



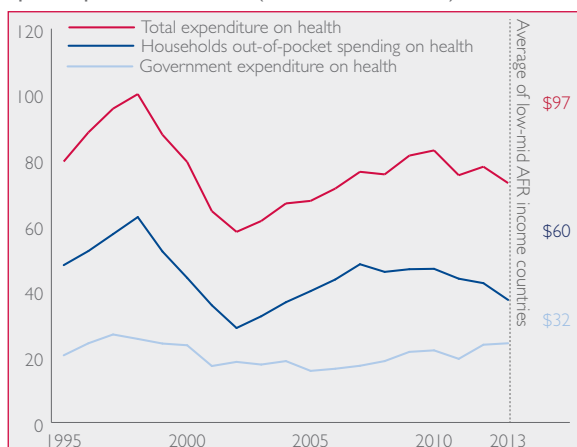
HEALTH FINANCING PROFILE: CÔTE D'IVOIRE

Key country indicators

Development indicators*	
Total population	22,600,000
Total fertility rate (births per woman)	4.8
Gross national income per capita (PPP)**	3,130 (2014)
Health care expenditure indicators***	
Expenditure ratio	
Total expenditure on health as % of GDP	5.7% ↑ avg. low-income countries (5%) ↓ global avg. (9.2%)
Level of expenditures	
General government expenditure on health as % of total government expenditure	8.5% ↓ targets set by Abuja Declaration (15%)
Selected per capita indicators	
Per capita total expenditure on health (PPP int.\$)	172
Per capita government expenditure on health at average exchange rate (US\$)	29
Per capita government expenditure on health (PPP int.\$)	57
Sources of funds	
General government expenditure on health as % of total expenditure on health	33.1%
Private expenditure on health as % of total expenditure on health	66.9%
External resources for health as % of total expenditure on health	7.7%
Out-of-pocket expenditures as % of private expenditure on health	76.5%

Note: WHO aggregates are calculated using absolute amounts in national currency units converted to Purchasing Power Parity (PPP) equivalents

Per capita expenditure in US\$ (constant 2013 US\$)**



*Demographic and Health Survey Program, 2012

**World Bank Indicators, 2015

***WHO Global Health Expenditure Database, 2013

Contextual Factors

After nearly two decades of strong economic growth, Côte d'Ivoire's economy experienced a long period of political and economic crises (1999-2011), which culminated in a short war following the 2010 presidential elections. The successive crises resulted in widespread deterioration of living standards and health services. Since mid-2011, stability has been largely restored, and economic growth has resumed. With a gross domestic product (GDP) growth of 8.5% in 2014, and robust growth projected for the years ahead, the medium-term economic outlook is positive.¹ However, poverty levels remain high at 46.3%, and the vast majority of the population does not have adequate access to health services.²

The provision of health care in Côte d'Ivoire is dominated by the public sector, which is divided into three levels. The primary level is composed of sanitary institutions of first contact (1,910), which include health centers, specialized health centers, and clinics. The secondary level is composed of health facilities used for first referrals, which include general (66), regional (17), and specialized hospitals (2). The tertiary level is composed of health facilities used for the second referrals, such as teaching hospitals (4) and specialized national institutes (9), including the National Institute of Public Health (INSP), National Institute of Public Hygiene (INHP), Follereau Institute (FRI), Pierre Richet Institute (GPI), and Cardiology Institute in Abidjan (ICA); four National Public Establishments (EPN) support the National Blood Transfusion Center (CNTS), National Public Health Laboratory (LNHP), New Pharmacy of Public Health (N-PSP), and Medical Aid Emergency Service (UAS).

The private sector also plays a key role in the provision of services. The supply of private health care has been steadily increasing, including non-profit, for-profit, and traditional medicine providers. These structures are primarily located in large cities. Private for-profit health care facilities represent over 25% of the country's health care supply and contribute significantly to the population's access to health care.²

Health coverage was previously financed by three sources: government funding, private payments made by households and businesses, and funding provided by development partners.³ Coverage was provided to a small number of private sector employees, civil servants, and military personnel. The vast majority of the population (roughly 90%) was excluded from coverage, representing those most vulnerable to the financial risks of ill health.

In this context, the 2012-2015 National Health Development Plan (PNDS) set the goal of creating a high quality health system to guarantee the highest possible level of health for all citizens, and in doing so, foster sustainable growth and development in Côte

d'Ivoire.³ The PNDS has made health financing a strategic priority for improving the health and well-being of the population through the following:

- Increased health financing through mobilization of internal and external resources;
- Strengthened integration of health financing;
- Allocation of resources with priority given to primary health care; and
- Well-managed use of financial resources.

Health Financing Functions

In May 2014, the government enacted mandatory health care coverage for all residents of Côte d'Ivoire. The National Health Insurance Fund (NHIF) is a single national fund established to consolidate, manage, and regulate existing health financing schemes. The NHIF is intended to manage risk and supervise operations for individual schemes.

The NHIF offers two schemes: a contributory Basic General Scheme (*Régime Général de Base*, RGB) and a non-contributory Medical Assistance Scheme (*Régime d'Assistance Médicale*, RAM) for low income persons or those living in extreme poverty.²

The RGB is a contributory scheme based on the principle of third-party payment and co-payment. It is available to all residents who are not eligible for the RAM. Enrollment is mandatory for those who are subject to income tax. The National Health Insurance Scheme (NHIS) is primarily funded by member contributions under the RGB. A fee of 1,000 West African Franc (FCFA) per person per month is required for all those over the age of five years.

The RAM is non-contributory, government-subsidized scheme based on the principle of national solidarity. Persons living in extreme poverty are exempt from paying a monthly contribution; the government pays 49 million FCFA into the national fund. Additionally, the government of Côte d'Ivoire made an initial donation of 20 billion FCFA to the NHIF.⁴

Revenue for the RGB is provided through mandatory contributions, late penalties, investment income, government subsidies, donations, and other funding mechanisms. The RAM is funded by subsidies from the central government and regional resources, investment income, donations, and earmarked taxes.

The NHIS mandates coverage for all citizens. The first stage roll out of the scheme prioritizes both private and public sector employees, retired persons, and producers of rubber and palm oil. The benefits package provides basic coverage of health services including: consultations (nurses, midwives, general medicine and specialists), medications, surgery, exams, laboratory tests, and hospitalizations (births, C-sections, and emergencies previously covered).

Meeting the Goals of Universal Health Coverage (UHC)

UHC can only be achieved when access to health services and financial risk protection are equitably addressed. Equitable financial protection means that everyone, irrespective of their level of income, is free from financial hardship caused by using needed health services.

Financial protection

Currently less than 10% of Côte d'Ivoire's population has adequate health coverage. The World Health Organization's (WHO) Global Health Observatory estimates that Côte d'Ivoire's total health spending was PPP\$172 per capita in 2013. Of this, 51% was paid out-of-pocket by households. Nearly 77% of all private health spending is made through household out-of-pocket spending, placing a significant financial burden on the poor and those most at risk of ill health.

According to data reported in the National Health Development Plan (*Plan National de Développement Sanitaire*) 2009-2013, the government spends a significantly larger share of funds on tertiary care than it does on secondary or primary care. These budget allocations are particularly unfavorable to the poor, who are more likely to use primary care.

Equity in financing and utilization

In 2007, only 44% of the population lived within 5 kilometers (km) of a sanitary institution of first contact, 27% between 5 and 15 km, and 29% were forced to travel more than 15 km to access a health facility.⁵ The 2012 Demographic and Health Survey indicated that 60% of women in the poorest quintile mentioned distance to health services as a major barrier to maternity care, compared to 25% for women in the wealthiest quintile. Additionally, nearly 75% of women in the poorest quintile indicated that a lack of money was a major barrier to maternity care, compared to 55% of women in the wealthiest quintile.⁶

In order to increase health care coverage for the population of Côte d'Ivoire, the government will need to expedite roll-out of the NHIS, while identifying those most vulnerable and advocating for increased resource allocation from internal and external partners.

Endnotes

1. [WHO Global Health Expenditure Database](#), 2014.
2. [World Bank Indicators](#), 2015.
3. Juillet, Anne, Clovis Konan, Laurel Hatt, Sophie Faye, and Sharon Nakhimovsky. [Measuring And Monitoring Progress Toward Universal Health Coverage: A Case Study in Côte d'Ivoire](#). Bethesda, MD: Health Finance & Governance Project, Abt Associates. May 2014.
4. [Strategie Nationale de Financement de la Sante pour tender vers la couverture universelle](#). Ministry of Health and the Fight Against AIDS. Republic of Ivory Coast. 24 Dec 2012. 4. Côte d'Ivoire. Health Systems Strengthening and Ebola Preparedness Project. World Bank. 4 Nov 2014.
5. International Monetary Fund. [Côte d'Ivoire: Poverty Reduction Strategy Paper](#). May 2009.
6. National Institute of Statistics and ICF International. ["Enquête Démographique et de Santé et à Indicateurs Multiples de Côte d'Ivoire 2011-2012."](#) Calverton, Maryland, USA. 2012.

Additional information can be obtained from:

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