE CETTE ETUDE.

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