Agreement for Performance of Work

Support services to enable country level collaboration for improved institutional frameworks in the area of health financing systems

MOZAMBIQUE Summary

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by

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2. ANALYSIS :

(i) Constitutional/Legal/Governance Challenges:

● In 2004, the Government of Mozambique adopted a new constitution, which paved the way for strengthening the legal and regulatory framework regarding healthcare[1]. Article 89 of the Constitution states that "All citizens

[1] The hierarchy of norms differs between countries but typically includes various types of legal instruments. A country's highest law - the Constitution - sets out the broad structure of Government as

shall have the right to medical and health care, within the terms of the law, and shall have the duty to promote and protect public health". Article 116 further stipulates that "medical and health care for citizens shall be organized through a national health system, which shall benefit all Mozambican people". In addition, " […] the State shall promote the expansion of medical and health care and equal access of all citizens to the enjoyment of this right"[2].

● Following these constitutional provisions, the Social Protection Law (4/2007) was adopted in 2007. The law established the legal basis for the social protection system, composed of three pillars: basic social protection, under the mandate of National Social Welfare Institute - INAS / MMAS; mandatory social security, under the mandate of MITRAB; and complementary social security, to be provided by the private sector. Then, in April 2010, the National Strategy for Basic Social Security (2010 - 2014) aimed at promoting an integrated approach to social protection and made specific provisions for health care as a core component of national social security[3]. Social protection thus gained a strategic position in key Government policies and action plans as a mechanism for poverty reduction and inclusive growth[4].

(ii) Political and Socio-Economic Challenges:

● Mozambique is a high-disease burden[5], low-income country of 25 million people with a predominantly rural population and one of the world's

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well as fundamental rights and duties. Legislation is a specific act or statute passed by the legislative or parliamentary branch of Government to help implement the broad mandates of the Constitution. For example, legislation can create a ministry of health to realize a constitutional right to health. A further step in operationalizing the law is the issuance of regulations by executive branch officials: for instance, ministers of health are often authorized by legislation to issue regulations, decrees, executive orders.

[2] Law N. 25/91(14) created in 1991 the National Health System (NHS) in light of the Republic Constitution of 1990. The NHS established a health organization at different levels of care : primary level consists of health centers and units, each comprising its respective areas of health; secondary level consists of district general and rural hospitals ; tertiary level consists of provincial hospitals; and quaternary level consists of central and specialized hospitals.

[3] The Regulation for Coordination of the Mandatory Social Security System (49/2009) and the Regulation of the Basic Social Security Sub-system (85/2009) should also be mentioned.

[4] A significant growth in budget allocations to basic social protection programmes have to be pointed out in the last decade. It have enabled an increase in the number of beneficiary households and the level of benefits.

[5] Communicable diseases are the leading causes of death in Mozambique : malaria (29% of all deaths), HIV/AIDS (27%), perinatal conditions (6%), diarrhoeal diseases (4%) and lower respiratory infections (4%). Differences in mortality also exist across urban and rural locations. Malaria was the

lowest population densities of doctors, nurses and midwives. In spite of recent improvement, the country remains one of the poorest and most underdeveloped in the world[6]. About 70% of the population lives in rural areas with a big majority engaged in agriculture[7] or working in the informal sector[8]. The Republic of Mozambique's health infrastructure remains limited with more than half of the population residing over one hour walking distance from the nearest health facility[9].

● If a considerable reduction in poverty should be pointed out in the last decade, inequality is still increasing in Mozambique with female-headed household's poverty higher than male-headed household[10]. The vulnerability of the system is strongly linked to determinants of health that condition the performance of the sector, such as the level of literacy, the weight of poverty, climatic conditions and their effects on health, as well as the internal national capacity for sustainable financing the health sector.

● Main obstacles to accessing healthcare services include : lack of sanitary infrastructure, insufficient health workforce, lack of equipment, higher demand for healthcare, difficulty of paying users for the services performed, inappropriate health professional attitudes and corruption, poor quality of health services provided. Chronic malnutrition, especially for children, high food insecurity, low levels of education of women, poor access to safe drinking water, inadequate levels of availability to basic sanitation and access to high quality health services, and the inequitable distribution of health care professionals in urban, peripheral and rural areas where health needs are higher still jeopardize progress towards Universal Health Coverage (UHC).

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leading cause of death in rural areas and HIV/AIDS was the leading cause of death in urban areas. Moreover, chronic malnutrition remains as another common health condition. The country still has one of the highest maternal and infant mortality rates in the world. New-borns and infant deaths in children under the age of 1 accounted for approximately one-quarter of all deaths, whereas passing of children from 1 to 4 years comprised 19 percent of the total. However, improvements have been made in some health areas, such as the increase of births attended by health professionals, set at 54.3%; reducing poverty by almost 50% and the reducing of neonatal mortality from 50% to 30.4%.

[6] GDP per capita is among the 10 lowest ones. Life expectancy at birth is 53.7 years and total fertility rate is 5.08 children born/woman (2017 estimates), while ranks 181st position out of 188 countries in the Human Development Index 2016 (United Nations Development Programme, 2016).

[7] Main occupation for 76.3% of the women and 55.9% of men.

[8] 10.5% of women and 8.7% of men according to the *Instituto Nacional de Estatística de Moçambique*, 2015.

[9] Health facilities in Mozambique face frequent shortage in medical supplies, electricity and running water.

[10] High illiteracy and widespread lack of access to education and knowledge are serious barriers to inclusivity, particular in rural areas and worse in the Northern provinces, also undermining agricultural productivity.

- The lack of funds for the health system, deficient information systems, negative relationships between health professionals and the people, late referral for more specialized care of patients, difficulties in decentralizing care processes and medical technologies, minimal coverage of NHS are aggravating factors which worsen the situation.
- Since 2015, the Ministry of Health (MoH) is developing a Health Financing Strategy (HFS) whose very purpose is to have an equitable, sustainable and efficient financing system that enables the delivery of quality health care to all Mozambicans without discrimination. If the strategy has not been formally finalized yet, it has already identified three key measures to realize this vision: increasing the sustainability of health financing; improving the efficiency of resource allocation; and improving the efficiency of the use of resources in the health sector[11]. The finalization of a robust HFS as a key policy and strategic document is a core priority which will also require to identify health financing reform priorities and associated implementation plans, as well as, areas of support from Development Partners (DPs)[12].
- In May 2022, critical challenges for the health sector are : the existence and implementation of a NHS; the adoption of a coordination mechanism / platform between the country's institutions and DPs for the establishment of a political dialogue for the health sector; the adoption of a new National Health Policy (NHP) in line with the Government's Five-Year Plan and the 2030 Agenda; the development of an effective and decentralized national capacity to respond to public health emergencies and the reinforcement of Primary Health Care (PHC).

[11] In Mozambique, the health sector is made up of the Ministry of Health of Mozambique (MoH), 11 Provincial Directorates of Health (DPS), 146 District Services of Health and Women and Social Affairs (SDSMAS). Besides, other health institutions receive autonomous budget allocation from the State Budget: Centre of Medicines and Medical Articles (CMAM), National Council for the Fight Against HIV/AIDS (CNCS) and also, three Central Hospitals, four General Hospitals, eight Provincial Hospitals, one District Hospital, and one Psychiatric Hospital. DPS and SDSMAS are subordinated to the MoH and the Ministry of Economy and Finance (MEF).

[12] In-depth analysis of current financing gaps and equity considerations have to be carried out. Identifying how to increase domestic financing in the health sector in order to mobilize additional public and private resources and enhance potential efficiency gains are key challenges as well as discussing the pooling of resources and realistic options for purchasing health care.

(iii) Financial Challenges:

● The Government health expenditure as a percentage of general Government expenditure (GGE) is 9.8% in 2016, still far from reaching the Abuja Declaration target of 15%. Total health expenditure (THE) per capita is US$42, which is scarce in comparison to the WHO recommendation of US$60, and heavily dependent on foreign assistance. The health sector is financed by the state budget, external funds from donors and, in a small portion, by the contribution of out-of-pocket payments (OOPs). If Mozambique has one of the lowest OOP rates in the world[13], OOP payments doubled from 6% of the Current Health Expenditure (CHE) in 2012 to 12% in 2015, pointing out the increasing user fees at hospital level in public facilities as well as the development of private healthcare. Besides, Mozambique's estimation of OOP spending is underestimated using currently available household survey data. The reality may be more in line with that of other low-income countries (40% of current health spending)[14].

● Over half of health spending (55%) in 2015 was financed by external donors (bilateral, multilateral and foundations). Government provides the second largest source of funding for health, representing 27% of total health spending in 2015. Households contribute to 11% of health spending, although this is likely underestimated. The nature of external sources of financing causes concern about the sustainability of health spending going forward. External funds from donors are received through the General Budget Support, the health common fund (PROSAUDE), the vertical funds and, in a very small proportion, by the donations of medicines and medical equipment[15]. Emphasis should be laid on the fact that total commitments from donors to support the PROSAUDE Common Fund is regularly decreasing, in line with the decision of donors to reduce or cease support in the form of General Budget Support and common funds. It is thus critical for the Government to find alternative

[13] This situation can be explained by several factors, in particular the low level of user fees in primary health care and the small size of the private sector. However, the OOPs may be largely underestimated since the data to measure it comes from National surveys and it only counts the self-reported direct payment. In addition, if WHO placed Mozambique in 2014 as the country with lowest annual OOP household spending on health in the world, the 2014/2015 direct payments on average represent a 312.59% increase in real terms when compared to 2008/09.

[14] Over half of out-of-pocket payments are made in private facilities for outpatient consultations.

[15] Most of the health spending is external and outside of the boundaries of the Government control. In 2013, the state budget only contributed 29% to health care spending, PROSAUDE 7% and the vertical funds 64%.

sources of financing to replace the funding that has been lost through the reduction of this support.

● The health sector budget represents about 9% of the overall volume of the State Budget and is one of the sectors receiving the most resources. However, the amount budgeted for 2019 decreased by 34% in real terms. In comparison with 2018, the health sector budget's share of the Gross Domestic Product (GDP) decreased by 0.4% points. The budget allocation to the sector thus remains well below the target, set at 15% of the State Budget total in the Abuja Declaration and in the Strategic Plan for the Health Sector (PESS) for 2014-2019.

● Financial resources can be reported to the State (on-budget) or not reported (off-budget) and can appear on the Government financial system (Conta Única do Tesouro "CUT") or off the system (off-CUT)[16]. As a result of this complexity in the financial system regarding budgetary issues, the accountability of the Parliament, public planning, and budgeting of the MoH are quite challenging.

● From the perspective of the health institutions, it should be noted that about half of the total health budget (49%) is allocated to the MoH, 25% are allocated to the District Health, Women's and Social Action Services (the SDSMAS), 11% to the Provincial Directorate of Health (the DPS), and 9% to Central Hospitals. From the level of care perspective, the central government received 5% of sector resources, followed by primary and secondary health care (22%), provincial administration (11%), quaternary health services (10%), and third party health services (7%)[17].

● The State Budget allocated and executed in the health sector has never reached the Abuja commitment, even after the coronavirus outbreak in 2020. The increase in the health budget over time does not mean greater capacity to provide health goods and services as it does not follow the inflation rate and population growth. As a result, there is a trend of decline in health budget indicators, aggravated by the Covid-19 pandemic. In addition, the health sector faces competition from other sectors for aid money and even when aid for health is committed, this does not always translate into real disbursements. Greater allocation of resources for the health sector is becoming urgent.

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[16] Spending financed by State budget and PROSAUDE is on-budget and on-CUT, whereas most of the vertical funding is off-budget and off-CUT.

[17] Only the Maputo Central Hospital (HCM), the Central Medical Stores (CMAM), the Regional Health Development Centre (CRDS), the National Institute of Health (INS), and the National Health Directorate report regularly on the income collected. The resources available to the health sector are thus not monitored in a satisfactory manner, contributing to poor transparency as regards their use.

- **Revenue Raising:**

● Sustainable health financing has to be driven by an increase in domestic revenue mobilization. In Mozambique, since 2016, the Health Financing Strategy Technical Working Group (GTF), supported by WHO, EU and the Government of Luxembourg, is working on possible strategies likely to reach such an objective. An increase in the user charge, the introduction of different financing schemes such as social health insurance, community based health insurance and private health insurance, the allocation of the oil revenues into health expenditure have been identified as possible options.

● Raising additional funds to progress towards UHC often implies increasing the fiscal space for health[18]. Administrative efficiency is key when developing new taxes. From this point of view, there is a huge concern in Mozambique for taxes on the extractive industries, since the set-up and running costs of the tax are expected to be high and technical capacity to be weak. New taxes on alcoholic drinks and on tourism services could be more promising. More attention is needed on how to improve tax collection since it is one of the most effective strategies to increase Government revenues. In-depth fiscal space analysis could help identify opportunities to increase domestic resources for health, e.g. taxes on cigarettes, currency transactions earmarked to health, or increased proportion of general tax revenue for health.

● The Joint Health Financing Group between the MoH and the Ministry of Economy and Finance (MoEF) started to work in 2019 to assess the health

[18] Fiscal space is defined as the ability of governments to increase spending for the sector without jeopardizing the government's long-term solvency or crowding out expenditure in other sectors needed to achieve other development objectives. Fiscal space for health can be expanded in several ways: general economic growth in a country; increased state or tax revenues and improved tax collection; an increased proportion of government spending on health; and improved efficiency in the use of funds. Mobilizing additional tax revenues can be done by introducing new taxes or increasing existing tax levels. Imposing taxes on specific products and services to increase general government revenue has also gained attention. The objective to increase fiscal space for health does not necessarily require new revenues to be earmarked for the health sector. Instead, the aim is to increase overall Government revenues and augment the share going to health. Earmarking for health may raise additional resources, but this may be offset by reducing discretionary budget allocations, resulting in little if any overall increased fiscal space for health. However, from the perspective of finance ministries, advocating for a specific tax increase to the health sector may be preferable, as it may increase acceptability by the public. Whatever the source of additional revenue, new revenue raising mechanisms should flow into the general Government budget rather than being developed for a specific sector or disease programme.

financing situation with domestic and external resources, analyse prospects and options of reform, and prioritize Health in the State Budget.

● The Government is currently working to enhance domestic fiscal space dedicated to basic social protection programmes implemented by INAS in order to promote coverage expansion to reach more vulnerable population[19]. And the MoEF is preparing a reform of the Specific Consumption Tax (ICE), which includes taxes on tobacco, alcohol, sugar-sweetened beverages, cars, and other consumption goods. The country operates in the Southern African Development Community (SADC) tax harmonization framework, which limits the possible increases. However, there is room to increase taxes related to unhealthy consumption, given the rise in Non-Communicable Diseases (NCD) in the country, especially diabetes and cardio-vascular diseases. The MoH has also developed a NCD Prevention Strategy which includes economic measures such as health taxes. Health taxes currently represent 1.3% of tax revenue in the country, as per Budget Execution Report of the Ministry of Finance.

- **Pooling[20]:**

● The Health Accounts analyse spending by financing scheme. The categorization of health spending by financing scheme helps to understand how funds are being raised and collected, how they are pooled to provide services, and who is entitled to those services[21]. Some schemes are more equitable than others, in particular schemes with a large proportion of OOP spending are less equitable than contributory schemes. National-level government schemes can also have the advantage of a large unified risk pool that can collect funds from a broad group of payers and allocate them to those most in need.

● In Mozambique, half of current health spending is pooled to provide services to the general population and managed by the Government. Approximately one third of spending is through private financing schemes, i.e., NGO, household, employer-based or insurance schemes. Donors channel 44% of their funding through the Government scheme, for example through the PROSAUDE health-sector basket fund. The Government has thus

[19] A major milestone of 2019 was Child Grant pilot for children 0-2 years old at full scale in four districts in Nampula province.

[20] Pooling is the accumulation of funds for health care on behalf of a population before they get sick. The main rationale for pooling of funds is that health care costs are unpredictable.

[21] A country can have multiple juxtaposing schemes, and there is no “ideal” benchmark for how spending should be allocated to these schemes.

programmatic influence over at least half of health spending in Mozambique.

● Donor schemes are another important mechanism for providing health services (17% of current health spending). These schemes are generally those whose resources are pooled abroad and managed by a foreign organization that designs the benefits of the scheme, e.g., where donor headquarters design projects that are implemented in Mozambique in coordination with the Government[22].

● Health insurance is still nascent in Mozambique and population coverage of existing schemes is unknown. However, a National Health Insurance Scheme for civil servants is under discussion[23].

● Pooling of prepaid revenues (taxation and the various forms of health insurance) have a big impact on financial risk protection and access to care. However, there is large evidence that multiple pools, each with their own administrations and information systems, are also inefficient and make it difficult to achieve equity. The definition of different financing schemes that range from community-based to private health insurance should enhance social solidarity and strengthen political support for a single pool payer system[24].

- Purchasing[25]:

● In Mozambique, 44% of current health spending is used to provide curative services to the population, 34% outpatient services, 6% inpatient services, and 4% other curative services such as home-based, rehabilitative and long-term care. Over one quarter of current health spending (27%) is used to provide health prevention and promotion services. Information, education and communications campaigns[26] represent 7%, testing 5%, immunization programs 3%.

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[22] Where donors disburse money to local NGOs, who design the benefits of the scheme, the scheme is considered an NGO scheme (these received 13% of health spending in 2015).

[23] Civil servants currently contribute 1.5% of their salaries to a medical assistance fund. Most companies finance health insurance premiums from corporate earnings.

[24] Multi-tiered health care financing, e.g., private health insurance for the rich, social health insurance for the middle and publicly funded "benefit packages" for the poor rarely provide for equitable distribution of resources for health.

[25] Purchasing is the process of allocating prepaid resources from pooled funds to providers for service benefits. Closely linked to purchasing are decisions on benefits (what services, and at what level of cost coverage) and provider payment methods. The way purchasing arrangements are set up will have significant implications for provider behaviour and efficiency.

[26] e.g., nutrition or HIV/AIDS.

● The Government is the largest purchaser of services (46%) through the MoH, the Provincial Health Directorate, the District Services for Health, Women and Social Action, and hospitals. The other purchasers of healthcare services are DPs (38%), voluntary schemes of payment (10%), and direct family payments (6%). The private sector is growing in urban areas, charging fee-for-service. By law, user fees in public facilities must be less than US$1 and all medicines are provided at a subsidized price[27].

● Current purchasing mechanisms in the Mozambican NHS are mainly based online-item budget where salary, supplies, transportation or drugs costs are calculated mainly based on historical budgets defined by MoEF. Regarding fee-for-service, few institutions are authorized, for example, the Central Hospital of Maputo[28].

● The development of the HFS constitute a real opportunity to explore the political feasibility of strategic purchasing of health services.

(iv) Collaborative Challenges:

● Within a relatively short time Mozambique has developed a well-established Sector Wide Approach (SWAp) which brings together 26 different partner agencies in support of the national strategic plan for health (PESS)[29]. A number of partners supporting the SWAp provide their support through the pooled funding instrument, e.g., PROSAUDE, with some donors providing their aid as Sector Budget Support (SBS)[30].

● Main DPs and stakeholders in Mozambique are the following: (i) WHO, which supports health financing policy processes, in particular regarding health taxes, costing of the strategic plan, and national health accounts; (ii) The World Bank, which basically manage the Global Financing Facility (GFF) operations; (iii) the GFF, newcomer embedded in the structure of the World Bank, interested in health financing in particular Performance-

[27] There are exemptions for indigent populations and specific diseases, such as HIV, tuberculosis, malaria, and maternal health.

[28] However, it is known that many informal practices occur at the health facility level.

[29] The main objectives of all DPs operating within the Mozambique health SWAp are to, increasingly improve the quality of the dialogue on health between Government and its partners, harmonise donor assistance modalities with Government systems, ensure that partner programmes are in line with the declared Government Strategy and Policy as much as possible and work to align donors' funding and reporting cycles with those of Government.

[30] A Memorandum of Understanding governs the relationship between Government and DPs engaged in PROSAUDE, and a code of conduct governs the engagement of all partners who are supporting the SWAp

based Management, e.g., expenditure tracking and monitoring; (iv) ILO, which focuses on social security and basic income topics, not social health protection (ILO have moved forward the idea of a National Health Insurance (NHI) but has not advanced yet, due to complexity and difficulties in a country with 75% informal economy); and (v) The International Health Partnership (IHP+). Mozambique is a signatory to IHP+, which reaffirms the commitment of all partners to increasingly harmonise and align their support with nationally defined priorities[31].

- In order to strengthen partnerships for health, the PESS has identified key interventions. They include: defining and implementing effective institutional mechanisms to improve inter-sectorial collaboration with a view to reducing health determinant effects and inequities, and facilitating sector decentralization; reviewing and implementing mechanisms to improve civil society involvement in the design, implementation and Monitoring and Evaluation (M&E) of health policies and programmes; developing and implementing a strategy for the establishment of Private-Public Partnerships (PPPs) supporting sector fundraising efforts and increasing health care access and use; strengthening mechanisms to improve dialogue and relationships with DPs and strengthen the MoH´s leadership role; and reviewing mechanisms for engagement with NGOs to strengthen their advocacy role and the implementation of health programmes[32].
- The Planning, Financing and Strategic Investment Coordination Group (PFSI) is the new dialogue structure established in the health sector in

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[31] Mozambique has a well-organized aid coordination framework, but the Hidden-debts case has strongly undermined DPs' confidence. Since early-2000s the aid coordination structure in Mozambique was built around a Memorandum of Understanding between the Government and a group of 19 Programmatic Aid Partners (PAP) known as "G19". The group served as a de facto coordination and management mechanism for the overall aid in the country, supported by sector and thematic groups covering all aspects of the country's development program. Official development Assistance (ODA) is increasingly channelled through direct project investment, and there is a progressive shift in allocations away from the Common Funds modality in favour of direct support to non-State actors. The Health sector is financed almost entirely by global initiatives such as Global Fund and GAVI, recently questioned due to governance issues. The World Bank, the European Union, Germany and UK, are the largest partners. Presence of non-traditional partners in the country is strong and expanding. China and Brazil have provided extensive credit lines, concessional and non-concessional, mostly directed at infrastructure. Other relevant partners are Vietnam, India and Korea.

[32] The following results are expected: an increased number of formal mechanisms established with relevant Government sectors to address health determinants; an increased number of forums for effective Civil Society Organization (CSO) participation, and of community-based programmes; an increased number of PPPs; a higher proportion of external funds on-budget and on-cut; and NGO activities included in district and provincial PES budgets (PESOD and PESOP).

Mozambique between MoH and the DPs[33]. The objectives of the Group are to ensure strategic planning and budgeting processes that can respond to health needs and promote efficiency and effectiveness[34]. A special attention is given to what is called Resource Monitoring and Expenditure Tracking (RMET), which intends to capture all sources of funding and track spending, so as to identify the linkages between spending and priority actions[35].

● Intersectoral collaboration is crucial to respond to emergencies and their consequences in the health sector. In recent years and during the Pandemic situation of COVID-19, DPs and national institutions have demonstrated a real collaborative capacity among them to respond to the immediate needs of the population and to ensure that health services reach the displaced populations. This response involved joint resource mobilization, procurement, transportation and availability of services to affected populations. The health sector alone cannot assure an improvement in the state of health of Mozambicans. Many other sectors play a crucial role in the improvement of living conditions of the people, through the provision of diversified food in quantity, drinking water, environmental sanitation, housing, transport, quality education, etc. The implementation of this intersectoral coordination should be inspired by the experiences in other countries. For intersectoral coordination to be effective and efficient, it must be institutionalized. It is under this framework that an Inter-Sector Health Coordination Council (CCIS) should be set up, a body whose mission will be to ensure inter-sector coordination, with the aim of taking concerted action on the social determinants of health at the different levels.

● Last but not least, the strengthening of coordination at the various levels - central, provincial and district - is paramount for the full success of the National Health Strategy. This requires strengthening the coordination mechanism at central level and the development of partnerships between the

[33] It includes six thematic working groups: Service Delivery, Planning, Financing and Strategic Investment (PFSI), Emergencies and public health, Logistics and Pharma, Data for decision making. The PFSI group is chaired by the National Director of Planning and co-chaired by the World Bank.

[34] The idea that UHC can be achieved in some form through selective vertical disease specific approaches identified and chosen through "cost-effectiveness" modelling is concerning. If donors choose the path of selective disease-specific support, it might finance NGOs rather than health systems, in order to reach specific, narrow targets. UHC requires on the contrary to build and expand in priority public-sector health services.

[35] P4H is part of this group, jointly with relevant players in the field, i.e. WHO, Belgian Cooperation, GFF, UNAIDS, USAID, Canada, Ireland. P4H contributes mainly to the area of health financing policy and expenditure analysis.

various relevant stakeholders at local level, inside and outside the basic social security sub-system.

(v) Human Resources Challenges:

● The legal and regulatory framework governing health workers has been established in 2009. Three main documents should be pointed out: The System of Career and Remuneration for the Public Sector (SCR), the General Statute of Employees and Agents of the State (EGFAE), and the Regulation of the General Statute of Employees and Agents of the State (REGFAE). The framework is thorough with regard to financial incentives for public servants including health workers. These include 17 types of allowances that if paid regularly might increase health worker hiring, distribution and retention.

● Increasing human resources for health in Mozambique is a fundamental step towards achieving and sustaining scale-up of health programs and services. Because country's density of health workers is inversely associated with rates of infant, child and maternal mortality, producing and retaining more health workers can broadly impact health. Mozambique relies primarily on public sector civil servants to deliver most health services. Private, for-profit health services other than traditional medicine remain inaccessible to the general population.

● Mozambique's large dependence on external resources for health services allows the country to temporarily hire health workers using donor funds whereas the national budget restricts the number of permanent employees.

● Important gaps remain, for example, to select more rural students for pre-service training in nursing, midwifery and medicine, and upon graduation, place them in rural areas. Other notable gap include improvement of rural infrastructure and services such as sanitation, electricity and schools for health workers and their families, plus reduction of professional isolation through professional networks and isolation. The recent adoption of the law establishing Mozambique's first nursing regulatory board may begin to fill this gap.

(vi) Health Information Challenges:

● In Mozambique, a large amount of data on health spending is available[36]. This is a significant advantage to make the National Health Accounts (NHA) exercise faster and more cost-effective by preventing the need for primary data collection[37].

● However, some issues remain challenging, for example the quality and completeness of existing data which could be improved. Likewise, data from the private sector is still limited. Limited access to information on Government health priorities, epidemiological trends, and socioeconomic profiles of underserved population groups restricts the private sector ability to assess market potential and may impede their efforts to align their activities to public health goals. Private health sector actors can also be distrustful. They can be reluctant to share information with Government for fear that they will be subject to more taxes and fees or possibly be closed down due to noncompliance. This shortfall in raw data affects the accuracy of NHA. A lack of compiled health information at the national level also makes data collection and central planning more difficult[38].

● NHA provide key information necessary for the MoH to understand its own health financing performance. They provide insights into the sustainability of health financing, equity of health financing, and efficiency of

[36] For example, spending by households is available in Mozambique's Instituto Nacional de Estatistica (INE, National Statistics Institute) household survey; Government spending in the electronic Sistema de Administração Financeira do Estado (eSISTAFE, the Government financial administration system); donor spending in the Inquérito de Fundos Externos (IFE, Database of External Funds) and the Official Development Assistance to Mozambique (ODAMoz) database, and Social Security spending in the Instituto Nacional de Segurança Social de Moçambique (INSS, National Social Security Institute) Annual Report. Mozambique also benefits from a large amount of secondary data, such as regular household surveys, databases that capture donor spending in the health sector, and the Mozambique Health Information System for Monitoring and Evaluation (SIS-MA) for capturing health utilization data.

[37] NHA are based on data collected by the Directorate of Planning and Cooperation (DPC) of the MOH - Department of Planning and Health Economy (DPES), along with the involvement of other central and provincial bodies of the MoH, development donors and partners, non-governmental organizations (NGOs), public-private companies, ministries, educational and research institutions, public institutions, tutored bodies, and other Government agencies.

[38] Much data now compiled at the provincial or district level, such as information on drugs distribution, would be useful if also compiled at the national level. For example, compiling pharmaceutical spending by provider and drug at the national level, will help to ensure that future Health Accounts can analyse drug spending, a priority issue for the MoH.

health spending. They can also serve as useful evidence in negotiating for increased domestic resources for health.

3. WHAT IS NEEDED?

(i) Strengthening policy frameworks by:

- **Adopting conducive policies and strategic plans:**

- The Government has developed important policy and strategic documents such as the Health Sector Strategic Plan, the Human Resources for Health, and the National Development Plan[39]. Technical and financial support is needed for the creation of a platform for Policy Dialogue in Health amongst the DPs and key stakeholders, and to finalize the HFS[40].
- A conducive HFS should include routine measurement of efficiency in the delivery of health services, e.g., performance of health service providers of different levels - districts, hospitals, health units - and adequate planning and budgeting instruments. Program-oriented budgeting together with strategic allocation mechanisms should allow to progressively reduce inequities in expenditure.
- To ensure sufficient funding for the health sector, the new HFS should cast light on the following priorities: (i) Prioritize health in the State budget; (ii) Permanent negotiation between MoH and MoEF on allocation and transfer of sufficient funds to the sector, based on costed needs; (iii) Promote debates on the relevance of health financing at Parliament; (iv) Increase and earmark health-related taxes; (v) Increase existing taxation on alcohol, tobacco, and sodas (vi) Assess other taxes on polluting activities and car insurance; (vii) Align external funding with service provision; (viii) Mobilize external funding to cover the needed resources to fund the benefit package; (ix) Prioritize the use of external funding for strategic investments rather than recurrent expenditure.

[39] To accelerate progress towards UHC, it is now critical to develop a benefit package focused on primary health, quality of services, and equity in resource distribution and to undertake the reform of the user fee system.

[40] The Health financing strategy 2020-2030 has been approved at technical levels at MoH but is still pending for high-level approval.

- **Elaborating costing frameworks:**

- The MoH is in the process of carrying on costing of health services, with a focus on hospitals[41].
- In order to progressively introduce a SHI scheme, it will be necessary to design its institutional arrangements and to analyse its financial sustainability. In particular, it is critical to determine the level of "structural" financing that will be required to implement the package of transfers envisaged in the Strategy on a national scale. Programmes with the largest budget are expected to be the Child Allowance, which will be expanded to reach 1.4 million beneficiaries in 2024, and the Allowance for the Elderly in the Basic Social Allowance Programme (PSSB), with more than a million direct beneficiaries in 2024.

- **Promoting equity in health system financing[42]:**

- Health inequities are one of the main obstacles to improving the quality of health care in Mozambique[43]. That's the reason why promoting equity in the allocation, provision and use of health services so that geographic location, gender relations, economic situation or health condition do not constitute barriers for use of services is a strategic objective of the PESS.
- In order to reduce geographical inequalities and inequalities between population groups in access to and utilization of health care services, several key interventions have been identified such as developing equity-based resource allocation mechanisms or strengthening social protection mechanisms for vulnerable groups, e.g., introducing free services or exemptions. Main expected results are a reduced inequity between funds allocated per capita and expenditure per capita, and in the distribution of Human Resources and Health Financing per inhabitant and reduced inequity between outpatient consultations per inhabitants and care unit per inhabitants.

[41] The objective is twofold: first, to determine the costs of service provision, and second, to train hospital managers in cost accounting.

[42] It is generally accepted that the burden of health financing should be distributed according to an individual's ability to pay, that is, the burden should increase as household income increases.

[43] The rates of infant mortality, maternal mortality and malnutrition in children aged under five are higher in rural areas than in urban areas (urban-rural ratio of 1.6); children in the lowest wealth quintile are 1.8 times more likely to die before the age of five than children in the highest wealth quintile; a child in Cabo Delgado Province is around three times more likely to die before the age of five than a child in Maputo City; around 55 per cent of children in rural areas are vaccinated compared to 74 per cent in urban areas; Maputo City (with a population of around 1.1 million) has twice the number of doctors as Zambezia Province (with a population of over 5.5 million).

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- **Ensuring financial sustainability and the efficient use of resources:**

- Quality and efficiency of health expenditures are not reviewed yet to ensure that health outcomes are commensurate with spending levels. An assessment of the institutional arrangements in the health sector should be carried out to map out the key constraints in procurement, financial management and other fiduciary functions[44].
- In order to improve efficiency of service provision and utilization of resources it is necessary to develop an essential minimum package of health services, to prioritize interventions that meet health needs and are cost-effective, to identify inefficiencies regarding staff productivity, clinical practices, budget execution, procurement systems, waste, drug misuse, medical and surgical equipment and other supplies, and to develop the corresponding mitigating measures.

- **Improving data availability to inform policy and decision making:**

- Institutionalizing NHA is a core priority in order to ensure that health expenditure data is available to decision-makers on a timely basis to support more-informed decision-making about raising money for health, pooling and managing health resources, and how to allocate those resources. NHA should be produced more quickly to feed into annual planning and budgeting cycles[45].
- A specific example of the improvements to be made in data availability to inform policy and decision making is the example of the Central Medical Store - *Central de Medicamentos e Artigos Medicos* (CMAM), which manages Mozambique's public health supply chain[46]. For many years, CMAM has received assistance from multiple donor partners, for both commodities and operational investments. While the capacity of CMAM has been strengthened,

[44] From this point of view, the National Health Accounts (NHA) remains a fundamental tool to describe and measure the flow of health expenditure resulting from public and private institutions, as well as from households, thus allowing for more effective planning and improving the provision of health services in Mozambique.

[45] However, if regular production of NHA data is necessary, it is not sufficient. The data must be user-friendly, and widely disseminated to those who need it. This also necessitates a team in place who have the necessary knowledge and experience in expenditure tracking.

[46] Its mandate is to manage the procurement, importation, central-level warehousing, and distribution to provinces for the medicines and commodities used by the public health system.

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measurable results have been limited because good quality data on performance is not available.

- In Mozambique, efforts toward the systemic recording and use of data have improved. In response to significant challenges in monitoring activities at the subnational level, the Government and the DPs are now in the process of developing a national dashboard with jointly agreed-upon indicators. In the meantime, quality-of-care scorecards for health centers and hospitals have been piloted and will be scaled up[47].

(ii) Strengthening legal and regulatory frameworks by[48]:

- **Adopting robust legislations:**

- The HFS should mention legal and regulatory implication of proposed financing option or payment mechanisms. Also a monitoring framework would help steer implementation and check progress.
- With the establishment of a comprehensive legal framework and the strengthening of technical capacity, the credibility of INAS and MMAS vis-à-vis Government and other ministries has improved. The participatory and multi-sectorial development process of the ENSSB reinforced a common vision of social protection and established the basis for coordination between the key partner ministries. MMAS and INAS have now more political influence on Government policies, and there has been an impressive increase in budget allocations to basic social protection programmes in recent years.
- The private sector is increasingly active in various health-related markets including service delivery, retail pharmacies and transport of health commodities for Government entities through public tenders[49]. However, an institutional framework regulating its activities is still lacking. Typically, the private for profit health sector remains mostly unregulated, allowing for the

[47] Also, vital statistics registration has improved, with the share of facilities using the Data Management Module (MGDH) to record cause of death rising from 70 to 100 percent among hospitals and from 0 to 50 percent among health facilities.

[48] Two types of indicators may be distinguished for assessing whether legal and regulatory frameworks are effectively and efficiently designed and implemented: rules-based and outcome-based indicators. Rules-based indicators measure whether countries have designed and adopted appropriate policies, plans and strategies to guarantee equitable and affordable access to health care for all. Outcome-based indicators measure whether rules and procedures are being effectively implemented or enforced.

[49] Interest in the private sector is increasing, as evidenced by USAID's recent Private Sector Engagement Strategy and by the call of the MoH for a public-private framework in the PESS.

growth of a sizeable informal, illegal health sector that creates strong competition with the formal private sector.

● **Adopting implementing/regulatory measures:**

- Following the Social Protection Law (4/2007), the legislative and regulatory framework was consolidated in 2009 through the approval of two regulations: (i) *The Regulamento de Articulação do Sistema de Segurança Social* Obrigatória (Regulation of Coordination of the Mandatory Social Security System - 49/2009), which introduced regulatory mechanisms to coordinate the contributory social security system for workers in the private and public sector; and b) *The Regulamento do Subsistema de Segurança Social Básica* (Regulation of the Basic Social Security Sub-system - 85/2009), which established the scope, structure and benefits of the non-contributive basic social protection system[50].
- Other important social regulations to be developed are facility licensing and accreditation, professional certification and continuing medical education since they can improve quality and influence supply and demand in a health market.

(iii) Strengthening institutional frameworks by:

● **Creating supportive environments:**

- The development of an action plan to strengthen capacity and build performance-based financial management is critical. The very purpose is to ensure that planned interventions are financed and converted in health services delivered. Progress in coverage and health outcomes are actually at risk, and the predominantly public system still has difficulty to provide quality health services to the whole population.
- The Government should also strengthen its capacity to regulate the activities of the other providers of health services. Private clinics, for example, currently operate without authorization from the competent authorities and several mandatory regulations issued by the MoH are not complied with by some service providers. Likewise, control over the sale of medicine whether by state-licensed pharmacies or operators in the informal market is not

[50] This regulation was the basis for the design of the National Strategy for Basic Social Security (ENSSB), which began in 2009 and was finalised in 2010 with technical support from the ILO.

effective[51].

- Strengthening the institutional framework for ENSSB in order to increase its capacity to implement the programmes of social transfers and the social welfare services is also a core priority.
- Creating supportive environments also means to guarantee greater proximity of the services to the public at community level. It is thus envisaged that the presence of INAS will be extended to all districts through allocating staff in the districts without delegations.

- **Advocating for new investments:**

- The State budget allocations for basic social protection remain low compared to regional standards, and the fiscal space currently available for the sector's operational development is insufficient. Despite increases in coverage, only 15% of households in a situation of poverty are covered in Mozambique. It is widely recognised that there is a need to create a clear multisectoral investment strategy directed at children. Besides, the establishment of a coordination mechanism for the financing of basic social protection programmes, currently being developed, will help to reduce the fragmentation of financial support to the sector.
- The Government is also seeking alternative options to improve equitable, quality Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH) through increased and strengthened financing mechanisms[52]. In this regard, the Government has leveraged an existing health sector coordinating platform to mobilize RMNCAH stakeholders, both domestic, international, and private sector[53].

- **Establishing close monitoring and accountability for results:**

- To increase transparency and accountability in how public goods are used, the PESS has identified several key Interventions which include strengthening sector accountancy and procurement systems at all levels and establishing effective mechanisms for civil society participation in monitoring the use of public resources allocated to health.

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[51] Mozambique is one of the few African countries and the only country in the SADC that does not have an operational regulatory authority for medicine.

[52] Specifically, the Government prepared to transition into a Global Financing Facility (GFF) recipient.

[53] The Government's five-year Investment Case (the 'program') for enhanced delivery of RMNCAH-N services aims to address these challenges by channelling financing to high impact investments.

- With regard to RMNCAH, developing mechanisms of awareness generation, social accountability and incentives in order to better engage beneficiaries in decision-making and hold public services accountable is urgent. Community mobilization is key to establish close monitoring and accountability for results[54]. Community participation should be institutionalized through the set-up of bodies responsible at all levels for ensuring increasing involvement by the citizens and communities in health sector activities[55].

- **Transferring powers and resources to local authorities (decentralization)[56]:**

- Decentralisation and local Government reform in Mozambique are the result of a complex process, interrupted by episodes of violence leading to peace negotiations and compromise in the redistribution of power from the central Government to sub-national level.
- The PESS clearly points out the priority to develop a reform agenda that effectively strengthens all components of the health system, with a focus on decentralization. Building the capacity of district health systems to implement strategic goals and prepare for effective decentralization is a strategic goal. District health systems are expected to have developed relevant capacities in relation to decentralization, planning, management, negotiation and leadership[57]. The very purpose is to improve the overall performance of the

[54] Community participation has two main aspects: (i) the right and duty of each citizen to participate individually and collectively in the planning and implementation of the health care aimed at them; and (ii) the need for the entities responsible for the provision of health care to be accountable to the citizens (or their representatives) for their actions.

[55] Mozambique has already experienced approaches to participation, engagement and accountability, applying tools such as social audits for the health sector, budget tracking, monitoring the quality of health services for citizens, the use of the community scorecard, the citizen report card, user satisfaction surveys, and public hearings among others.

[56] Deconcentration, refers to the transfer of authority, responsibilities and resources from central to lower levels within the same administrative structure, i.e., from the MoH to DPSs and SDSMASs; Delegation, implies transferring authority, responsibilities and resources from central level to organizations the sector is not directly responsible for, including semi-autonomous institutions (for example, hospitals, CMAM), NGOs, local governments, etc; Devolution, involves the transfer of authority, responsibilities and resources from central level to a separate administrative structure within the Public Administration, which is usually elected, such as local Town Councils.

[57] The PESS considers decentralization as the transfer of certain health system functions and attributions (health policies, management of the health system, health financing and the provision of services) from central to lower levels.

health system and to attain equitable results in fully taking into consideration local health needs and expectations.

- The Government determines at central level the percentage of the State's general budget for the MoH, and then the State distributes it to the provinces. Financial resources are thus channelled mostly to health facilities in the tertiary and quaternary levels, to the detriment of health centers, which are mostly in rural and peripheral areas of the cities. As a result, access of the population to health facilities is reduced. To tackle partially this issue, the MoH is analysing the pertinence of introducing a sort of Direct Facility Financing (DFF) in the country's health centres. This measure would intend to ensure sufficient funds for the normal running of small health centres. The DFF system would allow districts to open a "budgetary window" for each health centre. This would make easier to ensure that each of them have resources for basic expenses i.e. electricity, water, maintenance and repair, petrol, food.

● **Developing Public-Private Partnerships (PPP) and "contractual arrangements":**

- Private sector representatives are active in all areas of the health system, including service delivery, human resource training and production and distribution of drugs. They also provide key support functions such as finance, transportation and information technology services. PPPs can contribute to build a competitive health sector in Mozambique, capable of supplying drugs, vaccines and other health technologies that promote accelerated social inclusion and health security.
- Law n°15/2011 established the guidelines for the contracting, implementing and monitoring process of public-private partnerships, large-scale projects and business concessions and Decree n°16/2012 approved the related Regulation. The Law establishes that each sector of Government is responsible for the PPP concluded in its own sector. Each sector is tasked in particular to take care of the interests of users, to ensure that the project is sustainable, and that there is economic and financial balance among the contracting parties.

- One question that arises in the administration of PPPs is whether to have a centralized system, with one PPPs unit, or to have each Government department (i.e., education, health, transport, etc) operating its own system[58].

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[58] When each department develops its own PPP projects, there are more sectoral-specialized interactions with the potential bidders. A disadvantage is that there is much less learning on how to contract PPPs than when there is a central PPP unit that designs, in conjunction with the sectoral departments, the various PPPs. The centralized approach is a more efficient use of scarce qualified human resources, since it does not require that each department start its own PPP unit. However, it can lead to conflicts with the sectoral Ministries.