Mobilising tax revenues to finance the health system in

Côte d'Ivoire

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Foreword

The Global Fund to Fight AIDS, Tuberculosis and Malaria and the OECD Centre for Tax Policy and Administration (CTPA) are engaged in a joint project that aims at analysing countries' capacity to mobilise tax revenues to finance their health system, and particularly the fight against the three aforementioned diseases.

The project started with two pilot countries: Côte d'Ivoire and Morocco. The work with Côte d'Ivoire builds on a collaboration of CTPA with Côte d'Ivoire in the area of tax policy since 2015. This report is an input to inform the discussions of the National Platform for health financing co-ordination.

The Key Messages and Recommendations section of the report presents the main tax policy recommendations to strengthen the financing of the health system and the fight against AIDS, Tuberculosis and Malaria in Côte d'Ivoire. More detail and analysis is included in the subsequent chapters of the report.

This report was written and coordinated by Céline Colin, Tax Economist in CTPA, with input and under supervision from Bert Brys, Senior Tax Economist and Head of the Country Tax Policy Team and of the Personal and Property Taxes Unit, in the CTPA Tax Policy and Statistics division led by David Bradbury. The report has benefitted from input from colleagues in CTPA, in particular Gioia de Melo and Eugénie Ribault. The report also benefitted from comments from Jieun Kim from the OECD Development Co-operation Directorate and Caroline Penn James from the OECD Directorate for Employment, Labour and Social Affairs.

The analysis is based on the discussions held and information gathered during a country mission to Abidjan in January 2020 and videoconferences organised in April and May 2020.

The report was prepared in close collaboration with the Ministry of Health and Sanitation and the Ministry of Budget and State Portfolio in Côte d'Ivoire. In particular, the team would like to thank Alexandre Guebo, Technical Advisor at the Ministry of Health and Sanitation, and Daouda Kamagate and Hilaire Sea, Technical Advisors at the Ministry of Budget and State Portfolio, for their support.

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Glossary

CIE	Compagnie ivoirienne d'électricité
CNAM	*Caisse nationale d'assurance maladie* (National Health Insurance Fund)
COVID-19	Coronavirus disease-2019
DAC	Development assistance committee
DGD	*Direction générale des douanes* (Customs General Directorate General)
DGI	*Direction générale des impôts* (Taxes General Directorate)
Gavi	Global Alliance for Vaccines and Immunisation
GFF	Global Financing Facility
GIT	General income tax
IMF	International Monetary Fund
MCLU	Ministry of Construction, Housing and Urban Development
MBPE	Ministry of Budget and State Portfolio
MEF	Ministry of Economy and Finance
MSHP	Ministry of Health and Sanitation
NCA	Non-concessional assistance
ODA	Official development assistance
OOP	Out-of-pocket
PIT	Personal income tax
PNDS	*Plan national de développement sanitaire* (National Health Development Plan)
PNLP	*Plan national de lutte contre le paludisme* (National Malaria Control Programme)
PNLS	*Plan national de lutte contre le sida* (National Aids Control Programme)
PNLT	*Plan national de lutte contre la tuberculose* (National Tuberculosis Control Programme)
SDG	Sustainable Development Goals
SME	Small and medium-sized enterprises
TB	Tuberculosis
TWS	Taxes on wages and salaries
UHC	Universal health coverage
VAT	Value added tax
WAEMU	West African Economic and Monetary Union
WHO	World Health Organization

Executive Summary

Despite that Côte d'Ivoire reacted rapidly to the COVID-19 crisis with a Health Response Plan and an Economic, Social and Humanitarian Support Plan, the crisis will still have a significant economic and social impact. In the short term, the country will need donors to increase the fiscal space for health, while prioritising health in the budget and securing its sources of funding will be the medium-time requirements.

The level of Côte d'Ivoire's health performance is close to that of the least developed countries, despite it being more developed. Malaria's incidence is high. HIV prevalence is among the highest in the region. Tuberculosis (TB) is the leading cause of death among people living with HIV. At the same time, the burden of non-communicable diseases on the health care system is increasing.

The level of financing for the health sector is insufficient. Public funding is low, with a budget for health that has remained between 5% and 6% of the total state budget for many years, even though the crisis in the 2000s led to the partial destruction of health care facilities.

Before the COVID-19 crisis, the state agreed to use tax revenues to finance an annual 15% increase in the health budget until 2030, or a minimum of XOF 47 billion a year. While this commitment is welcome, estimates show that Côte d'Ivoire would need a greater increase if it wants to make headway towards health-related SDG targets between now and 2030, take better control of the financing of universal health coverage (UHC), and successfully manage the donor transition. Accordingly, based on an methodology developed by the IMF health expenditure could aim to reach the ambitious target of 10.6% of GDP in 2030 (+4.6 GDP percentage points), or an annual increase of XOF 166 billion in public health expenditure.

A gradual tax reform is required to finance this increase in public health expenditure. Indeed, even if economic growth translates into higher public health expenditure in Côte d'Ivoire, the long-term trends reveal that this alone will not be enough. In addition, growth is expected to be affected by the repercussions of the COVID-19 crisis. As a result, Côte d'Ivoire has to make health a budget priority, and ensure that it is funded by tax revenues. However, the decline in tax revenues caused by the crisis represents an additional challenge for the future of tax revenue funding. Accordingly, it seems inevitable that an extensive tax reform aimed at broadening tax bases and reducing rates is needed to generate sufficient fiscal room for manoeuvre, but should be implemented gradually over time.

The tax reform will have to be ambitious and concern all types of taxes. Those directly related to health (such as excise duties on products harmful for health and UHC contributions) will be taking the lead in financing the health sector. Other taxes, through their impact on increasing tax revenues for the general state budget, will also help improve funding for the sector.

Côte d'Ivoire has the potential to increase revenues from excise duties on products harmful for health. Tobacco taxation raises less revenue than other near-income countries, and the tax rate could be raised as it is below World Health Organization (WHO) standards and lower than in some countries in the region. While the taxation of beverages raises more revenues, there is still room to increase excise duties

on alcohol. Lastly, Côte d'Ivoire could continue to introduce new excise duties on products from the list of the West African Economic and Monetary Union (WAEMU).

The recent introduction of UHC is welcome. Nevertheless, the way it is financed, with a monthly contribution of XOF 1 000 by each insured party, will have to be reviewed in the medium term to take account of the tax burden on labour. The basic general scheme contribution can change along with the basket of care and become more progressive. One scenario could be to maintain the current contribution level (or increase it very gradually) and complete it with a progressive component with a base other than labour. For example, a social value added tax (VAT) could be put in place, with proceeds resulting from the abolition of non-targeted VAT reduced rates or VAT exemptions. In the long term, to give informal workers an incentive to join the formal economy and contribute to UHC, one possibility would be to change the system into a two-pillar system. The first pillar would be a free basic and universal coverage for all Ivoirians, financed by the general revenues of the state budget, completed by a second pillar with a more generous basket of care funded by compulsory and progressive contributions by formal workers.

Future demographic changes are an opportunity for Côte d'Ivoire to strengthen UHC funding, subject to a broadening of the tax base by reducing informality. Because 90% of workers are informal, more formal taxpayers are required to finance the UHC scheme and thus better protect citizens from catastrophic health expenditure. Côte d'Ivoire has adopted measures to reduce the informal sector but they remain marginal given the extent of the issue. Measures such as the reform of the flat-rate tax ("*impôt synthétique*") and the streamlining of parafiscal taxes are necessary and should be integrated into a global strategy to formalise the economy, the importance of which is emphasised by the recent health crisis.

The tax reform will also have to embrace other taxes. This will involve looking into enhancing environmental taxation, streamlining tax expenditures, overhauling personal income taxation, increasing the role of recurrent taxes on immovable property, and strengthening the fight against tax fraud.

Given the significant challenges brought on by the COVID-19 crisis, Côte d'Ivoire may reassess the arguments in favour of earmarking certain taxes. Little tax revenue is earmarked for health. The Ministry of Budget and State Portfolio (MBPE) has adopted a cautious approach by not retaining previous proposals concerning the earmarking of revenues from certain taxes or part of the revenue from consumption taxes, given their lack of direct links to health. Nevertheless, given the funding needs for the sector as a result of the COVID-19 crisis, a greater earmarking of revenues from tobacco taxation or from some or all of the taxes on alcohol and sugary drinks could be considered. Another possibility would be to earmark the additional tax revenues generated by raising these taxes. These hypotheses must not obscure the importance of a tax reform to be implemented gradually to increase the level of tax revenues in the general state budget, thus benefiting all sectors.

In this respect, the National platform for health financing co-ordination and its technical working parties offers many opportunities. In particular, the platform helps Côte d'Ivoire improve inter-ministerial dialogue on health financing and put the subject of earmarking resources for health as well as the case for a tax reform for health financing on the table. Moreover, it provides a space for discussing the financing of the fight against certain diseases such as AIDS, TB and malaria. Even if this funding does not seem threatened by the crisis, it could nevertheless be affected by the budget constraints that the health sector is likely to face in the future.

Lastly, the platform gives an opportunity to prepare in advance for donor transition. In particular, the absence of any donor withdrawal in the short term, with the exception of Gavi, The Vaccine Alliance, means that Côte d'Ivoire can reform the health sector at the same time as it undertakes a tax reform. This will help make public health expenditure more efficient, which is considered essential. Indeed, compared to the rest of the region, Côte d'Ivoire's health performance is among the poorest in terms of the levels of public funding.

Key messages and recommendations

Côte d'Ivoire and the COVID-19 crisis

Governments around the world reacted decisively to the COVID-19 crisis, during which this report was prepared, and Côte d'Ivoire was no exception. A Health Response Plan (XOF 96 billion, 0.3% of GDP), and an Economic, Social and Humanitarian Support Plan (XOF 1 700 billion, 5% of GDP), which included tax measures were introduced.

Despite these efforts, the crisis will have significant economic and social impacts. According to the Ivoirian authorities, growth in 2020 is expected to fall from the initial estimate of 7.2% to 3.6%. According to the IMF, the budget deficit is expected to worsen to 5.2% of GDP (versus an estimate of 2.3% of GDP before the crisis), with public debt increasing to 42.1% of GDP in 2020 (versus a previous estimate of 38.2% of GDP).

In the wake of the crisis, there are various possible solutions for increasing the fiscal space for health. In the short term, Côte d'Ivoire will need international support from donors. The fall in remittances, which may actually decline even further in coming months, could penalise Ivoirian households, whose out-of-pocket (OOP) expenditure for health care is high. In the medium to long term, prioritising health in the budget and securing its sources of funding will be the main requirements.

Financing for AIDS, TB and malaria do not appear to be threatened by the crisis. These diseases are included in the national priority programmes which will continue to run and receive financing. However, problems of executing some activities, such as purchasing drugs and reaching out to sick and at-risk populations, who are visiting health centres less frequently for fear of contracting COVID-19, have occurred. Therefore, the Global Fund finances contingency measures such as additional activities to mitigate the impact of avoidance of services across all disease programs.

The need to continue inter-ministerial discussions on health financing

The level of Côte d'Ivoire's health performance is close to that of the least developed countries, despite it being more developed. Malaria's incidence is high. HIV prevalence is among the highest in the region. Tuberculosis (TB) is the leading cause of death among people living with HIV. At the same time, the burden of non-communicable diseases is increasing.

The level of financing for the health sector is insufficient. Total health expenditure represented 4.5% of GDP in 2017, which is below the average of low-income countries (6.3% of GDP) and lower-middle-income countries (5.3% of GDP). Public health expenditure as a percentage of GDP, a priority indicator for the Millennium Challenge Corporation for which Côte d'Ivoire is eligible and receives financing, remain low. Total health expenditure per capita was USD 70 in 2017, lower than lower-middle-income countries

(USD 130). Nevertheless, health financing is higher compared to the rest of the region, which in light of its poor health performance, suggests that health expenditure in Côte d'Ivoire is not efficient.

At the end of 2019, Côte d'Ivoire launched a universal health coverage (UHC) scheme. Government schemes play an important role in health financing in Côte d'Ivoire. Eventually, the compulsory contributions-based health-financing scheme (UHC) is expected to play a more dominant role. OOP expenditure for health care by Ivorian households is high. Lastly, voluntary private payment schemes for health care are also well developed, especially corporate schemes.

There are multiple funding sources for the various schemes. In 2017, OOP payments are the main source, representing 39% (above the WHO's 25% standard), followed by domestic resources (28% - mainly comprising tax revenues, as the proportion of health contributions is still very low), then other private expenditure (19%), and international co-operation (13%).

Within international co-operation, a small number of donors finance a large part of the fight against certain diseases. The United States government (via PEPFAR) is the primary health donor, and the main contributor to the fight against AIDS. The Global Fund is the second largest donor, and the main contributor to the fight against malaria. Since 2003, it has provided almost USD 640 million. Gavi, The Vaccine Alliance is the third largest donor, and the main contributor to vaccination. However, between now and 2025, Côte d'Ivoire will no longer be eligible for Gavi support and the country will be fully responsible for funding vaccinations, which means it needs to start the search for domestic funding as soon as possible. The Global Fund has no plans to withdraw but its policy is to involve countries in domestic resource mobilisation to finance an increase in public spending on health, as well as a gradual absorption of the main programme costs. Its support also comes with an incentive envelope or "co-financing" incentive of 20% for Côte d'Ivoire (or EUR 46 million over the 2021-23 period, at least 50% of which must be invested into fighting AIDS, malaria and TB). However, given the uncertain effects of COVID-19, securing co-financing commitments from Côte d'Ivoire for the next funding cycle may prove difficult.

Public funding is low. The Ministry of Health and Sanitation (MSHP) is the main actor in health funding. Even if its budget is increasing in nominal terms (from XOF 178 billion to XOF 446 billion between 2013 and 2020), the budget for health has been stagnating between 5% and 6% of the total state budget for many years, even though the crisis in the 2000s led to the partial destruction of health care facilities. This is low in comparison with other regional countries or the WHO standards, and is reflected in the deficits of the national disease control programmes, in particular for TB and malaria, and in the poor upgrading of health care facilities such as hospitals. As a result, an increase in MSHP's budget seems essential for better funding of the sector and sectorial programmes. Indeed, while funding for AIDS and TB is largely donor-driven, it is mainly household-driven for malaria.

In 2019, the state agreed to increase the health budget by at least 15% annually until 2030. After Côte d'Ivoire joined the Global Financing Facility (GFF) (November 2017), an investment case was put together in which it was estimated that XOF 1 658 billion was needed over five years (this figure has not been officially approved yet). A discussion on the different options for funding the health system was organised in April 2019 and resulted in the state's commitment to increase the health budget by 15% annually until 2030 (i.e. a minimum of XOF 47 billion per year, based on the 2018 budget) relying on tax revenues.

It will be important to ensure that this announcement actually results in a relative increase in the health budget. However, the macroeconomic situation resulting from the COVID-19 crisis, with a fall in tax revenues, could jeopardise the commitment to annual increases in the health budget. While the signals coming from senior politicians remain positive, the challenge will nevertheless be to ensure that the health budget is not neglected as of 2021. This is all the more important as the health sector is at serious risk during donor transition. On the one hand, this is due to the fact that private sector development is slow to intervene and does not allow the full amount of donor funding to be offset upon withdrawal. On the other

hand it is due to the fact that the health sector has significant needs that are likely to increase as the country develops and the population ages.

Côte d'Ivoire has enough time to prepare for the transition, but needs to take a proactive approach. Côte d'Ivoire can develop discussions on the best way to finance the health system through the National platform for health financing co-ordination created in 2019. The work of its four technical working parties will have to play a leading role in forthcoming discussions, which this report will be able to inform.

This discussion on health system financing can also help improve inter-ministerial exchanges. The MSHP could take advantage of this situation to build on its capacity for advocacy with the Ministry of Budget and State Portfolio (MBPE), notably through a more systematic use of quantitative studies. This could work in MSHP's favour during budget negotiations by improving the Ministry's own budget allocations and demonstrating the need for additional funding to other ministries. More broadly, more regular and structured discussions through the platform will make it possible to strengthen budget governance.

The need to increase public funding in the health sector

Over the period 2013-17, growth in *total* health expenditure was driven by public spending. The main factor behind growth in *public* health expenditure is economic growth. Accordingly, strong economic growth since the end of the political crisis has increased public spending on health. In this context, the slowdown in economic growth resulting from the COVID-19 crisis is expected to have a negative impact on public health expenditure in 2020, or even beyond if the crisis were to continue. The second factor is the increase in total public spending, which highlights the fact that improving the state's budgetary situation is of extreme importance for the public funding of the health system in Côte d'Ivoire. This calls for an extensive tax reform, to be implemented gradually, to increase the fiscal room for manoeuvre for the health sector.

Côte d'Ivoire's poor health performance demonstrates that public health spending will need to be increased significantly in the medium term, and its efficiency improved. Based on methodology developed by the IMF, if Côte d'Ivoire wants to move closer to the health-related Sustainable Development Goals by 2030 (SDG 3), its health expenditure would need to represent 10.6% of GDP (+4.6 GDP percentage points). This increase would multiply per capita health expenditure by 3.3, the number of doctors by 6, and the number of medical staff by 4.5 (if current health workforce policies are kept constant). The 4.6 GDP percentage point increase in health expenditure would represent an increase of XOF 4 617 billion (XOF 330 billion per year) over the period 2016-30, of which XOF 2 322 billion would be public health spending (XOF 166 billion per year). This amount includes specific health expenditures such as the commitment to an annual increase in MSHP's budget, coverage of Gavi's withdrawal, the Global Fund's co-financing policy, and the financing of UHC. Accordingly, while the commitment to increase the health budget by XOF 47 billion per year is welcome, the estimates above show that Côte d'Ivoire will need a larger increase if it is to get close to SDG 3, and better manage the financing of the UHC and donor transition.

The precise estimate of the financing UHC costs is difficult, given that it was only introduced at the end of 2019 and that the start of 2020 was overshadowed by COVID-19, meaning that the vision of actual health expenditure is not sufficiently sound. Projections for UHC expenditure indicate that the scheme is financially sustainable for five years if the basket of care and the amount of contributions remain the same. Nevertheless, UHC will make a loss if the basket of care, which is currently relatively limited, is extended to cover other medical conditions. Accordingly, if the actuarial studies will need updating in 2021, it seems clear that the basic general scheme contribution (XOF 1 000 per month and per insured party) will need to increase as the basket of care widens, and be made more progressive. Similarly, more tax revenues will need to be mobilised to finance the medical assistance scheme, notably by making greater use of taxes on products harmful for health.

There is no question that a tax reform is needed to mobilise sufficient resources for the health system. Indeed, even if economic growth leads to an increase in public spending in Côte d'Ivoire, this will not be enough on its own, as the long-term trends reveal. In addition, growth is expected to be impacted by the repercussions of the health crisis in 2020, or even longer if the effects of the crisis were to last. Accordingly, even if Côte d'Ivoire can rely on economic growth to increase its public health spending, the fact remains that this needs to be accompanied by making health a budget priority. This prioritising needs to be financed by a tax reform, to be implemented gradually, to create sufficient fiscal room for manoeuvre.

Use of innovative financing will not be enough. According to MSHP's *dialogue national sur le financement de la santé* (national dialogue on financing the health system), health financing will partially make use of innovative funding mechanisms (development of impact bonds, green funds, taking advantage of the potential of regional entities). Nevertheless, even if the innovative funding mechanisms can help top up financial resources, the main challenge for Côte d'Ivoire is to better mobilise domestic tax revenues.

Before the crisis, a tax reform already seemed essential if Côte d'Ivoire were to reach a higher level of development. The country's tax revenues are struggling to take off, stuck between 15% and 16% of GDP since 2014, i.e. well below the WAEMU target of 20% by 2020, and are expected to be affected by the COVID-19 crisis. The tax structure has barely evolved and remains dominated by taxes on exports and imports and the VAT.

As a result, in 2019, Côte d'Ivoire's pledge to reduce its budget deficit forced it to reduce investment expenditure. However, on the one hand, a downturn in investment expenditure can have a negative impact on medium-term economic growth (and the financing of total health expenditure). On the other hand, it can also lead to budget cuts in social sectors, including health.

The future tax reform will have to prioritise broadening the tax base, rather than raising rates. Given the extent of the informal sector and fraud, the tax base in Côte d'Ivoire is narrow, resulting in formal companies paying high taxes, which in turn penalises growth and output at a time when private investment was once again becoming the main driver.

Insofar as there are winners and losers in all tax reforms, one of the prerequisites for its accomplishment will have to be recognition at a high political level of the need for such a reform. It can be launched at the end of the health crisis and after the presidential elections in October 2020.

With the exception of growth, which is expected to shrink in 2020, thus complicating the adoption of a reform of this kind, several conditions are in place to allow its successful achievement. On the one hand, the increased capacities of the tax and customs administration will support its preparation and implementation. On the other hand, the absence of any short-term donor withdrawals (with the exception of Gavi) means that a tax reform can be carried out at the same time as a health sector reform.

The health sector reform is required to improve the efficiency of public health expenditure, which will be increased through additional financing. For example, the management and planning of public health financing will need to be improved by closer monitoring of the financial flows, audits and assessments of the various health projects and programmes financed by public funds.

The targets in terms of the tax burden should be ambitious. The World Bank considers that Côte d'Ivoire could have a tax to GDP ratio of 25.3% (versus 17% currently). Tax under-mobilisation is estimated to be 7.4 GDP percentage points (6 p.p. for VAT and 1.4 p.p. for direct taxation). According to CERDI, the tax burden rate for the period 2010-15 could be 22.5% of GDP. Since the estimated additional amount of public health spending for Côte d'Ivoire is XOF 166 billion a year, Côte d'Ivoire needs to set ambitious targets for its tax reform, with staggered measures. In the short term, for example, there are possibilities for financing health with excise duties on products harmful for health.

Approaches for a better domestic financing of the health system

Improving the financing of the fight against AIDS, TB and malaria will be based on three main pillars. First, strengthening the health system financing in light of the new challenges that emerged during the COVID-19 crisis will be necessary. Second, given the health crisis generated by the COVID-19, encouraging individuals to contribute to UHC and to finance this new scheme will be required. Finally, ensuring that budgetary pressures on the health sector in the aftermath of the COVID-19 crisis are not detrimental to the financing of the fight against AIDS, TB and malaria will be crucial. The following recommendations aim at developing this last point.

Increase health-related tax revenues

Excise duties on products harmful for health

With total tobacco duties in Côte d'Ivoire amounting to 45% of the ex-factory selling price excluding tax (versus 65% in Senegal and 150% in Ghana), **Côte d'Ivoire has room to increase tobacco taxation**. Taxation of tobacco comprises a single ad valorem rate of 38% of the ex-factory selling price excluding tax, a 5% special tax for sport development and a 2% solidarity tax to combat AIDS and smoking. Total tobacco duties are below the WHO standard (75% of the retail value) and WAEMU guidelines (minimum of 50%). Taxation of tobacco raised XOF 22 billion in 2019 (0.5% of total tax revenues), which is low compared to other near-income countries. As a result, the country has decided to gradually increase the ad valorem rate, but before doing so it needs to tighten up its policies for combating smuggling.

Excise duties on alcohol could continue to be raised. Taxation on beverages raised more than on tobacco (XOF 28 billion in 2019, i.e. 0.7% of total tax revenues). Excise duties on alcohol were increased in 2018 to respect the WAEMU range (15%-50%) but could be raised further. Taxes on energy drinks and non-alcoholic beverages (excluding water) have been increased and are in the WAEMU range.

In addition to duties on tobacco and alcohol, Côte d'Ivoire has also introduced 10% excise duties on heavy-duty vehicles and marble, two products on the WAEMU list. Initially, Côte d'Ivoire also wanted to introduce excise duties on cosmetics, but this plan was abandoned. It could however be reassessed in light of budget developments stemming from the COVID-19 crisis.

Compulsory health insurance contributions

Within the framework of the basic general scheme, the design of compulsory health insurance contributions, introduced in July 2019, could be reviewed. The scheme guarantees provision of care to all populations in exchange for a monthly contribution of XOF 1 000 per insured party. There are, however, several drawbacks. On the one hand, the contribution is regressive, as it is not adjusted to income. On the other hand, in the private sector, the employer covers 50% of the contribution for employees, their unemployed spouses and a maximum of six children who are either under the age of 21 or disabled, which is a clear advantage over the self-employed, self-employed entrepreneurs and workers in the informal sector. Thus, in order not to discourage the employment of workers with families, the employer contribution for this category should not be higher than for workers without children

The challenge in the short term is to ensure the full collection of private sector contributions, and the compliance of all companies. In 2019, even if 90% of projected contributions were collected, most of them came from the public sector (72%). The low level of collection in the formal private sector is due to the fact that not all companies report all their employees, and the collection of contributions from the National Health Insurance Fund (CNAM) is not carried out in a systematic manner. In order to increase the collection of private sector contributions, inspections could be strengthened by cross-referencing the information submitted by companies to the tax administration and the CNAM. In addition, the right to deduct wages and the employer contribution to compulsory health insurance from the corporate tax base could be made conditional upon proof of the declaration of employees to the CNAM.

In the medium term, the UHC scheme is not financially sustainable and the contribution should be reviewed. The scheme is sustainable for five years if the basket of care and the amount of contributions remain the same. As a result, it has been estimated that the monthly cost of UHC is closer to XOF 1 215 per insured party, and that, to improve the financial sustainability of the system, the monthly contribution should be closer to XOF 1 500. These projections should be updated to reflect the scheme's actual expenditure in 2019 and 2020. Nevertheless, it seems undeniable that the basic general scheme contribution will have to change along with the basket of care, and become fairer and more progressive. Similarly, the mobilisation of additional tax revenues to finance the medical assistance scheme will be expected, for example via greater use of taxes on products harmful for health.

The upward revision of the UHC contribution should not increase the tax burden on labour, so as not to discourage the creation of formal jobs. The burden is relatively high, particularly for low-income earners, and affects incentives to work and informality. It is also substantial for very high earners, which encourages tax evasion. Accordingly, one possibility would be to maintain the current level of contribution (or increase it very gradually over a long period) and then supplement it with a second progressive factor that would not be based on labour. For example, this could involve introducing a social VAT, the proceeds of which would come from the abolition of non-targeted VAT reduced rates or VAT exemptions.

In the long term, in order to encourage informal workers to join the formal system and contribute to UHC, one possibility would be to evolve the current system into a two-pillar system. Despite the mandatory nature of UHC, the enrolment of informal workers and their payment of contributions are carried out on a voluntary basis, which poses a problem for the sustainability of this system for this population. The first pillar would be free basic and universal coverage for all Ivoirians (not just the indigent category), financed by the general revenues of the state budget. This would then be completed by a second pillar offering a more generous basket of care funded by compulsory and progressive contributions by formal workers. In this manner, workers would have access to more health services provided that they had a sufficiently long history of payment of contributions. These contributions should be progressive, so that informal workers are not put off joining the formal system, and mandatory, to ensure that formal workers and government officials do not withdraw from the public system and turn to their private care plans. Otherwise, the outcome would be a two-tier medical insurance system, with an under-financed public portion.

It makes all the more sense to reduce informality in order to broaden the tax base as future demographic developments are an opportunity for Côte d'Ivoire to strengthen its UHC financing. While 90% of workers are informal, developing a broader tax base with a high number of formal taxpayers will help improve UHC financing, and thereby better shield citizens from catastrophic health expenditure. The COVID-19 crisis was a timely reminder of the need to do so. It therefore seems necessary to develop a strategy to formalise the economy in order to finance the health sector. To this end, Côte d'Ivoire has taken measures to reduce the informal sector but they remain marginal given the extent of the issue. Measures such as the reform of the flat-rate tax ("*impôt synthétique*") and the streamlining of parafiscal taxes are expected and should be integrated into a global strategy to formalise the economy.

Environmental taxation

Environmental taxation in Ivorian tax policy is almost inexistent. It is only the subject of several ill-assorted measures, such as tax credits for entreprises in waste recycling, a tax on timber sales, or parafiscal taxes. The recent debate on the carbon tax did not lead to its implementation.

The COVID-19 crisis could be an opportunity to put environmental taxation back in the picture. For a start, it represents an untapped potential source of tax revenues; it also plays an important role in sustainable growth and positive health outcomes; and lastly it would help diversify the Ivoirian tax structure.

Health-related tax expenditures

There are many substantial tax expenditures. This observation is underscored by the introduction of the new Investment Code, and tax exemptions in 2019 and 2020. Generally speaking, Côte d'Ivoire needs a broader tax base, and the tax incentives in place should seek to stimulate job creation rather than attract capital-intensive foreign direct investment. The health sector also benefits from tax expenditures related to taxes on wages and salaries and the VAT, such as the National AIDS, Malaria and Tuberculosis Control Plans.

Increase the tax revenues of the general state budget

Côte d'Ivoire could streamline VAT exemptions. Revenues from indirect taxation, notably VAT, are partially reduced by numerous exemptions, some of which support the health sector. Generally speaking, while measures have been taken to improve the efficiency of this tax, the streamlining of certain VAT exemptions is expected, as many parts of the economy continue to be exempted (including the agricultural sector).

Despite a fast growing economy over the past years, corporate income tax has been falling as a result of the numerous tax exemptions or very generous sector codes (including for mining). The health sector benefits broadly from the new Investment Code and the 2020 tax annex that provides additional incentives for the pharmaceutical industry. Indeed, Côte d'Ivoire's priority is to increase domestic production of drugs in order to reduce their costs and encourage the installation of pharmaceutical production units in the country.

There is potential for direct household taxation, but this is only short term as the personal income tax (PIT) hinges on formal workers, who do not represent the majority of the working population. The PIT is based on an old schedular tax system that is complex and opaque, thus acting as a tax disincentive. It could move towards a dual tax system, whereby income from work would be subject to a progressive tax, while capital income would be taxed at a flat and lower rate.

If recurrent taxes on immovable property are to play their full role, coverage by the land register and the valuation of associated property assets are required. Only 25% of the territory is covered by the register. Land registration efforts need to be improved using additional resources, and the information used to value property assets, especially in urban areas, should be better aligned with market values.

Côte d'Ivoire is involved in the fight against tax fraud, but needs to pursue its efforts as fraud is still prevalent in certain sectors (trade, construction, subcontracting) **and among certain actors**. In particular, tax avoidance is widespread within the independents. To measure this reality accurate data on the extent of the problem, improved traceability of non-wage income, and better database interconnection within the administration are needed.

Discussion on earmarking resources for health

Less than 1% of tax revenue is earmarked in Côte d'Ivoire, the majority of which is allocated to the energy and transport sectors as well as for social security funds (excluding UHC). Thus, relatively little tax revenue is earmarked for health care.

Part of the taxation of tobacco is earmarked for health programmes. The proceeds from the ad valorem rate go to the general state budget. The proceeds from the special tax for sport development are allocated to sport federations. The solidarity tax to combat AIDS and smoking is allocated to the AIDS Control Fund (70% of the revenues from this tax, i.e. XOF 910 million in 2019) and the National Programme to Combat Tobacco, Alcohol, Drug and Other Addictions (30%, or XOF 390 million in 2019).

A comprehensive tax reform, to be implemented gradually, is both a necessity and a priority before earmarking tax revenues for health. The MBPE did not endorse the ideas put forward during the 2012 debate on financing the health system with regard to earmarking revenues from airport and port taxes (which represented XOF 655 million in 2019), from telecommunications taxes (XOF 52 billion), from banking taxes (XOF 70 billion) and some of the proceeds from consumption taxes. These taxes represent respectively 0.14%, 12% and 16% of MSHP's 2020 budget. This decision from the MBPE is welcomed, as these taxes have no direct link to health. Moreover, one of MBPE's arguments was that it is impossible to prioritise one sector over another during budget allocation given the budgetary demands exceeding the existing budget. This reality once again underscores the need for Côte d'Ivoire to increase the overall level of tax revenues in the general state budget, which will benefit all ministries, including the MSHP, rather than to earmark a share of tax resources, which are already limited, to health.

Earmarking resources for financing health programmes that are currently covered by donors would be ambitious. If these programmes were to see a fall in their external resources, financing using general state budget revenues would seem a better choice than just earmarking resources, given the high financial amounts at stake.

Conversely, given the significant challenges brought on by the COVID-19 crisis (growth slowdown and diminishing tax revenues), **Côte d'Ivoire can reassess the arguments in favour of earmarking some or all of the taxes on products harmful for health to ensure minimum financing of the health sector**. For example, Côte d'Ivoire could consider earmarking for health a larger proportion of revenues from tobacco taxation, or earmarking some or all of the taxes on alcohol or sugary drinks. Another option would be to earmark for health the additional tax revenues generated by reviewing these taxes, such as the increased tax rates on tobacco, alcohol and sugary drinks.

In the future, if Côte d'Ivoire were to start earmarking greater tax revenues for health, its success would depend upon several conditions, including the MSHP, the MBPE and the Ministry of Economy and Finance (MEF) aligning their health policy objectives, and the assessment of the outcomes of earmarking revenues for the National AIDS Control Fund. Other conditions would be necessary to counteract some or all of the limitations of this method of financing (described in Chapter 5).

Recommendations

The following recommendations can be used to inform the discussions of the National platform for health financing co-ordination. They aim to encourage the financing of the health system, and in particular efforts to combat AIDS, TB and malaria. The first recommendations focus on taxes directly (excise duties on products harmful for health, UHC contributions) and indirectly (environmental taxation, tax expenditures) related to health. Then recommendations for increasing tax revenues for the general state budget, and thus contributing to better financing of the MSHP, are examined.

Finance the fight against AIDS, tuberculosis and malaria

- Strengthen the health system financing in light of the new challenges that emerged during the COVID-19 crisis
- Given the health crisis generated by COVID-19, encourage individuals to contribute to UHC and to finance this new scheme
- Ensure that budgetary pressures on the health sector in the aftermath of the COVID-19 crisis are not detrimental to the financing of the fight against AIDS, TB and malaria
- In general, reinforce the role of the National platform for health financing co-ordination

Increase health-related tax revenues

Excise duties on products harmful for health

- Continue the gradual increase of the single ad valorem rate on tobacco to bring it in line with WAEMU guidelines
- Continue to raise excise duties on alcohol, in particular beer and cider
- Strengthen controls to prevent an increase in smuggling as a result of increased excise duties
- Introduce new excise duties on products on the WAEMU list. In particular, reconsider previous plans to introduce excise duties on cosmetics
- Continue negotiations at the regional level on the WAEMU excise duty directive regarding the application of duties on the retail price (and not the ex-factory selling price)

Environmental taxation

- Put environmental taxation back on the table

Compulsory health insurance contributions

Improvements to financing the UHC system can be staggered:

In the short term:

- Ensure the full collection of private sector UHC contributions, and the compliance of all companies
  - Strengthen inspections by cross-referencing the information that companies submit to the tax administration and the CNAM
  - Make the deduction of wages and the employer contribution to compulsory health insurance from the corporate tax base conditional upon proof by the company of the declaration of employees to the CNAM
- Update the expenditure projections for the UHC scheme based on actual expenditure in 2019 and 2020
- Inject additional tax revenues to finance the medical assistance scheme, for example by making greater use of taxes on products harmful for health

In the medium term:

- Make the basic general scheme contribution fairer and more progressive by taking into consideration its impact on labour tax
  - In order not to discourage the employment of workers with families, make sure that the employer contribution for this category is not higher than for workers without children
  - Consider maintaining the current level of the contribution (or increasing it gradually over a long period) and supplementing it with a second progressive factor that is not based on labour, for example by introducing a social VAT, the proceeds of which would come from the abolition of non-targeted VAT reduced rates or VAT exemptions

In the long term:

- Evolve the current UHC system into a two-pillar system designed to encourage informal workers to enter the formal sector and to contribute to the UHC, with:
  - A first pillar in the form of free and basic universal health coverage for all Ivoirians, financed by the general revenues of the state budget
  - A second pillar offering a more generous basket of care funded by compulsory and progressive contributions by formal workers (provided that they have a sufficiently long history of payment of contributions)

- Pursue a global strategy to formalise the economy
  - Continue to strengthen controls of companies subject to the flat-rate tax ("*impôt synthétique*"), consider consolidating in a report all types of tax avoidance observed, and reform the flat-rate tax
  - Analyse the income distribution of companies according to their turnover, and ascertain whether they deliberately choose not to expand so as not to be taxed at higher rates
  - Restore the entire VAT chain in the agricultural sector
  - Publish and use the Review of special and administrative taxes, and then streamline parafiscal taxes
  - Increase the administration's capacity to audit SMEs

Tax expenditures

- Obtain a better vision of health-related tax expenditures by including in the tax expenditures report the cost of all those concerning VAT exemptions on certain health products
- In general, broaden the tax base. For existing tax incentives, aim at job creation rather than attracting capital-intensive foreign direct investment

Increase tax revenues of the general state budget

Value added tax

- Pursue efforts to streamline VAT exemptions, in particular in the agricultural sector (where the VAT could be applied at a reduced rate) and in doing so draw closer to WAEMU guidelines
- Put in place a plan to streamline tax and customs exemptions
- Carry out a study of the distributional impact of VAT exemptions and reduced rate to ascertain which socio-economic group benefits most in comparison to its total consumption
- Collect VAT on the international supply of intangible services using a simplified registration and collection system

Corporate income tax

- Stop granting tax exemptions and tax benefits
- In general, gradually change the type of instruments used for tax incentives, in all sectors (including health)
  - Encourage tax incentives related to business costs (deductions, accelerated depreciations) rather than profits (exemptions, preferential tax rates)
  - Favour temporary, rather than permanent, tax incentives
  - Systemise the conditions associated with the tax incentives (in particular, the number of jobs created)
- Ensure the monitoring of tax expenditures related to the application of the provisions of the new Investment Code and their fair estimation
- Take account of international tax developments when deciding on the taxation to be applied in the new special economic zones
- Improve taxation of mining resources
  - Limit the tax benefits granted in the Mining Code, especially by considering the abolition of exemptions from customs duties (in so far as capital goods may be imported under suspension of duties under the customs procedure for temporary admission)
  - Eliminate VAT exemptions in the production phase

- Abolish the tax holiday for the tax on business profits and the lump-sum minimum tax
- Cease extending the tax benefits granted to the holders of mining rights to their affiliates and subcontractors

Personal Income Tax (PIT)

- Put in place a simpler and more neutral system for the PIT
  - Simplify the scheduler system, by introducing for example a dual taxation system whereby income from work would be subject to a progressive tax, while capital income would be taxed at a flat and lower rate
  - Reduce the rates and broaden the base of General Income Tax (GIT) by revising the scale (two or three brackets and lower tax rates) and limiting deductions
  - Combine the tax on wages and salaries and the national contribution and transform them into a withholding tax on GIT
- Implement the integrated management information system to capture all revenue flows for cross-checking purposes

Recurrent taxes on immovable property

- Pursue efforts to modernise and improve the coverage of the land register by increasing human and financial resources
- Monitor the additional tax revenues generated by extending the land register
- Make effective use of land register information to value property assets, especially in urban areas, and try to bring them more in line with market values. To do so, put in place a simple and clear method of assessing the value of property assets
- Pursue operations to collect property tax
  - Continue to update the landowner database
  - Continue efforts to cross-reference data and information, especially with water and electricity suppliers
  - Conduct a physical inventory of plots of land

Tax avoidance and tax fraud

- Refine risk analysis by establishing indicators based on company data and their scoring
- Continue to use risk management as the basis for selecting cases for inspection
- Continue to increase headcount and the capacities of officials in the Investigation, Cross-checking and Risk Analysis Directorate
- Increase the frequency of inspections and diversify audit methods, especially in sectors where fraud is common
- Pursue efforts to exchange and cross-reference information, in particular database interconnections within the administration and with the CNAM
- Complete the National Register of Natural Persons and link it to the Tax Administration and the CNAM databases
- Pursue efforts to reduce fraud risks by better monitoring goods in transit and strengthening the presence of customs services along all borders (especially in the north) to deter smuggling. In particular, consider more efficient collaboration between police services and the Trade Ministry (better circulation of information, provision of shared tools, etc.)
- Continue to regularise companies that are already established so that they have their own unique national identifier.

- Put in place certified electronic invoicing

Earmark tax revenues for health

- Make an extensive and gradual tax reform a priority over earmarking resources for health
- Avoid earmarking resources for financing health programmes that are currently covered by donors given the high financial amounts at stake
- Nevertheless, given the significant challenges generated by the COVID-19 crisis, envisage a greater earmarking of tax revenues for the health system
  - Consider earmarking a larger share of income from tobacco taxation
  - Consider earmarking some or all of the taxes on alcohol and sugary drinks
  - Consider earmarking the additional tax revenues generated by the revision of the taxes mentioned above (such as rate hikes)
- In future, if Côte d'Ivoire were to start earmarking greater tax revenues for health, ensure that the conditions for its success are in place
  - Use regular dialogue within the National platform for health financing co-ordination to make sure that the MSHP, the MBPE and the MEF have the same vision in terms of the objectives of resource allocation
  - Assess the outcomes of earmarking revenues for the National AIDS Control Fund
  - Guarantee a series of other conditions to counteract some or all of the limitations of this method of financing (see Chapter 5)

1 Côte d'Ivoire and COVID-19

The coronavirus disease-2019 (COVID-19) crisis, during which this report was written, has provoked strong responses from governments worldwide, including Côte d'Ivoire. The analyses contained in this report take account of recent developments in the health sector where possible. While some analyses are independent of the current context, others will feed into a broader discussion on health financing in the aftermath of the crisis.

Côte d'Ivoire has adopted several measures to contain COVID-19

A Health Response Plan, costed at almost XOF 96 billion (0.3% of gross domestic product (GDP)), has been implemented to tackle COVID-19. The government is providing XOF 25 billion to finance this plan, with donors contributing the rest (Côte d'Ivoire, 2020[1]). Given that some disbursements not covered by the budget have already been paid, Côte d'Ivoire is now working to amend the 2020 budget.

An Economic, Social and Humanitarian Support Plan has been implemented to mitigate the economic impact of the crisis. This plan, amounting to XOF 1 700 billion (5% of GDP), includes measures to support businesses, the economy and the population.

Tax measures have also been taken, including temporarily suspending tax audits, postponing some flat-rate taxes and other taxes and charges (particularly in those sectors most severely affected), reducing transport licence fees, exempting COVID-19-related health equipment from duties and taxes, and reimbursing value added tax (VAT) credits within two weeks.

Despite these efforts, the crisis will have a significant economic and social impact

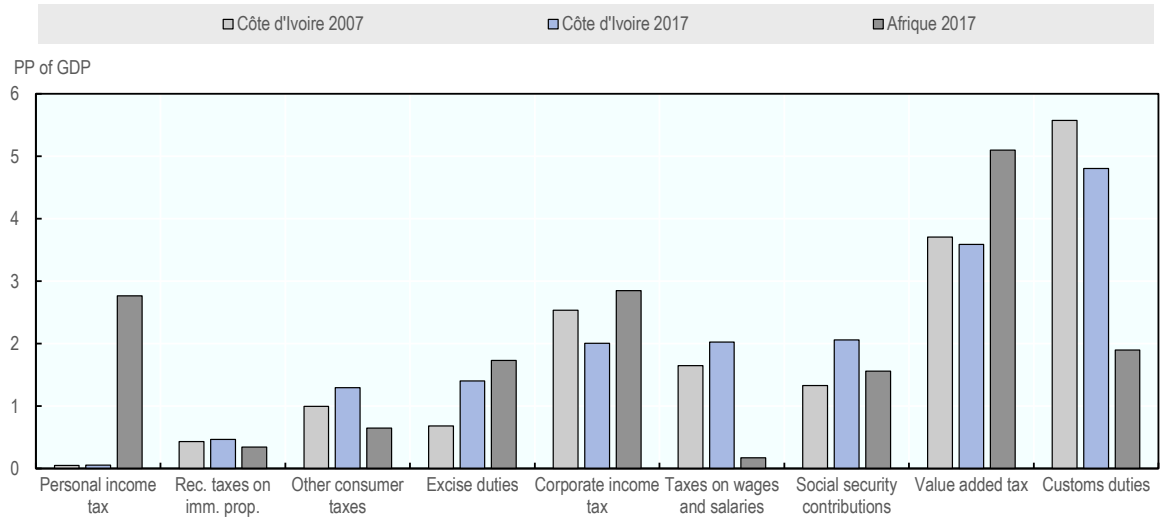
The Ivorian authorities have revised their economic growth estimate down from 7.2% to 3.6% in 2020, assuming that the pandemic is brought under control by the end of June 2020 (Côte d'Ivoire, 2020[1]).

The International Monetary Fund (IMF) has projected growth of 2.7% in 2020 (compared with 6.7% before the crisis) (IMF, 2020[2]). In Côte d'Ivoire, the budget deficit is expected to deteriorate to 5.2% of GDP (compared with the pre-crisis projection of 2.3%). Public debt is expected to increase to 42.1% of GDP in 2020 (compared with an estimated 38.2%). External debt is expected to rise from 26.6% of GDP in 2019 to 31.5% in 2020. It is estimated that the pandemic will cost 2.75% of GDP in Côte d'Ivoire (IMF, 2020[3]). To support the country's balance of payments and state budget, the IMF disbursed USD 886 million (100% of Côte d'Ivoire's quota and 1.5% of GDP). This support was provided by the Rapid Credit Facility (USD 295 million) and the Rapid Financing Instrument (USD 590 million) (IMF, 2020[3]).

While the exact impact of the crisis on tax revenues is difficult to predict at this stage, some trends are emerging based on Côte d'Ivoire's tax structure. The IMF has forecast that tax revenues will fall from the 12.4% of GDP projected before the crisis to 11.8% of GDP (IMF, 2020[3]). Although corporate income tax revenues are generally sensitive to changes in GDP, as evidenced by the 2008 financial crisis, given that the current crisis is not financial in nature and that corporate income tax is a minor component

of the Ivorian tax structure, its impact on this tax is expected to be marginal (Figure 1.1). Conversely, this crisis is expected to impact revenues from comsumption taxes, personal income tax and social security contributions (SSC), as well as revenues related to international trade, more sharply than the 2008 crisis. Tax revenues in particular are expected to be negatively affected by the fall in the price of Côte d'Ivoire's raw material exports, including cocoa and palm oil. This is particularly problematic given that the country's tax structure relies heavily export and import taxes and the VAT (Figure 1.1).

Figure 1.1. The tax structure relies heavily on export and import taxes and the VAT, which are expected to be severely impacted by COVID-19



Note: The ratio of tax revenues to GDP in Côte d'Ivoire was 15.3% in 2000, 17.1% in 2007 and 17.9% in 2017. It was 17.2% in Africa in 2017.
Source: Database: Revenue Statistics (OECD).

The decline in some tax revenues highlights the need to diversify the tax structure. There are several ways in which Côte d'Ivoire could achieve this:

- **Broadening the tax base**: abolishing certain tax expenditures, tackling tax evasion, implementing a policy to reduce the informal sector.
- **Harnessing underutilised taxes**: such as personal income tax or recurrent taxes on immovable property.
- **Introducing new taxes**: such as carbon pricing.

With tax revenues declining, approaches to increasing fiscal space for health vary:

- **In the short term**, Côte d'Ivoire will need support from donors to withstand the health, economic and social shock. Migrant remittances have declined during the crisis and are expected to settle at low levels in the coming months. This situation risks making out-of-pocket expenditure for health even more difficult for Ivorian households.
- **In the medium to long term**, prioritising health in the budget and securing its sources of funding will be the main requirements. This report is part of that process. Before the crisis, Côte d'Ivoire set up a National platform for health financing co-ordination. Strengthening the role of this platform will be crucial in the post-crisis period.

At this stage, the precise impact of crisis on health expenditure is difficult to estimate. While some health expenditure have increased, other have been reduced, in particular non-urgent care.

There is a risk that financial support for AIDS, tuberculosis (TB) and malaria control will stagnate or even fall. This could be due, on the one hand, to increasing health expenditure failing to have a positive impact on these three diseases or, on the other, to shifting priorities within the health sector (such as a greater focus on preparing for future health crises) leading to budget reallocations.

However, in Côte d'Ivoire, the current crisis does not seem to pose a threat to funding for these three diseases. In fact, these three diseases are covered by national priority programmes under which activities and funding are continuing despite the COVID-19 crisis. Nevertheless, implementing some activities have become difficult. For example, the New Public Health Pharmacy struggles to procure TB drugs given the impact of COVID-19 on the institution's funds. Moreover, people, fearful of catching COVID-19, are less attending health centres, a situation that presents its own challenges (resurgence of diseases, under-vaccination, etc.). Therefore, the Global Fund finances contingency additional activities to mitigate the impact of avoidance of services across all disease programs.

2 The need to continue inter-ministerial discussions on health financing

Côte d'Ivoire's health sector performs well below expected for the country's level of development

The performance of Côte d'Ivoire's health sector is similar to that of least developed countries, despite having a higher income level following strong growth since 2012 (Figure 2.1 – Panels A to C). Life expectancy is 54 years (2016). The maternal mortality rate is 617 per 100 000 live births (2017). The under-five mortality rate is 84 per 1 000 live births (2017). Given this context, Côte d'Ivoire has set objectives to reduce the maternal mortality rate to 515 deaths per 100 000 live births, the neonatal mortality rate to 30 per 1 000 (Côte d'Ivoire, 2019[4]).

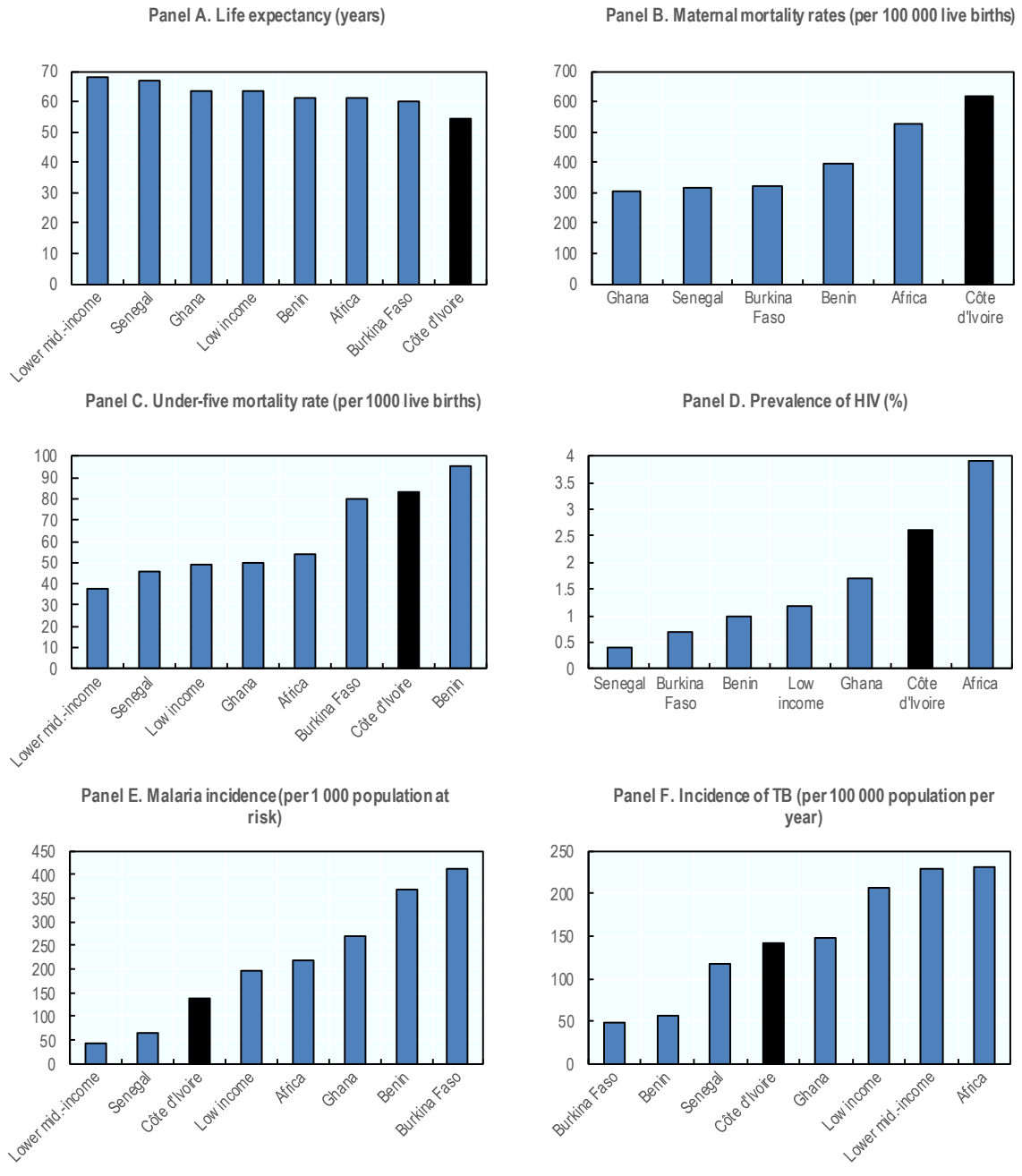
Côte d'Ivoire's epidemiological status is also among the worst in the region (Figure 2.1 – Panels D to F)**.** Malaria's incidence is 138 per 1 000 population. HIV prevalence is one of the highest in the region, at 2.6% (in 2019, Côte d'Ivoire achieved 72-82-77 compared with the 90-90-90 target).[1] TB is the leading cause of death among people living with HIV (World Bank, 2018[5]).

At the same time, the burden of non-communicable diseases is increasing (MSHP, 2019[6]). This is particularly the case for chronic diseases (long-term conditions), which become more common with age and in response to changing consumer patterns and behaviour.

Finally, despite the fall in the population growth rate (to 2.6% in 2016, for a population of 25 million, 50% of which lives in rural areas), Côte d'Ivoire's demographic profile poses a challenge for the health system. With 60% of the population aged under 25 in 2020 and 46% of the population living below the national poverty line, the demand for health care is high (Figure 2.2). Moreover, this demand is expected to increase over time given that the fertility rate remains high (4.6 births per woman in 2016).

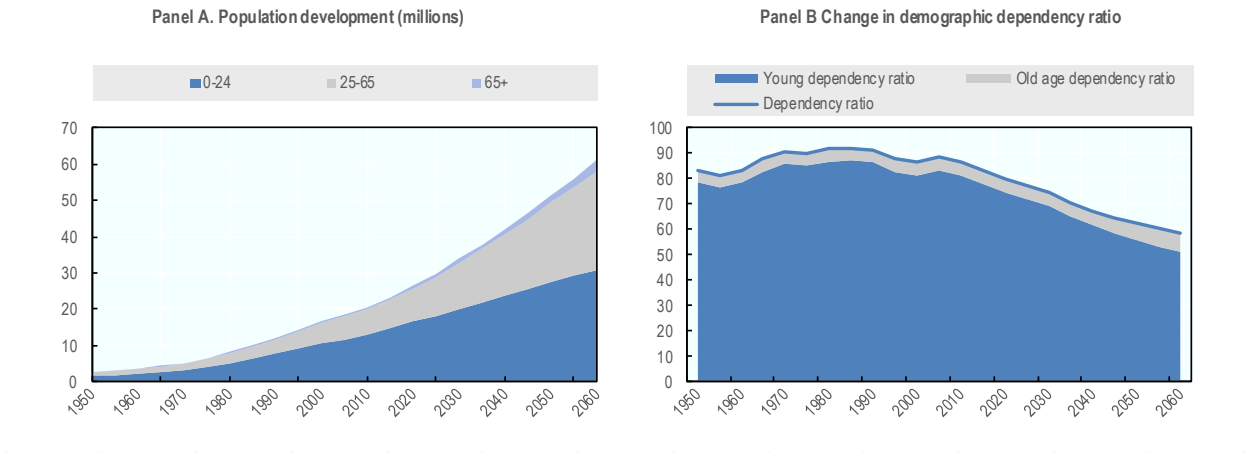
[1] The targets: 90% of people living with HIV know their HIV status; 90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy; 90% of all people receiving antiretroviral therapy have viral suppression.

Figure 2.1. Côte d'Ivoire's health sector performs well below expected for the country's level of development



Notes: Panel A: WHO data for 2016, except for income averages (World Bank, 2017). Panel B: WHO data for 2017. Panel C: WHO data for 2017, except for income averages (World Bank). Panel D: WHO data for 2018, except for income averages (World Bank). Panel E: WHO data for 2017, except for income averages (World Bank). Panel F: WHO data for 2017.
Sources: WHO; World Bank.

Figure 2.2. Côte d'Ivoire's population is young



Notes: An average fertility rate is assumed.
Panel B: The demographic dependency ratio is defined as the population aged 0–24 years and 65+ years divided by the population aged 25–64 years. The old-age dependency ratio is defined as the population aged 65+ years divided by the population aged 25–64 years. The youth dependency ratio is defined as the population aged 0–24 years divided by the population aged 25–64 years.
Source: Database: World Population Prospects: 2017 Revision (United Nations).

Health financing faces several challenges

Health financing is insufficient and health spending ineffective

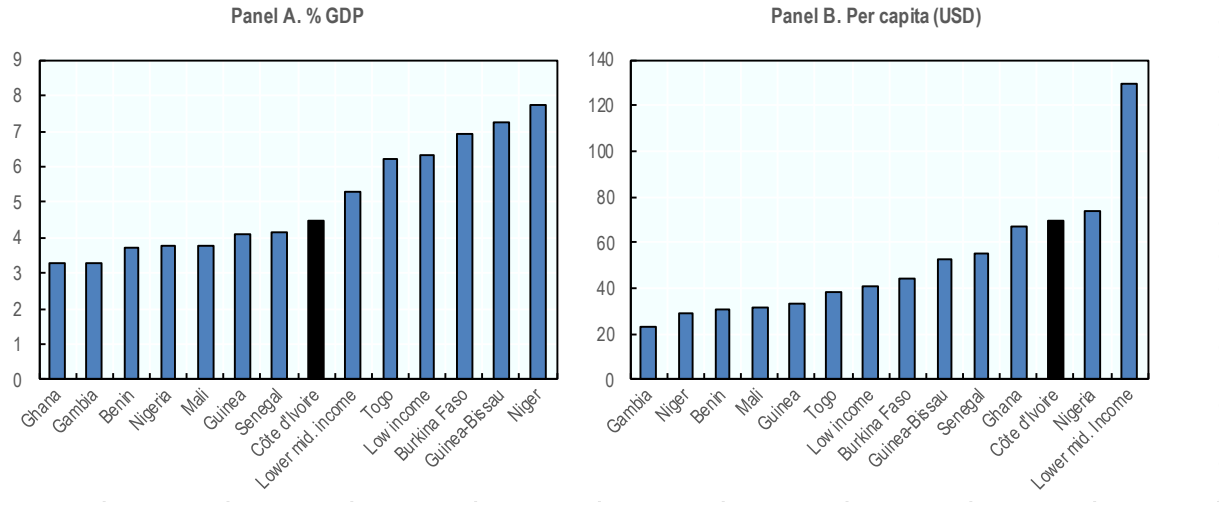
Côte d'Ivoire does not allocate a sufficient level of funds to the health sector. Its total health expenditure was USD 1.75 billion in 2018 (MSHP, 2019[7]), or 4.5% of GDP in 2017 (WHO, n.d.[8]). This level is below the average for low-income countries (6.3% of GDP) and lower-middle-income countries (5.3% of GDP) (Figure 2.3) (WHO, 2019[9]).

Total health expenditure per capita in Côte d'Ivoire was USD 70 in 2017, which is higher than that of low-income countries (USD 41), but well below the average for lower-middle-income countries (USD 130) (WHO, 2019[9]).

Nevertheless, compared with the rest of the region, health financing is higher in Côte d'Ivoire. Health expenditure represents 3.3% of GDP in Ghana (USD 66 per capita), 3.7% of GDP in Benin (USD 31 per capita) and 4.1% of GDP in Senegal (USD 55 per capita) (Figure 2.3). Given that its health performance is among the worst in the region, this suggests that health expenditure in Côte d'Ivoire is ineffective.

Figure 2.3. Côte d'Ivoire only allocates a small amount of funding to health, but still more than other countries in the region

Total health expenditure, 2017



Source: Database: Global Health Expenditure (WHO).

Côte d'Ivoire's health system does not rely heavily on the compulsory health insurance system

Out-of-pocket expenditure accounts for 39% of health financing.[2] Public sector schemes and health financing schemes based on compulsory contributions play a significant role (36%) and are dominated by public sector schemes. Health financing schemes based on compulsory contributions are still poorly represented, reflecting the recent introduction of universal health coverage (UHC) in October 2019 (see the decree of 29 June 2017 for the composition of the UHC services package). Voluntary private payment schemes for health care are also well established (25% – Table 2.1), especially corporate schemes.

Health care is organised on three levels (primary, secondary and tertiary), comprising a public sector, a private for-profit sector and a private not-for-profit sector.

The private for-profit sector plays a major role in health financing with an average contribution of XOF 131 billion per year from 2013 to 2018. With more than 2 000 facilities, this sector plays a significant role in health care, particularly in urban areas. Although its engagement in AIDS control is marginal, this sector plays a more substantial role in TB control, in particular through companies in the interior of the country that have authorised TB control activities to be implemented at their health centres (these centres are open to people directly employed by these companies as well as those working for them indirectly). However, private clinics play a more limited role in TB control because their laboratories are often not equipped to deal with this disease or due to concerns about its contagiousness. In general, the private health sector needs to be better supervised and regulated to prevent it from the development of facilities that do not comply with standards. The private not-for-profit sector is also involved in private health care, especially primary care, and had 49 facilities in 2011 (WHO, n.d.[10]).

[2] Financing schemes are the main types of arrangements used by the population to purchase and access health services.

Table 2.1. Health financing schemes in 2017

	Share
1. Out-of-pocket expenditure	**39%**
2. Public sector schemes and health financing schemes based on compulsory contributions	**36%**
2.1. Public sector schemes	35%
2.2. Health financing schemes based on compulsory contributions	1%
2.2.1. Health insurance schemes	*1%*
2.2.2. Compulsory private insurance schemes	*0%*
3. Voluntary private payment schemes for health care	**25%**
3.1 Corporate financing schemes	11%
3.2 Voluntary health insurance schemes	8%
3.3. Not-for-profit organisation schemes	6%

Note: This figure complements Table 2.2. While this figure presents health financing *schemes*, Table 2.2 presents the *sources* of health financing.
This figure does not include UHC (introduced at the end of 2019). From 2019–20, data on the contribution of UHC will appear under category 2.2.
Source: Database: Global Health Expenditure (WHO).

Health financing relies heavily on households

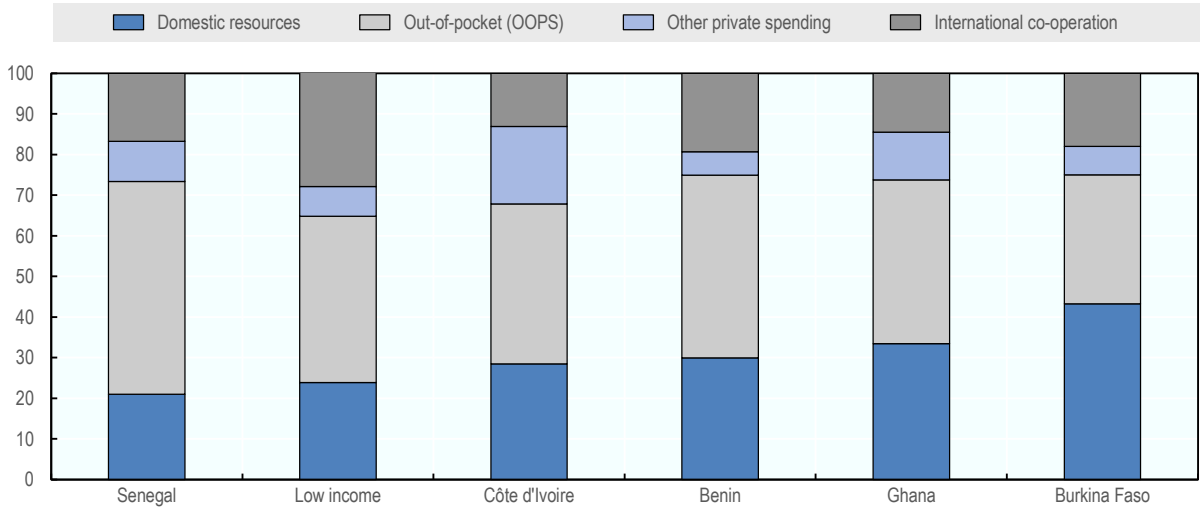
Out-of-pocket payments by households are the main source of financing, representing 39% (well above the World Health Organization's (WHO) 25% standard), followed by domestic resources (28% – mainly comprising tax revenues, as the proportion of SSCs is still low – Table 2.2), then other private expenditure (19%), and international co-operation (13%) (Figure 2.4). Other private expenditure includes indirect spending by households (e.g. private insurance policies) and businesses (e.g. if they have a health centre). The contribution of voluntary prepayments (i.e. through private health insurance) is low, although this sub-sector is now growing.

Out-of-pocket expenditure for health care, primarily spent on medication (especially for non-communicable diseases), can lead to catastrophic expenditure.[3] In the past, this would have affected between 12% and 18% of Ivorian households (MSHP, 2019[11]) (World Bank, 2019[12]). Out-of-pocket expenditure for health care is high because health coverage is low and because more than three quarters of household expenditure on drugs is spent in the private sector, where prices are higher than at public facilities (MSHP, 2019[7]). However, it should be noted that household expenditure has been declining over the long term (52% of health financing in 2014) (MSHP, 2019[7]).

[3] Expenditure is defined as catastrophic when a household uses at least 40% of its capacity on out-of-pocket spending (WHO).

Figure 2.4. As is the case in many other countries, health financing in Côte d'Ivoire relies primarily on out-of-pocket expenditure

Composition of health financing, 2017



Notes: The quality of the data prevents the inclusion of the lower-middle-income country category. SSCs to health are not included as they were introduced in 2019.
Source: Database: Global Health Expenditure (WHO).

Table 2.2. Sources of health financing in Côte d'Ivoire (2017)

Source of financing	Amount (XOF billion)	Share (%)
Total	**986**	**100%**
Out-of-pocket expenditure	**388**	**39%**
Domestic resources	**277**	**28%**
Internal transfers and donations	265	27%
Government transfers for specific groups	12	1%
Social security contributions	3.5	0%
Other private expenditure	**186**	**19%**
Voluntary prepayment	77	8%
Other corporate financing	109	11%
International co-operation	**129**	**13%**

Notes: This figure complements Table 2.1. While this figure presents the *sources* of health financing, Table 2.2 presents health financing *schemes*.
Source: Database: Global Health Expenditure (WHO).

Some donors are set to withdraw

Some diseases are mainly funded by donors. Their withdrawal will have a considerable impact on financing for these diseases, making the sustainability of external support a major concern.

The United States government, via the President's Emergency Plan for AIDS Relief (PEPFAR), is the largest donor to health in Côte d'Ivoire, as well as the main contributor to HIV control. The Global Fund is the second largest donor and the main contributor to malaria control. Since 2003, it has provided almost USD 640 million in Côte d'Ivoire (Figure 2.5). Gavi, the Vaccine Alliance is the third largest donor and the main contributor to vaccination (Côte d'Ivoire, 2019[4]). Many donors, including those

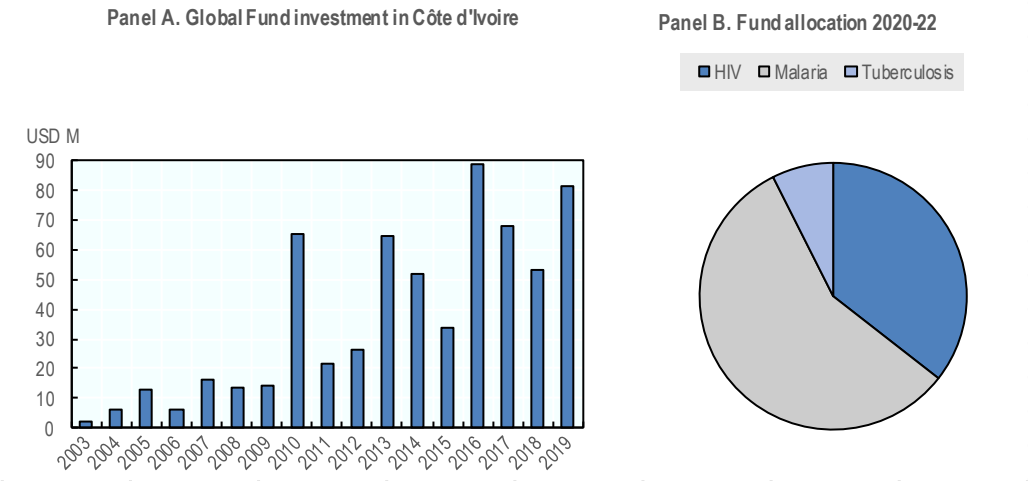
mentioned, provide off-budget funding. This type of funding can have the advantage of providing a degree of transparency, though it also increases the administrative burden.

By 2025, Côte d'Ivoire will no longer be eligible for Gavi funding (Box 2.1). Gavi provided XOF 41 billion in support to Côte d'Ivoire from 2016 to 2018 (Côte d'Ivoire, 2019[4]). However, the organisation expects Côte d'Ivoire to start an accelerated transition in 2020 (based on its average gross national income over three years) and plans to withdraw in 2025. To date, Gavi is the only donor to have officially announced its withdrawal from Côte d'Ivoire. On Gavi's withdrawal, Côte d'Ivoire will assume full responsibility for financing vaccination. This means that a source of domestic funding must be identified now (MSHP, 2019[13]). To this end, Côte d'Ivoire has begun to prepare for the transition with Gavi and a unit has been set up to manage external financing. Consequently, Côte d'Ivoire must increase its contribution each year by increasing the budget line for vaccine procurement and financing operational and logistics costs.

The Global Fund, which has no plans to withdraw from Côte d'Ivoire, seeks to engage states in domestic resource mobilisation by providing access to additional grants. In this way, the Global Fund requires countries to gradually increase their public health expenditure and gradually take over the main programme costs.

Furthermore, Global Fund support is accompanied by an incentive or co-financing package. If countries in Côte d'Ivoire's income bracket contribute domestic resources amounting to at least 15% of their Global Fund funding, they can access an additional package of the same amount from the Global Fund. These additional domestic resources must be used to gradually take over the main costs of the HIV, TB and malaria programmes. Côte d'Ivoire is currently contributing 20%, i.e. EUR 46 million for 2021–23 (for a total allocation of EUR 232 million), of which at least 50% must be invested in efforts to control the three diseases (MSHP, 2019[13]). The Ministry of Health and Sanitation (MSHP) can use this co-financing policy as a tool to urge the Ministry of Economy and Finance (MEF) to make health a higher priority.

Figure 2.5. The Global Fund, a major donor to health in Côte d'Ivoire



Source: Global Fund.

Box 2.1. Gavi, the Vaccine Alliance: Transition policy

For Gavid, the transition begins once the country has a gross national income per capita of more than USD 1 045, resulting in a steady increase in the share of domestic co-financing of vaccines supported by Gavi (Phase 1). Once gross national income per capita exceeds USD 1 580, the country may no longer access new support and existing support decreases (Phase 2). The country should increase its share of vaccine co-financing from the rate achieved at the end of the first phase to cover the full cost over a five-year period. In Phase 3, the country is no longer dependent on financial support from Gavi but can procure the vaccines supported by Gavi at preferential rates over a five-year period. Côte d'Ivoire is expected to cross the gross national income per capita threshold of USD 1 580 and enter Phase 2 in 2020.

Source: OECD.

Public funding for health is low

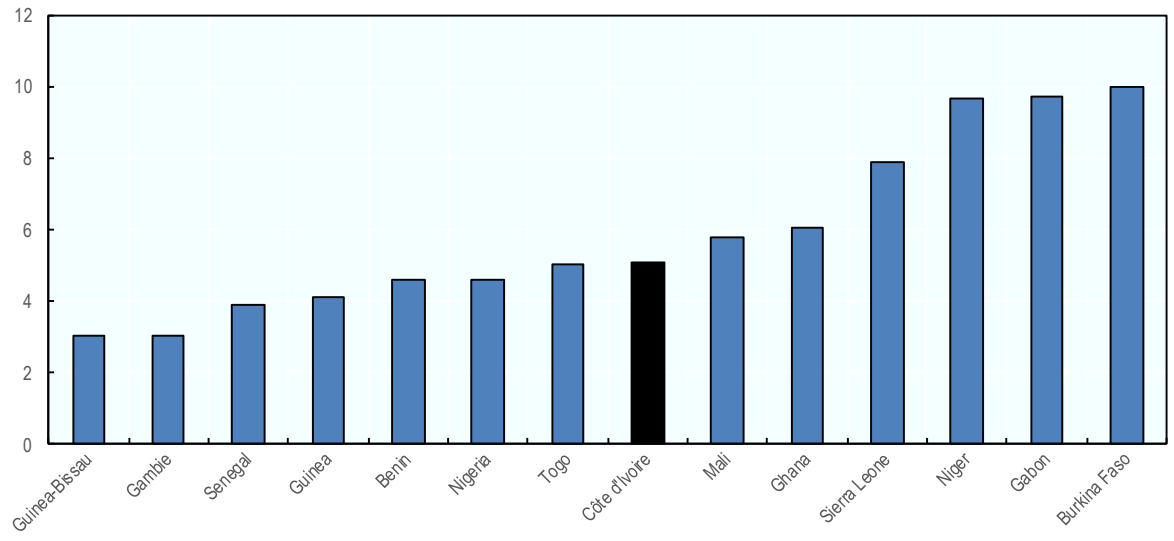
The MSHP is the main public body involved in health financing. Other public entities provide health care through their facilities or are involved in health through their activities (e.g. through the multi-sectoral committees for AIDS, malaria or TB control). This is the case for the Ministries of Defence; Women, Family and Children; National Education; Employment and Social Protection; and the Interior. However, their role is marginal compared with that of the MSHP (XOF 7.2 billion in 2019 financed from the general state budget, compared with XOF 446 billion for the MSHP in 2020), with the exception of the Ministry of the Interior, which has been absorbing the health budget of the regional councils since 2020.

Although the MSHP's budget has been increasing in nominal terms, the state budget earmarked for health has been stagnating between 5% and 6% of the total state budget for many years, even though the crisis in the 2000s led to the partial destruction of the health care facilities. The MSHP's budget increased from XOF 178 billion in 2013 to XOF 446 billion in 2020 (with a 16.6% increase in 2020 compared with 2019). On average, the MSHP's budget was 6% from 2013 to 2019, which is low compared with other countries (Figure 2.6) (MSHP, 2019[14]).

The low health budget is reflected in the deficits of the national disease control programmes, in particular for TB and malaria (Table 2.3), and the failure to upgrade health care facilities, such as hospitals. Increasing the MSHP's budget is therefore essential to better finance the sector, including sector programmes. Indeed, funding for AIDS and TB is primarily provided by donors, while funding for malaria is primarily provided by households (Figure 2.7).

Figure 2.6. The budget earmarked for health is low

Health budget, percentage of GDP, 2017



Source: Database: Global Health Expenditure (WHO).

Table 2.3. Many sectoral plans are underfunded

In XOF billion

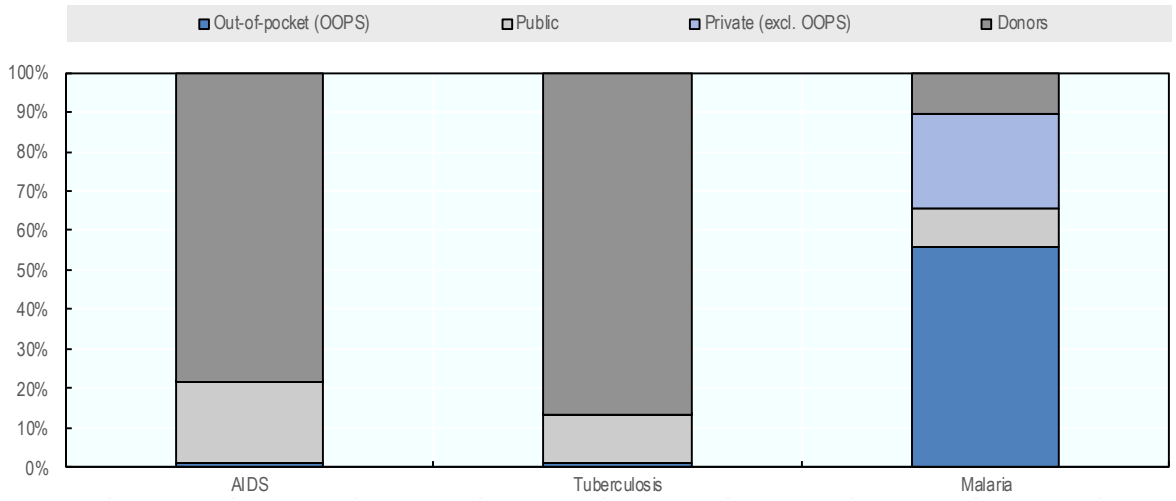
	Strategic Plan for AIDS		Strategic Plan for Tuberculosis		Strategic Plan for Malaria	
	2016–20	2021–25[1]	2016–20	2021–25[1]	2016–20	2021–25[1]
Total budget	556	In the process of being finalised	80	92	Information to be communicated	950
State (tax revenues)	Information to be communicated		14	13	Information to be communicated	Information to be communicated
Donors	Information to be communicated		11[2]	12[2]	Information to be communicated	Information to be communicated
Funding gap	No gap[3]	No gap	66% gap	60% gap	25% gap[4]	There will be a gap

1. May 2020 estimates.
2. Global Fund only.
3. Funding for the National AIDS Control Programme (PNLS) is provided by the government and donors (in particular PEPFAR, the Global Fund and bilateral partners). There was no gap over the 2016–20 period. The government has honoured all its commitments and even increased its contribution with an additional XOF 7 billion per year from 2019 for three years, with the aim of controlling the epidemic.
4. Gap of 45% according to the Global Fund. While Côte d'Ivoire has increased its contribution over the years, it is still not enough to implement its strategic plan.

Sources: Telephone interviews; information provided by the sectoral programme directors/coordinators and MSHP.

Figure 2.7. Public funding for AIDS, TB and malaria is limited

2018



Source: (MSHP, 2019[7]).

The government has committed to increasing the health budget by 15% annually until 2030

In 2019, the government agreed to increase the health budget by at least 15% annually until 2030. After Côte d'Ivoire joined the Global Financing Facility (GFF) (November 2017), an investment case was put together which estimated that XOF 1 658 billion was needed over five years (this figure has not been officially approved yet). A discussion on the different options for funding the health system was held in April 2019, which led to government, donor and private sector commitments. The government has committed to increasing the health budget by 15% annually until 2030 (i.e. at least XOF 47 billion per year, based on the 2018 budget) using tax revenues. In this scenario, donors are expected to increase their funding level by 5% per year (MSHP, 2019[6]).

It will be important to ensure that this pledge results in a relative increase in the health budget. If the total state budget increases at the same (or a higher) rate, the health budget will not have been made a higher priority, whereas if a relative target is set for the health budget (e.g. to make it 6% to 8% of the state budget), this will ensure the sector is better prioritised. However, unless the efficiency of public health expenditure is significantly improved, this is not necessarily the best option.

However, the macroeconomic situation resulting from the COVID-19 crisis, with a fall in tax revenues, could jeopardise the commitment to annual increases in the health budget. While the signals coming from senior politicians remain positive, the challenge will nevertheless be to ensure that the health budget is not neglected as of 2021.

If the country is to meet its commitments and prepare for the transition, inter-ministerial collaboration on health financing will be essential

The donor transition poses a high risk for health

As countries develop, their financing needs and the structure of available financing change. Two major trends emerge: first, the replacement of external financing flows with domestic financing flows, followed by the replacement of public domestic flows with private flows[4] (OECD, 2019[15]).

These changes occur at different levels of development and at different paces across sectors. Figure 2.8 shows trends in official development assistance (ODA – which are concessional flows) and non-concessional assistance (NCA) flows; the latter can be seen as a proxy for the development of private flows, since they are closer than concessional flows to market conditions. Several observations can provide information on the health sector's level of vulnerability during the transition:

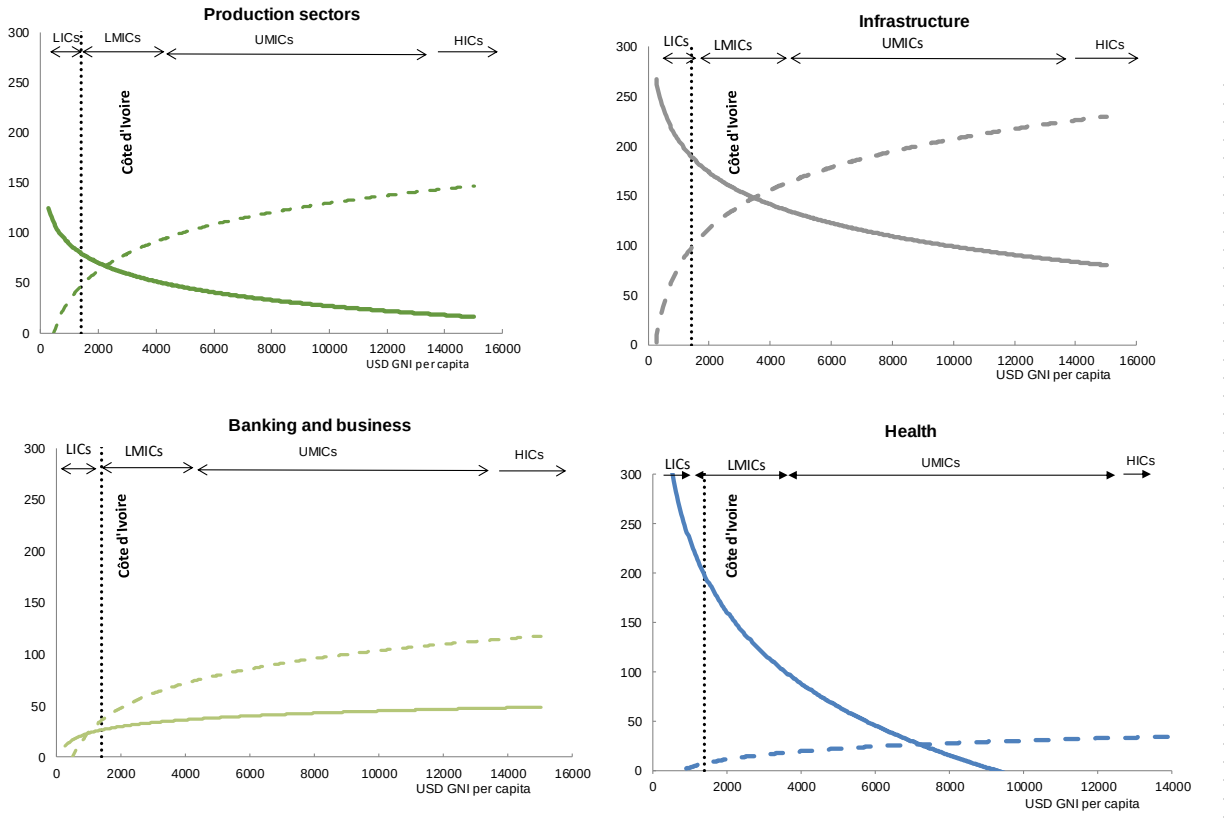
- In countries with low levels of development, relatively high levels of concessional flows are injected into the health sector, particularly compared with other sectors such as infrastructure or productive sectors (agriculture, fisheries and industry). However, donors withdraw faster than in other sectors and, unlike in other sectors, concessional flows do not appear to be fully offset by non-concessional flows. The health sector thus faces a paradox: while it initially attracts high levels of concessional flows, it then experiences a rapid reduction in these flows, which are not fully offset. **This suggests that the health sector experiences a significant funding risk during the transition. At this stage, domestic financing plays a crucial role, which the authorities must anticipate and prepare for.**
- The tipping point between concessional and non-concessional flows occurs at different levels of development depending on the sector: at a gross national product per capita of USD 1 000 for banking/business services, USD 2 000 for productive sectors, USD 4 000 for infrastructure, and USD 7 500 for health. **Health thus appears to be one of the last sectors in which public flows are replaced by private flows. This can be explained by its unattractiveness to the private sector,** with fewer private investment flows, particularly when compared with more profitable sectors such as banking, infrastructure or industry (as highlighted by the lower slope of the dotted line for health in Figure 2.8).

These observations underscore the importance of the need for public resources to support health financing during donors' transition (primarily Gavi). On the one hand, this is due to the fact that private sector development is slow to intervene and does not allow the full amount of donor funding to be offset upon withdrawal. On the other hand, this is due to the fact that the health sector has significant needs that are likely to increase as the country develops and the population ages. Lastly, the quality of the response to infectious diseases such as HIV and AIDS, TB and malaria is very closely linked to overall funding levels.

[4] Investment flows.

Figure 2.8. Donors' withdrawal creates a particularly high funding risk for the health sector

Disbursements in USD million from Development Assistance Committee (DAC) and non-DAC donors, multilaterals and private donors, average 2012–17. Solid lines represent ODA flows. Dotted lines represent NCA flows.



Notes: The graph is based on logarithmic regression values with GNP per capita as an independent variable and ODA and NCA flows by sector as dependent variables. The productive sector includes agriculture, fishing, industry, mining and construction. The health variable includes the categories of health, population policies and programmes, and reproductive health from the Creditor Reporting System (CRS) database. Private donors are included in the ODA flows for health insofar as they traditionally contribute a significant share of health flows in the form of donations. Note that 39 out of 122 countries do not have data on private donor assistance for health.
Sources: Database: World Development Indicators (for GNP per capita) (World Bank); Database: CRS (OECD); (OECD, 2019[15]).

Côte d'Ivoire has enough time to prepare for the transition, but needs to take a proactive approach

Côte d'Ivoire can develop discussions on financing the health system through the National platform for health financing co-ordination, created in 2019. The work of its four working parties will have to play a leading role in future discussions, which this report will be able to inform. Several factors should be taken into account by the authorities as they prepare for this transition: i) the significant contribution of development assistance to health (about 10% of assistance received in 2012–17); ii) assistance flows that are mainly off-budget; and iii) the high volume of grants (over 90% of all assistance for health in 2017), even if recourse to loans is increasing, in particular through the World Bank (OECD,

n.d.[16]). The platform will also ensure that the budgetary commitments made concerning the sector in 2019 (annual 15% increase in MSHP's budget) are fulfilled.

In particular, although there is some inter-ministerial dialogue (collaboration between MSHP, MEF, MBPE, and Ministry of Planning on the government investment programme, the government's social plan, the Comorex platform, within the GFF, or for the implementation of the Health Response Plan), **it could be strengthened**. The MSHP's capacity to advocate with the MBPE could also be strengthened through the systematic use of quantitative studies. For example, while national health accounts have existed for a long time, providing regular updates and policy briefs on specific topics, there are, conversely, neither harmonised long-term projections of health expenditure (taking into account several criteria, including population projections), nor projections of the tax revenues required. Although the health programme budget sets out projections for the level of resources expected over three years (including external resources) and the National Health Development Plan (PNDS) provides short-term projections, there are no harmonised long-term projections. This could work in the MSHP's favour during budget negotiations by improving the Ministry's own budget allocations and demonstrating the need for additional funding to other ministries. Planning capacities could also be strengthened to build strong links between the PNDS and vertical strategic plans. Issues around planning led to the failure to increase the health budget from 5% to 10% of the total state budget, as announced during the 2012 dialogue on health financing.

This report can be used as a basis for inter-ministerial discussions. It is intended to inform the platform's discussions and, in particular, those of technical working group n°3, on how to improve financing efficiency and make domestic financing sustainable in the context of transition.

These inter-ministerial discussions are all the more important because the failure to sufficiently mobilise tax revenues makes it more difficult to finance health. Tax revenues (17.9% of GDP in 2017) are particularly low and are insufficient to enable Côte d'Ivoire to finance all the public goods and services required for its economic and social development.

3 The need to increase public funding in the health sector

The components of growth in health expenditure must be analysed to understand how much and what type of financing (public or private) **the health sector requires.** First, the growth in *total* health expenditure is broken down into public financing, household spending, other private expenditure and international co-operation. Then the growth of *public* health expenditure is analysed (calculation of the fiscal space).

This chapter discusses medium-term health expenditure targets. To this end, several factors are considered, including the need to make progress towards Sustainable Development Goal (SDG) 3, to compensate for the withdrawal of Gavi and to co-finance Global Fund support, as well as more recent developments affecting health expenditure (such as membership of the Global Financing Facility (GFF) and the resulting investment requirements). Finally, it presents the role of different taxes in financing this health expenditure.

Since 2013, growth in total health expenditure has been driven by public funding

The growth in total health expenditure in Côte d'Ivoire over the 2013–17 period was driven by public funding. The breakdown of the growth in total health expenditure (as well as total health expenditure per capita) illustrates this point (Table 3.1). It appears that the contribution of public funding was relatively constant over the period.

The contribution of international co-operation, on the other hand, was more volatile, due to the nature of these flows. This reinforces the importance of mobilising public funding for health financing to smooth out fluctuations in the contribution of international co-operation (despite these funds having increased over the period as a whole: from XOF 87 billion in 2013 to XOF 229 billion in 2018).

Finally, the growth in out-of-pocket expenditure made a small contribution to the growth of total health expenditure. Out-of-pocket expenditure, although high, has therefore not increased since 2013. The same is true for other private expenditure.

Table 3.1. Over the 2013–17 period, the growth in health expenditure in Côte d'Ivoire was driven by public funding

Breakdown of health expenditure growth over the 2013–17 period, nominal term

		Total health expenditure
Health expenditure growth (%)		24
Breakdown (percentage points)	Domestic resources	16
	Out-of-pocket expenditure	-7
	Other private expenditure	8
	International co-operation	8

Source: OECD based on the database: Global Health Expenditure (WHO).

Economic growth is the main factor in public health expenditure growth

The fiscal space methodology can be used to break down the various drivers of public health expenditure growth (Box 3.1): i) economic growth; ii) changes in public spending as a share of GDP; and iii) public health expenditure as a share of total public spending, which reflects the extent to which a government regards health as a priority for public action over a given period.

Box 3.1. Methodology of the fiscal space for health

Fiscal space is the leeway that allows a government to dedicate resources to pursue objectives without jeopardising its fiscal sustainability, given existing budgetary conditions and long-term imperatives. This concept, which can be applied in general or to a sector such as health, is not intended to provide a normative indication of a particular level of public spending to be achieved, and focuses only on public spending (omitting interactions with private household spending, for example).

Breaking down public health expenditure growth, which is a proxy for fiscal space, makes it possible to separate out its various drivers: i) economic growth; ii) changes in public spending as a share of GDP; and iii) public health expenditure as a share of total public spending, which reflects the extent to which a government regards health as a priority for public action over a given period.

WHO data (Global Health Expenditure Database) can be used to produce a comparative analysis of the weight of the various drivers (otherwise the use of national data is preferable).

According to WHO data, economic growth was the main contributor to public health expenditure growth in Côte d'Ivoire over the 2013–17 period (Table 3.2). This aligns with the findings of work conducted previously by WHO over the 1995–2015 period, which indicated that 53% of the growth in public health expenditure could be explained by GDP per capita growth and the positive impact of improvements in the country's overall wealth on public health expenditure (WHO, n.d.[10]). Strong growth since the end of the political crisis has therefore resulted in increased public health expenditure. In this context, the slowdown in economic growth caused by the COVID-19 crisis is expected to have a strong negative impact on the growth of public health expenditure in 2020 and in the longer term if the crisis persists.

The second biggest contributor is the change in total public spending. This also aligns with WHO work showing that public health expenditure responded positively to the improvement in public funding over the 1995–2015 period (WHO, n.d.[10]). Improving the country's fiscal position therefore has a key role to play in public health financing in Côte d'Ivoire, reinforcing the need for extensive tax reform to be implemented gradually over time.

The prioritisation of health in the budget does not seem to have been a significant factor for the growth of public health expenditure, given that the weight of MSHP's budget as a share of the total state budget has not changed. Notwithstanding the current crisis, Côte d'Ivoire must therefore prioritise health in its budget if it is to see a marked increase in public health expenditure.

This analysis points to three major findings:

- **Economic growth has a major role to play in the growth of public health expenditure, but it must go hand in hand with the prioritisation of the sector within the budget.** Economic growth alone has not been, and will not be, sufficient to increase public health expenditure. This aligns with the national dialogue on financing the health system, which states that "*Economic growth has not led to high health expenditure, financed by the government"* (MSHP, 2019[11]), though this contrasts with the investment case, which states that "*Continued economic growth will create the*

necessary fiscal space for Côte d'Ivoire to invest in social sectors and improve the health and well-being of its population", since growth alone is not a sufficient condition (MSHP, 2019[17]).

- **Prioritising health will be all the more important if Côte d'Ivoire is to increase its public health expenditure given the slowdown in growth following the COVID-19 crisis.** In this context, mobilising tax revenues will be essential.
- **However, lower tax revenues due to the crisis may also make it more difficult to prioritise the sector in the budget going forward**. Therefore, although a major tax reform seems inevitable, Côte d'Ivoire could also re-examine the **case for earmarking certain tax revenues for health to ensure the sector receives a minimum level of financing.** In particular, earmarking all or a share of the revenues from the taxation of products harmful for health should be considered (see Chapters 4 and 5).

Table 3.2. Breakdown of fiscal space for health, based on WHO data, 2013–17

	Public health expenditure per capita growth (%)	Breakdown of fiscal space (% share)		
		Economic growth	Change in total public spending	Prioritising health in the budget
Nominal	2.7%	52%	25%	23%
Real	2.2%	42%	30%	27%

Notes: Methodology similar to the paper (World Bank, 2018[18]). For calculations in real terms, 2017 prices.
Source: OECD based on the database: Global Health Expenditure (WHO).

Public health expenditure will need to increase significantly in the medium term

If Côte d'Ivoire is to make progress towards SDG 3 by 2030, total health expenditure should be 10.6% of GDP, an increase of 4.6 percentage points (Table 3.3). This analysis is based on the methodology developed by the IMF, which provides orders of magnitude of the financing needed to make progress towards SDG 3 by 2030 (IMF, 2019[19]) (Box 3.2). This increase would multiply per capita health expenditure by 3.3, the number of doctors by 6, and the number of medical staff (excluding doctors) by 4.5 (if keeping current workforce policies constant). Compared with other countries, Côte d'Ivoire is in the medium-high range, but close to countries in the region such as Benin and other least developed countries in terms of its health performance (Figure 3.1).

Box 3.2. Details of the methodology developed by the IMF

The methodology developed by the IMF identifies the main cost drivers in the health sector (number of doctors and medical staff, remuneration of doctor and medical staff, demographic factors and share of non-compensation health expenditure). These cost drivers are used in an equation to estimate health expenditure as a percentage of GDP in 2016.

To estimate health expenditure as a percentage of GDP in 2030, the cost drivers used are the median values of a small group of countries. These countries are those i) with GDP per capita less than USD 3 000 in 2016 and ii) that are the best-performing countries in terms of health (with an SDG 3 index > 70). These countries are also those for which health expenditure is most effective.

The expected increase in health expenditure for Côte d'Ivoire to reach the level of countries with similar incomes but superior health performance is therefore calculated as the difference between health expenditure in 2016 and 2030.

One option is to consider differentiated the health costs according to the age of the population, in particular by calculating the share (and health costs) of the population under 5 years and over 65 years of age. This was not done due to the lack of data of sufficient quality.

Source: (IMF, 2019[19]).

Public health expenditure could increase by 2.7 percentage points. According to the analysis, health expenditure in 2016 was 6% of GDP, of which 2.4 percentage points were public expenditure and 3.6 percentage points private expenditure (out-of-pocket expenditure and other private household expenditure). By 2030, health expenditure is expected to rise to 10.6% of GDP, of which 5.1 percentage points will be public expenditure (an increase of 2.7 percentage points) and 5.5 percentage points private expenditure (an increase of 1.9 percentage points). The increase in public expenditure is therefore expected to be greater than the increase in private expenditure, which affects the tax revenues that will need to be collected.

In nominal terms, a 4.6 percentage point increase in health expenditure as a share of GDP compared with 2016 would amount to an increase over the period 2016-30 of XOF 4 617 billion (i.e. an annual increase of XOF 330 billion), including XOF 2 322 billion of public expenditure (i.e. an annual increase of XOF 166 billion) (Table 3.4).

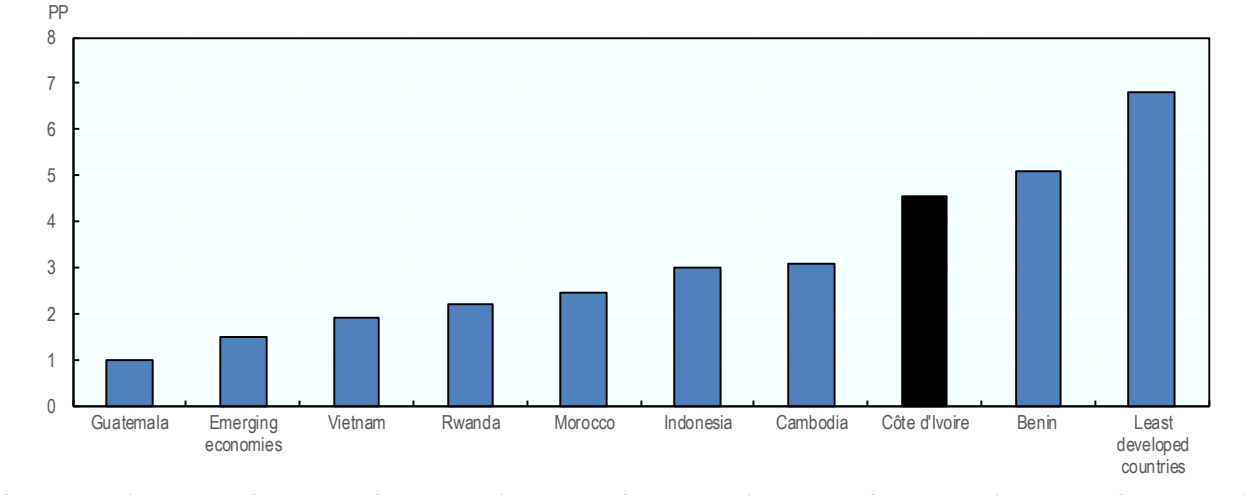
Table 3.3. To achieve the health SDGs by 2030, Côte d'Ivoire will have to increase health expenditure by 4.6 percentage points of GDP

		Countries with GDP per capita less than USD 3 000 in 2016			Côte d'Ivoire			
		All countries	Low-performing countries (SDG index < 70)	High-performing countries (SDG index > 70)	2016	2030	Increase 2016–30 (percentage points)	Annual increase (%)
GDP per capita (USD)		1 296	1 154	2 289	1 451	2 759		
GDP (constant prices, USD M)					35.3	93		
SDG 3 index		51.3	47.6	74.4	36.3	> 70		
Factors	Doctors (per 1 000 people)	0.14	0.09	0.91	0.14	0.91		
	Other medical staff (per 1 000 people)	1.5	1.3	4.3	0.9	4.3		
	Doctor's salary (ratio to GDP per capita)	19.8	22.8	10.4	29.2	10.4		
	Non-salary health expenditure (% of total health expenditure)	70.0	70.0	62.3	70.0	70.0		
	Ratio of other medical staff's salaries to doctors' salaries	0.5	0.5	0.5	0.5	0.5		
	Private expenditure (% of total expenditure)	50.9	49.5	51.8	59.6	51.8		
Results	**Health expenditure (% of GDP)**	**5.8**	**5.8**	**8.4**	**6.0**	**10.6**	**4.6**	**4%**
	Public health expenditure (% of GDP)	2.8	2.9	4.0	2.4	5.1	2.7	5%
	Private health expenditure (% of GDP)	2.9	2.9	4.3	3.6	5.5	1.9	3%
	Health expenditure per capita (USD)	**75**	**67**	**192**	**87**	**291**	**204**	**9%**

Notes: This analysis does not take into account demographic aspects or the differentiated cost of health expenditure according to population age (children under 5 years and people over 60 years have higher health expenditure than the young or working population).
This analysis is based on the IMF methodology, which estimates health expenditure as a percentage of GDP using an equation that factors in different cost components. It should be noted that health expenditure of 6% of GDP in 2016 is higher than the WHO figure of 4.5% of GDP (GHED). Using national data, published by MSHP, could allow for a more accurate analysis.
Health expenditure is broken down into public and private expenditure using the same approach as for cost variables (see Box 3.2). In other words, the median value for high-performing countries (SDG 3 index > 70) in 2016 is used to make projections for Côte d'Ivoire. Private health expenditure is estimated to have been 60% of health expenditure in Côte d'Ivoire in 2016 (database: Global Health Expenditure from WHO), including out-of-pocket expenditure and other private expenditure.
Source: OECD.

Figure 3.1. Côte d'Ivoire's increase in total health expenditure is high compared with other countries

Estimated increase in total health expenditure required to achieve SDG 3 by 2030 in percentage points



Note: For Morocco: OECD calculation. For Cambodia: (IMF, 2019[20]). For Benin: (IMF, 2018[21]). For Rwanda: (IMF, 2019[22]). For the other countries: (IMF, 2019[19]). In this methodology, emerging economies are those with GDP per capita of between USD 3 000 and USD 6 000 (72 countries). Least developed countries have a GDP per capita under USD 3 000.
Source: OECD.

Table 3.4. A 4.6 percentage point increase in health expenditure as a share of GDP is equivalent to an increase of XOF 4 618 billion over the 2016–30 period

		2016	2030	Increase 2016–30	Annual increase
Total health expenditure	As a % of GDP	**6**	**10.6**	**+4.6 pp**	**+4% pp**
Public		2.4	5.1	+2.7 pp	+5% pp
Private		3.6	5.5	+1.9 pp	+3% pp
Total health expenditure	In XOF billion	**1 272**	**5 890**	**+4 618**	**12%**
Public		514	2 836	+2 322	13%
Private		758	3 054	+2 296	10%
Total tax revenues (including SSC)[1] (in XOF billion)		**3 761**	**13 563**	**+9 802**	**10%**

Note: 1.Assuming an average annual increase of 9.9% in tax revenues between 2019 and 2030, as observed over the 2014–18 period. Database: Revenue Statistics (OECD).
Source: OECD.

This methodology considers, to some extent, rising income levels as a contributor to health expenditure growth. However, other components, such as productivity gains, demographic changes or technological advances are not included (Box 3.3), but could be considered in future work.

Côte d'Ivoire will play its role in managing health expenditure growth. Even though the OECD's work (Lorenzoni et al., 2019[23]) does not incorporate every component of health expenditure growth, its conclusions are still applicable to Côte d'Ivoire. Côte d'Ivoire will have to make several choices to achieve the expenditure target set: whether or not to have a cost control policy, whether increased productivity in the health sector will play a specific role, whether to control medicine prices, how to use new technologies, how to monitor and regulate the private sector, how to promote healthier lifestyles and how much weight to give prevention policies.

Box 3.3. Components of health expenditure growth

The OECD has analysed the components of health expenditure growth in OECD countries. It has identified four main components:

- Rising income levels, measured as the income elasticity of health expenditure (which captures the change in health expenditure in response to a given change in income).
- Productivity gains, measured as the impact of productivity growth in the health sector (relative to other sectors) on health expenditure.
- Demographic changes, which depend on i) changes in the size and structure of the population, ii) changes in the share of the elderly population and iii) specific increases in life expectancy over time.
- Technological advances, as measured by product, knowledge or process innovations.

On average, over the 2015–30 period, it is estimated that health expenditure among OECD member countries will increase by 2.7% annually (compared with 3% over the 2000–15 period), with variations between countries depending on their population structure. It appears that rising income levels are the main driver of health expenditure growth (explaining up to 50% of growth), followed by demographic changes (25%) and productivity gains (12%).

Source: (Lorenzoni et al., 2019[23]).

It is reasonable to assert that the increase in public health expenditure required to achieve SDG 3 by 2030 must include specific health expenditure, such as: the commitment to an annual increase in the MSHP's budget, taking over areas from which Gavi is withdrawing, accessing the Global Fund co-financing package or better financing UHC.

Table 3.5 presents an estimate of these various costs.

Table 3.5. Estimated public health expenditure requirements over time

	Cost over 2020–30 (XOF billion)	Comment
To achieve SDG 3	**2 322**	See analysis above.
Comprising:		
Commitment to a 15% annual increase in the MSHP's budget	470	The investment case sets out an annual cost increase of XOF 47 billion compared with the 2018 budget. This figure is a low-end estimate given that it does not account for the change in the budget reference point from one year to the next.
Takeover of Gavi withdrawal	102	Gavi provided XOF 41 billion of support in 2016–18. This figure multiplied by 2.5 was used for the 2025–30 estimate. It does not therefore account for the ongoing transition plan or the co-financing policy for 2020 to 2025. These components of the analysis could be made more precise subject to data availability.
Global Fund co-financing policy	30	Côte d'Ivoire will co-finance EUR 46 million over the 2021–23 period, i.e. XOF 30 billion. Again, this figure is a low-end estimate because it does not take into account future co-financing.
UHC financing	Insufficient information available	
Ratio:		
Annual total	166	

In % of GDP in 2020	0.6%	The GDP figure used is XOF 28 307 billion in 2020 (IMF).
In % of 2018 tax revenues	4.2%	The tax revenue figure used is XOF 3 972 billion in 2018 (OECD).[2]

1. Rounded.
2. Database: Revenue Statistics (OECD).
Source: OECD.

UHC financing is not included in the estimated future public health expenditure due to a lack of data, given that UHC was introduced in late 2019 and early 2020 saw the outbreak of COVID-19. Box 3.4 describes the UHC system and its financing, which is based on a monthly contribution from those insured of XOF 1 000 (basic general scheme) and tax revenues (medical assistance scheme).

Box 3.4. Universal health coverage in Côte d'Ivoire

Prior to the introduction of UHC (October 2019), 6% of the Ivorian population had health insurance (MSHP, 2019[7]). With the exception of occupational diseases, the social protection system did not cover the risk of falling ill. At present, the COVID-19 crisis is hindering the rollout of UHC. Prior to its general roll-out, pilot programmes were run from 2017 to 2018 with 150 000 students from universities and colleges (enrolment rate of 78%). The government paid their contributions (XOF 900 million) and invested XOF 2.2 billion in renovating and fitting out nine university health centres.

By February 2020, 2 million people had enrolled (16% of the population). The target is to enrol 4 million people by the end of 2020 (23% of the population). In February 2020, 41% of those insured were formal private sector workers, 23% civil servants, 20% informal sector workers, 10% deprived people and 7% students.

The UHC network comprises 880 health care facilities and 733 private pharmacies. In 2020, the target is to extend the network to an additional 400 new health care facilities and an additional 224 private pharmacies.

UHC comprises a basic general scheme (contributory scheme – 90% of those enrolled) and a medical assistance scheme (non-contributory scheme aimed at the economically vulnerable or deprived). The *Caisse nationale d'assurance maladie* [National Health Insurance Fund] (CNAM) manages and regulates UHC.

The basic general scheme guarantees all populations access to health care (employees in the private sector, the self-employed, small business owners, pensioners, civil servants, students, workers in the informal sector, etc.) in return for a monthly contribution of XOF 1 000 per insured person per month. In the private sector, employers must pay 50% of this contribution (i.e. XOF 500 per month) for their employees, as well as an unemployed spouse and a maximum of six children aged under 21 years or living with a disability. This financing mechanism was proposed by Ivorian employers, who saw it as an opportunity for private sector businesses to move away from private insurance policies for their employees. The UHC scheme covers 70% of members' treatment costs (with the remaining 30% at their own expense). This scheme is compulsory for the civil service and the formal private sector (direct automatic deductions by the Treasury or the National Social Security Fund (CNPS).

The medical assistance scheme is covered in full by the state for people who meet the eligibility criteria (people who are destitute, who receive free care funded by health programmes such as HIV/AIDS, TB and malaria, and who are already receiving care under a targeted free care programme, such as pregnant women and children under 5 years). The household income assessment takes into account several criteria (cash income, property, housing, etc.) based on National Institute of Statistics surveys. Households are then scored to identify those that are vulnerable. These results are then submitted to rural authorities or urban social services for assessment. Economically vulnerable and deprived populations are currently being identified: 585 616 people have already been identified and are in the process of being enrolled.

The basket of care is the same under both schemes and is defined by the decree of 29 June 2017. It covers care in the event of sickness or accidents, maternity care, physical rehabilitation and functional rehabilitation (excluding industrial injuries and occupational diseases). This includes treatment for HIV, TB and malaria.

Source: OECD; *Plan social du gouvernement* [Government Social Plan] (PSG 2018–20); (CNAM, 2020[24]).

Increasing public health expenditure will not be possible without an extensive tax reform to be implemented gradually

The need to mobilise health financing is unequivocal. According to the national dialogue on financing the health system, this will involve increasing the state budget for health using innovative funding mechanisms (impact bonds, green funds, harnessing of regional bodies' potential, etc.) and donors.

Nevertheless, even if the innovative funding mechanisms can help top up financial resources, the main challenge for Côte d'Ivoire is to better mobilise domestic tax revenues. Côte d'Ivoire can fund the increase in public health expenditure by XOF 166 billion per year in two ways:

- **Through tax reform**, which will provide fiscal room for manoeuvre to prioritise health in the budget, to be implemented gradually over time.
- **Through economic growth**, which will carry over to public health expenditure growth (as discussed above). However, economic growth is expected to be negatively impacted by the health crisis in 2020 and in the longer term if the crisis persists. Therefore, although Côte d'Ivoire could gamble on growth automatically increasing its public health expenditure, a tax reform will be necessary if the country is to get public health financing off the ground.

The need for tax reform was clear before the COVID-19 crisis

Before the COVID-19 crisis, a tax reform was considered essential to Côte d'Ivoire achieving a higher level of development. The country's tax revenues are struggling to take off. Since 2014, they have been stuck between 15% and 16% of GDP, well below the West African Economic and Monetary Union (WAEMU) target of 20% by 2020, and are therefore failing to serve the country's ambition to emerge. This can be explained by GDP and tax revenues increasing at the same rate, despite successful reforms of the tax administration (World Bank, 2019[25]). Between 2014 and 2017, countries such as Cape Verde, Burkina Faso, Egypt, Ghana, Mali, Mauritania and Uganda all had higher increases in their tax revenue to GDP ratio than Côte d'Ivoire. The ongoing GDP rebasing is likely to reduce this ratio further.

The tax structure has barely evolved since 2014 and remains dominated by export and import taxes and the VAT. This reflects, to some extent, the size of Côte d'Ivoire's informal sector, which reduces the domestic tax base.

In 2019, the failure to mobilise sufficient tax revenues and Côte d'Ivoire's pledge to reduce its public deficit forced the country to reduce its public expenditure, particularly investment expenditure. On the one hand, a downturn in investment expenditure can have a negative impact on medium-term economic growth (and the financing of total health expenditure). On the other hand, it can also lead to budget cuts in social sectors, including health.

In 2020, tax revenues are expected to be severely affected by the COVID-19 crisis, linked to the drop in activity (see Chapter 1). This further reinforces the need for an extensive tax reform, to be implemented gradually, once the health crisis is over.

Once the health crisis and presidential elections are over, Côte d'Ivoire will be unable to avoid a tax reform

The future tax reform should focus on broadening the tax base, rather than raising tax rates. Given the extent of the informal sector and fraud, Côte d'Ivoire's tax base is narrow, resulting in high levels of taxation for formal businesses. This could penalise growth and output, even though private investment was the main driver before the crisis.

Insofar as there are winners and losers in all tax reforms, one of the prerequisites for its accomplishment will be recognition at a high political level of the need for such reform. It can then be implemented once the health crisis and the October 2020 presidential elections are over.

Although economic growth is expected to fall sharply in 2020, thus complicating the adoption of such a reform, several conditions are in place to allow its successful achievement. Having recently undergone capacity building to increase its human and material resources, the tax and customs administration should be in a good position to support the preparation and implementation of the reform (World Bank, 2019[25]). Moreover, given that no donors in the health sector (other than Gavi) are set to withdraw, it will be possible to implement tax reform at the same time as a health sector reform. A health sector reform is required to improve the efficiency of public health expenditure, which will be increased through additional financing.

The tax reform in 2021 will have to take account of the recent economic and social changes brought about by the health crisis. In 2015, the Ivorian government and the private sector outlined a tax reform for Côte d'Ivoire. The analyses and benchmarking will now need to be revised and the 2015 recommendations reassessed given the socio-economic upheaval brought about by the recent health crisis. This is the only way to bring the reform of the entire tax system up to date.

Moreover, this exercise presents an opportunity to tailor future tax measures to the objectives set by the tax reform. In other words, the objectives of the tax reform will have to meet the needs of the current economic and social structure, as well as that of the Côte d'Ivoire of tomorrow. This work could be closely tied into the discussions on the growth model underpinning the new National Development Plan 2021–25. The numerous platforms for discussion and exchange with the private sector will therefore have a key role to play.

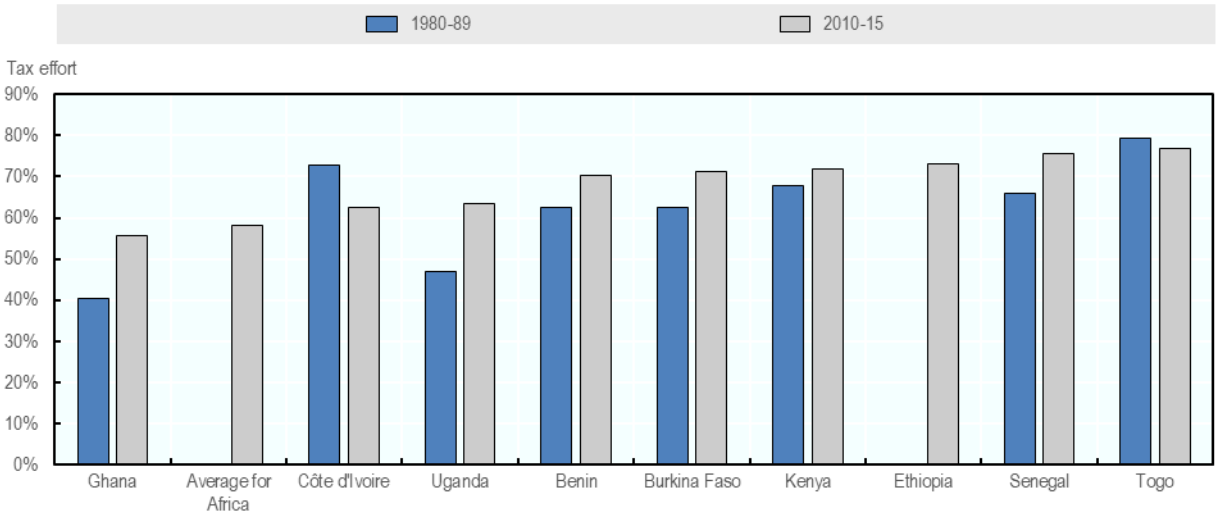
The tax reform should set an ambitious target of tax revenues to GDP

According to the World Bank, Côte d'Ivoire could have a tax burden rate of 25.3% (World Bank, 2019[25]). Tax under-mobilisation is estimated to be 7.4 GDP percentage points, comprising 6 percentage points for VAT and 1.4 percentage points for direct taxation (World Bank, 2019[25]). Mobilising this potential would increase the ratio of tax revenues to GDP from 17.9% to 25.3%.

According to CERDI, Côte d'Ivoire's tax burden rate for 2010-15 could have been 22.5% of GDP, subject to a significant increase in the tax effort (Emilie Caldeira, Ali Compaoré, Alou Dama, Mario Mansour, 2020[26]). Tax effort is defined as the difference between the tax revenues collected and the

maximum possible tax revenues based on a range of macroeconomic criteria. It is estimated that Côte d'Ivoire's tax effort over the 2010–15 period was 0.624, which suggests that the country is mobilising 62% of its potential tax revenues (Figure 3.2). In other words, based on a tax revenue-to-GDP ratio of 14.02%, if its full tax potential were used, Côte d'Ivoire could reach a tax revenue-to-GDP ratio of 22.5%. This tax effort is higher than the average for Africa (0.58), but has deteriorated since the 1980s. This contrasts with the performance of other countries, such as Ghana, Senegal and Uganda, which have made notable improvements over this period.

Figure 3.2. Côte d'Ivoire's tax effort has been falling for a long time and is now lower than that of many countries



Notes: Tax effort is defined as the difference between the tax revenues collected and their potential level taking into account macroeconomic criteria.
Source: (Emilie Caldeira, Ali Compaoré, Alou Dama, Mario Mansour, 2020[26]).

These orders of magnitude are relatively close to the average tax revenues in Latin America (22.8% of GDP). To reach the level of tax revenues achieved in Latin American, Côte d'Ivoire would need to increase its tax revenue-to-GDP ratio by almost 5 percentage points (Table 3.6). This increase is very ambitious and few countries with similar levels of development and tax burden have managed to increase their tax-to-GDP ratio so significantly in the medium term. However, Bolivia increased its ratio from 19.4% to 26.7% (from 2003 to 2013), Tunisia from 24.2% to 30.3% (from 2000 to 2010) and Belize from 18.9% to 25.1% (from 1999 to 2009).

Improving the design of each tax should be at the heart of the tax reform

If Côte d'Ivoire were to aim for the level of tax revenues raised in Latin America (22.8% of GDP), this would involve changes to all types of taxes. Based on an analysis of Latin America's tax structure and comparison with that of Côte d'Ivoire (Table 3.6), this would mean significantly increasing the VAT (+2.4 percentage points), the personal income tax (+2.2 percentage points), SSCs (+1.8 percentage points) and the corporate income tax (+1.4 percentage points), as well as larger relative increases to excise duties (+0.7 percentage points) and property tax (+0.3 percentage points). These changes are not targets to be achieved, but are intended to illustrate the profound changes the tax structure would have to undergo to increase the tax burden.

Table 3.6. Change in the weight of different taxes to reach the average tax burden in Latin America

2017

	Tax revenues in Côte d'Ivoire	Tax revenues in Latin America	Expected change to halve the gap		Expected change to eliminate the gap	
	% of GDP		Percentage points	XOF billion	Percentage points	XOF billion
Tax revenues	**17.9**	**22.8**	**2.4**	**542**	**4.9**	**1 084**
Personal income tax	0.1	2.2	1.1	240	2.2	480
Corporate income taxes	2.0	3.4	0.7	156	1.4	313
Social security contributions	2.1	3.9	0.9	200	1.8	400
Property tax	0.5	0.8	0.2	38	0.3	75
VAT	3.6	6.0	1.2	268	2.4	536
Excise duties	1.4	2.2	0.4	83	0.7	166
Import duties	2.4	1.1	-0.6	-139	-1.3	-279
Export taxes	2.4	0.0	-1.2	-264	-2.4	-528
Other	3.5	3.2	-0.2	-40	-0.4	-80

Source: OECD based on: Revenue Statistics (OECD).

Fulfilling certain preconditions will be essential for the proper use of public funds

Public health expenditure must be made more efficient

Côte d'Ivoire could improve its health performance by making public health expenditure more efficient. According to a WHO study, the efficiency of public health expenditure in Côte d'Ivoire is far below the average for developing countries. Half of the resources committed over the 1993–2015 period are estimated to have been unproductive (WHO, n.d.[10]). Although this estimate indicates the general level of improvement needed in the efficiency of public health expenditure (rational use of resources, removal of bottlenecks in the management of public finances, establishment of reference prices, etc.), the analysis could be updated with more recent data covering a shorter period that excludes the political crisis of the 2000s.

This is all the more important given that the MSHP's budget implementation rate is high. It has been 80–90% over the last five years (source: Global Fund). While this is encouraging, given that other developing countries such as Morocco have not reached these rates, it also underscores the need for greater efficiency in public health expenditure.

Management and planning of public health financing must be improved

Côte d'Ivoire could strengthen the monitoring of financial flows, audits and evaluations of various publicly funded health programmes and projects. This would increase transparency around the use of resources, accountability, oversight and reporting processes.

Better planning of budget allocations within the MSHP will also be needed to improve the allocative efficiency of resources. For example, epidemiological data from the private sector are still not integrated into the national health information system. Likewise, a mechanism for systematically reporting financial data for the production of health accounts would also be required (MSHP, 2019[7]).

4 Approaches for better domestic financing of the health system

This chapter discusses the approaches available to Côte d'Ivoire for mobilising additional tax resources for health financing. It aligns with previous work, such as the Côte d'Ivoire Investment Case, which notes the need to "*mobilise additional resources and encourage the optimal use of the resources allocated to the health sector*" (MSHP, 2019[6]), the WHO report, which indicates that "[...] *tax mobilisation policies, budgetary reforms aimed at bolstering the budgetary position and accelerating growth, will make it possible to unleash Côte d'Ivoire's potential for the benefit of health. The analysis carried out provides very little information on the room for manoeuvre already available to increase the resources allocated to health*" (WHO, n.d.[10]), or the work of the tax reform commission in 2015, which indicates that tax revenues are below potential levels (Commission de réforme fiscale, 2015[27]).

This chapter will therefore serve as a reference in the discussions of the National health financing co-ordination platform, which is responsible for "mobilising additional resources" (MSHP, 2019[17]). Indeed, "[...] *Côte d'Ivoire has a significant margin for collecting more revenues*" (World Bank, 2019[25]).

This chapter is divided into two sections. The first section considers taxes that are directly related to health (excise duties on products harmful for health, UHC contributions) or indirectly related to health (environmental taxes, tax expenditures). The second section discusses ways to increase the level of tax revenues for the general state budget, which could also contribute to increased financing for the MSHP. Table 4.1 sets out the tax policy objectives, the various taxes, their link to health and the change in these taxes required to close the gap between the tax burden of Côte d'Ivoire and Latin America.

Table 4.1. Overview of tax types, link to health and the change required

Link to health financing	Tax type	Tax policy objective	Change required for Côte d'Ivoire's tax burden to reach that of Latin America	
			Percentage points	XOF billion
Direct link to health	Excise duties	Broadening the tax base[1]	0.7	166
	Social security contributions	Making greater use of underutilised taxes	1.8	400
Indirect link to health	Environmental taxes[2]	Implementing new taxes		
Increasing tax revenues for the general state budget	VAT	Broadening the tax base[1]	2.4	536
	Corporate income tax		1.4	313
	Personal income tax	Making greater use of underutilised taxes	2.2	480
	Recurrent taxes on immovable property		0.3	75

1. Broadening the tax base also involves abolishing certain expenditures, tackling tax evasion and reducing the informal sector. Given that these are not taxes as such, they are not presented in this table, but are discussed in the chapter as they contribute to increased tax revenues for the general state budget.
2. The Revenue Statistics Database (OECD) does not include a specific category for environmental taxes for Côte d'Ivoire.
Source: OECD.

Approaches for increasing health-related tax revenues

Excise duties on products harmful for health

In Côte d'Ivoire, excise duties are levied on tobacco, alcoholic and non-alcoholic beverages, petroleum products, marble and large cars. Rates vary by product and are governed by WAEMU directives.

Tobacco

The WAEMU directives provide for the application of both an ad valorem duty (minimum 50% and maximum 150% on the ex-factory price) **and a specific duty**. In most OECD member countries, excise duties are calculated based on the retail price. As such, negotiations at the regional level to apply excise duties to retail (rather than ex-factory) prices should be continued.

Total tobacco duties (cigars, cigarillos, cigarettes, smoking tobacco, other tobacco) in Côte d'Ivoire amount to 45% of the ex-factory selling price excluding tax. Taxation of tobacco in the country comprises a single ad valorem rate (38% of the ex-factory selling price excluding tax, which cannot be less than XOF 15 000 per 1 000 cigarettes),[5] a special tax for sport development (5% of the selling price) and a solidarity tax to combat AIDS and smoking (2% of the selling price). There is no specific rate. The single ad valorem rate introduced in 2018 applies to all categories of tobacco and replaces various rates that were applicable depending on the type of tobacco. Unlike a specific rate, it is less sensitive to money erosion but less easy to administer and monitor. For comparison, the rate applied in Senegal is 65% and in Ghana (which is not a WAEMU country) 150%.

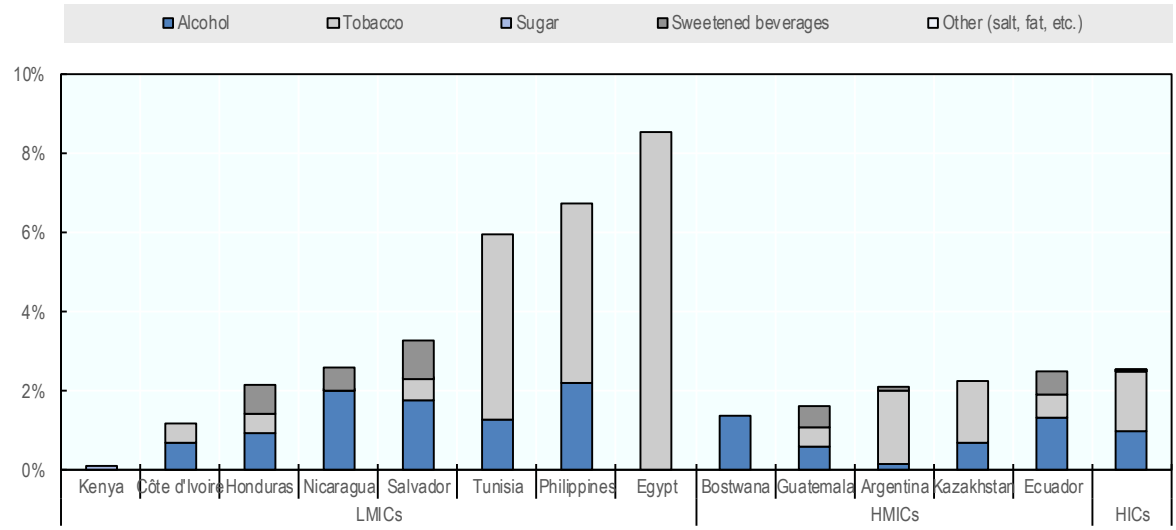
Taxation of tobacco raised XOF 22 billion in 2019 (0.5% of total tax revenues), which is less than the taxation of alcoholic and non-alcoholic beverages. This is relatively low compared with other near-income countries (Figure 4.1).

The country is gradually increasing the ad valorem rate to align with the WAEMU directives. Côte d'Ivoire increased the ad valorem rate by one point in 2019 and 2020. Under the 2020 budget, the increase in tobacco excise duties (1 percentage point) should raise XOF 820 million. Too sharp an increase could harm production at the Bouaké factory and is likely to lead to an increase in smuggling (an estimated 33%–50% of cigarettes in Côte d'Ivoire are smuggled). In the absence of strengthened anti-smuggling measures, there are therefore no plans to markedly increase rates, a situation that the COVID-19 crisis has done nothing to change.

[5] In the case of imported tobacco, the taxable amount is determined based on the customs value plus all customs duties and taxes, excluding value added tax. This value may not be less than XOF 15 000 per 1 000 cigarettes for products manufactured in a state with which Côte d'Ivoire is bound by a customs union agreement or XOF 20 000 per 1 000 cigarettes for products manufactured in other states.

Figure 4.1 Côte d'Ivoire collects little tax revenues from tobacco and alcohol compared with other countries

% of total revenues



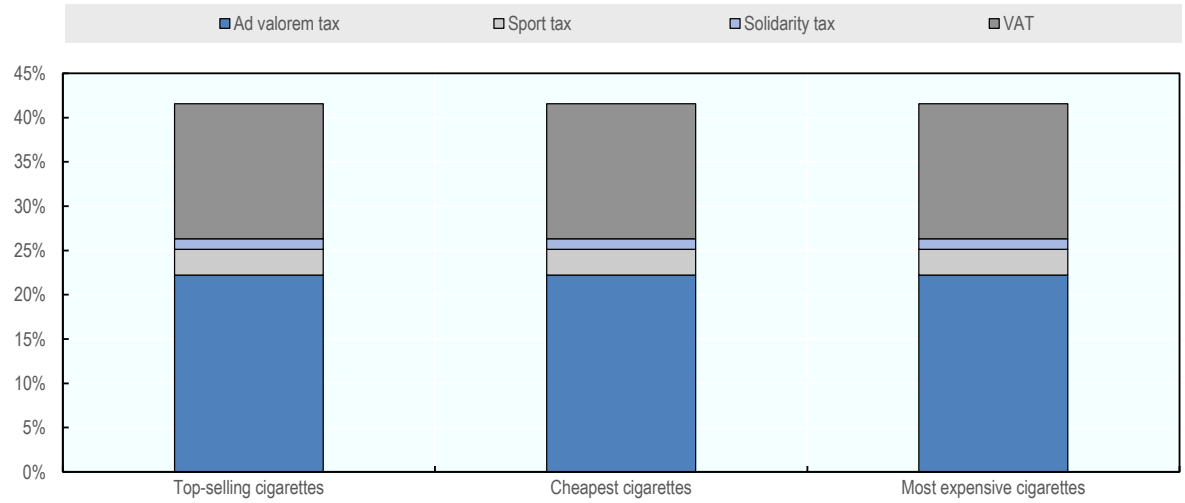
Note: The high earners category is an average of OECD member countries and non-member economies for which a breakdown by type of excise duty exists in the Revenue Statistics Database (OECD), i.e. 34 countries. For Côte d'Ivoire, these are local data.
Source: Database: Revenue Statistics (OECD).

Côte d'Ivoire falls short of the WHO recommended level of tax, i.e. at least 75% of the retail price (WHO, 2019[28]). Tax makes up 42% of the retail price for all types of cigarettes (Figure 4.2). According to WHO, buying 2 000 cigarettes in 2018 was equivalent to spending 7% of GDP per capita, less than in 2008, suggesting that GDP per capita has risen faster than cigarette prices. Once it has strengthened its anti-smuggling measures, Côte d'Ivoire should therefore continue to increase the ad valorem rate on tobacco, which would also bring it into line with the minimum rate set out in the WAEMU directives.

Part of the taxation of tobacco is earmarked for health. The proceeds from the ad valorem rate go to the general state budget. Half of the proceeds from the special tax for sport development are earmarked for the Ivorian Football Federation, 35% for other sports federations and 15% for the Ministry of Sport's socio-sports infrastructure project unit. The solidarity tax to combat AIDS and smoking is earmarked for the AIDS Control Fund (70% of the revenues from this tax) and the *Programme national de Lutte contre le Tabagisme, l'Alcoolisme, la Toxicomanie et les autres addictions* [National Programme to Combat Tobacco, Alcohol, Drug and Other Addictions] (30%). In 2019, the solidarity tax to combat AIDS and smoking raised XOF 1.3 billion, of which XOF 910 million went to the AIDS Control Fund and XOF 390 million to the National Programme to Combat Tobacco, Alcohol, Drug and Other Addictions.

Figure 4.2. Taxation makes up 42% of the retail price for all types of cigarettes

% of retail price



Source: OECD.

Beverages

Taxation on beverages (alcoholic and non-alcoholic) raised XOF 28 billion in 2019 (0.7% of total tax revenues). The proceeds from the taxation of beverages are not earmarked for specific programmes or projects and go in their entirety to the general state budget.

Excise duties on alcohol increased in 2018 from 25% to 40% for champagne, from 25% to 35% for ordinary wine, from 30% to 40% for sparkling wine, from 15% to 17% for beer and cider (as opposed to the 25% initially planned) and from 35% to 40% for other alcoholic beverages containing less than 35% alcohol by volume (ABV). The rate remained at 45% for other alcoholic beverages above 35% ABV. These rates are within the established range for the WAEMU area (15–50%), but could be increased further, especially on beers and cider. The WAEMU Council of Ministers decided to revise Directive 03/2009 to raise the rates applicable to alcoholic beverages between 20% and 70% by 2020, giving even more room for manoeuvre (Conseil des Ministres de l'UEMOA, 2019[29]).

For energy and non-alcoholic beverages (excluding water), the rates have been increased from 12% to 14% of the ex-factory selling price excluding tax[6] (compared with the 20% initially planned), i.e. within the 0–20% range for the WAEMU area. The WAEMU Council of Ministers decided to raise the rate on non-alcoholic beverages to between 10% and 20% by 2020, and to authorise the taxation of broths (between 10% and 15%), fruit and vegetable juices (between 5% and 20%) and mineral water (between 5% and 10%) (Conseil des Ministres de l'UEMOA, 2019[29]).

[6] Until 2017 it was the ex-factory cost price excluding tax.

Other products

Côte d'Ivoire has introduced excise duties on two products on the WAEMU list[7] in addition to tobacco and alcohol. In 2018, an excise duty of 10% entered into force on large vehicles and marble.

Initially, Côte d'Ivoire also wanted to introduce excise duties on cosmetic products (projected revenue of XOF 12 billion), but this plan was abandoned. Reconsidering the proposed introduction of excise duties on cosmetic products could be a first step. More generally, the country could continue this trend by introducing new excise duties (up to a maximum of six products in addition to tobacco and alcohol), in particular because the WAEMU Council of Ministers decided to revise Directive 03/2009 to increase the number of taxable products from six to ten (in addition to tobacco and alcohol) by 2020 (Conseil des Ministres de l'UEMOA, 2019[29]).

Compulsory health contributions

Box 3.4 describes the UHC scheme, which comprises a basic general scheme and an assistance scheme for the most deprived.

In the short term, it is necessary to ensure that all companies comply

From July to December 2019, 92% of expected contributions were collected (XOF 7.3 billion), largely from the public sector. The public sector contributed 72%, the formal private sector 26% and the informal and student sector around 1% (CNAM, 2020[24]). The low level of collection in the formal private sector is due to the fact that not all companies report all their employees, and the collection of contributions by the CNAM is not carried out systematically on a monthly basis.

In the short term, the goal should be to ensure that all companies comply so that private sector contributions can be collected in full. Ideally, all companies in the formal sector would declare all their employees and pay their contributions. To this end, inspections would have to be strengthened by cross-referencing the information submitted to the tax administration and the CNAM. The right to deduct wages and the employer contribution to compulsory health insurance from the corporate tax base could also be made conditional upon proof that of the declaration of employees to the CNAM.

In the medium term, the UHC contribution should be reviewed

Since its inception in October 2019, the UHC system has had expenditure of XOF 48 million (Table 4.2). This has mainly been for drugs (72%) and biology (20%). Consultations account for a small share of UHC expenditure because they are mainly conducted at university health centres.

Unless the basket of care and contributions change, the scheme is sustainable for five years (Table 4.3). However, the technical balance is theoretical because it is based on constant assumptions (such as the rate of attendance at health care facilities), conservative pricing for services and medical procedures and the same basket of care. Indeed, the 2018 study on the cost of providing care for the population under the UHC scheme found that it would be in deficit as early as 2019 (Box 4.1).

[7] The list includes coffee, cola nuts, wheat flour, edible oils and fats, perfumery and cosmetic products, tea, arms and ammunition, plastic bags, marble, gold ingots, precious stones and private vehicles of 13 horsepower or more.

Table 4.2. Summary of UHC services

Service	% of number of events	Total amount (XOF M)	UHC share (XOF M)	% of UHC expenditure
Consultations	47%	2	1.4	3%
Biology	11%	14	10	20%
Dental care	4%	3	2	4%
Specialist appointments	0%	0.03	0.02	0%
Pharmacy	38%	50	35	72%
Total	**100%**	**69**	**48**	**100%**

Note: Consultations account for 47% of all services but only 3% of expenditures because consultations are generally free of charge at university health centres.
Source: (CNAM, 2020[24])

Table 4.3. Projected financial equilibrium of UHC

	2020	2021	2022	2023	2024	2025
Coverage rate	**17%**	**23%**	**28%**	**33%**	**38%**	**44%**
Ivorian population (M)	23.6	23.6	24.1	24.7	25.2	25.8
Population covered (%)	4	5.3	6.7	8.2	9.7	11.3
General basic scheme						
Population (M)	1.4	4.6	5.7	7	8.3	10
Expected contribution (XOF billion)	17.2	54.4	68.7	83.7	100	117.2
Assistance scheme						
Deprived population (M)	0.6	0.8	1	1.2	1.4	1.5
Subsidy for deprived population (XOF billion)	8.7	11	14	17	19	21
Resources						
Operating subsidy (XOF billion)	3	3	3	3	3	3
Total financial resources (XOF billion)	28.9	68.4	85.7	103.7	122	141.2
Resources, net of expenses (15%)	25	58	73	88	104	120
Estimated health care expenditure (XOF billion)	10.2	34.9	44	53.4	63	73.7
Estimated technical balance (XOF billion)	**14**	**23**	**29**	**35**	**41**	**46**

Source: (CNAM, 2020[24]).

Box 4.1. Cost of providing care for the population under the UHC framework

The average cost of the basket of care is estimated at XOF 14 550 (monthly cost of XOF 1 215). Based on this assumption, services with an associated cost would total XOF 274 billion in 2018 and XOF 623 billion by 2028. With a contribution of XOF 1 000 per month per insured person, contributions would total XOF 301 billion in 2018 and XOF 379 billion in 2028. Therefore, the gap between contributions and services provided would be positive initially (XOF +27 billion) in 2018, then become negative, growing from XOF -45 billion in 2019 to XOF -245 billion in 2028.

Source: (CNAM, 2018[30]).

The scheme will go into deficit if the basket of care, which is currently modest, is expanded to cover other conditions (such as diabetes, hypertension and breast cancer). As a result, it has been estimated that the monthly cost of UHC is XOF 1 215 per insured party, though in order to improve the

financial sustainability of the system, it should be closer to XOF 1 500 (World Bank, 2018[5]) (CNAM, 2018[30]).

These projections should be updated with the scheme's actual expenditure in 2019 and 2020. Since the UHC scheme has only been operational since October 2019 and the beginning of 2020 has seen the outbreak of COVID-19, the CNAM has not yet been able to collect sufficient data to update the projections. It therefore plans to update its actuarial studies in 2021 to generate realistic expenditure and revenue projections based on health care consumption since the introduction of UHC. Nevertheless, it is clear that the contribution for the basic general scheme will need to increase as the basket of care widens, while being made more progressive. Similarly, more tax revenues will need to be mobilised to finance the medical assistance scheme (the non-contributory scheme aimed at the economically vulnerable or deprived population, which is fully covered by the state), for example, by making greater use of the taxation of products harmful for health.

The social security funds are not, however, in deficit, thanks to measures taken to restructure them and diversify their investments, as well as the demographic profile of the Ivorian population. However, given that SSCs have been postponed due to the COVID-19 crisis, financial performance is expected to be weaker in 2020, though this should not call into question the financial soundness of the social protection system. The collection of SSCs is, nevertheless, a problem in its own right, as some companies do not (or only partially) declare their pay bill. Strengthening inspections is important in this regard, as discussed above.

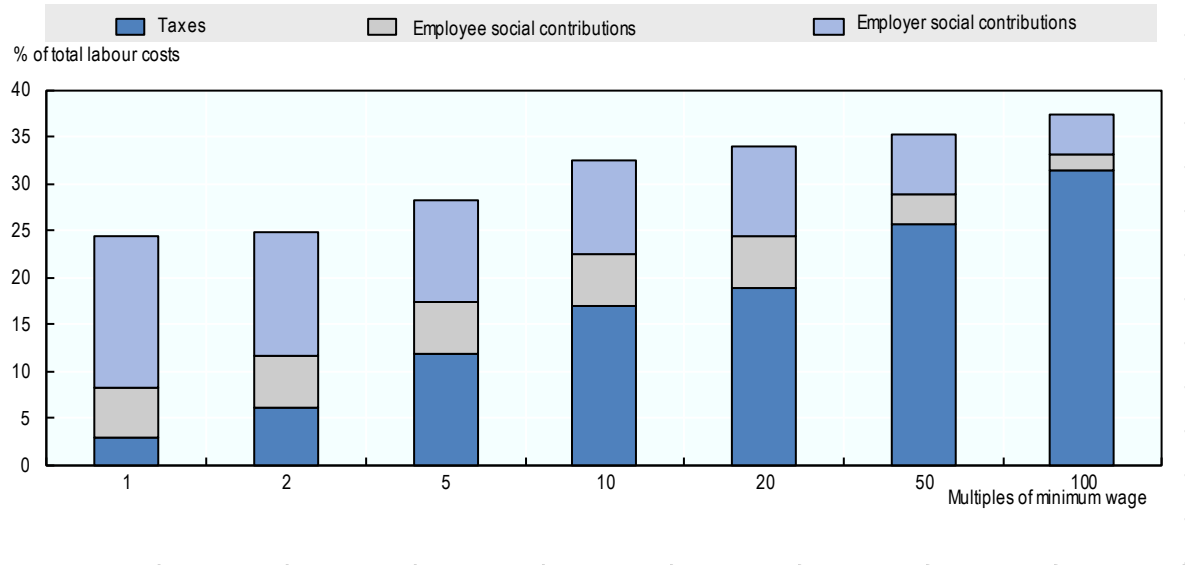
In the medium term, the design of the compulsory SSCs for health care under the basic general scheme could be reviewed. This scheme guarantees provision of care to all populations in exchange for a monthly contribution of XOF 1 000 per insured party. There are, however, several drawbacks. On the one hand, the contribution is regressive, as it is not adjusted to income. On the other hand, in the private sector, the employer covers 50% of the contribution for employees (i.e. XOF 500 per month), as well as their unemployed spouse and a maximum of six children who are either under 21 years or living with a disability, which is a clear advantage over the self-employed, self-employed entrepreneurs and workers in the informal sector. To avoid discouraging employers from hiring workers with large families, the employer contribution for this category should not be higher than for workers without children.

Any future review of UHC contributions must be part of a general assessment of the tax burden on labour. This burden is relatively high, particularly for low-income earners, and affects incentives to work (for employees and employers). In 2015, it was 24.3% of total labour costs for a worker paid the minimum wage (XOF 60 000) (Figure 4.3) (OCDE, 2016[31]), which is high compared with Indonesia or South Africa. This comparatively high tax burden encourages low-income earners to stay in the informal sector. The tax burden borne by individuals with very high incomes is also high, in particular due to the general income tax burden. For workers earning the equivalent of 50 times minimum wage, for example, the tax burden on labour income is more than 35% of total labour costs. The high tax burden also encourages tax evasion by wealthy households.

The upward revision of the UHC contribution should not increase the tax burden on labour so as not to discourage the creation of formal jobs. One possibility could therefore be to maintain the current level of contribution (or to increase it very gradually over a long period) and then supplement it with a second progressive factor not based on labour. For example, this could involve introducing a social VAT, the proceeds of which would come from the abolition of non-earmarked reduced rates or VAT exemptions. This progressive factor could then be used to strengthen UHC financing.

Figure 4.3. The tax burden on labour is relatively high

Total tax burden on labour as a percentage of total labour costs at different multiples of minimum wage in 2015



Notes: The tax burden of income tax and SSCs is measured using the "tax wedge", i.e. the total amount of taxes paid by employees and employers, after deducting family benefits received, expressed as a percentage of the total labour costs for employers. The UHC contribution is not included here. Updating the model, subject to access to the responses to the survey on taxing wages, would allow for a more accurate analysis, in particular by including UHC.
Source: (OCDE, 2016[31]).

Increasing UHC and incentivising formal work in the long term

Despite the mandatory nature of UHC, the enrolment of informal workers and their payment of contributions are voluntary, which poses a problem for the sustainability of this system for this population. A disadvantage of the current UHC system is that there is no incentive to enter formal work to access health insurance. People working in the informal sector are enrolled in UHC on the same basis as the other target populations and are invited to pay their contributions through electronic payment channels or over the counter at financial and banking institutions. Studies are under way among the various socio-professional categories in the informal and agricultural sector to attract people to start and continue making contributions. Draft inter-ministerial decrees are currently being validated with some stakeholders in the informal sector (cotton, cashew nut, palm oil and rubber producers, village-based sugar cane producers, artisans and traders subject to the flat-rate tax) to identify agreed and systematic means of making direct deductions. Ultimately, this will cover all informal agricultural and non-agricultural stakeholders (CNAM, 2018[30]).

In the long term, in order to encourage informal workers to join the formal system and contribute to UHC, one possibility would be to evolve the current system into a two-pillar system. The first pillar would provide access to free basic and universal health coverage for all Ivoirians (not just deprived populations), financed by the general revenues of the state budget. This would be complemented by a second pillar offering a broader basket of care funded by compulsory and progressive contributions from formal workers. Workers would then have access to more health services provided they had a sufficiently long history of paying contributions. These contributions should be progressive, so as not to discourage informal workers from joining the formal system, and mandatory, to ensure that formal workers and civil servants do not withdraw from the public system and use their private care plans instead. If this were to

happen, it would result in a two-tier health insurance system, with the public side underfunded. This system should, however, permit individuals who wish to take out private health insurance to do so. If Côte d'Ivoire moves towards such a system, integrating the two pillars of the system and including contributions for private health insurance should be considered.

Reducing informality to broaden the tax base is all the more advisable as future demographic developments are an opportunity for Côte d'Ivoire to strengthen its UHC financing. The dependency ratio is expected to fall gradually, mainly due to the falling youth dependency ratio (see Chapter 2), increasing labour market participation and the relatively low number of elderly people. If this change is accompanied by the formalisation of the economy, SSCs will play a greater role in financing the social protection system, including health, especially since the contributions depend on salaried workers, a minority in Côte d'Ivoire where 90% of workers are informal.

Côte d'Ivoire has implemented measures to reduce the informal sector. Firstly, checks on companies subject to the flat-rate tax scheme have increased, with companies selected based on the size of their transactions (imports and exports, funds transfers, local sales and purchases) compared against their tax contribution. The government should continue these efforts, as although the number of flat-rate taxpayers inspected has increased (from 229 to 544), it remains relatively low. The findings of these audits could be compiled in a report that could serve not only to train future auditors, but also to identify the most common tax evasion practices. Ultimately, this will help improve the quality of audits and the design of the Ivoirian tax system. The 2020 tax schedules introduced measures to incentivise businesses and small and medium enterprises (SMEs) (turnover less than XOF 1 billion) to declare. These measures will need to be assessed. The effective implementation of the unique identifier should also help to reduce informality. Other measures have also been implemented, such as the creation of the status of entrepreneur.

However, such measures aiming to tackle informality remain marginal in comparison with the scale of the issue. Only an inter-ministerial response that involves the Ministries of Budget, Trade, Employment and the Interior, etc. will significantly reduce the informal sector. The VAT will also play a leading role. It will therefore be necessary to reinstate the entire VAT chain in the agricultural sector.

A reform of the flat-rate tax is also necessary. The proposal to reform the flat-rate tax (1% on turnover between XOF 5 million and XOF 50 million), which aimed to raise the minimum and maximum thresholds and abolish the simplified real profit system, was rejected. Côte d'Ivoire should, however, reform this tax from a fixed amount to a percentage of turnover for each turnover bracket. Making it progressive so that companies in the upper brackets have an incentive to move to the standard real profit system could also be considered. Conversely, the rate could be very low on microenterprises to encourage them to formalise. As such, a study analysing the distribution of companies by turnover would be useful to identify whether they intentionally decide not to grow to avoid being taxed at higher rates.

Finally, parafiscal taxes should be streamlined. Such taxes amount to XOF 760 billion in the 2020 draft budget. Greater transparency is required to provide the private sector with more accurate information on parafiscal taxes. Small taxes that penalise private sector development and promote informality should also be streamlined.

Environmental taxation

Environmental taxation is almost non-existent in Ivoirian tax policy. It does not form part of a comprehensive tax revenues mobilisation strategy. The few existing measures are patchy and are divided into taxes on polluting products, charges that cover the costs of environmental services (mainly in the areas of water and waste), and tax incentives (exemptions, deductions and rate reductions) to promote environmentally-friendly behaviours. The recent debate on the carbon tax has not led to its implementation (Box 4.2).

The COVID-19 crisis may provide an opportunity to put environmental taxation indirectly linked to health on the agenda. it represents an untapped potential source of tax revenues; it also plays an important role in sustainable growth and positive health outcomes (i.e. environmental taxes could be classed as health taxes, for example, taxes on particulate emissions); and lastly it would help diversify the Ivoirian tax structure.

Box 4.2. Feasibility study on introducing carbon pricing in Côte d'Ivoire

In 2016, Côte d'Ivoire conducted a study to assess the introduction of carbon pricing in the country to finance the low-carbon development strategy. The proposed carbon pricing scenario is based on the "polluter pays" principle. Carbon pricing should primarily affect the energy sector (to align with global trends) and the forestry sector (to tackle deforestation). This tax would be applicable to natural and legal persons consuming or using fossil fuels or exploiting wood leading to deforestation. Suggested prices ranged from an initial price of XOF 1 000 (for cumulative revenue of XOF 493 billion) and an ambitious scenario price of XOF 2 500 (for cumulative revenue of XOF 1 233 billion).

Source: (Ministère de l'Environnement et du Développement Durable, 2016[32]).

Health-related tax expenditures

There are many substantial tax expenditures. This observation is underscored by the new Investment Code and the tax exemptions for certain business sectors and SMEs in the 2019 and 2020 tax schedules. Tax expenditures will reach XOF 331 billion in 2019, i.e. 1.3% of GDP (excluding products taxed at 0% VAT or reduced rates). They mostly target the industrial sector and mainly concern VAT, customs duties, corporate income tax and trade licensing (Comité national d'évaluation des dépenses fiscales, 2019[33]). Generally speaking, Côte d'Ivoire needs to broaden its tax base, and the tax incentives in place should seek to stimulate job creation rather than attract capital-intensive foreign direct investment.

The health sector also benefits from some tax expenditures (Table 4.4) that relate to taxes on wages and salaries and the VAT. It should be noted that certain projects under the PNDS and the national TB and malaria control programmes are exempt from VAT. The 2019 tax expenditure report does not provide figures for every item included in Table 4.4. It would be helpful to have better oversight of health-related tax expenditures, in particular those related to VAT exemptions on certain products.

Approaches for increasing the tax revenues of the general state budget

Value added tax

Revenues from indirect taxation, notably the VAT, have long been in decline (World Bank, 2019[25])**.** In 2017, Côte d'Ivoire's VAT scheme was the least efficient in the region, mainly due to the country's inefficient tax mobilisation policy rather than an inability to reform the administration of this tax.

Table 4.4. Health-related tax expenditures

Exemption measures	Incentive measures	Cost
Relating to taxes on wages and salaries	Exemption of taxes on wages and salaries: employer's expenditure related to: • medical and paramedical care for people with HIV, AIDS or cancer • the cost of dialysis for patients with renal failure • the cost of a first aid kit for providing first aid to sick employees • the cost of treating malaria, TB, viral hepatitis, diabetes and high blood pressure among employees • amounts paid to employees' private health schemes or insurance companies, their brokers or portfolio managers, within the framework of the health insurance group contract.	No information
Relating to VAT	Exemption: • fees for members of the medical profession and or providing medical care • hearing aids • hospital care, food and transport for injured and sick employees provided by approved hospital facilities • deliveries of drugs, pharmaceutical products, equipment and specialised products for the medical activities listed under the annex to Directive No. 06/2002/CM/UEMOA of 19 September 2002 identifying the common list of drugs, pharmaceutical products, equipment and specialised products for medical activities.	No information as it is not included in the tax expenditure report
	Exemption for grants from charities (international NGOs): • to people living with disabilities, through companies incurring expenditure for the provision of rehabilitation facilities, or orthopaedic and other specific equipment • to disadvantaged patients referred by the health or social services or by public health centres • to associations working for the rehabilitation of people with drug or alcohol addiction • to companies for financing, building, renovating or fitting out schools, health centres or multipurpose community centres.	No information
	Alliance nationale contre le VIH/SIDA [National HIV/AIDS Alliance]	XOF 12.1 million (2019)
	Fondation mondiale de recherches et prévention sida [World Foundation for AIDS Research and Prevention]	XOF 2.7 million (2018)
	National AIDS Control Programme (PNLS)	XOF 1.3 million (2019)
	National Malaria Control Programme (PNLP)	XOF 1.9 million (2018)
	National TB Control Programme (PNLT): Project for the prevention of multidrug-resistant TB by strengthening comprehensive TB care	XOF 4.8 million (2019)
	Agence Ivoirienne de Marketing Social [Ivorian Social Marketing Agency] Family planning and AIDS prevention project	XOF 10 million (2019)
	Elizabeth Glaser Pediatric AIDS Foundation: Exemption of grants to tackle paediatric AIDS	XOF 0.4 million (2018)
Import duties and taxes	Exemption of certain products imported by the central public health pharmacy: alcohol for medical and pharmaceutical uses, photographic film, products used to develop x-rays, some chemical products, medical and surgical instruments and devices, orthopaedic devices and prostheses.	
	Customs duty of 0% for: drugs, medical and surgical devices and condoms.	

Source: (Comité national d'évaluation des dépenses fiscales, 2019[33]).

Generally speaking, although measures have been taken to improve the efficiency of the VAT, Côte d'Ivoire still has much to do in terms of streamlining VAT exemptions. The IMF estimates that VAT exemptions could yield revenues equivalent to 1.5% to 2% of GDP. A *Plan de rationalisation des exonérations fiscales et douanières* [Plan to rationalise tax and customs exemptions] (2020–24), many of which concern VAT, was adopted in 2019 but implementation has been postponed to 2021. Nevertheless, this measure could raise 0.75% of GDP by 2023 according to the IMF (IMF, 2019[34]) and should be implemented by the authorities without delay. Several VAT exemptions also support the health sector (Table 4.4). Recently, other VAT and customs duty exemptions have been introduced for renewable three-month periods for the procurement of health supplies to tackle COVID-19.

There are also other approaches for increasing VAT revenues, such as making it applicable to offshore services or revising the tax threshold, as discussed in (World Bank, 2019[25]).

Corporate income tax

Despite the economy experiencing strong growth over the past years, corporate income taxes have declined (World Bank, 2019[25]). Comparing Côte d'Ivoire with other similar countries suggests that the untapped potential of this tax is likely to be around 1.5% of GDP.

The new Investment Code is particularly generous, **which benefits the health sector** (Box 4.3). In 2019, 12% of tax expenditures related to the Investment Code (XOF 40 billion) (Comité national d'évaluation des dépenses fiscales, 2019[33]). As regards health, a notable change is that it has been targeted as a priority sector (Box 4.3). Côte d'Ivoire has prioritised improving the population's access to health care, in particular by increasing domestic production of drugs to reduce their cost. To this end, the country is encouraging the installation of pharmaceutical production units in its territory to meet growing demand. The 2020 tax schedule has therefore provided additional incentives for the pharmaceutical industry (exemption from customs duties and VAT on the equipment, materials and tools, including spare parts, required to produce drugs in Côte d'Ivoire).

However generally speaking, using tax exemptions in this way has several disadvantages. It is harmful to long-term growth as it leads to economic distortions and contrasts with the trend of strengthening the tax administration. While a more efficient tax administration should help avoid the use of generous incentives, this reform has the opposite effect of increasing the complexity of the tax system. It can be costly for the state, but still fail to respond to private sector demands (stable electricity supply, sufficient skilled labour, etc.). In addition, it fails to correct fundamental problems in the tax system. For example, some tax exemptions (such as the exemption from licence duties) are temporary, even though reviewing how licence duties are calculated more generally could benefit all operators and all sectors, without generating additional tax expenditures. Finally, this use of tax expenditures leads to distortion between sectors, especially given that sectoral tax advantages are difficult to withdraw in the long term due to pressure from lobbies.

Therefore, stopping the granting of tax exemptions and advantages will be necessary. It will be important for Côte d'Ivoire to gradually change the nature of the tax incentive instruments used in all sectors (including health). This means favouring tax incentives linked to business costs (deductions, accelerated depreciation) rather than those linked to profits (exemptions, preferential tax rates), favouring temporary rather than permanent tax incentives, and systematically applying conditions to tax incentives (in particular, regarding the number of jobs created). At the same time (and prior to stopping granting tax exemptions and advantages), monitoring and accurately estimating the tax expenditures arising from the new Investment Code in the tax expenditure report will be necessary.

Box 4.3. The health sector under the new Investment Code

There are two tax incentive schemes under the new Investment Code. The declaration scheme: applicable to investments in starting a business, with advantages reserved for once the business is in operation. The approval scheme: applicable to investments in starting or developing a business, in the establishment and operating phases. Health, agriculture, agro-industry and hospitality are category 1 sectors, and have more generous incentives than category 2 sectors. The incentives vary depending on the tax incentive scheme, the investment area (A, B or C), the phase of the investment (establishment, operation) and the size of the business (large or medium/small).

Source: OECD; Order No. 2018-646 of 1 August 2018 on the Investment Code; (OECD, 2020[35]).

Personal income tax

Direct taxation of households has potential, but it is limited in the short term (World Bank, 2019[25])**.** This is because personal income tax relies on formal workers (civil servants and the formal private sector), which does not account for the majority of the active workforce.

The current personal income tax system is complex and lacks transparency. It would be advisable to introduce a simpler and more neutral system, which would encourage more taxpayers to pay their taxes. Côte d'Ivoire should therefore seek to shift from a scheduler system (each income type – income from commercial activities, salaries, income from land and buildings, income from property – is taxed separately) to a dual tax system, in which income from labour is subject to a progressive tax and capital income is taxed at a lower uniform rate (OCDE, 2016[31]).

Recurrent taxes on immovable property

If property taxes are to play their full role, coverage by the land register the valuation of property assets are required. Only 25% of land is currently registered. Land registration efforts need to be improved using additional resources, and the information used to value property assets, especially in urban areas, should be better aligned with market values.

Tax evasion and fraud

Côte d'Ivoire is committed to tackling tax evasion. Several initiatives are noteworthy: the creation of the Directorate of Investigation, Cross-referencing and Risk Analysis; the launch of the unique national business identifier project; the requirement for all companies to provide certified or approved financial statements to the authorities; the implementation of a standardised electronic invoice; and the obligation to consolidate turnover for SMEs owned by the same entity or group.

Nevertheless, Côte d'Ivoire needs to do more to tackle tax evasion, which remains pervasive in some sectors (commerce, construction, subcontracting) **and among some stakeholders** (independent workers). Côte d'Ivoire could draw inspiration from Morocco, whose tax administration has worked to collect information and data to build an accurate picture of taxpayers who do not pay their fair share of taxes (OECD, 2019[36]). This would be a first step before improving the traceability of non-wage income (World Bank, 2019[25]). Côte d'Ivoire should also streamline its inspections by refining its risk analysis processes and smooth the flow of tax information between administrations (in particular by linking databases).

5 Discussion on earmarking tax revenues for health

The earmarking of tax revenues is widespread internationally, despite its disadvantages

Many countries have established earmarking mechanisms. These can be rigid (hard earmarking) or flexible (soft earmarking). Hard earmarking means that all revenue from a tax is kept separate from the state's general revenue, and can only be used to finance a specific expenditure programme in its entirety. Another example of hard earmarking is when a fixed share of the revenue from a particular tax finances a specific expenditure programme in its entirety (for example, x percentage of personal income tax is earmarked for a specific expenditure programme). In the case of soft earmarking, the earmarked tax finances only part of an expenditure programme, with the remainder financed from the general state budget. SSCs, for example, are a form of earmarking. Internationally, earmarking taxes on products harmful for health is common (Table 5.1). Box 5.1 sets out the benefits and limitations of this mechanism.

Table 5.1. Examples of countries that earmark a large share of tobacco taxation for health

Country	Description
Argentina	A 7% taxation of the selling price of cigarettes is earmarked to finance health and social programmes.
Cape Verde	All revenue from a tobacco excise duty is earmarked for sport and health.
Colombia	All revenues from an ad valorem excise duty (10% of the selling price) and the vast majority of revenues from specific excise duties (COP 2 100 per packet) are earmarked to finance health insurance. A small share of the specific excise duty is earmarked to finance sport.
Costa Rica	All revenue from a specific excise duty is earmarked to finance programmes for preventing and treating tobacco-related diseases, cancer treatment and sport.
Egypt	An additional EGP 0.1 is levied on each packet of cigarettes to finance student health insurance. An additional EGP 0.75 is levied on each packet of cigarettes to finance the health insurance system.
El Salvador	35% of the tax revenues from excise duties on tobacco, alcohol and weapons is earmarked to finance the Solidarity Fund for Health.
Guatemala	All revenue from a tobacco excise duty is used to fund health programmes.
Indonesia	A 10% surcharge is applied to a tobacco excise duty. At least 50% of revenue from this is earmarked for regional health programmes, 75% of which is earmarked for financing the health insurance system. In addition, 2% of tobacco tax revenues are earmarked for regional governments, a share of which must be used for health.
Panama	50% of revenue from tobacco taxation is earmarked for the National Cancer Institute and the Ministry of Health (to prevent cigarette smuggling).
Paraguay	40% of revenue from a tobacco excise duty is earmarked for the Ministry of Health for the prevention and treatment of non-communicable diseases and 18% is earmarked for the National Sports Development Fund.

Source: (WHO, 2019[37]).

Box 5.1. Benefits and limitations of earmarking tax revenues

Benefits

- **It strengthens political legitimacy.** It is easier to gain public support for (new) taxes that are earmarked for specific social objectives.
- **It provides guidance to taxpayers on the actual cost of programmes.** In health care, this improves the population's awareness of the significant costs of the sector. This argument is less valid in the case of soft earmarking.
- **It supports the principle that individuals contribute to the extent that they benefit from a state programme.** However, in the case of health, this principle should not apply: a population affected by a disease should not have to pay a specific tax earmarked for the treatment of that disease.
- **It increases the visibility of programme funding sources.** This strengthens long-term planning and budgeting and provides some funding stability. However, in some cases, it will be difficult to know in advance precisely how much revenue will be earmarked.

Limitations

- **It can crowd out public resources**. Other sources of funding, such as general revenues from the state budget, may be reduced by earmarking.
- **It can make budgets inflexible.** Earmarking reduces government discretion and flexibility. This may, in some situations, jeopardise macroeconomic stability by hampering the scope for budgetary adjustments. To reduce this risk, some countries have created reserve funds into which earmarked taxes can be directed if new priorities emerge.
- **It lacks the capacity to adapt financing to real programme needs.** Earmarked funds do not vary according to the size of the programmes or projects they fund. As a result, they do not necessarily fund all needs. In the health sector, this may become unsustainable if coverage or usage rates increase.
- **It risks inefficiency in programmes funded by earmarked resources** as these programmes are often subject to less scrutiny. In the health sector, this can lead to inefficiencies in public spending.
- **It risks pro-cyclical financing.** Some earmarked taxes generate pro-cyclical revenues, which can lead to significant fluctuations in financing, in conflict with the need for stable financing. However, programmes financed by counter-cyclical earmarked taxes may be better protected from budget cuts.
- **In the case of soft earmarking, it fragments funding sources,** making programme management more complex.

Source: (Boakje, 2016[38]), (Carling, 2007[39]), (Murray, 2018[40]), (Wright & al, 2017[41]), (WHO, 2016[42]), (WHO, 2017[43]),

Cote d'Ivoire should prioritise a gradually implemented and extensive tax reform over earmarking resources for health

About 0.9% of tax revenues is earmarked in Côte d'Ivoire, the majority of which is allocated to the energy and transport sectors, as well as for social security bodies (excluding UHC). Côte d'Ivoire

earmarks little tax revenues for health. Only a small share of tobacco taxation is earmarked for specific programmes to combat AIDS and addictions (tobacco, alcohol and other addictions) (Chapter 4).

The MBPE did not endorse the ideas put forward during the 2012 debate on financing the health system with regard to earmarking the revenues of certain taxes, such as airport and port taxes (XOF 655 million in 2019), telecommunications taxes (XOF 52 billion), the banking taxes (XOF 70 billion) or some of the proceeds from consumer taxes. These taxes amount to 0.14%, 12% and 16% of MSHP's 2020 budget. This is to be welcomed as these taxes are not directly related to health. Furthermore, as argued by the MBPE, it would not be possible to prioritise one sector over another. In fact, it is not possible to meet the funding needs of all ministries through earmarking resources. This reality underscores the need for Côte d'Ivoire to increase the overall level of tax revenues in the general state budget, which will benefit all ministries, rather than earmarking a share of the already limited tax resources for health alone. **To achieve this, an extensive tax reform, to be implemented gradually, is necessary and should be prioritised with respect to earmarking tax revenues for health.**

However, given the significant challenges caused by the COVID-19 crisis, more resources could be earmarked

Chapter 3 highlighted the role of economic growth in the growth of public health expenditure, which must go hand in hand with the prioritisation of the sector within the budget. However, the current context is characterised by a slowdown in growth following the COVID-19 crisis. This will have the knock-on effect of slowing the growth of public health expenditure. Lower tax revenues will also make it more difficult to prioritise the sector in the budget in future.

Côte d'Ivoire may therefore want to re-examine the arguments for earmarking all or part of the taxes on products harmful for health to ensure a minimum level of funding for the sector. For example, Côte d'Ivoire could consider earmarking a larger share of the proceeds from tobacco taxation for health or earmarking all or some of the taxation of alcohol or sugary drinks. An alternative would be to earmark the additional tax revenues generated when these taxes are reviewed, such as the increase in rates on tobacco, alcohol or sugary drinks.

If Côte d'Ivoire were to start earmarking a larger share of tax revenues for health, **its success would depend upon several conditions.** There would be two prerequisites:

- The MSHP, MBPE and MEF would have to work together. The introduction of earmarked taxes reflects political support for one or more health priorities, which requires the ministries to align on the objectives to be achieved.
- The evaluation of the outcome of earmarking revenues to the National AIDS Fund (around 80% financed by the special solidarity tax to combat AIDS and smoking, and the rest by the general revenues of the state budget).[8]

In addition to these preconditions, other conditions should be met to counteract some or all of the limitations of this type of financing (Box 5.2**).** It should also be noted that earmarking resources to finance health programmes currently funded by donors for which funding will decline over time is ambitious given the substantial amounts of funding this would entail. It would therefore be more appropriate to finance such programmes from the general revenues of the state budget.

[8] 2020 operating budget of XOF 1 094 million. Special solidarity tax to combat AIDS and smoking of XOF 910 million in 2019.

Box 5.2. Conditions for counteracting, fully or in part, the limitations of earmarking resources

- The introduction of earmarked taxes is not an isolated measure, but an integral part of an overall health financing strategy.
- When resources are earmarked, awareness campaigns are run on the role of the earmarked tax and the health programme that will benefit from its funding.
- Earmarked resources are first used to finance specific health programmes (in terms of budget, scope and objective). These programmes should be subject to a prior needs assessment to take into account possible increases in their use or coverage.
- Flexible resource earmarking mechanisms are prioritised to limit budgetary inflexibility.
- Specific measures on the management of health programmes are implemented when introducing earmarking. For example, the MBPE could make the introduction of earmarked taxes conditional on the MSHP improving the quality and efficiency of its public spending.
- Programmes that benefit from earmarked resources are regularly evaluated to ensure accountability.
- The number of taxes earmarked is limited to avoid the fragmentation of funding sources.
- Earmarked resources are transferred to the health programmes they fund in a timely manner.
- Resource earmarking is conditional on the agencies' ability to absorb and manage the influx of new income.
- The resource earmarking mechanism is set out in a clear and transparent manner.

Source: OECD.

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The Global Fund to fight AIDS, tuberculosis and malaria is the second largest donor in the health sector in Côte d'Ivoire. Its policy is to involve the country in mobilising domestic resource to increase public spending on health. This report analyses the tax measures, and in particular health-related measures, that will allow Côte d'Ivoire to mobilise more revenues.

In Côte d'Ivoire, health financing is low, and in particular public health financing. Health expenditure accounted for 4.5% of GDP in 2017, or USD 70 per capita, below the average for lower-middle-income countries.

The report welcomes the governement's engagement to increase the health budget until 2030, and the implementation of the National platform for health financing co-ordination. Increasing the health budget will not be possible without an extensive tax reform, to be implemented gradually, that should be tailored to the new economic and social challenges caused by the COVID-19 crisis. At the same time, the Platforme will have a key role to play in the interministerial dialogue on health financing. However, the report stresses the need to improve public health spending efficiency prior to any increase in funding.

The report presents recommendations on how Côte d'Ivoire could improve the design of its tax system, and its health taxes in particular. It includes a discussion on the financing of the health compulsory insurance system, introduced in 2019, on ways to increase tax revenues from products that are harmful for health, and points to the need to give more prominence to environmentally-related taxes given their positive indirect impact on populations' health.

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