Health Financing Progress Matrix assessment

Mauritius 2023

Summary of findings and recommendations

THE REPUBLIC OF MAURITIUS

World Health Organization

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About the Health Financing Progress Matrix

The Health Financing Progress Matrix (HFPM) is WHO's standardized qualitative assessment of a country's health financing system. The assessment builds on an extensive body of conceptual and empirical work and crystallizes "what matters in health financing for universal health coverage" (UHC) into nineteen desirable attributes that form the basis of the assessment.

A HFPM reports identify areas of strength and weakness within a country's current health financing system with reference to these attributes. Based on this, the reports recommend adjustments to health financing policy, specific to the context of the country, which can help to accelerate progress towards comprehensive UHC.

The qualitative nature of this analysis, together with supporting quantitative metrics, allows almost real-time performance information to be provided to policy-makers. In addition, the structured nature of the HFPM lends itself to the systematic monitoring of progress of the development and implementation of health financing policies. Country assessments are implemented in four phases, as outlined in Fig. 1. Given that no preliminary research is required, assessments can be implemented within a relatively short time period.

Fig. 1: Four phases of HFPM implementation

Phase 2 of the HFPM consists of two stages of analysis:

- Stage 1: a mapping of the health financing landscape comprising a description of the key health coverage schemes in a country. For each, the key design elements are mapped, such as the basis for entitlement, benefits, and provider payment mechanisms, providing an initial picture of the extent of fragmentation in the health system.

- Stage 2: a detailed assessment based on thirty-three questions of health financing policy. Each question builds on one or more desirable attribute of health financing and is linked to relevant intermediate objectives and the final goals of UHC.

Countries are using HFPM findings and recommendations to feed into policy processes including the development of new health financing strategies, the review of existing strategies, and for routine monitoring of policy development and implementation over time. HFPM assessments also support technical alignment across stakeholders, both domestic and international.

Further details about the HFPM are available online:
https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix

About this report

This report provides a concise summary of the Health Financing Progress Matrix assessment in Mauritius, identifying strengths and weaknesses in the health financing system, and priority areas of health financing which need to be addressed to drive progress towards UHC. Findings are presented in several different summary tables. By focusing both on the current situation, as well as priority directions for future reforms, this report provides an agenda for analytical work and related technical support. The latest information on Mauritius' performance in terms of Universal Health Coverage (UHC) and key health expenditure indicators, are also presented. Detailed responses to individual questions are available on the WHO HFPM database of country assessments or upon request.

This report represents the fourth and final phase in the HFPM implementation process in Mauritius (see Fig. 1 earlier) and is based on the detailed responses for each question conducted in Phase 2, which involves completion of HFPM Stages 1 and 2, and which were subject to external review (Phase 3). Detailed responses to individual questions are available on the WHO HFPM database of country assessments or upon request. This assessment is a living document and is circulated for further feedback and comments; it can also form the basis of annual updates for monitoring purposes.

Abbreviations

CHE	Current Health Expenditure
FMIS	Financial Management Information Systems
HFPM	Health Financing Progress Matrix
HSSP	Health Sector Strategic Plan
MCH	Maternal and Child Health
MSISSNS	Ministry of Social Integration, Social Security & National Solidarity
MOFEPD	Ministry of Finance, Economic Planning and Development
MOHW	Ministry of Health and Wellness
OOP	out-of-pocket
OOPs	out-of-pocket payments
NCD	Noncommunicable diseases
PHC	primary health care
SDGs	Sustainable Development Goals
UHC	universal health coverage
WHO	World Health Organization

Methodology and Timeline

WHO headquarters and WHO Regional Office for Africa invited the WHO Mauritius Country Office to conduct the HPFM assessment. The assessment was originally undertaken by a national consultant with the support of the WHO Country Office during the end of 2021 and the exercise was based on the following methodology:

- Meeting of Steering Committee
- Working Sessions with Staff of the Ministry of Health and Wellness (MOHW) and representative of WHO Country office in Mauritius and other stakeholders
- Review of published documentation
- Exit interviews with staff of Health Economics Unit, Chief Health Statistician, staff of Finance Division and Procurement Division
- Exit interviews with Mr E.M Jhummoo, Freelance National Health Accounts Consultant research work through internet
- Exit Interview with Dr P. Chandydyal, Bon Pasteur Clinic (Private Sector) Online Training on Development of Health Care Financing Progress Matrix by WHO headquarters, Geneva

Moreover, WHO internal and external reviewers had the responsibility to review and validate the assessment and update information where necessary and provide the scores in 2022. The finalization of the Report was ensured by WHO Regional Office for Africa, WHO Country Office and the officers from MOHW.

The MOHW is presently implementing a Health Sector Strategic Plan (HSSP) for the period 2020-2024 which conforms to Government's policy in the health sector, which aims at achieving the highest standards of good health among the population. One of the Strategic Goal of the HSSP focuses on Health care Financing as the Ministry envisages to develop a Health Financing Strategy. Thus, the results of the Health Financing Progress Matrix provide an important baseline in relation to the HSSP goals.

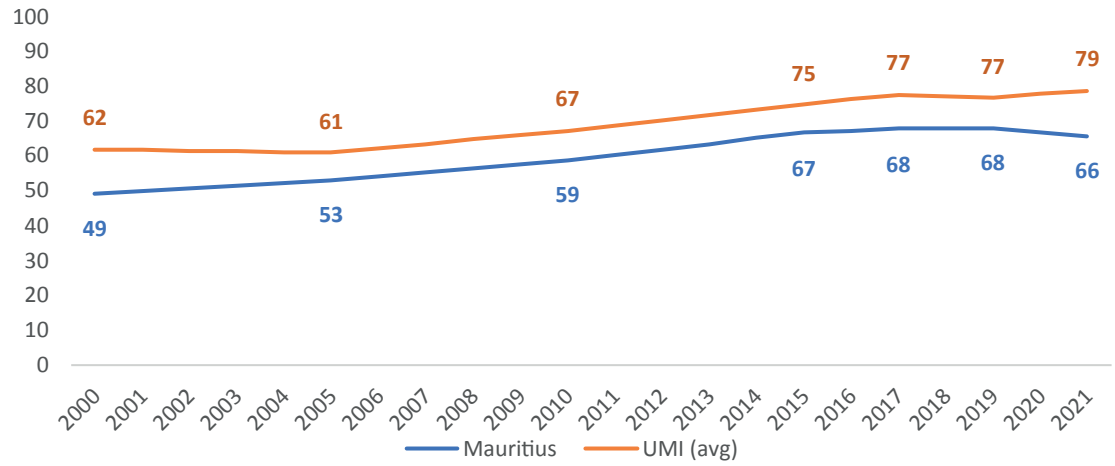
The Principal Investigator was an external contributor hired through a WHO procurement contract; declaration of conflict of interest was managed in the processes related to this contract.

Mauritius UHC Performance

Sustainable Development Goal (SDG) indicator 3.8.1 is defined as the average coverage of essential services for fourteen tracer interventions that include reproductive, maternal, new-born and child health, infectious diseases, noncommunicable diseases (NCDs) and service capacity and access (World Health Organization, 2021). The Universal Health Coverage (UHC) service coverage index is a score between 0 and 100, calculated as the geometric mean of coverage for each of the tracer interventions.

The service coverage index for Mauritius has improved significantly since 2000, rising from 49 to 66 in 2021, despite remaining below the average for upper middle-income countries. The progress in UHC has been remarkably evidenced through the improvement of the overall health status of the population.

Fig. 2: Service coverage index trend in Mauritius 2000-2021

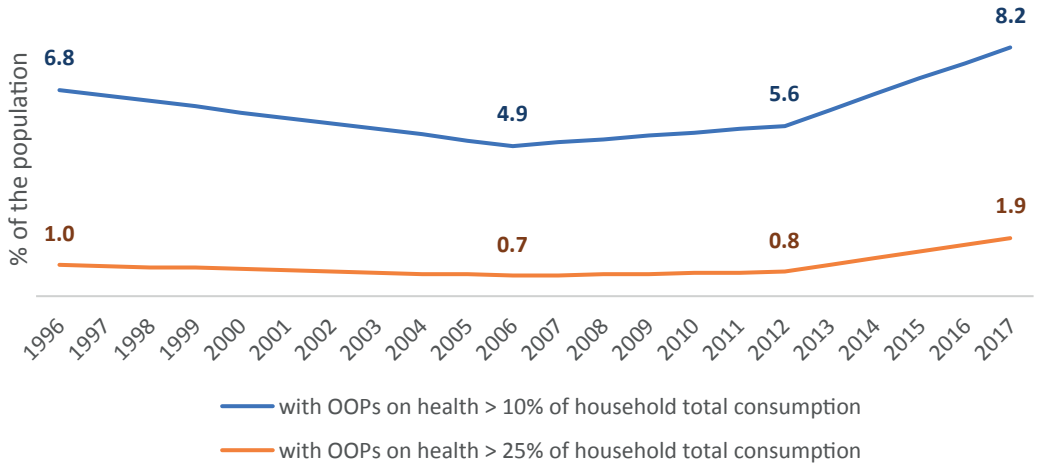


Source: Global Health Observatory 2023 (https://www.who.int/data/gho/data/themes/topics/service-coverage, accessed 1 August 2023)

SDG indicator 3.8.2 relates to financial protection, measured in terms of catastrophic health expenditure. As the official indicator for SDG 3.8.2, catastrophic health expenditure is based on the budget share method and is defined as the "Proportion of the population with large household expenditure on health as a share of total household expenditure or income" with two different thresholds (10% and 25%).

In Mauritius, according to the 2023 WHO Global Monitoring Report for tracking UHC, the percentage of people who spent more than 25% of their household budget on health was only 1.9% in 2017 as shown in Fig. 3.

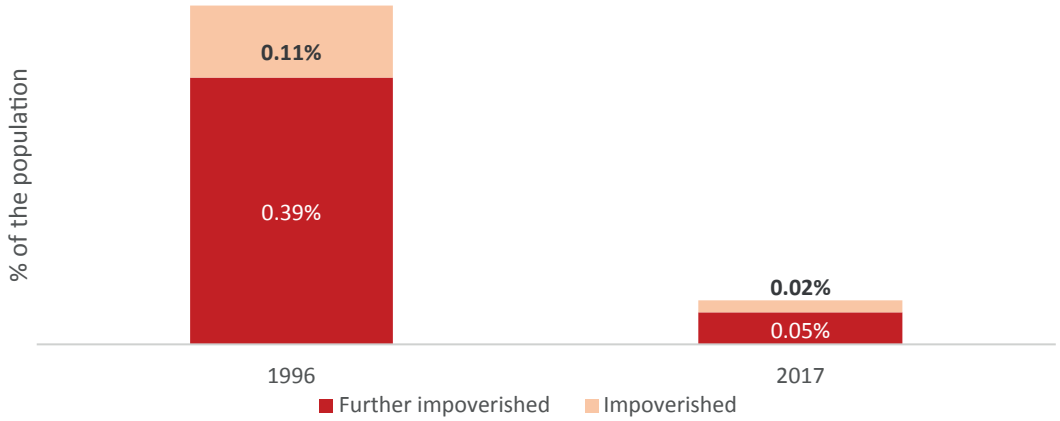
Fig. 3: Trend in catastrophic health spending in Mauritius 1996-2017



Source: Global database on financial protection assembled by WHO and the World Bank, 2021 update. SDG 3.8.2 Catastrophic health spending (and related indicators) [online database, accessed 1 August 2023]. Global Health Observatory. Geneva: World Health Organization; 2021.

Though not an official SDG indicator, an additional metrics of financial protection looks at health spending which leads to impoverishment. In this context, some people (the poor and the near poor in particular) are not able to spend more than 10% of their household budget on health. Indicators of impoverishment are defined as the proportion of the population pushed and further pushed below the poverty line (less than Purchasing Power Parity (PPP) $1.90 a day person and where even the most basic standard of living is not guaranteed) as a result of out-of-pocket health spending. In Mauritius, the impoverishing out-of-pocket health spending is very low and has improved over the years as depicted in Fig. 4.

Fig. 4: Impoverishing out-of-pocket health spending in Mauritius 1996-2017



Note: Those living in households already below the poverty line before incurring health out-of-pocket payments are considered further impoverished.

Source: https://www.who.int/data/gho/data/themes/topics/financial-protection [accessed 10 April 2023]

Summary of findings and recommendations by assessment area

Using the guidelines to the Health Financing Progress Matrix (HFPM), the paragraphs below summarize the key recommendations that are important for Mauritius to make further progress towards UHC. All recommendations are backed by evidence on what other countries needed to do to progress towards UHC.

For all the below sections, the recommendations are coming straight from the extensive evidence review that WHO did and documented in the guidebook of the HFPM. The recommendations are adapted to the Mauritius context. WHO has summarized what works and has worked in other countries with regards to health financing reform in the various areas in order to make progress towards UHC. The way the recommendations should be read therefore are "based on evidence from other countries, if we implement this, we will make progress towards UHC".

Summary of findings and recommendations

Assessment area	Summary findings	Status
Policy process & governance	Since 2020, COVID 19 continues to impact negatively on economic growth and health of nations throughout the world. Weak health systems have largely contributed to millions of deaths globally. Mauritius was impacted during the first wave of the COVID-19 pandemic with significant disruption of health care delivery. The health systems resilience improved during subsequent waves of the pandemic in Mauritius as evidenced by second round of the WHO Pulse survey (2021). The Government continues to invest increasingly in the health care delivery through allocation of supplementary funds to counter the increasing incidence of NCDs. Evidence-based information available from international institutions indicate that worldwide health care costs will continue to escalate in the coming years. Mauritius is no exception. Presently the country does not have a written health financing policy statement guided by goals and based on evidence– a policy which focuses on the core functions of the health system, that is, revenue raising, pooling of funds and purchasing of services specific for the health sector. However, the country is implementing a Health Sector Strategic Plan 2020-2024 focusing on the provision, extension and improvement of the quality of care in the public sector and recommends the development of new health care financing strategies Based on the present assessment and the country's commitment towards UHC, it is recommended that Mauritius: 1. Develops a National Health Care Financing Strategy which will consider ways and means to sustain the provision of free health services. 2. The Government announced the setting up of a Medical Insurance Scheme for public sector employees as part of budgetary measures in 2017. This is yet to be implemented. However, prior to implementing such a decision, the most recent international evidence and debate need to be considered to ensure that the introduction of a medical insurance scheme is in alignment with the objectives and goals of UHC 3. Generates evidence through studies on the economics of medical care to support amendment to the existing legislation on the private health sector and to include a mechanism for harmonising and regulating user fees in the private sector to ensure financial risk protection. 4. Strengthens the existing structure institutionalised within MOHW to better evaluate, improve policy development and implementation.	Established

Summary of findings and recommendations

Assessment area	Summary findings	Status
Revenue raising	In Mauritius, public revenues are raised through direct and indirect taxes, sin taxes, levies and allocated to different sectors, whilst private revenues come largely through out-of-pocket spending and to some extent through voluntary private health insurance. External financing is very limited. Health care services, from primary care to secondary care and specialized medicine, are free of any user cost at the point of entry in the public sector. Government spending on public health care has resulted in significant pro-poor services distribution, while this is offset by pro-rich distribution in the private sector. Sin taxes are well-established and levied on alcohol, tobacco and sugar sweetened products in Mauritius. The revenues are credited into the Consolidated Funds as part of overall budget allocations to the health sector. While the Government has endorsed Resolutions to specifically allocate sin tax revenues to the health sector, these recommendations have not been implemented to date. Sin tax revenues between 2019-2020 were equivalent in size to 90% of the total health budget. The use of government, or public funding, is critical to the improvement of financial protection and hence and progressing towards UHC, particularly for the poor and marginalized. The recent NHA reports demonstrates that the budget share allocated to health as percentage of General Government Expenditure (GGE) has been stagnant since 2014 (see Fig. 10). Both per capita Government expenditure on health, and Government expenditure on health as a percentage of Gross Domestic Product (GDP) have been steadily rising over the past decade, whilst out-of-pocket has steadily declined (see Fig. 10 and Fig. 11). However, between 2012 and 2017 the incidence of catastrophic spending increased (see Fig 3), with more recent estimates not yet available, the drivers of which require a deeper understanding. Special mechanisms for revenue raising were introduced during the COVID-19 pandemic such as the COVID-19 Vaccination Fund based on an additional petrol levy. The following are proposed in respect of revenue raising: • Maintain the recent trend of public revenues growing as a share of total health spending given its critical role in progressing towards UHC. • Improve understanding of the drivers of OOPs and catastrophic health spending in Mauritius, with a view to informing revenue raising and other areas of health financing policy.	Advanced 
Pooling revenues	The revenue is collected in the public sector from different sources including taxation. These revenues are pooled in the Consolidated Fund of Government. There is no social health insurance or compulsory health insurance in Mauritius. Health services are provided free from any user cost to all citizens in all public health institutions. Voluntary private health insurance co-exists with the public health care financing system in the country. It is estimated that 12% of the population are covered by voluntary private health insurance representing 98,200 people. Given that the government considers to further increase the reliefs on health insurance policies, it is critical that attention should also be given to ensuring that lower income households benefit equally from what is essentially a public subsidy.	Established 

Summary of findings and recommendations

Assessment area	Summary findings	Status
Purchasing health services	Whilst information on health needs forms an important basis for the allocation of resources to providers, further work is merited to reflect the growing burden of noncommunicable diseases and the service delivery model to address this challenge, and to ensure that the staff with the appropriate clinical skills are present in the right health facilities The Health Sector Strategic Plan 2020-2024 outlines several initiatives to improve the strategic nature of purchasing in the health system including: • enhance the Complaint Management System by using the E-Health System efficiently and effectively to further promote quality of care • improving the quality of data related to purchasing of health services by adopting a redesigned business process supported by innovative e-health technologies including an Integrated Health Management Information System based on an up-to-date, accurate and complete patient database The area greatest in need of attention relates to the low financial autonomy and accountability of service providers. The Health Sector Strategic Plan 2020-2024 includes the following to support providers to manage their day-to-day businesses more effectively, including more autonomy at the regional level: • revisit the management structures of public health institutions with a view to fostering greater synergy between the central and regional levels of management • establish an effective governance framework which includes policies and strategies centred on rules-based, transparent and accountable processes and procedures • implement best practice and recommended frameworks to improve accountability and governance, such as the Anti-Corruption Framework	Established ●●●○
Benefits & entitlements	Entitlements and obligations are well-defined and clearly understood by the population. There is a set of services at all levels of care within a unified framework for all people. Defined benefits are aligned with available revenues and health services. Benefit design does not include user charges in view of the fact that services are provided free of any user cost in the public sector. The Health Sector Strategic Plan 2020-2024 makes various recommendations to further improve benefits and conditions of access. It is understood that the strategic actions of the Plan are being implemented. Furthermore, provision exists for patients, whose family's earnings are less than Rs 100,000, and who cannot be treated locally, to be transferred to health institutions abroad while the Government bore the costs up between Rs 0.8 million to Rs 1 million.	Advanced ●●●●

Summary of findings and recommendations

Assessment area	Summary findings	Status
Public financial management	Mauritius has a good system in place for health expenditure reporting. The aim of the Public Financial Management manual is to provide the framework for effective financial management in the public service of Mauritius. It is designed to improve the quality of service provided by enhancing the ability of the public service to achieve its objectives of implementing Government policies and programs economically, efficiently, and effectively. Assessment and review of the Financial Management Information Systems (FMIS) to cope with changes and further improve public financial management in line with the best international practices is implemented, as and when required, in the country. A Financial Management Kit provides public officers with an all-inclusive set of reference documents, and it is intended to ensure uniformity and standardization in public financial management. Regular assessment of key public financial management bottlenecks, including health are made. A thorough assessment of the Public Expenditure and Financial Accountability was undertaken in 2015 by the European Union. Updates are done periodically in form of circulars. Procedures are well-embedded and respected. The accounts are regularly audited and there is transparency and accountability brought by Committee of needs and public accounts committee. The use of e-public management system is being encouraged. It is recommended to sustain the implementation of recommendations from the Audit Reports of the National Audit Office and the Internal Control.	Advanced ●●●●
Public health functions and programmes	In Mauritius, specific health programmes are aligned with the overall financing policies of Government with key objectives to meet increasing demands for specific services, cope with both other internal and external factors such as acquiring latest technology and new and more efficient medical drugs and additional personnel, with the ultimate goal of achieving UHC. There has always been a timely response by Mauritius to deal with public health emergencies. The country has maintained a strong record of responding rapidly and effectively to several public health threats. Furthermore, during the first wave of COVID-19, MOHW was able to redeploy and recruit health professional retirees on a short-term basis. The following are recommended: 1. Emergency Procurement of goods and services for a significant value should be undertaken in a more transparent way through a dedicated authority which is to be established for better "Value for Money". 2. Identify and pre-specify emergency public financing mechanism that can be accessed to strengthen preparedness interventions (in line with the National Action Plan for Health Security) and for immediate mobilization at national and subnational levels for the timely distribution and execution of funds by all sectors during a health emergency (including outbreaks or epidemics).	Advanced ●●●●

Stage 1 assessment

Stage 1. Health coverage schemes in Mauritius: health financing arrangement

Key design feature	Government health budget	Trust Fund For Specialized Medical Care	Ministry Of Social Integration, Social Security & National Solidarity	Private Health Insurance
A) Focus of the scheme	**GENERAL BUDGET FUNDING** SCOPE: All citizens Government recognizes health as a basic human right. POLICY OF GOVERNMENT: To provide free health care services, from primary to secondary and specialized services, free of any user cost, to all citizens. CITATION FROM PARAGRAPH 1.2.3. OF HEALTH SECTOR STRATEGIC PLAN 2020-2024 approved by GOVERNMENT: "Ensure universal health coverage, so that every citizen has access to different levels of health care in a timely, cost-effective and seamless manner on the basis of need, rather than the ability to pay". Horizontal Programmes include the following: 1. Selective PHC Services 2. Health Promotion Programmes 3. Curative Services 4. Selected Specialized Services 5. Clinical Management of Covid-19 cases since 2020) 6. Other Services Vertical Programmes include the following: 1. Expanded Programme of Immunization 2. Maternal and Child Health (MCH) Services 3. Family Planning 4. Control /Eradication of Infectious Diseases 5. Contact Tracing/Screening of targeted population for Covid-19 (since 2020) 6. HIV and AIDS 7. Hepatitis C 8. NCD Screening 9. School Health Programme 10. Occupational Health 11. Traditional Medicine Government schemes cover the provision of a wide range of service, including the following: 1. Integrated package of PHC services, including immunization, MCH, screening for communicable and noncommunicable diseases, dental, health promotion, school health activities, traditional medicine, and specialist clinics.	**GENERAL GOVERNMENT:** CARDIAC CENTRE SCOPE: To provide high quality, patient- centred and compassionate care in line with international best practices to people in need of specialized medical treatment. NCDs such as diabetes, cardiovascular diseases, cancer and chronic respiratory diseases account for 88.7% of all deaths. Heart diseases was one among the principal underlying causes of mortality in 2021, with 2,772 (21.3%) deaths.* The Trust Fund For Specialized Medical Care Act 1992 allows for the setting up of a Cardiac Centre, with the main objective of the provision of high-tech medical care. The Fund is managed by a Board of Trustees and may amongst others, raise funds, charge fees for the provision of medical care and receive grants in aid, donations, or legacies. However, in line with the welfare policy of Government, it provides free services to all citizens. The Centre operates under the aegis of the MOHW. The main Centre is located in the north of the island and has 60 beds. In 2020 its bed occupancy rate was 57.4. The second hospital has 27 beds, with an occupancy rate of 26.7 in 2020. This is a vertical programme dedicated for cardiology services, including cardiac surgery	**GENERAL GOVERNMENT** Scheme is operated by Medical Unit of the Ministry of Social Integration, Social Security & National Solidarity (MSISSNS) SCOPE: To provide medical and support services to elderly people and the disabled FOCUS: To provide, 1. medical, paramedical Services and health education to all Elderly, 2. preventive, promotive, curative and rehabilitative services to elderly people and disabled. Free Care Vertical Programme for the elderly and people with disabilities Activities: (i) Weekly visits to Infirmaries of charitable institutions by medical officers, nursing officers, physiotherapists, and occupational therapists to Charitable Institutions to provide care and treatment to the elderly and handicapped. (ii) Domiciliary visits to persons over 90 years and above to assess their state of health and medical officers prescribe medicines where necessary. (iii) Domiciliary visits by medical officers to bedridden persons 60 – 89 years including children 0-19 who are bedridden and severely handicapped. Drugs are made available at the local health centres or the regional hospital. (iv) Health Clubs have been set up in Elderly Day Care Centres for the well-being of the elderly. (v) Elderly above 90 years who are bedridden or severely disabled in receipt of carers allowance permanently receive the services of Physiotherapists and Occupational Therapists on the recommendation of the Medical Officer.	**PRIVATE SECTOR:** (VOLUNTARY PRIVATE HEALTH INSURANCE SCHEMES} SCOPE: Ensure financial risk protection to individuals as well as employees of private enterprises who opt for care and treatment in the for- profit private health care system. FOCUS: Individuals and Households Employment Group Insurance covering employees in private enterprises and businesses and parastatal organizations Mostly Horizontal Programmes, including curative and specialized services

* Country reported data

Key design feature	Government health budget	Trust Fund For Specialized Medical Care	Ministry Of Social Integration, Social Security & National Solidarity	Private Health Insurance
A) Focus of the scheme, cont.	2. Hospital and Specialized Services, including Accident & Emergency, general surgery, paediatric surgery, neonatal ICU, ophthalmology, orthopaedics, mental health, plastic surgery, respiratory medicine, rheumatology, intensive care, general medicine, infectious diseases management, nephrology, including renal dialysis and transplantation, gynaecology and obstetrics, ENT, dental, oncology and radiotherapy, neurosurgery, occupational and physiotherapy, diabetes and endocrinology, cardiology and cardiac surgery, gastro-enterology, traditional medicine and support services which include laboratory and imaging services and SAMU, etc		(vi) Health Promotion and Disease Prevention programmes are undertaken on a routine basis. The topics addressed are diabetes, hypertension, cardiovascular diseases, mental problems, falls in the elderly and the most important topic being palliative care for people in their end of life. Elderly are screened for diabetes mellitus and hypertension. Diabetic patients benefit from foot care demonstrations and foot hygiene to prevent leg amputations. (vii) Anti-influenza vaccines are provided to the elderly persons above 60 years and to disabled children to prevent complications due to influenza and to improve the quality of life of the elderly.	
B) Target population	**All citizens** Population: 1,222,000 However, it is assumed that an estimated 82% of the population representing 1,002,000 people were in need of a health care service in 2019. Out of this number of 1,002,000 people, it is estimated that, 75% of people sought care in the public sector and 25% in the private sector. However, these percentages vary in relation to the type of care needed. Ambulatory Services at PHC level and in hospitals: 1,002,000 Deliveries: 12,000 Immunization: 12,700 Dental Services: 150,000 Inpatient services in hospitals: 260,000 Surgical Interventions: 78,300 Renal Dialysis: 1,402 School Health Services (Primary Schools): 72,000 Overseas Treatment Abroad: 243 HIV Patients: 6,924	All citizens with chronic conditions of NCDs, especially cardiac patients in need of clinical interventions. Estimated No of People to receive services: 3,451	Estimated No of people to benefit from services: 7,000 beneficiaries	It is estimated that 25% of the population seek care in the private sector. 12% of population are covered by private health insurance, representing 98,200 people. It is assumed that the remaining 13% pay direct user fees through out-of-pocket (OOP) expenditure on health. Ambulatory Services: 334,000 Deliveries: 3,600 Immunization: 1,700 Dental Services: 75,000 Inpatient services: 65,000 Surgical Interventions: 27,200 Renal Dialysis: 18 For the above indicators, patients effected payments either through direct OOP or through insurance cover.

Key design feature	Government health budget	Trust Fund For Specialized Medical Care	Ministry Of Social Integration, Social Security & National Solidarity	Private Health Insurance
C) Population covered	Ambulatory Services at PHC level and in hospitals: 668,000 Deliveries: 8,400 Immunization: 11,000 School Health Services (Primary: Schools): 42,000 Dental Services: 75,000 Inpatient services in hospitals: 195,000 Surgical Interventions: 51,100 Renal Dialysis: 1,402 Overseas Treatment Abroad: 243 HIV Patients: 6,924	Estimated No of People who underwent cardiac surgery: 526 Estimated No. of people who received other cardiology services: 2,925 Annual budget allocated by Government averages Rs 265,000,000.00	Estimated No of people covered under scheme: 7,000	Ambulatory Services: 37,176 Deliveries: 401 Immunization: 189 Dental Services: 8,348 Inpatient services: 7,235 Surgical Interventions: 3,028 Renal Dialysis: 2
D) Basis for entitlement/ coverage	Automatic by citizenship & non-contributory Free health care services to all citizens without any user fee in the public sector	Automatic Free services without any user fee	Automatic. Free medical services to bedridden or severely disabled elderly above 60-89 and all elderly above 99 years and children with severe disabilities or bed ridden 0-19 years.	Not required by law. Voluntary Basis. Required by some employers. People have their own choice for treatment either in the public sector where all services are free or in the private sector on a user fee basis paid directly through OOP or through an insurance company (voluntary private health Insurance)
E) Benefit entitlements	All services and medicine provided. Some complicated cases which cannot be managed locally are sent abroad for treatment at the expense of Government. These cases are • Leukaemia • Cochlear Implant • Liver Transplant • Heart Transplant • Osteosarcoma • Renal Transplant • Cancer • Neurosurgery • Orthopaedic etc. • Complicated Eye Treatment Household income ceiling eligibility criteria has been revised from Rs 50,000 to Rs 100,000 for accessing government support for overseas treatment. Few super-specialty services have been recently initiated such as Infertility Services, and Care for Autism. Other services that are currently in the planning stages are human tissue transplant including renal transplant services	Services provided by Cardiac Centre Treatment of: Angina Pectoris Acute Myocardial Infarction Chronic Ischaemic heart diseases Nonrheumatic mitral & aortic valve disorders Heart failure cardiac Septal Defect Congenital malformation of the heart Other heart diseases All services including medicine provided	Services provided by MSISSNS 1. medical, paramedical Services and health education to all Elderly, 2. preventive, promotive, curative and rehabilitative services to elderly people and disabled. Free Care Vertical Programme for the elderly and people with disabilities Activities: (i) Weekly visits to Infirmaries of charitable institutions by medical officers, nursing officers, physiotherapists and occupational therapists to provide care and treatment to the elderly and handicapped. (ii) Domiciliary Visit to persons over 90 years and above to assess their state of health and medical officers prescribe medicines where necessary.	Insured have the choice to opt for different schemes of medical care and treatment (both outpatient and inpatient services). User fees are paid directly to providers or can be refunded to the insured. Benefits include the following: 1. Inpatient services for surgical interventions and medical treatment. 2. Treatment abroad which covers cost of treatment, airfare, hotel accommodation, local transport and airfare and hotel for one accompanying person. 3. Outpatient services, including medical consultation, medicine, optical costs, dental costs and a number of specified chronic diseases.

Key design feature	Government health budget	Trust Fund For Specialized Medical Care	Ministry Of Social Integration, Social Security & National Solidarity	Private Health Insurance
E) Benefit entitlements, cont.			(iii) Domiciliary Visits by medical officers to bedridden persons 0 – 89 years including children who are bedridden and severely handicapped. Drugs are made available at the local health centres or the regional hospital. (iv) Health Clubs have been set up in Elderly Day Care Centres for the well-being of the elderly. (v) Elderly above 90 years who are bedridden or severely disabled in receipt of carers allowance permanently receive the services of Physiotherapists and Occupational Therapists on the recommendation of the Medical Officer. (vi) Health Promotion and Disease Prevention programmes are undertaken on a routine basis. The topics addressed are diabetes, hypertension, cardiovascular diseases, mental problems, tendency to fall among elderly and the most important topic being palliative care for people in their end of life. Elderly are screened for diabetes mellitus and hypertension. Diabetic patients benefit from foot care demonstrations and foot hygiene in order to prevent leg amputations. (vii) Anti-influenza vaccines are provided to the elderly persons above 60 years and to disabled children in order to prevent complications due to influenza and to improve the quality of life of the elderly.	4. Maternity and Child Health, including deliveries. Co-payments exist For surgical interventions, refund is 100% of expenses, subject to certain limits. Benefits vary among different insurers. Medicines, laboratory, imaging and other support services are covered. Private hospitals are also providing inpatient services for COVID 19 patients including screening.

Key design feature	Government health budget	Trust Fund For Specialized Medical Care	Ministry Of Social Integration, Social Security & National Solidarity	Private Health Insurance
F) Co-payments (user fees)	No user fees and any type of co-payment. Household income ceiling eligibility criteria is Rs 100,000. • Financial assistance granted under Overseas Treatment Section: (1) Rs 1,000,000 (inclusive of air fare for patient and one attendant) for the treatment of: — Leukaemia — Cochlear Implant — Liver Transplant — Heart Transplant — Osteosarcoma (2) Rs 800,000 (inclusive of air fare for patient and one attendant) for the treatment of: — All other cases such as Cancer, Neurosurgery, Orthopaedic etc. (3) Rs 500,000 for eyes treatment — From 1 July 2019 to 30 June 2020, 243 patients have benefitted assistance under this scheme. — An amount of approximately Rs 88.6 Million has been disbursed for their treatment. — From 1 July 2020 to 30 June 2021, 179 patients have benefitted assistance under this scheme.	Services are free from any user fee and any type of co-payment	No user fees or any type of co-payment	Co-payments exist for voluntary private health insurance. There are no exemptions in regard to income/poverty status and sex. At the time of buying a policy cover, there are certain conditions, which include a medical examination, age and people suffering from chronic diseases. People have to make co-payments if in case the claim exceeds the ceiling mentioned in his/her policy. Some insurers have co-payment policies in form of a percentage of the total bill.

Key design feature	Government health budget	Trust Fund For Specialized Medical Care	Ministry Of Social Integration, Social Security & National Solidarity	Private Health Insurance
G) Other conditions of access	Referral system. Patients are referred to hospitals from the first level of contact point, that is the PHC Level. This condition is not a rigid one. Free health services are available only in the public sector except for complicated cases which are sent to foreign private hospitals at the expense of Government and to depending on certain criteria. For Overseas Treatment Scheme the following conditions apply: Household income ceiling eligibility criteria should be Rs 100,000. — Financial assistance granted under Overseas Treatment Section: (1) Rs 1,000,000 (inclusive of air fare for patient and one attendant) for the treatment of: — Leukaemia — Cochlear Implant — Liver Transplant — Heart Transplant — Osteosarcoma (2) Rs 800,000 (inclusive of air fare for patient and one attendant) for the treatment of: — All other cases such as Cancer, Neurosurgery, Orthopaedic etc. (3) Rs 500,000 for eyes treatment Other condition: Both generic and brand name medicines Medical Board to recommend for treatment overseas	Referral system. Patients are referred for surgeries by cardiac units of regional hospitals. CONDITION: Referral/ Treatment Intervention/ Facility Type Mainly brand name medicine	Approval of Medical Board for those who are 0-18 years and 60-89 years and those above 90 years on the basis of age Limited to public health facilities Generic medicine Limits to treatment provided. (Recipients under this scheme are referred to public facilities operated by the MOHW for further and advanced treatment if necessary)	Condition of access to private hospitals. A deposit has to be made at the time of admission Health insurance policies are required at time of admission Depend on affordability of people Patients are admitted or may seek other type of treatment/ service on the advice of their medical practitioners. Facility Type: 1. Private Hospitals 2. Private Laboratories 3. Private Imaging Centres 4. Ambulatory Services 5. Other Private Entities

Key design feature	Government health budget	Trust Fund For Specialized Medical Care	Ministry Of Social Integration, Social Security & National Solidarity	Private Health Insurance
H) Revenue sources	Line-Item Budget of MOHW Funds are raised by the Mauritius Revenue Authority through direct and indirect taxes, including sin taxes. Budgeted Funds are allocated to the Ministry of Health and Wellness (MOHW) by the Ministry of Finance, Economic Planning and Development. The Health Budget is a 3-year rolling budget. It comes with a strategic plan which highlights the Mission Statement of the MOHW, the current situation and challenges, the three-year strategic direction with respective enablers and key deliverables and key performance indicators. The MOHW has to report on achievements and performance indicators every year. The second part of the three-year rolling budget is dedicated to financial resources which is presented by economic categories, both recurrent and capital expenditures. The following 5 programmes/schemes with their respective codes are: 1. General Expenditure which include salaries of staff at the HQ level, grants to international organizations and capital outlays amongst others. Scheme 2. Hospital and Specialized Services, including expenditure for medical supplies, drugs and equipment, grants to the Trust Fund for Specialized Medical Care and capital expenditure Scheme 3. Primary Health Care and Public Health Scheme 4. Treatment and Prevention of HIV, AIDS and Drug Abuse Scheme 5: Prevention of Noncommunicable Diseases and Promotion of Quality of Life The budget also includes a detailed quantitative description of all categories of personnel of the MOHW There is a high degree of flexibility to negotiate for reallocation of funds or request additional funds if need arises.	Line-Item Budget of MOHW Funds are raised by the Mauritius Revenue Authority through direct and indirect taxes, including sin taxes. Budgeted Funds are allocated to the Ministry of Health and Wellness (MOHW) by the Ministry of Finance, and Economic Planning and Development. The Health Budget is a 3-year rolling budget. It comes with a strategic plan which highlights the Mission Statement of the MOHW, the current situation and challenges, the three-year strategic direction with respective enablers and key deliverables and key performance indicators. The MOHW has to report on achievements and performance indicators every year. The second part of the three-year rolling budget is dedicated to financial resources which is presented by economic categories, both recurrent and capital expenditures. Budgetary allocation comes under Hospital and Specialized Services, including expenditure for medical supplies, drugs and equipment, grants to the Trust Fund for Specialized Medical Care and capital expenditure The budget also includes a detailed quantitative description of all categories of personnel of the MOHW There is a high degree of flexibility to negotiate for reallocation of funds or request additional funds if need arises.	Line-item Budget of MSISSNS (Item No 22120.001 & 22140) Rs Funds are raised by the Mauritius Revenue Authority through direct and indirect taxes, including sin taxes. Budgeted Funds are allocated to the MSISSNS by the Ministry of Finance and Economic Development. The allocated Budget for the Medical Unit of the MSISSNS s a 3-year rolling budget. It comes with a strategic plan which highlights the Mission Statement of the MSISSN, the current situation and challenges, the three-year strategic direction with respective enablers and key deliverables and key performance indicators. The MSISSNS has to report on achievements and performance indicators every year. The second part of the three-year rolling budget is dedicated to financial resources which is presented by economic categories, both recurrent and capital expenditures. The budget also includes a detailed quantitative description of all categories of personnel of the MSISSNS There is a high degree of flexibility to negotiate for reallocation of funds or request additional funds if need arises. Over and above the budgeted amount, additional funds may be provided through contingencies. This should be approved by the National Assembly (Estimates of Supplementary Expenditure)	Premiums paid by 1. Individuals for self-insurance and members of household, as the case may be. 2. Co-payments by employers and employees.

Key design feature	Government health budget	Trust Fund For Specialized Medical Care	Ministry Of Social Integration, Social Security & National Solidarity	Private Health Insurance
H) Revenue sources, cont.	Over and above the budgeted amount, additional funds may be provided through contingencies. This should be approved by the National Assembly (Estimates of Supplementary Expenditure)	Over and above the budgeted amount, additional funds may be provided through contingencies. This should be approved by the National Assembly (Estimates of Supplementary Expenditure) Funds allocated to the scheme are earmarked under SubHead 18-102: Hospital and Specialized Services Vote Item 26313.095 of the MOHW Budget indicates the actual expenditure during the past FY which represented an amount of Rs 260 M. Funds earmarked for the present FY 2021/22 are to the tune of Rs 265 million and the same amount for the other two respective Financial Years.		
I) Pooling	Self Accounting Ministry. (Within the budget of the MOHW/ reallocation up to 2%) If greater than 2% – MOHW should seek clearance from the Ministry of Finance, Economic Planning and Development. Fragmentation is possible. The scheme pools its revenue through a single fund, that is the Consolidated Fund. Revenues are collected through direct taxes, indirect taxes and sin taxes. Revenues for all schemes are held at the national level (Consolidated Fund), allocated to the MOHW. A very limited amount allocated to Regional hospitals to meet expenses related to emergency procurement	Self Accounting Ministry. (Within the budget of the MOHW/reallocation up to 2%) If greater than 2% – MOHW should seek clearance from the Ministry of Finance, Economic Planning and Development. Fragmentation is possible. The scheme pools its revenue through a single fund, that is the Consolidated Fund. Revenues are collected through direct taxes, indirect taxes and sin taxes. Revenues for all schemes are held at the national level (Consolidated Fund), allocated to the MOHW.	Self Accounting Ministry. (within the budget of MSISSNS/ reallocation up to 2%) If greater than 2% – MSISSNS should seek clearance from the Ministry of Finance, Economic Planning and Development. Reallocation is possible. The scheme pools its revenue through a single fund, that is the Consolidated Fund. Revenues are collected through direct taxes, indirect taxes and sin taxes. Revenues for all schemes are held at the national level (Consolidated Fund), allocated to the MSISSNS.	1. Premiums by individuals for individual/family policy holders 2. Contribution by both employers and employees 3. Co-payments The number of private insurers is on the increase. There is competition in the market, and this is beneficial to the insured who can satisfy their needs related to the types of treatment they are looking for and a value for money service. Specific population groups and geographical areas are not applicable to Mauritius.

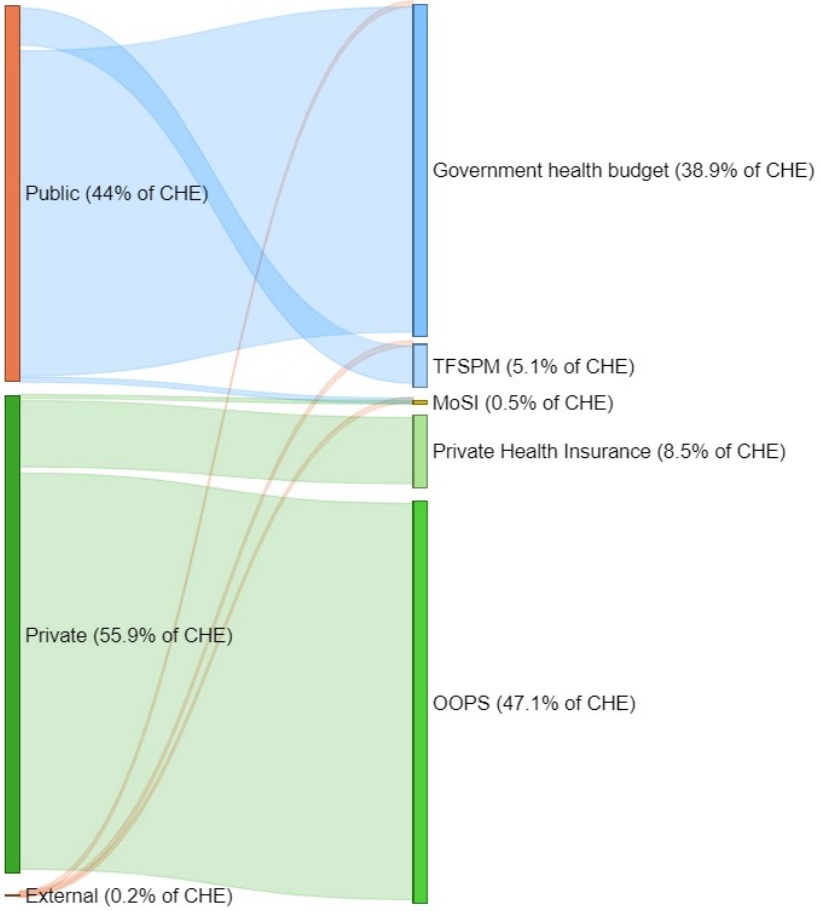
Key design feature	Government health budget	Trust Fund For Specialized Medical Care	Ministry Of Social Integration, Social Security & National Solidarity	Private Health Insurance
J) Governance of health financing	1. Committee of Needs 2. Budget Monitoring Committee 3. MIH Finance Committee 4. Cardiac Trust Fund Board 1. The National Audit Office-an independent public body established by the Constitution of the Republic of Mauritius. It provides high quality audit services geared towards transparency, accountability and good governance. It ensures that Ministries, including the MOHW and Government Departments are managing and utilizing resources economically, efficiently and effectively and laws and regulations are being complied with. Every year the Director of Audit submits his Report on the audit of accounts to the Minister of Finance, Economic Planning and Development to be tabled before the National Assembly. 2. The Public Accounts Committee deliberates on the Report and may call upon government officials to account for lapses, where it deems necessary. The Public Accounts Committee which is composed of Members from both sides of the National Assembly and is chaired, by convention by a Member from the Opposition party is the main form of parliamentary control over public expenditure. 3. Central Procurement Board 4. Procurement Policy office 5. e-procurement 6. Financial Management Manual which elaborates the basic principles and procedures to be followed in day-to-day operations of Ministries and Departments when dealing with public Funds. 7. Internal Audit	1. The National Audit Office-an independent public body established by the Constitution of the Republic of Mauritius. It provides high quality audit services geared towards transparency, accountability and good governance. It ensures that Ministries, including the MOHW and Government Departments are managing and utilizing resources economically, efficiently and effectively and laws and regulations are being complied with. Every year the Director of Audit submits his Report on the audit of accounts to the Minister of Finance, Economic Planning and Development to be tabled before the National Assembly. 2. The Public Accounts Committee deliberates on the Report and may call upon government officials to account for lapses, where it deems necessary. The Public Accounts Committee which is composed of Members from both sides of the National Assembly and is chaired, by convention by a Member from the Opposition party is the main form of parliamentary control over public expenditure. 3. Central Procurement Board 4. Procurement Policy office 5. e-procurement 6. Financial Management Manual which elaborates the basic principles and procedures to be followed in day-to-day operations of Ministries and Departments when dealing with public Funds. 7. Internal Audit	1. The National Audit Office-an independent public body established by the Constitution of the Republic of Mauritius. It provides high quality audit services geared towards transparency, accountability and good governance. It ensures that Ministries, including the MSISSNS and Government Departments are managing and utilizing resources economically, efficiently and effectively and laws and regulations are being complied with. Every year the Director of Audit submits his Report on the audit of accounts to the Minister of Finance, Economic Planning and Development to be tabled before the National Assembly. 2. The Public Accounts Committee deliberates on the Report and may call upon government officials to account for lapses, where it deems necessary. The Public Accounts Committee which is composed of Members from both sides of the National Assembly and is chaired, by convention by a Member from the Opposition party is the main form of parliamentary control over public expenditure. 3. Central Procurement Board 4. Procurement Policy office 5. e-procurement 6. Financial Management Manual which elaborates the basic principles and procedures to be followed in day-to-day operations of Ministries and Departments when dealing with public Funds. 7. Internal Audit	1. Insurance Act 2005 2. Voluntary private health insurance is regulated and supervised by the Financial Services Commission (FSC) under the Insurance Act 2005.The FSC operates under the aegis of the Ministry of Finance, Economic Planning and Development. 3. Insurer's Association of Mauritius 4. Health Insurance Code of Practice 5. Regulatory Framework 6. Annual Report to Companies Division

Key design feature	Government health budget	Trust Fund For Specialized Medical Care	Ministry Of Social Integration, Social Security & National Solidarity	Private Health Insurance
K) Provider payment	1. Payment to public health providers (salaries of staff in Hospitals and other recurrent costs associated with personnel) Line-item Budget of MOHW 2. Payment for hotel services like laundry, watch-keeping which are outsourced to private contractors are effected by MOHW on a fee for service basis as per contract. Line-item Budget of MOHW 3. Other operational Costs- Line-item Budget of MOHW 4. Drugs and medical supplies: Line-item Budget of MOHW 5. Medical Equipment- Line-item Budget of MOHW 6. Maintenance of equipment: Line-item Budget of MOHW 7. Very limited Financial Autonomy to Regional Hospitals: Line-item Budget of MOHW Line-item Budget, Fee for Service, Case Payment	Line-item Budget: 1. Payment to public health providers (salaries of staff in Cardiac Centre and other recurrent costs associated with personnel) 2. Hotel services, laundry, catering watch-keeping outsourced to private contractors and effected by MOHW 3. Other operational Costs 4. Drugs and medical supplies 5. Medical Equipment 6. Maintenance of equipment 7. Limited Financial Autonomy to Cardiac Centre	1. Line-item Budget: Payment effected by MSISSNS to Health providers (salaries of medical and paramedical staff and other recurrent costs associated with personnel) 2. Other operational Costs 3. Medical Devices	1. Co-payment by insured 2. Direct payment by insurers 3. Refund to the insured In 2019, there was a total number of 24,890 policies, out of which 14,417 policies were held by individuals and 10,473 on behalf of groups/companies. 159,971 lives were covered, that is,142,438 through groups/ companies and 17,533 were individual policy holders. Percentage of the population covered by a voluntary private health insurance scheme was 12.6%. Premiums paid by individuals and group/ companies amounted to Rs 2.5 billion. Claims paid directly to health care providers amounted to approximately Rs 1.25 billion. Reimbursements made directly to policy holders were to the order of Rs Rs 650 million.

Key design feature	Government health budget	Trust Fund For Specialized Medical Care	Ministry Of Social Integration, Social Security & National Solidarity	Private Health Insurance
L) Service delivery & contracting	All public health facilities. (Primary health Care Institutions, District and Regional Hospitals, Specialized Health Institutions) Services Provided: Outpatient Inpatient Primary Care Secondary Care Tertiary care Support Services Contract is in place with a private-non-profit organization for renal dialysis. Procurement of goods, infrastructures and services is done through tendering process. Service Contracts Agreement (MOUs) are also in place with foreign hospitals for the treatment of complicated cases which cannot be managed locally. Contracts to foreign hospitals are awarded in line with procurement policies.	Cardiac Centre is a Government-owned facility Secondary and tertiary care provided	Medical Unit of MSISSNS Services provided: Outpatient (preventive medicine, curative rehabilitative care).	Private-for profit health care institutions, including private hospitals, private imaging and laboratory facilities, ambulatory health care providers. Private hospitals provide a wide array of services, including outpatient, inpatient, primary, secondary and tertiary services, high tech imaging facilities and day care services, prescribed glasses and contact lenses, gynaecologist visits, artificial aids, psychological trauma, hearing aids, dental treatment, etc. Facility Type: 1. Private Hospitals 2. Private Laboratories 3. Private Imaging Centres 4. Ambulatory Services 5. Other Private Entities Accreditation schemes exist for private hospitals. Preferred Provider Network: Health consumers have their personal preferences. However, very often, patients are referred for treatment to specific private hospitals by their treating doctors. Other factors include price charged for treatment and quality of care.

Health expenditure by Stage 1 coverage schemes

Fig. 5: Expenditure flows by scheme (Sankey diagram)



WHERE DO SCHEMES/PROGRAMMES REVENUES COME FROM?

STAGE 1 SCHEMES	PUBLIC	PRIVATE	EXTERNAL	TOTAL
Government health budget	99.8%	-	0.2%	100%
Trust Fund For Specialized Medical Care (TFSPM)	99.9%	-	0.1%	100%
Ministry Of Social Integration,Social Security & National Solidarity (MoSI)	25.6%	55.3%	19.1%	100%
Private Health Insurance	-	100.0%	-	100%
OOPS	-	100.0%	-	100%

HOW ARE REVENUE SOURCES DISTRIBUTED ACROSS SCHEMES/PROGRAMMES?

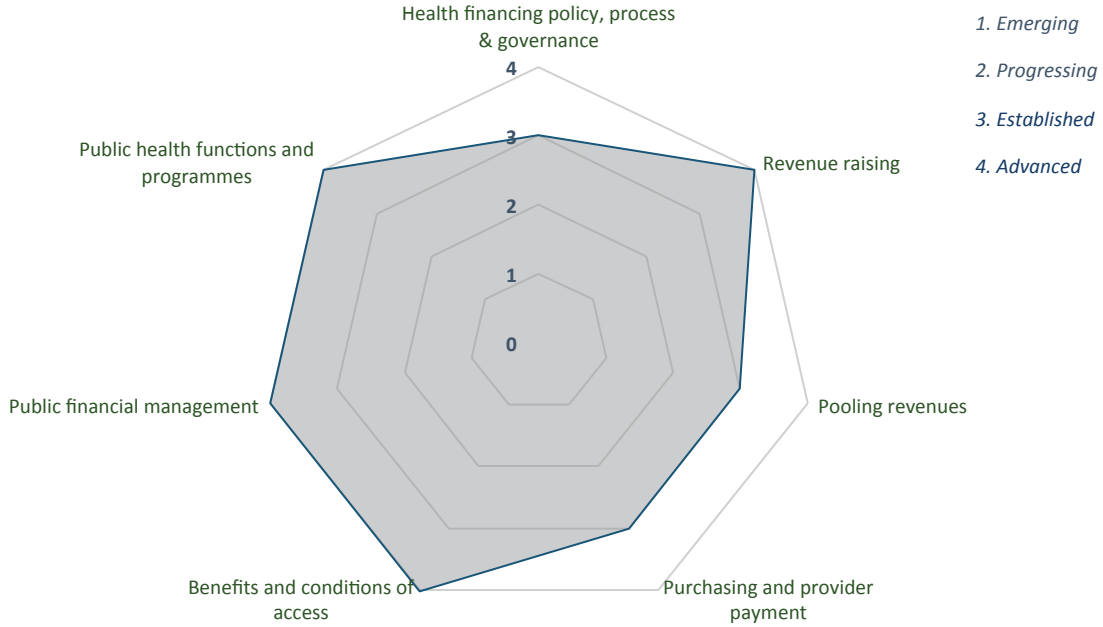
STAGE 1 SCHEMES	PUBLIC	PRIVATE	EXTERNAL
Government health budget	88.2%	-	39.1%
Trust Fund For Specialized Medical Care (TFSPM)	11.5%	-	1.8%
Ministry Of Social Integration,Social Security & National Solidarity (MoSI)	0.3%	0.5%	59.2%
Private Health Insurance	-	15.2%	-
OOPS	-	84.4%	-
TOTAL	100%	100%	100%

Source: Author estimates based on the HF x FS breakdown available using Health Accounts 2020 (Ministry of Health and Wellness, Publications, National Health Accounts Report 2020), supplemented by the most recent expenditure estimates for the schemes/programmes identified in Stage 1. (29).
Note: CHE: current health expenditure.

Stage 2 assessment

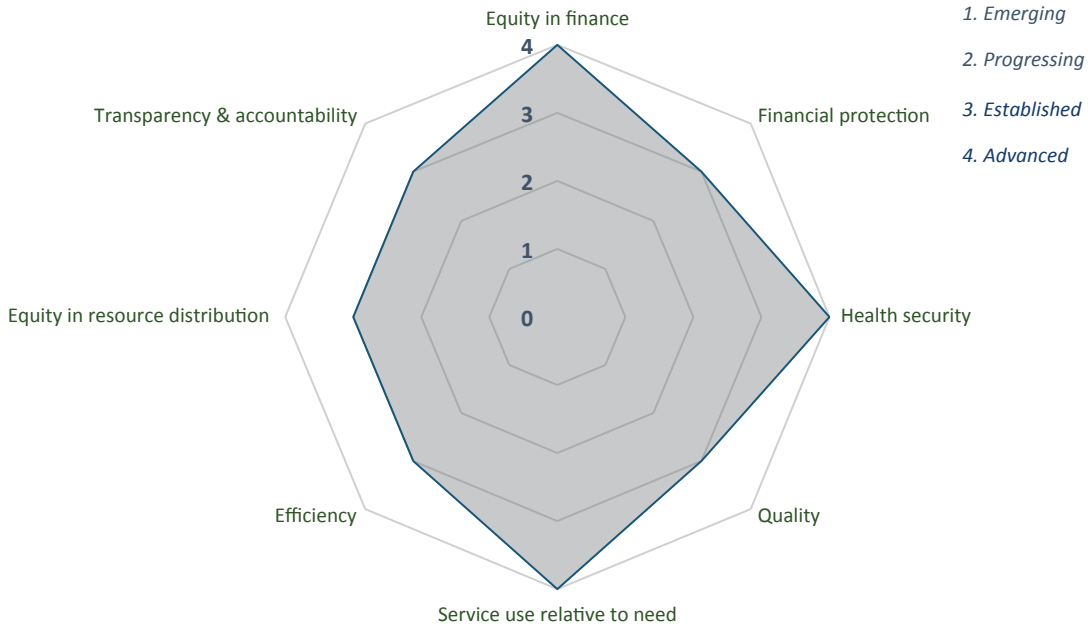
Summary of ratings by assessment area

Fig. 6: Average rating by assessment area (spider diagram)



Source: Based on HFPM data collection template v2.0, Mauritius 2022

Fig. 7: Average rating by goals and objectives (spider diagram)

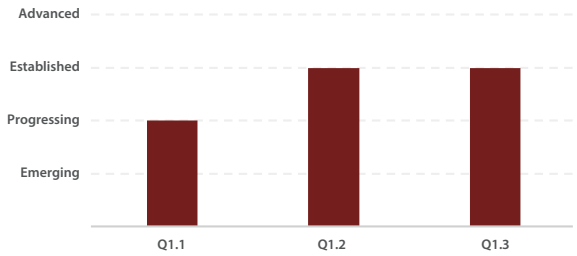


Source: Based on HFPM data collection template v2.0, Mauritius 2022

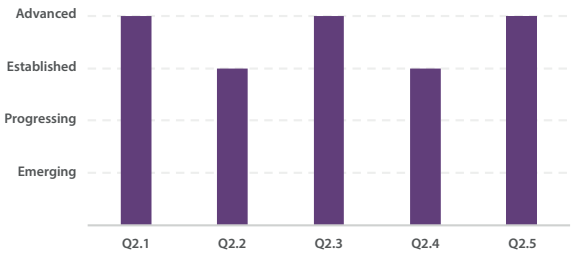
Assessment rating by individual question

Fig. 8: Assessment rating by individual question

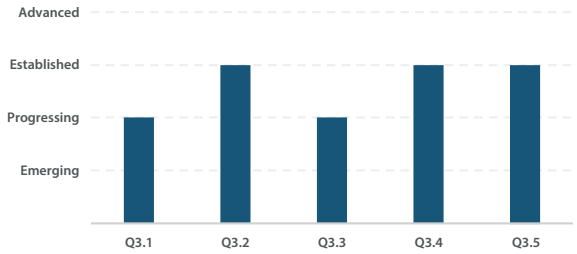
1. Health financing policy, process & governance



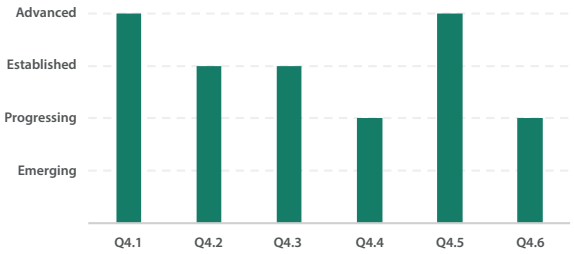
2. Revenue raising



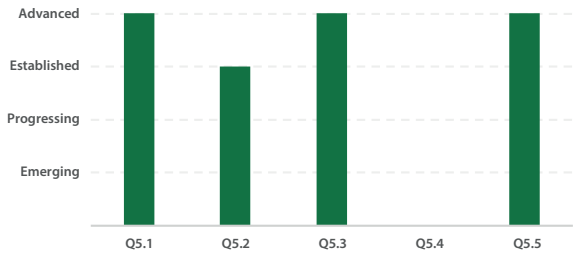
3. Pooling revenues



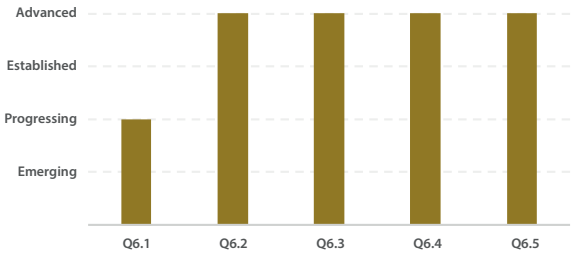
4. Purchasing and provider payment



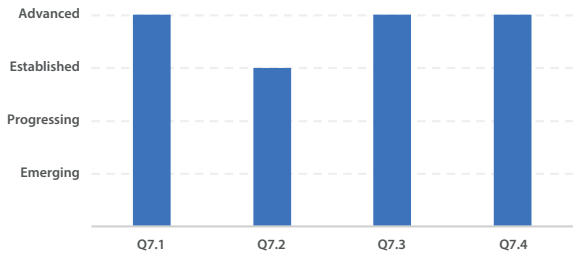
5. Benefit and conditions of access



6. Public financial management



7. Public health functions and programmes

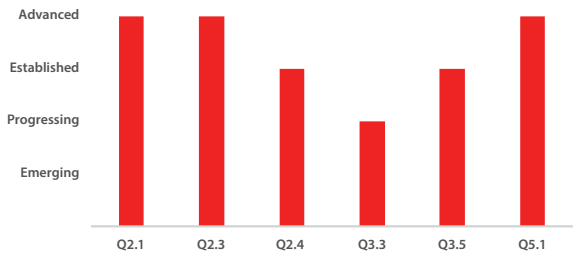


See Annex 3 for question details

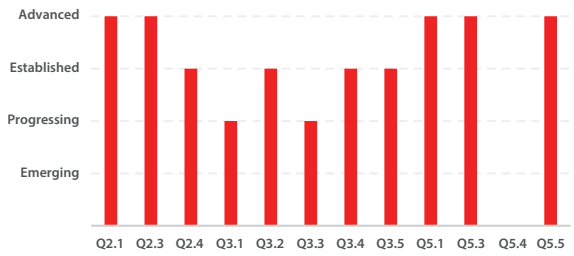
Assessment rating by UHC goals

Fig. 9: Assessment rating by intermediate objective and final coverage goals

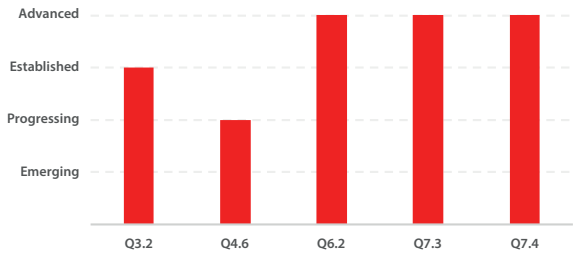
Equity in finance



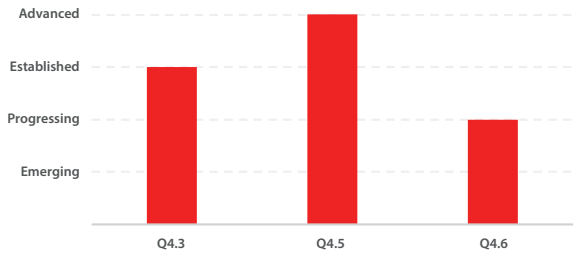
Financial protection



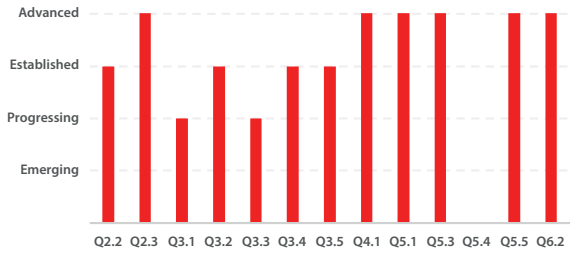
Health security



Quality



Service use relative to need

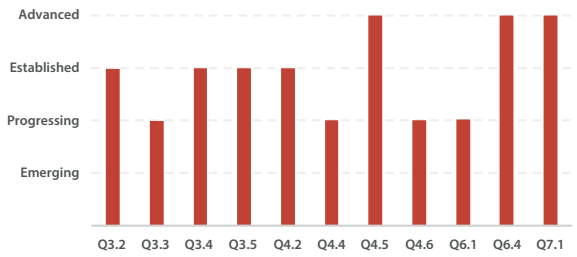


See Annex 3 for question details

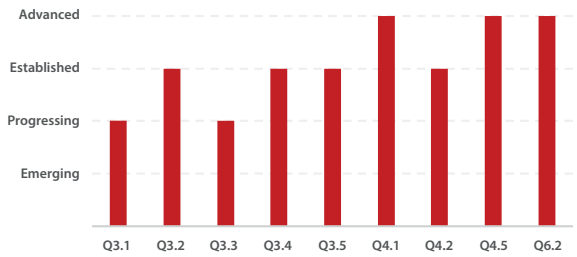
Assessment rating by intermediate objective

Fig. 9 (continued): Assessment rating by intermediate objective and final coverage goals

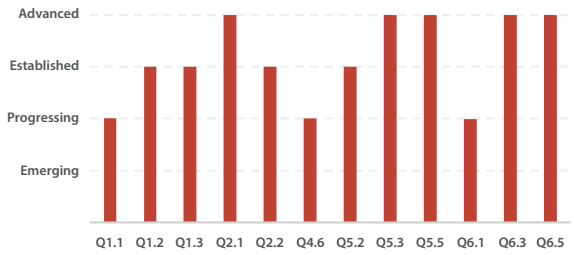
Efficiency



Equity in resource distribution



Transparency & accountability



See Annex 3 for question details

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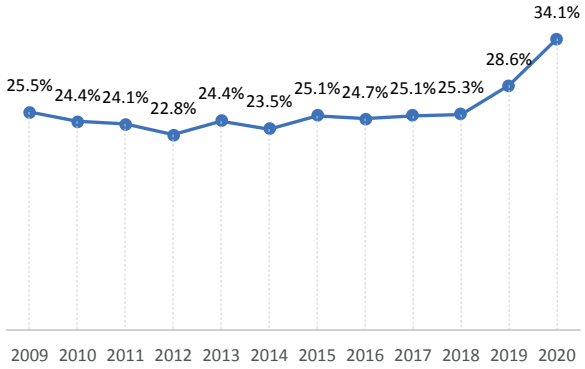
Annexes

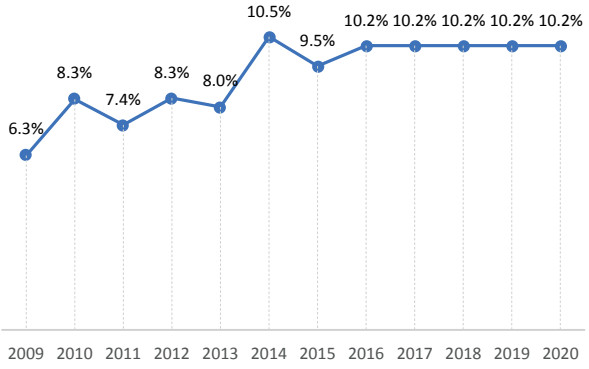
Annex 1: Selected contextual indicators

Fig. A1.1.: Health expenditure indicators for Mauritius

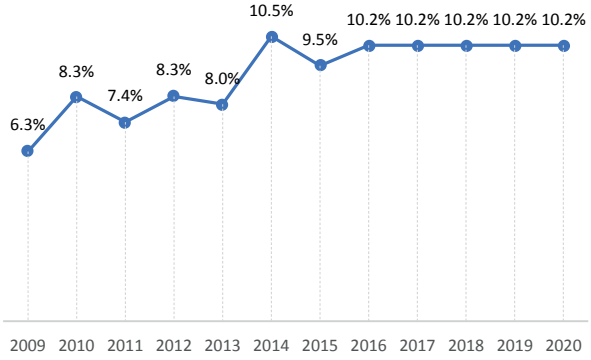
General goverment expenditure (GGHE-D % GGE)



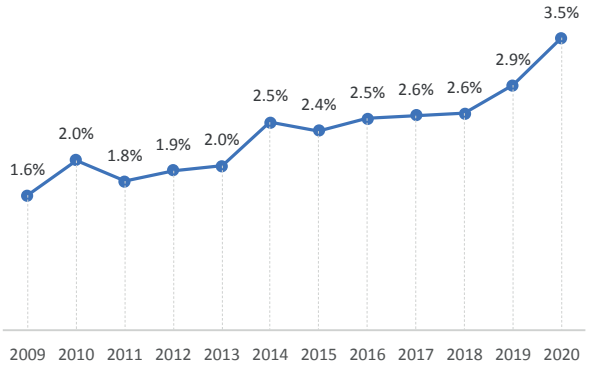
Domestic General goverment health expenditure (GGHE-D) as % General Government Expenditure (GGE)



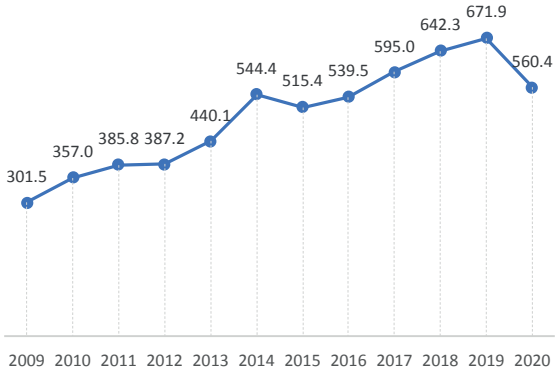
Out-of-pocket spending (OOPS % CHE)



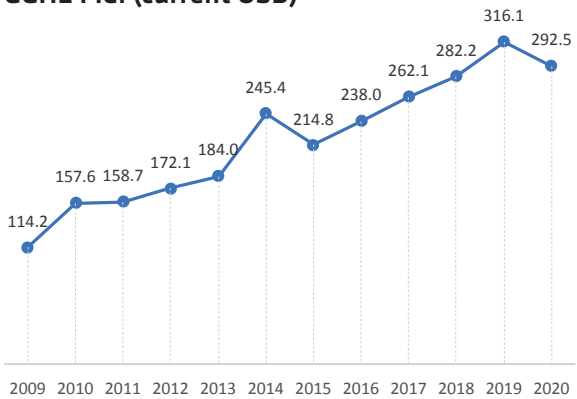
Public spending on health as GDP (GGHE-D % GDP)



Total health spending (CHE per capita current USD)

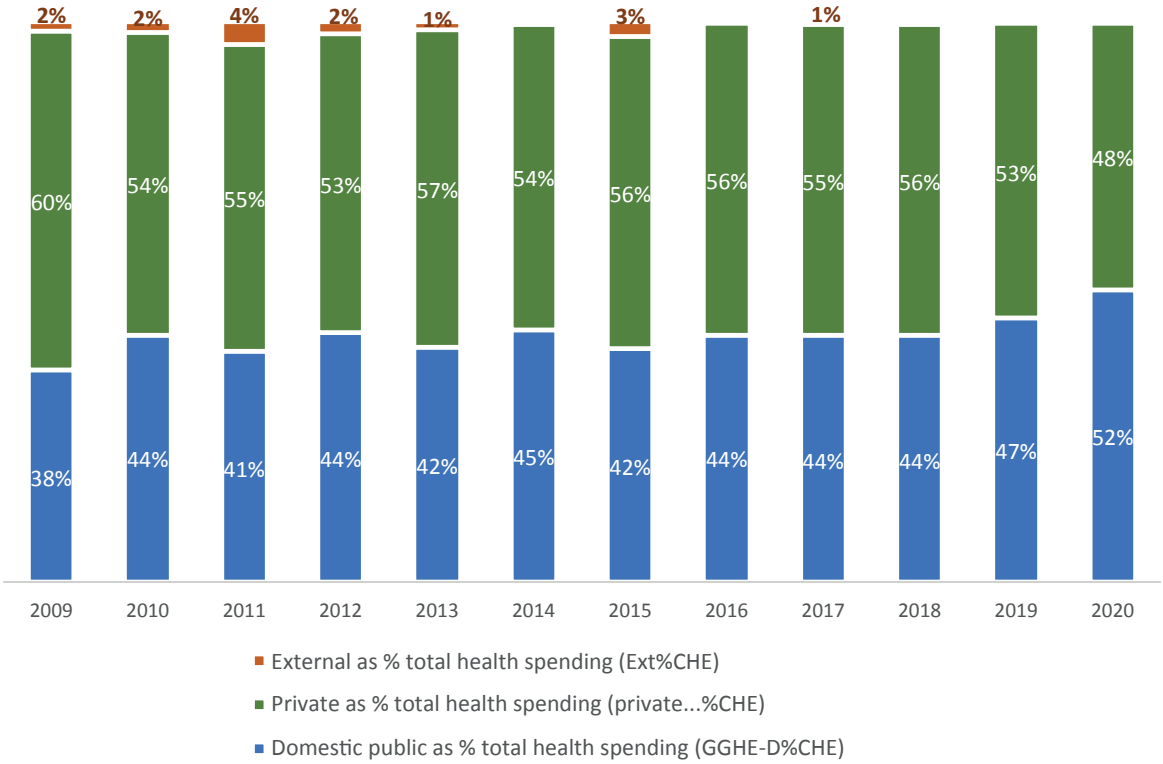


GGHE P.C. (current USD)



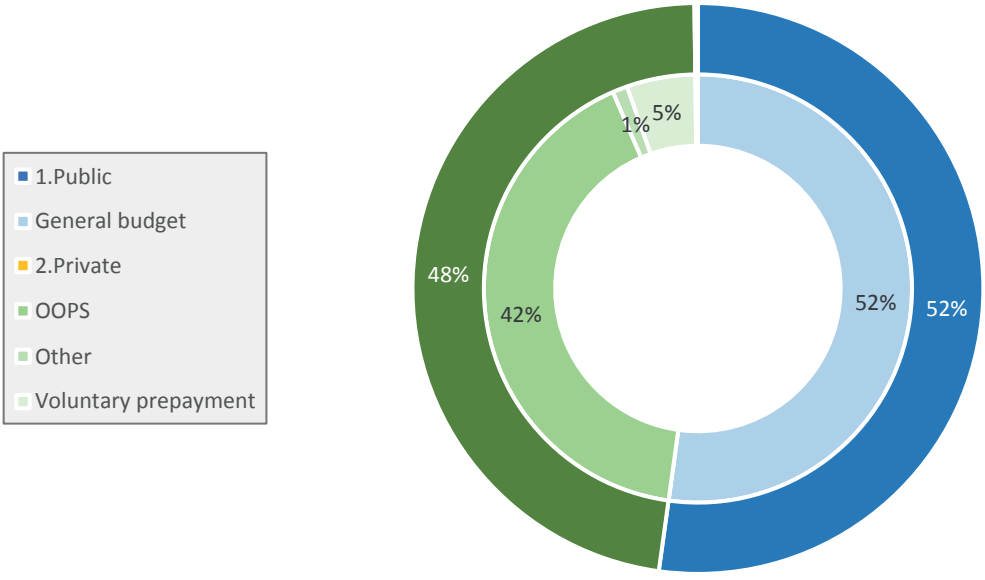
Source: WHO Global Health Observatory, 2023 (https://apps.who.int/nha/database/Home/Index/en, accessed 1 August 2023)

Fig. A1.2.: Revenue sources for health in Mauritius



Source: WHO Global Health Observatory, 2023 (https://apps.who.int/nha/database/Home/Index/en, accessed 1 August 2023)

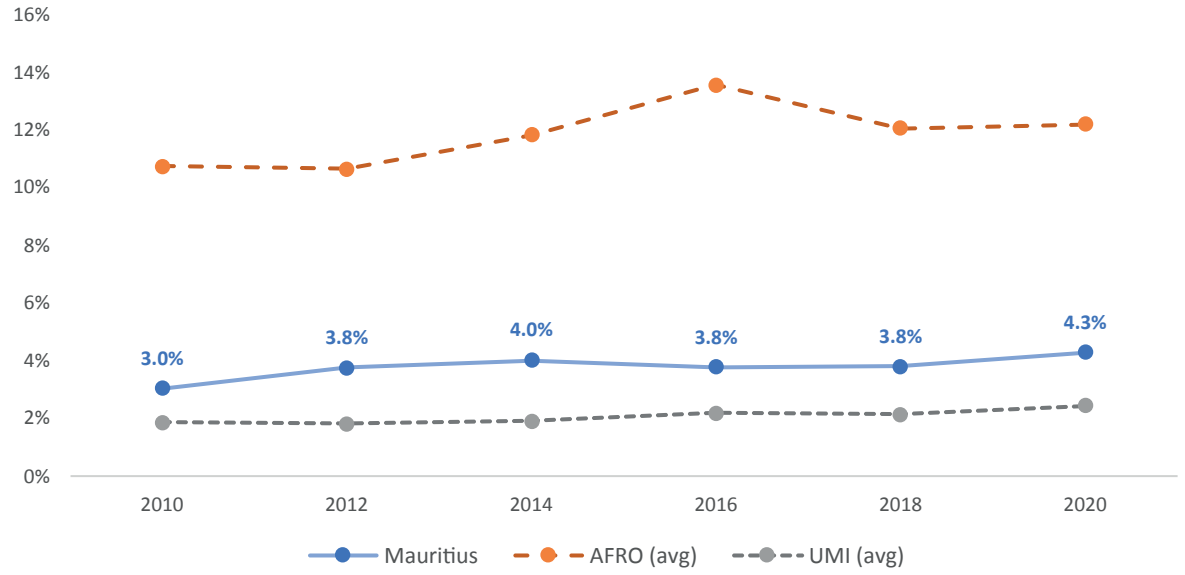
Fig. A1.3.: Recurrent expenditures by revenue source 2020



Source: WHO Global Health Observatory, 2023 (https://apps.who.int/nha/database/Home/Index/en, accessed 1 August 2023)

Fig. A1.4.: Cigarette affordability in Mauritius

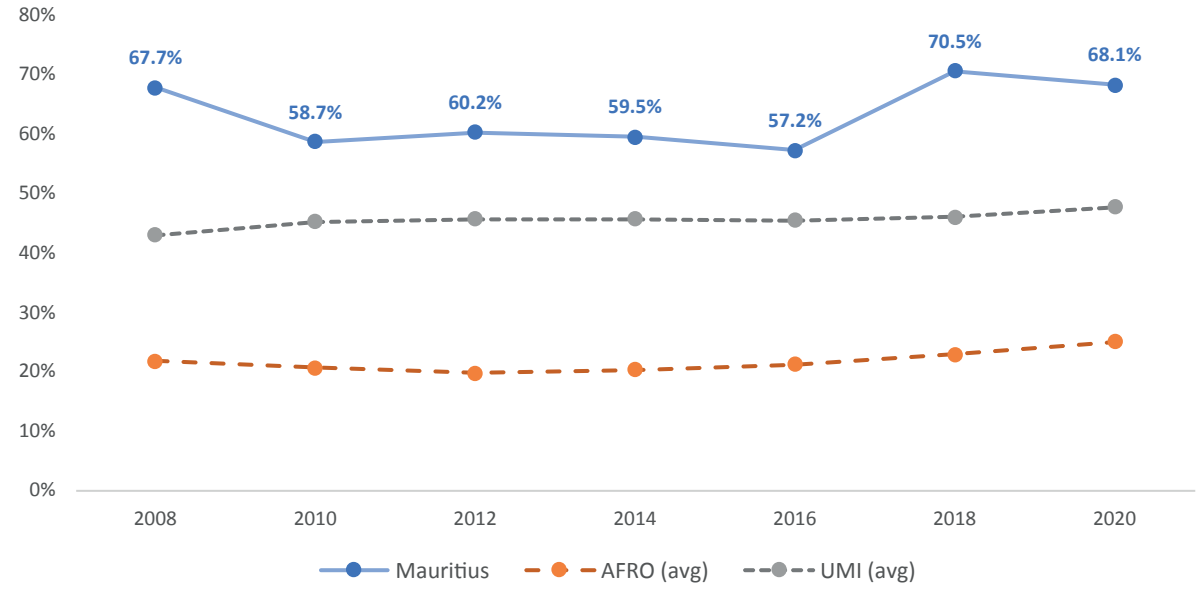
Reducing affordability is an important measure of the success of tobacco tax policy and is measured in terms of the percent of GDP per capita required to purchase 2000 cigarettes (100 packs) of the most sold brand. Fig. 13 presents this data for Mauritius showing that, although only slightly, cigarettes have become less affordable in recent years.



Source: WHO report on the global tobacco epidemic 2019 (https://www.who.int/teams/health-promotion/tobacco-control/%20who-report-on-the-global-tobacco-epidemic-2019, accessed 1 August 2023)

Fig. A1.5.: Excise tax share in Mauritius (cigarettes)

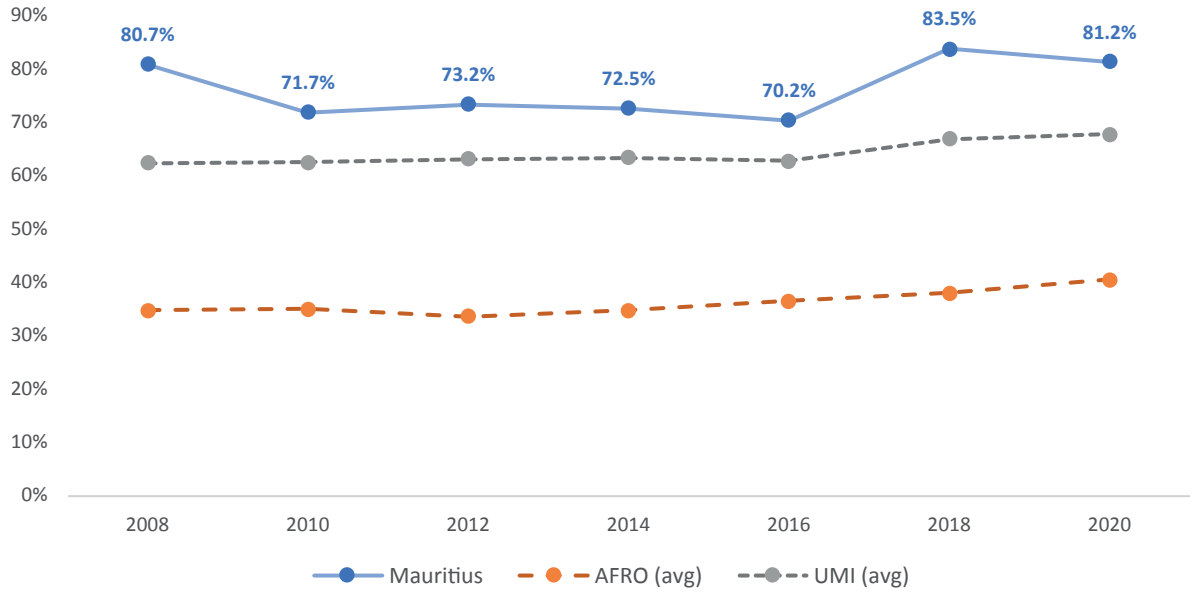
WHO recommends an excise tax share of 70%. Total tax share includes import duties and levies.



Source: WHO report on the global tobacco epidemic 2019 (https://www.who.int/teams/health-promotion/tobacco-control/%20who-report-on-the-global-tobacco-epidemic-2019, accessed 1 August 2023)

Fig. A1.6.: Total tax share in Mauritius (cigarettes)

This indicator represents the best comparable measure of the magnitude of total tobacco taxes relative to the price of a pack of the most widely sold brand of cigarettes in the country. Total taxes include excise taxes, VAT/sales taxes and, where relevant, import duties and/or any other indirect tax applied in a country.



Source: WHO report on the global tobacco epidemic 2019 (https://www.who.int/teams/health-promotion/tobacco-control/%20who-report-on-the-global-tobacco-epidemic-2019, accessed 1 August 2023)

Annex 2: Desirable attribute of health financing

Policies which help to drive progress to UHC are summarized n terms of nineteen desirable attributes of health financing policy. For further information see: https://www.who.int /publications/i/item/9789240017405

Table 1: Desirable attributes of health financing systems

Health financing policy, process & governance	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies for both individual and population-based services
	GV2	There is transparent, financial and non-financial accountability, in relation to public spending on health
	GV3	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments
Revenue raising	RR1	Health expenditure is based predominantly on public/compulsory funding sources
	RR2	The level of public (and external) funding is predictable over a period of years
	RR3	The flow of public (and external) funds is stable and budget execution is high
	RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms
Pooling revenues	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Purchasing & provider payment	PS1	Resource allocation to providers reflects population health needs, provider performance or a combination
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Benefits & conditions of access	BR1	Entitlements and obligations are clearly understood by the population
	BR2	A set of priority health service benefits within a unified framework is implemented for the entire population
	BR3	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments
	BR4	Defined benefits are aligned with available revenues, health services and mechanisms to allocate funds to providers
	BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups
Public financial management	PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
	PF2	Providers can directly receive revenues, flexibly manage them and report on spending and output

Table 1: Desirable attributes of health financing systems

Public health functions & programmes[3]	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies
	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PF1	Health budget formulation and structure supports flexible spending and is aligned with sector priorities

Annex 3. HFPM assessment questions

Assessment	Question number code	Question text
1) Health financing policy, process & governance	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
2) Revenue raising	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q2.5	To what extent does government use taxes and subsidies as instruments to affect health behaviours?
3) Pooling revenues	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
4) Purchasing & provider payment	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?

Assessment area	Question number code	Question text
5) Benefits & conditions of access	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
6) Public financial management	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.4	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
7) Public health functions & programmes	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

Annex 4: Questions mapped to objectives and goals

Each question represents an area of health financing policy, selected given its influence on UHC intermediate objectives and goals, as explicitly defined below.

Objective / goal	Question number code	Question text
Equity in resource distribution	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
Efficiency	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.4	Are there measures to address problems arising from both under- and over- budget spending in health?
	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?

Objective / goal	Question number code	Question text
Transparency & accountability	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
Service use relative to need	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?

Objective / goal	Question number code	Question text
Financial protection	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
Equity in finance	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
Quality	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
Health security	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

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