**Co-existence of High Out of Pocket payments for health and free health care in public health facilities a paradox for consolidating primary health care in Mauritius.**

Mr Ajoy Nundoochan, World Health Organization, Country Office, Mauritius,

[nundoochana@who.int](mailto:nundoochana@who.int)

Dr Laurent Musango, World Health Organization, WHO Representative, Country Office, Mauritius, [musangol@who.int](mailto:musangol@who.int)

Mr Yusuf Thorabally, [Ythorabally@yahoo.fr](mailto:Ythorabally@yahoo.fr)

Mr Sooneeraz Monohur, Ministry of Health and Quality of Life, Mauritius, smanohur@govmu.org

**Background:** Mauritius is embracing welfare state principles since four decades and any citizen indistinctly is eligible for free health care in public health facilities, including tertiary specialised care. Paradoxically, a new trend has emerged recently with Household Out of Pocket (OOP) expenditure on health outweighing General Government Health Expenditure (GGHE). This may hinder progress made till date to strengthen Primary Health Care (PHC) for achieving Universal Health Coverage (UHC).

**Objectives**: This paper analyses trends in OOP and its impact on key indicators of financial protection i.e. Catastrophic Health Expenditure (CHE) and impoverishment due to OOP health expenditure. The study, also, determine benefit distribution of health care, in terms of pro-rich or pro-poor.

**Methods:** Using multiple Household Budget Surveys, incidence of CHE is estimated using the capacity to pay and the budget share standard approach. Impoverishment due to OOP is measured by changes in incidence of poverty and severity of poverty based on the US$ 3.1 international poverty line. To carry out the benefit incidence analysis a four -stage approach is implemented, starting with ranking household using expenditure variables followed by estimating utilization rates of day care services for each household, multiplying the utilization rate of health services, and aggregating benefits of utilization expressed in monetary terms, for each household. The distribution of health benefits across income quintiles is estimated using a concentration index.

**Findings:** A declining trend in CHE and impoverishment over the ten-year period in the lowest quintile is confirmed. Conversely, for other income quintiles CHE increased across all the three thresholds (10%, 25% and 40%) from 2001 to 2012. The incidence of CHE is more significant in urban area prompting a dichotomy between urban and rural regarding equity of access health services. Households pushed below the poverty line due to OOP spending dropped from 0.0848% to 0.054% over the ten-year period. In 2012, only households classified under Quintile 1 (0.244%) and Quintile 2 (0.025%) were drifted under the poverty line due to OOP expenditure on health. Concentration index for all income quintiles was 0.12, inferring health care policies are pro-poor oriented and promotes financial protection. The quality of care in public services was not assessed in this study.

**Conclusion:** Progress towards UHC can be accelerated through expansion of the fiscal space. Existing conducive macroeconomic fundamentals favour potential expansion through widening of tax base, improved use and performance of public resources as well as assessing the quality of care in public health services. Taxes on Tobacco and Alcohol represent 80% of GGHE. However, instituting earmarking taxes may lead to fungibility and reprioritization within the health sector rather than between health and other sectors.

[434 Words].

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