**REPUBLIC OF MAURITIUS**

# KEYNOTE ADDRESS BY DR SIVALINGUM RAMEN, DIRECTOR GENERAL HEALTH SERVICES

## Workshop on Health Financing
## and
## Second Meeting on Health Economics Community of Practice

*30 January 2020, Intercontinental Hotel, Balaclava*

**Dr. Laurent Musango, World Health Organization Representative**

**Prof. Yoswa Dambisya, Director General, East Central Southern Africa-Health Community**

**Dr. Paul Revill, Senior Research Fellow at the Centre for Health Economics, University of York and Programme Director of Thanzi la Onse**

**Distinguished delegates from ECSA-HC Member States, the University of York and Thanzi la Onze**

**All Protocols Observed**

**Ladies and gentlemen**

At the very outset, I wish to convey to you the apologies of the Honourable Minister of Health and Wellness for being unable to join you on this auspicious occasion. He sends to you all his compliments and wishes you a very successful and fruitful meeting as well as a pleasant stay in the island.

It is my pleasure to join previous speakers in welcoming you all to the opening of this workshop on Health Financing and to the second meeting on Health Economics Community of Practice. To all foreign delegates who have come from ECSA Member States and the United Kingdom, I bid you a very warm welcome to Mauritius. We are indeed honored to have you here with us.

I would like to thank the East Central Southern Africa- Health Community for organizing this important event. I also extend my gratitude to the Centre for Health Economics, University of York and Thanzi la Onse (Health for All) based in Malawi for their support to this important meeting.

It is not my intention on this platform, due to time constraint, to make an exposé on the exquisite island of Mauritius. However, I would like to cite famous writer Mark Twain who when visiting the island in 1896 said **“Mauritius was made first and then heaven; and heaven was copied after Mauritius”.** End of citation.

**Theme of Workshop and Meeting**

**Ladies and Gentlemen,** the theme of this workshop on “Health Financing” and that of the second meeting on Health Economics Community of Practice underscore the importance of health financing resources and economic analysis in health care to modify the incidence and impact of morbidity, mortality and disability in our society and eventually produce better health outcomes.

At this juncture, I wish to congratulate Thanzi la Onse, that is, Health for All and all its partners which include the ECSA Health Community, the Centre for Health Economics at the University of York, the Centre for Global Development, the College of Medicine at the University of Malawi and the Imperial College of London, for their endeavour to improve the health of people and reduce health inequities in Malawi, Uganda and Southern and East Africa. Health Economics which is at the top of the research agenda of Thanzi la Onse aims at developing methods and producing analyses to inform decision making in the allocation of resources to health.

**Importance of Health Financing**

**Ladies and Gentlemen,** health is increasingly recognized as a key aspect of human and economic development. Countries all over the world are making investments to improve health outcomes and accelerate progress towards the Sustainable Development Goal 3, including universal health coverage. For all these to happen, we need financial resources. We need the required funds to set up and maintain health infrastructures, acquire medical equipment, purchase drugs and hospital disposables and pay the health personnel.

According to the World Health Organization, the purpose of health financing is to make funding available and to set the right financial incentives to providers in order to ensure that all people have timely access to effective healthcare services.

**Global and Regional Outlook**

The health sector has become one of the main sectors of the global economy, linked to economic growth, demographic change and technological change. It is estimated that in 2016 the world spent the significant amount of US$ 7.5 trillion dollars on health. This amount represented nearly 10% of global Gross Domestic Product. Between 2000 and 2016, global spending on health increased every year, growing in real terms at an average annual rate of 4.0%, faster than the 2.8% annual growth of the global economy.

Allow me to mention, that health expenditure as a percentage of should GDP is greater in high income countries, at around 8.2% on average. For both low and middle-income countries, health expenditure is approximately 6.3% of GDP. Health spending has increased most rapidly in low and middle-income countries, at around 6% or more annually on average. However, despite GDP and health spending are growing fastest in low and middle-income countries, a large gap still persists between rich and low-income countries. In 2016, median per capita health spending was over US$ 2,000 in high income countries, but just a fifth of that amount, that is, US$ 400 in upper-middle income and one-twentieth, representing only around US$ 100 in low and lower-middle income countries.

Besides, this inequity in health spending is also illustrated by the imbalance between health spending and population. Only 20% of the world's population live in high income countries, and yet these countries account for close to 80% of global health spending. Whereas the top 10 countries spent US$ 5,000 or more per person in 2016, the bottom 10 countries spent less than US$ 30 per person.

**Need for Health Economics for Evidence-Based Policy Making**

**Ladies and Gentlemen,** at the beginning of the second decade of this new millennium, many countries around the globe are faced with numerous health challenges such as the double burden of diseases, both communicable and non-communicable diseases, an ageing population, rising costs of health care and resurgence of past diseases and emergence of new ones, such as the new coronavirus with is actually threatening humanity nowadays.

We recognise that health improvement of the population is limited very often, not so much by the lack of effective interventions, but from limited budgets with which to fund health care. This means that decisions need to be taken as to how to generate additional resources and what to prioritize within the limited means at our disposal. it is imperative that we make judicious use of our scarce resources and provide services in the most cost-effective way. This is where health economics – the science of resource allocation, as applied to health – comes in. In fact, health economics pave the right directions to address resource allocation challenges and use limited resources in the most cost effective ways.

The Africa Region has amongst the greatest burden of disease in the world, but incongruously the lowest available per capita budgets for health care. The need for applied health economics expertise is therefore greater in the Region than anywhere else in the world. Therefore, it is important that the expertise in health economics is developed and organized among ECSA-HC Member States so as to enhance policy decision making and undertake cost- effective interventions.

Allow me to mention, the use of health economic approaches to inform decisions that can improve the health of our populations are based on three fundamentals: Firstly, research to produce the necessary evidence, Secondly, capability to generate that research and thirdly, facilitation of its use within policy-making.

**Situation in Mauritius**

**Ladies and Gentlemen,** Government in Mauritius recognises health as a human right. Health is placed within the overall sustainable development framework of our economy. Free health services, from primary health care to curative and specialized services are provided, free of any user cost, to the entire population.

National Health Accounts indicate that, Mauritius spent an estimated amount Rs. 25.3 billion or US$ 707 million on health in 2016. Government Expenditure on Health represented 44.73% of Total Health Expenditure whereas Private Health Expenditure, including household out-of-pocket spending on health, as a percentage of Total Health Expenditure was 55.27%. Rs. 16.5 billion, that is, 65.2% of Total Health Expenditure were spent on non-communicable diseases including diabetes, cardiovascular diseases and cancer.

Life expectancy at birth has improved and it is currently 71.2 years for male and 77.6 for female. In 2018, Infant Mortality Rate was 14.0 per thousand live births, whereas Maternal Mortality Rate was 0.39 per thousand live births. Premature morbidity and mortality associated with infectious, parasitic and water-borne diseases have significantly decreased. Most of these diseases are no longer a matter of critical concern for the country. The incidence of HIV is less than 1% in the population. According to the 2017 WHO Global Monitoring Report, the Universal Health Coverage Index for Mauritius was 64 in 2015.

**Ladies and Gentlemen,** our healthcare system is currently facing complex challenges, stemming partly from pressures, such as growing prevalence of non-communicable disease, an ageing population, rising labour costs, intensive use of expensive, yet vital lifesaving medical technologies, and increasing expectations of patients for improve quality of care. To deal with this challenges, Government is making significant investment in health. Government expenditure on health has increased by 42.4% over the past five years, from only Rs. 9.2 billion (US$ 300.46 million) in 2014 to Rs. 13.1 billion (US$ 368.18 million) for FY 2019-2020. Per capita Government Expenditure on Health is currently Rs. 10,351 or US$ 296.

The Ministry of Health and Wellness makes extensive use of economic analysis and evaluation for policymaking. The Health Economics Department of the Ministry, set up in the nineties, is responsible for tasks related to health economics and which include, amongst others, economic analysis, budgeting, development of annual National Health Accounts and National AIDS Spending Assessment, hospital costings, formulation of strategies and projects

write-ups. We recognise that training in health economics is important to further built the capacity of our Economist. In this respect, the Ministry is envisaging to field its Health Economists for the summer course at the University of York with the support of the WHO and ECSA-HC. Besides, we also expect to benefit more in health economics capacity building from Thanzi la Onse.

**Conclusion**

**Ladies and Gentlemen,** we are grateful to the ECSA-HC Secretariat for taking the initiative in making efforts to strengthen capacity building in health economics among its Member States. I commend the initiative of ECSA-HC in establishing a Regional Community of Practice in Health Economics.

The ECSA Health Economics Community of Practice will provide an environment for Health Economists in the Region within Governments, academia and other non-governmental organisations to share knowledge and experience of the challenges of designing and implementing resource allocation policies. It will also provide opportunities for training.

I encourage you to discuss and agree the priority research topics on which to concentrate, coproduce research on these topics together, help to ensure the research is used to guide policy and practice and provide the necessary trainings to enhance analytical skills in our Region. I understand that tomorrow you will hear about a baseline mapping exercise on health economics training as it currently stands across the Region, followed by a course in health care finance and purchasing.

I reiterate my gratitude to the Thanzi la Onse programme and the University of York for funding and organizing the workshop and training, and all attendees who have joined us here.

Good luck to you all – enjoy the workshop and the meeting. I wish you fruitful deliberations and learning. I look forward to learning about the outcome.

It is now my pleasure to declare this Workshop on Health Financing and the Second Meeting on Health Economics Community of Practice open.