Is a Social Health Insurance (SHI) scheme feasible in Mozambique? A political economy assessment

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Context

The possibility of creating a SHI scheme has been considered in Mozambique in the last decade, ideally to complement the tax-based funding of its universalistic and underfunded National Health Service.

The African experience in SHI and Community-Based Health Insurance (CBHI) draws interesting lessons on the feasibility of these schemes, especially in distributional terms. Compared to the scenario of no insurance and full out-of-pocket payments, the existence of insurance increases access and reduces financial burden for those insured. But, as Kutzin (2013) states, these schemes promote "silos", segments of population that may increase its access to service, while the rest continues to suffer exclusion and ill health. In the era of Universal Health Coverage (UHC), financial arrangements must ensure universal access to services.

The public funding that is used to promote SHI and CBHI in Africa is also analyzed in several studies, that evidence regressive distributional effects, for example in Tanzania. Public budgets complement premium payments to segments of population that will access high quality services in the private sector, while budgets for the rest of the population are reduced.

Three questions for Mozambique

In Mozambique, the first reflection is if the SHI scheme would effectively fund the National Health Service, or would be a publicly-managed scheme that would include private provision to those that contributed. The political lines seem to point to the first option, however, local elites strongly prefer subsidized access to private practice, including in neighboring South Africa, given the low quality available in public facilities (availability of services and supplies, waiting times, diagnostic precision).

The second question is who would finance this scheme. The idea is to create a new payroll tax for the formal economy, which accounts for 20% of the total workforce (latest Survey of Households, 2015). As workers already pay the income tax, it would be worth analyzing the rationale and tax fairness of this additional payment on work incomes. Why should the capital factor of the economy (owners, companies, heritage) not contribute to this additional effort to fund health services? Why should the unwaged (and financially able) non contribute to this scheme? The idea of linking one sort of payment with service provision is far from collective responsibility over public policies.

A third question is the fiscal legitimacy of such a scheme. After paying a share of their earnings "for health", citizens will realize that quality at NHS continues to not respond to their needs. Is it feasible to impose a new payment on the 5th Quintile (the richest 20%, the one that composes the tax collection), while service provision has low quality? Linking contributions to entitlements in a setting with limited quality generates unsatisfaction and unwillingness to contribute.

Moreover, the non-contribution of the informal economy can undermine the desire of cross-subsidization, as redistribution will be even more visible. Specific contributory schemes for the informal economy have been proposed, however, evidence shows the financial low relevance an instability of such sort of contributions, and feasibility and administrative costs should be assessed against its possible gains.

The way out of this labyrinth may be not linking contributions with entitlements. There is a risk of fragmentation of schemes, as powerful groups in the State Administration demand separate health insurance, which in practical terms would imply public subsidies for the most well-off, and that these funds are not pooled with those of the rest of the population.

Mozambique has many challenges in health policy, but fragmentation is not amongst them. Quality is. Maybe the response is to try to focus on the main challenge: The delivery of responsive and available health services to all with quality, with the resources available (that have increased at 20% nominal rate per year in the last decade), and trying to increase funding in the most aggregated and progressive manner. The strengthening of the link Funding-Results, including PFM, can be identified as the key question in health financing in Mozambique.