Report

Health Financing Policy for Universal Health Coverage in Mozambique: Developments, challenges, and the role of partners

Prepared for the Swiss Development Cooperation

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Maputo, November 2020

Summary

This report aims at analyzing health financing situation in Mozambique, recent policy developments, and the role of a technical adviser to the Ministry of Health and P4H Focal Point, with the objective of informing SDC decisions.

Mozambique's health situation has experienced relevant advancements in recent years, visible in the improvements of life expectancy, especially in children, and in a substantial reduction of burden of disease of main communicable diseases. However, complex challenges remain, such as high and stagnant maternal mortality, and a high burden of communicable diseases, and emerging non-communicable diseases.

The country's health system is also strengthening its capacities to deliver health services, being key policy developments a unified benefit package, focused on Primary Health Care, an increased investment in human resources and logistic chain, and the prospect of an integrated plan on infrastructure, human resources, equipment and supplies. Covid has stretched already available services and has put pressure on continuity of care.

Health financing policy lies at the core of policies leading to advancements towards Universal Health Coverage (UHC). Mozambique's health system offers universal access to health services to its population, through the National Health Service (*Serviço Nacional de Saúde* – SNS). The range and quality of services are severely limited. Revenues are raised via general taxation, pooled by the Ministry of Finance and allocated to the Ministry of Health and the National Health Service. This policy architecture delivers a unified system that entitles everyone with similar or equal benefits, unlinked from contributions, with quantifiable redistributive effects.

Main challenges in health financing are low quality of service delivery (which drives low efficiency and can undermine fiscal legitimacy of the system) and structurally low levels of public funding, compared to needs, but also compared to wealth (GDP), overall State Budget and other sectors. This topic and its causes and implications is analyzed in the document. Other challenges are related to Public Financial Management (PFM), including weak procurement processes, financial management and revenue collection and use.

The formulation of a Health Financing Strategy (HFS) has concentrated the effort in the wide health financing area in recent years. Main agreements relate to the continuation of universality with regards to access and similar/equal benefits for all (not to fragment the system), the need to enhance allocative and technical efficiency, an increase in public internal resources devoted to health (in agreement with the Ministry of Finance), and the regulation of user fees. Other aspects that are included but will need more development are the implementation of a Social Health Insurance (SHI) and the outsourcing of selected services, which are further analyzed in the document.

The role of an advisor focused on technical-political issues has been relevant to advance some agendas that need the inclusion of international evidence, the generation of rooted knowledge, capacity building of national teams and agreement amongst key national partners, e.g. the reflection on community-based and social health insurance, the reflection on the role of user fees and the varied landscape of user fees in Mozambique, the macro-fiscal environment in which budget ceiling negotiations occur, etc.

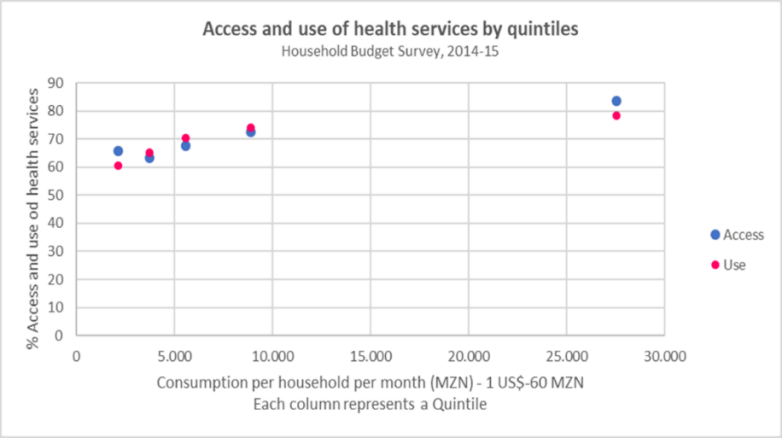
The role of a facilitator of partners' alignment has also been useful, especially in information sharing and harmonization of partners' narratives towards the Ministry of Health. Partners have been consulted in the process of elaboration of the HFS. The 2030 Agenda and its UHC indicators set clear goals and orientations, and narratives are aligned amongst partners. Health Financing is considered a key aspect in the relationship between MoH and partners and will be a central part of the new SWAP agreement.

1. Health service provision, coverage and quality

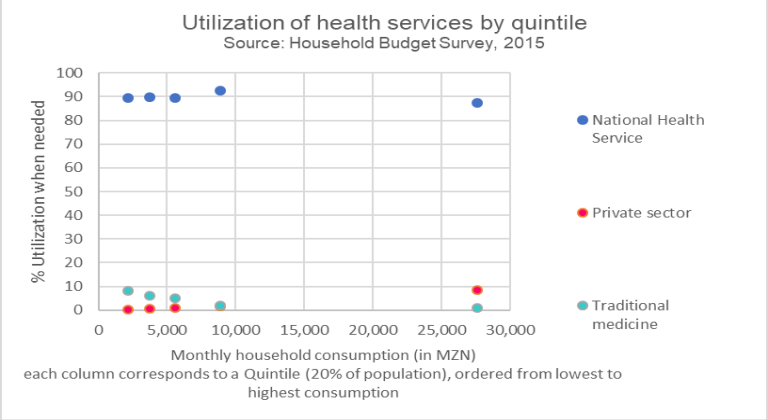
After independence from Portugal in 1975, Mozambique nationalized health facilities and created the publicly run and financed National Health Service (NHS). The NHS now serves a population of 27,9 million (Census 2017), 64% of it living in rural areas, with a structure of 1.627 health units and 65 hospitals (MoH, 2019).

Access to health services is quantified at 68% of the population by the Household Budget Survey (HBS), measured as the percentage of population having a health unit at less than 30min by foot. Other estimates of coverage, as the Effective UHC Coverage Index (Lancet, 2020) recognizes high achievements in areas such as inmunization, but low coverage in others such as cancer treatment.

The National Health Service (NHS) has a unified structure, with similar entitlments to every citizen. Urban middle class prefers private medicine when afrordable, due to quality concerns. Differences in access and use of health services by socioeconomic groups are small, compared with the large consumption disparity (proxy of socioeconomic status), as shown in the Household Budget Survey. Access to health services is not, in general, dependent on economic position.



The NHS is the primary source of health services for the Mozambican population, used by 90% of intervewed households when needed.



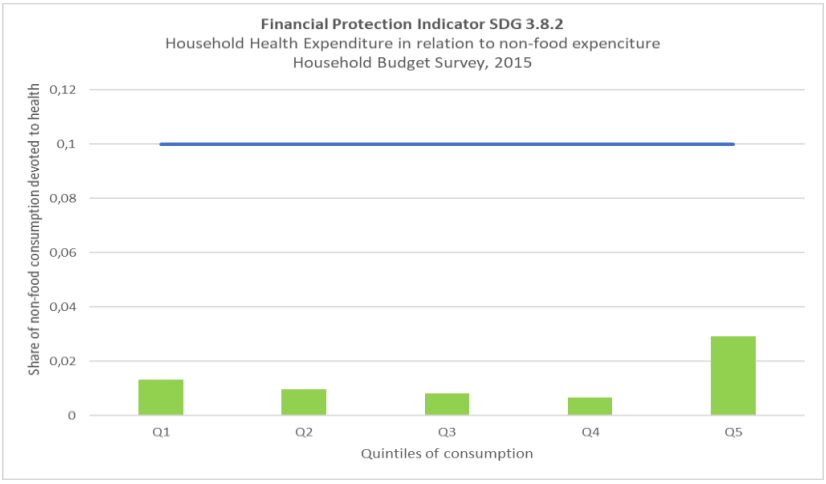
Available data show low quality of provision, especially on following of clinical guidelines, and diagnostic precision (Service Delivery Indicators, 2015). Times and Movement Study has also shown a high degree of absenteeism of staff in health centers (Cabral, 2018). Quality is also influenced by the physical capacity of health infrastructure to respond to needs: SARA diagnostic (Service Availavility and Responsiveness Assessment) concludes that only 14% of health facilities have all equipment and supplies needed to properly work (MoH, 2020).

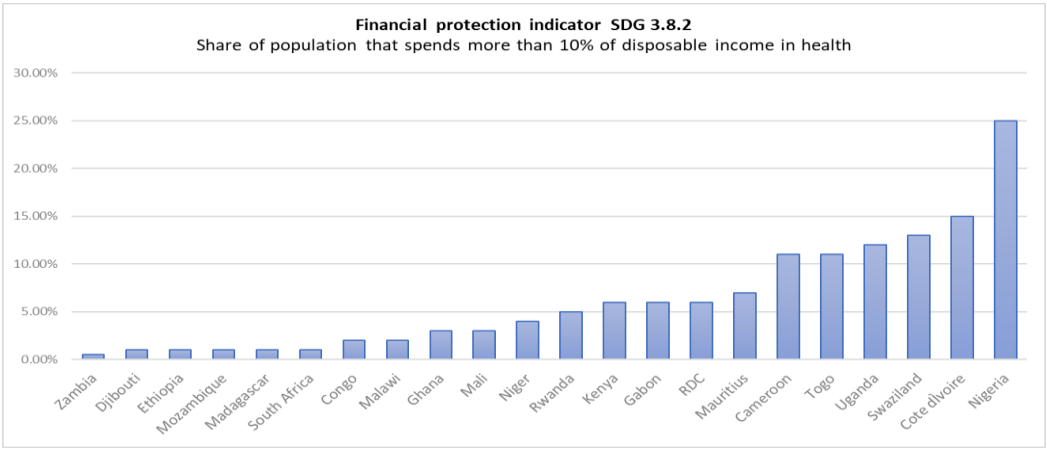
NHS is funded through general taxes. **User fees are low and generally do not represent a barrier to access.** User fees were introduced in Mozambique in 1987, after the World Bank' Akin Report (1987) that identified lack of resources and excess of utilization of hospitals as main challenges for health systems functioning in low-income settings. The Bamako Declaration (1987), signed by African Heads of State, UNICEF and WHO promoted user fees up until 15% of expenses of health units to moderate the demand and raise funds, as well as and community involvement.

User fees are considered "symbolic" and established at 1mt for consultation and 5mt for medicines. They have not been changed in this 33-year period, and they equate to 1 cent€ and 5 cent€ respectively. Other charges are applied in urban central and general hospitals, e.g. 1€-5€ for deliveries and emergency services. **User fees represent 0,6% of total expenditure** (MoH, 2019)

Mozambique has one of the lowest levels of out-of-pocket (OOP) payments in the world (WHO, 2018). Underreporting of user fees by households in the Household Budget Survey and the small size of the private sector are other explanations to the Mozambican situation. The relative relevance of the private sector is one of the drivers of OOP spending in Africa. National Health Accounts 2015 show that OOP doubled in a short period of time, from 6%of the Current Health Expenditure in 2012 to 12% in 2015.

Financial protection is high in Mozambique. Household health expenditure represents 1% of consumption of households, well below the 10% threshold of financial protection (SDG 3.8.2). This financial protection co-exists with a limited access and low quality, which makes financial protection a partial view





Source: McIntyre,D, Barasa, E., Ataguba, J (2018) : *Challenges in financing Universal Health Coverage in Sub-Saharan Africa*. Oxford Research Enciclopaedia of Health Economics

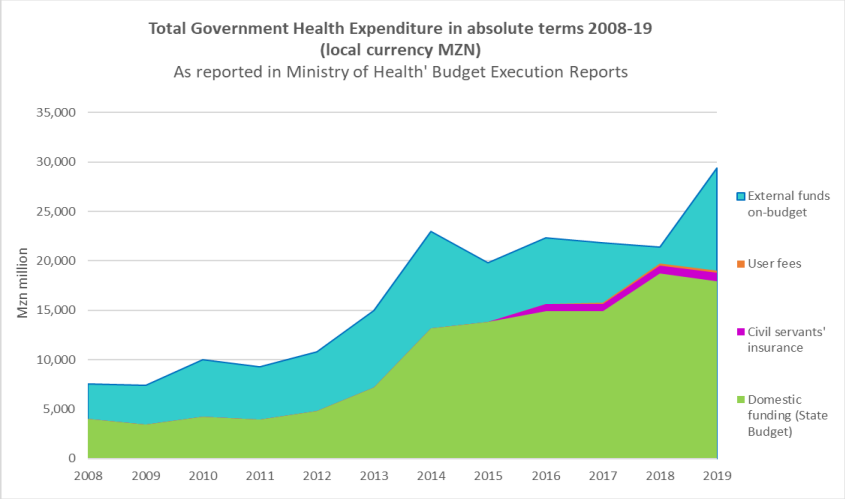
2. Health financing: Figures and trends

Public expenditure in health, **both internal and external (in cash or in kind) is channelled to the National Health Service.** Budget Execution Reports offer a complete view of all **on-budget funding** (funds challenned through the Single Treasury Account -bilateral programmes, multilateral, basket fund-, or planned jointly with MoH and timely reported)

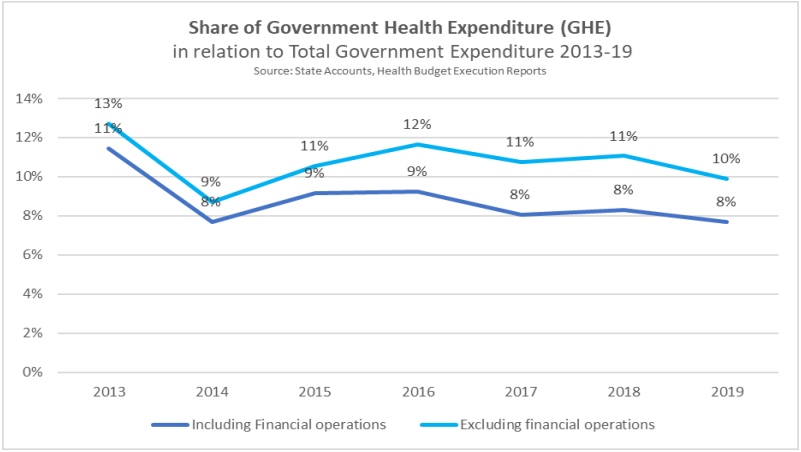
The outlook at financing trends in the last decade shows how **domestic funding has become the main source of funding** of the health sector, if we consider **on-budget funding**. The increase in domestic funding has been, in nominal terms, around 20% per year, except for the period 2018-19, where the execution stagnated. Liquidity was low in 2019, and winfall revenues at the end of the year did not allow the sectors to spend properly, following procurement processes.

The relevance of external funds reported at REO has been relatively stable along the years. While in 2008 external funding represented a 50% of the budget executed by the Ministry of Health, in 2019 it represented a 30%.

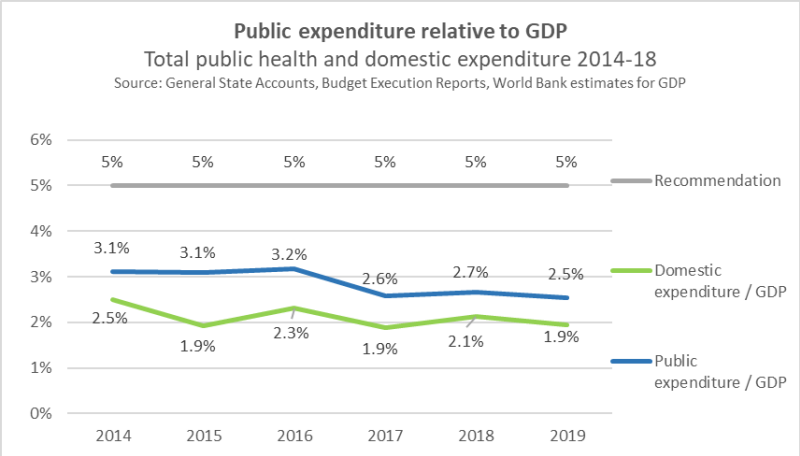
The chart also shows the irrelevance of user fees to fund the health sector, and the small -and controversial- contribution of the civil servants insurance scheme.



Priority given to Health has stayed stable along the years around 8-9% of total public expenditure. This value is higher if we do not consider financial operations in the denominator, which is the usual way of calculating the Abuja commitment. In recent years, the country has experienced an increase of financial operations and debt service in total expenditure.



Public expenditure in Health represents around 2,5% of GDP, and around 2% if we consider only internal resources. These figures are well below the international recommendations of 5-6% of internal resources devoted to health (McIntyre, 2017).



External funding in the health sector

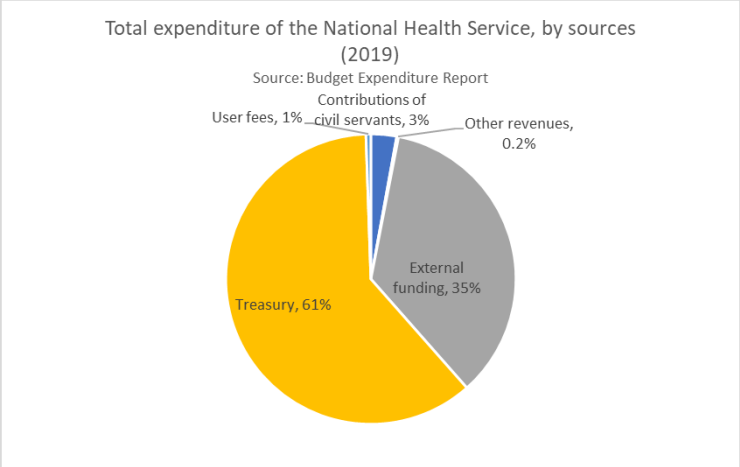
In general terms, **external aid represents around 50% of the total health sector expenditure** (MoH NHA, 2015), with an estimate inflow of around 500M US$/year. These figures are estimates as no report includes complete information of off-budget funding, despite its relevance, due to the difficulty of systematically obtaining real expenditure data through surveys and reports.

The common understanding of the Ministry of Health and partners in Mozambique is that **aid reflected in the Budget Execution Report (BER) equates with aid on-systems**. The BER includes funds channeled through the Single Treasury Account, bilateral transfers and in-kind support, especially in Medicines. The general picture of the funding of the NHS presents a **total spending of 474 M$** in 2019**,** being funds coming from Treasury 290 M$ (61%), **external aid 168 M$ (35%),** contributions of civil servants 13M$ (3%)[1] and user fees less than 3M$ (1%).

Composition of the external aid on-systems

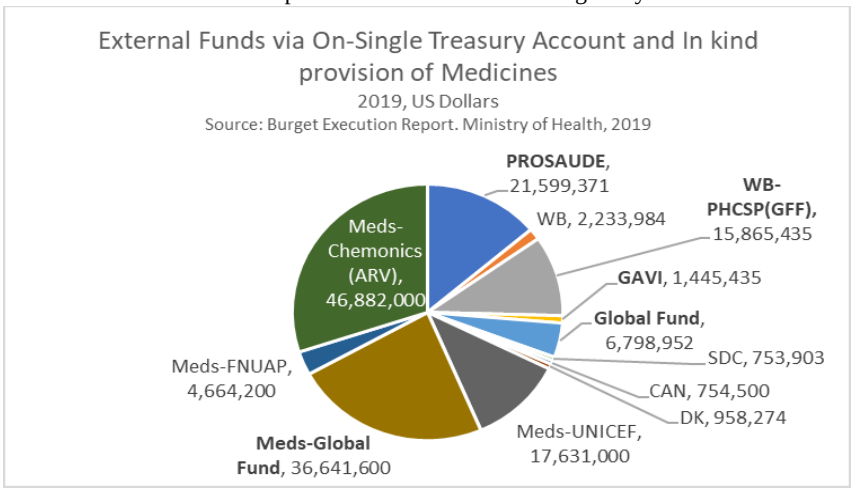
External aid reported by MoH is mainly formed by <u>in-kind medicines (68%),</u> amounting **110 M$,** and being mainly provided by the Global Fund (GFATM) and by Chemonics (HIV and malaria), this latter being funded by the United States (CDC, PEPFAR). These medicines are externally purchased, sent to the country, and included in the national logistical chain mechanisms to be delivered through the National Health Service. This external support in Medicines represents 65% of the total expenditure in Medicines in 2019 in the country, being the rest funded by the State Budget.

[1] Civil servants contribute 1,5% of their salary to a fund called "Health Assistance", collected by the Ministry of Public Administration, transferred to the Ministry of Health, and executed with the rest of the public funding. This payment was created in 1996 when civil servants were exempted of tax payment. It brought a set of lightly differenciated health services to this group of the society (preferent rooms, reduced waiting lists, medicines guaranteed). The fiscal reform of 2003 introduced tax payment for civil servants, however, "Health Assistance" was maintained.
In reality, service delivery in the NHS for civil servants is practically the same compared to the rest of the population. 35% of civil servants have not requested the Health Insurance card, as they think it is not useful. From a welfare systems analysis perspective, this equality in service provision is an interesting feature of the unified health financing System. However, civil servants are contributing more to the NHS than the rest of the society and receiving nearly the same. This fact generates instatisfaction and a constant demand for change, either with differenciated provision, either with an equalization of contributions. This is one critical point in the Health financing discussions, as the objective would be to impede fragmentation.



The external support <u>in form of grants represent 55M$</u>**, a **<u>32%</u>** of the external aid. PROSAUDE Common Fund represents the biggest share with around 21 M$. The Primary Health Care Strengthening Program (PHCSP) led by the World Bank, which includes the GFF, amounted 15M$ in 2019. The rest are bilateral supports, and a significant grant by the Global Fund to Health systems strengthening and operations costs (6,8 M$). The remainder **2,2M$ (1%) are in the form of **credit**, provided by WB.

Chart 1. Composition of the external funding on-systems



Off-systems funding

Off-systems funding is conceptualized in Mozambique as the aid **channeled out of the Single Treasury Account that is not reflected in the MoH' Budget Execution Reports (BER).** It is estimated that this flow of funds reaches around 400 M$ per year. Main funders such as USAID/CDC/PEPFAR channel high amounts to NGO/Universities to carry out vertical programs.

Analyzing more of 70 NGO reports that jointly amount 280 M$ for 2018, **MoH estimates that 63% of this spending was dedicated to the National Health Service (NHS) in kind,** in the form of technical assistance, salaries of seconded staff, training, monitoring, equipment, and supplies. The remaining 37% was used to fund NGO' costs. Main providers of off-budget funding in 2018 were FHI360 (75M$), FGH (31M$), ICAP at Columbia University (17M$) and Jpiehgo at Johns Hopkins University (16M$), Elizabeth Glaser Pediatric AIDS Foundation (13M$).

The alignment of the off-systems funding is one of the main challenges MoH faces in the area of health financing.

3. Main challenges in health financing policy

1) **Low quality of care**

Evidence available indicates that quality levels are insufficient to ensure a proper service delivery. Health facilities are operating with a low level of equipment and supplies (SARA, 2018), which has made MoH accelerate investment on physical assets and supplies, especially in the wake of Covid-19. However, main challenge lies on human resources performance: Low adherence to clinical guidelines and low diagnostic capacity have been identified in Service Delivery studies (World Bank, 2015). Times and Movements Study (TMS) identified high absenteeism and short time dedicated to each patient, including deliveries (Cabral, 2018).

This situation is associated with many socioeconomic and institutional factors, including low salaries and weak performance monitoring by MoH. Payment mechanisms are being reviewed with the objective of enhancing productivity in the National Health Service.

Low quality has deeper political implications: As middle and high-income groups do not find the quality and responsiveness they need, they progressively withdraw their support to the public health system. This can lead to a loss of legitimacy of the public system and to political coalitions that advocate for lower taxes and less spending in health in the future.

2) There's room to improve efficiency in the allocation and use of resources

Mozambique is considered to have a medium level of efficiency in the use of resources, depending on the sources available and indicators used. Most recent estimates of Effective Universal Health Coverage (Lancet, 2020) can be compared with expenditure per capita (WHO, 2019) and results give a mixed view, more efficient than Angola, Lesotho, Eswatini or Bissau, but less than Malawi -one of the most efficient- or Ethiopia. When studies give a high relative weight to determined variables, such as immunization, Mozambique appears with high level of efficiency (Jowett, 2018). When general variables lead the analysis, such as life expectancy, Mozambique performance is in the lower band (World Bank, 2015).

At an operational level, MoH puts efficiency as the primary objective, i.e. in the forthcoming Health Financing Strategy. However, practical and feasible strategies to enhance efficiency both in allocation and in the use of resources are not easy to identify, develop, implement and monitor. By the moment, chosen options relate to program-based planning and budgeting methods and to payment mechanisms, such as capitation and a possible introduction of Performance-Based Financing (PBF). These developments should be taken with caution, as implementation capacity is limited, and there is the risk of reinforcing existing inequalities (Friedberg, 2010).

Attention can be put in medicines purchasing and use, being one of the main areas of inefficiency in health systems, according to WHO (Chrisholm, 2010), as well as on measures to understand and reduce the estimated high administrative costs (26%), one of the highest at international level (National Health Accounts, 2016).

The focus on primary level service delivery, designed by the new benefit package, can be an efficiency-enhancing reform, as hospital utilization is well beyond international standards, and many conditions could be treated in a well-equipped primary level with lower costs.

3) Stagnant and insufficient budget for health

After years of a relevant increase of domestic expenditure in nominal terms (2008-18) of around 20% yearly, 2019 experienced a sharp stagnation of Treasury Resources devoted to the health

sector, at 19.985 M Mzn (around 333 M$). When figures are compared with other sectors and with the global execution of internal resources, a clear image of de-prioritzation of health in the State Budget appears, for many reasons:

- **The burden of financial operations** and debt service, which has increased significantly in recent years, reaching a 19% of the domestic budget in 2018 (MoF).
- **Competing priorities** inside Governments' plans. Prioritization of Agriculture, Education, and Governance (Parliament, internal security, defense and peacekeeping). The non-ended civil war and the new Islamic attacks in Cabo Delgado province are causing a humanitarian crisis that counts 350.000 internally displaced people (UNICEF, 2020).
- **The crowding-out effect** in social sectors, especially Health, related to donor funding. Health is considered to be supported by external funding, so major increases in budget are directed to other less served sectors.

In this regard, MoH is strengthening communication and advocacy with MoF to overcome this narrative and allow for relevant increases in the budget. Demographic and epidemiological transition will require additional resources, alongside existing challenges, such as communicable diseases and high maternal mortality.

In 2020, Covid-19 has acted as a revulsive and has allowed for mid-year reallocations directed to health, until 25.011 M Mzn (+25% increase compared to 2019).

4) Limited capacities at MoH/ DPC to manage Health Financing Policy

DPC is in charge of fundamental routine processes at MoH, e.g data management and information systems, planning, budgeting, monitoring and reporting. Alongside these, other areas require effort of DPC' workforce, such as National Health Accounts (NHA), Medium-Term Fiscal Framework, Health Sector Strategic Plan (PESS) and its costing, etc.

Health Financing policy analysis requires specific skills to assess the feasibility, pertinence and implications of different policy options. It requires capacity to:

- Integrate available evidence in various areas into policy debates
- Use available information to analyze sector' situation and trends (e.g. fiscal space for social spending, Budget Execution Reports, data on user fees)
- Produce knowledge to inform policy debates (e.g: The barrier effects of user fees, the implications of a Social Health Insurance scheme, the effects of contracting out)
- Critically analyze policy proposals and assess feasibility, pertinence and implications
- Lead multisectorial discussions that have deep social, political and economic implications, e.g. on rights, deservingness, redistribution.
- Joint work with MoF to support budget negotiation

These capacities are minimally present at that moment, that's why one of the focus of the health financing advisor / P4H Focal Point is and will be to build capacities.

5) Challenges in Public Financial Management

- **Weak planning and monitoring processes**: Planning is based on historical plans and budgets, with a difficulty to link macro planning with operational planning and budget (especially in a scenario of multiple funding streams). Program-based planning is proposed as a new methodology to overcome these difficulties.
  Allocative efficiency remains a challenge, and it is difficult to study.

- **Procurement** processes are heavy in terms of procedure and not always leading to timely and efficient purchases, especially in Medicines.
- **Financial management** has shortcomings, especially in documenting expenditure, which is visible in audit results
- **User fees revenue** is unknown to financial managers and hospital management department at central level. Data is available for those streams that perfectly follow national procedure. However, there are parts that are used at the source (which can be a good practice, supported by WHO -Barroy, 2018- but it is not legal). Other parts of the revenue collection and use is managed through parallel systems (i.e. meds).

6) Difficulty to ensure alignment of external funding

External funding is theoretically embedded in the routine planning processes, that includes several columns as "sources of funding". However, partners have their own procedures, that often do not coincide with MoH' cycles. It is a major difficulty to MoH to align external funding with sector' priorities, especially regarding off-budget funding, channeled through NGO.

Generally, it can be assumed that external funding imposes a high toll on MoH in terms of **transaction costs** (understanding partners' proposals, assessing their feasibility and fitting them into Departments and responsible staff, negotiation of contracts, monitoring, responding to reporting, evaluation and audit requests, new tools and methodologies proposed, training, missions, etc.). The Common Fund (*Prosaúde*) has partially contributed to reduce these costs, and the new SWAP is expected to streamline the coordination work.

7) **Some policies in place exacerbate inequalities**:

- **Increasing user fees at public hospital level** that limit access and put households at risk, e.g. dialysis. This includes normal fees and those intended to generate a two-tier system within public service delivery. It is an area of utmost relevance to research and reflect, in order to avoid segmentation and deepening of already widening inequalities.
- **Private practice in public hospitals** uses public goods funded by all to serve a small group of the society, pushing the rest to long waiting lists and lower quality service delivery. The common argument of needed revenue collection is not backed by evidence, which shows that two tier-service in Maputo Central Hospital is mainly funded by State Budget (McPake, 2017). However, these inequality considerations are not on the table, as the priority is to collect more and keep doctors working in the public sector with this incentive scheme.

4. Policy developments and the Health Financing Strategy

4.1 General framework

Discussions on health financing policy developments in Mozambique are framed within the SDG Agenda and the Universal Health Coverage (UHC) principles, described in the World Health Report (2010) and in some crucial guidelines and papers, such as Kutzin (2013).

UHC Final objectives are:

i) **Universality:** All persons can utilize services upon need
ii) Service for all must have sufficient quality
iii) **Financial protection** must ensure that no one faces financial hardship from paying for health services
iv) **Equity in resource distribution** means that regardless the policy instrument used, policies should dedicate similar resources to all in the society (and citizens should be entitled to services of similar quality)

To put these principles in practice, WHO defines a health financing system with 4 functions:

- **Revenue raising**, prioritizing publicly collected and managed sources
- **Pooling**: Putting all collected resources in the same basket to offer similar or equal benefits to all
- **Purchasing**: Contracting providers or providing the service to ensure maximum quality and efficiency
- **Benefit package design**: Design of the entitlements, including ways of accessing it, explicit rationing and user fee policy (WHO recommends them to be low and flat).

4.2. Content of the Health Financing Strategy

The preparation of the Health Financing Strategy (HFS) has allowed an in-depth negotiation exercise to agree on basic principles of the National Health Service, which are universality, quality, efficiency, equity and transparency. The HFS, still not published, will focus on 3 objectives:

1) ***Ensure universal access to health services with quality,*** which includes:

i) **Implementation of the new benefit package** focused on Primary Health, preventive services, quality of provision and equity in resource distribution (*one package for all*). From a health financing perspective, it is very relevant to delimitate services offered and to clarify what is funded by pooled funds (NHS) and what is funded though fragmented funds (user fees).

ii) **Reform of the user fee system**, focused on:
- Improvement of user fee management – Publicly available information, use of national procedure
- Simplification of user fees (reduced number of user fees and equal in all the country)
- Follow WHO guidelines on user fees: **Low and flat** (not as a share of the cost, **known in advance**)

2) Improve efficiency in health services delivery

- **Routine measurement of efficiency** in the delivery of health services – Performance of health service providers of different levels (Districts, hospitals, health units) compared to benchmarks and to expenditure.
- **Improvement of Planning and budgeting instruments**, including:
  - Program-oriented budgeting

        - Priority to primary health, as an efficient way to achieve health gains (prevention)
        - Application of allocation criteria to progressively reduce inequities in expenditure
    - **Introduction of strategic allocation mechanisms to incentivize governance for quality**
        - Funding mechanisms based on providers' information, prioritizing per capita allocation at primary level
        - Introduction of additional incentive mechanisms to public providers that show positive performance in quality and quantity of services provided, compared to previsouly agreed benchmarks.

3) Ensure sufficient funding for the health sector

- **Prioritize Health in the State Budget**: Commitment of a relevant increase of internal resources devoted to health for the period 2021-30.
- **Increase and earmark health-related taxes**, especially alcohol and tobacco. Main objective is to reduce the burden of NCD, not the collection itself (1%)
- **Align external funding with service provision**
    - Mobilize external funding to cover the needed resources to fund the benefit package
    - Promote the alignment of external funding with national procedure
    - Prioritize the use of external funding for strategic investments rather than recurrent expenditure
- Progressively introduce a Social Health Insurance (SHI) to **complement tax-based funding** of the National Health Service. It will be necessary to design **institutional arrangements** of the SHI scheme and pay special attention to its **distributive effects** (Avoid two-tier system, upward redistribution, etc.)

4.3 Reflection on main policy developments

Reform of user fee system

The user fee system was created in a moment when narratives suggested the need to moderate the demand for hospitals and make patients directly finance and support their health facilities (Bamako Declaration, 1987). In the SDG era and with the strong leadership of WHO in health financing, user fees are not recommended as a form of financing health systems (WHO, 2010), as they act as barriers to access and are the most regressive form of financing (Wagstaff, 2017). SDG 3.8 is committed to Universal Health Coverage and to reduce catastrophic health expenditure.

In Mozambique, prospects for reform have considered increasing user fees, as State Budget is considered structurally insufficient. However, international ideas on financial protection and the right to health make it difficult to advocate for such an increase. As the former Minister Nazira Abdula put it "high user fees could endanger the advancements that Mozambique has achieved". Alternatively, the proposal would be to maintain these low and flat user fees, to unify them in the whole country with known levels, and to manage them following national procedure.

There is a need to increase capacities to analyze the user fees' current situation, sources of user fees, differences in prices, circuits of collection, registration, declaration to the fiscal authority, earmarking back to the health units, and the broader effects on access, coverage, quality, incentives, management of health units, and inequalities in a broad sense. This analysis has to be extended to what are called "special services", which are two-tier systems in public hospitals, that provide higher quality (lower waiting times) to patients with capacity of payment.

The prospects of creating a Social Health Insurance (SHI)

The possibility of creating a SHI scheme has been considered in Mozambique in the last decade, ideally to complement the tax-based funding for the 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. However, if the design defines better services for those insured, these schemes can promote "silos", segments of population that may increase their access to services, while the rest of the population (uninsured or members of other schemes, e.g. "for poor") continues to suffer exclusion and ill health. In the era of Universal Health Coverage (UHC), financial arrangements must ensure universal access to services and equity in resource distribution. Unified policy architectures serve better these objectives than fragmented schemes for different segments of the population (Martinez-Franzoni, 2013).

ILO supported a consultancy in 2018-19 to prepare a technical proposal of SHI for Mozambique. It was inspired by the SHI systems in Costa Rica (publicly provided services funded by payroll tax) and Cape Verde (public and private provision, mainly funded by general taxation, with a contribution of payroll tax). The proposal was focused on creating a payroll tax, that would be managed by a newly established agency, which would purchase services both in the public and private health sectors. Budget for the first year of implementation was 10-fold the budget executed by MoH in 2018.

MoH did not reach internal agreement on this proposal, competing with the private sector for allocations, negotiating with MoF for a substantial increase in resources to cover uninsured population, and subsidizing private medicine with scarce public resources, which would imply losing the universalistic character of the system.

The only way payroll taxes could be used to fund the health system while maintaining a unified system (same or equal benefits for all) would be as an additional contribution to the NHS in exchange for the same services that already exist. This option has severe political economy constraints: the formal sector of the economy (estimated at 20%[2]) will probably not accept a new tax (additional to income tax and indirect taxes) to fund a service to which they are already entitled and has limited quality. In a situation like this, it is maybe more feasible to increase income taxation of to introduce wealth taxation, as recommended by the IMF (2011, 2020), and ensuring relevant increases in allocations to the sector.

The implications of outsourcing

Outsourcing of non-clinical services has been proposed as a way of enhancing efficiency in the health sector. The expected result is that hospitals will free critical human resources if they focus on their core functions (clinical services) and outsource the rest to specialized and more efficient companies.

The scoping study commissioned by the World Bank in 2018 and carried out by ThinkWell gave a more complex landscape: Hospital administrators would agree with outsourcing as a way of reducing their work burden, but they considered that costs of outsourcing would be higher, as companies' fees (for security, laundry, gardening or food services) would be higher than costs of producing these services in the public sector.

Outsourcing of clinical services has been proposed as a way of increasing access to health services. This policy option will need profound analysis and debate, as introducing private providers in the public system have deep implications in the incentives, practices and results of the National Health Service, especially on inequality.

Evidence finds similar level of efficiency in public and private providers of health services in LMICs (Basu, 2012). In the case of hospitals, evidence suggest similar costs for governments to produce

[2] Inquérito Continuo aos Agregados Familiares, INCAF, 2007

services and to contract out. e.g. in South Africa (Mills, 1997). Contracting out implies a high capacity to negotiate, monitor and enforce contracts. WHO recommends governments to have high control capacities in case of contracting out (Mathauer, 2018).

Strenghtening the "outside option" means that practices such as self-referral, under or over-provision depending can have more opportunities to happen, as reflected in the case of Zimbabwe (Hongoro, 2000). System-wide, amplifying the "outside option" can fragment the system and lead to differentiated qualities accessed by different groups in society. Therefore, deep analysis have to be carried out to assess the feasibility and pertinence of this option.

The politics of prioritizing Health in the State Budget

Increasing the share of health in the State Budget may be as "pushing an elephant up the stairs" (Tandon, 2014). Competing priorities in national agendas and the prominent role of development partners can contribute to difficult prioritization of health in the State Budget.

In Mozambique, social sectors have traditionally been strongly supported by partners. Health is an example of a sector in which partners support exceeds internal resources. National Health Accounts concluded that 58% of health expenditure in 2012 was externally funded, which included off-budget funds. With this reality, the crowding-out effect is plausible when the Ministry of Finance allocates resources to more and less served sectors.

The initiative of the GFF to tie commitment to finance the health sector (measured by internal resources) with grants (Disbursement-linked indicators) was an interesting attempt of putting on the agenda the prioritization of health in the State Budget, otherwise much expected by partners but less put as requirement for support. However, this indicator may change in the future. The existence of revenue in the sector is another argument not to increase substantially allocations. However, revenue represents a 0,6% of the total expenditure, as per Budget Execution Report (2019), and may remain low (at least user fees), as part of the UHC Agenda.

Competing priorities are not expected to let much fiscal space for health in the coming years, given debt service, as concluded by UNICEF fiscal space analysis (2019) and given deteriorating humanitarian situation in Northern Mozambique, with more than 350.000 internally displaced persons in 2020. 41 health units are not operative due to the conflict. However, national wealth (GDP) is expected to recover in 2021, as per IMF estimates (2020), a fiscal reform is foreseen for the coming years, and the sector will continue to advocate for more resources to provide comprehensive health services for the popularion.

5. Partners' support to health financing in Mozambique

Partners' interests and ways of support

Development partners have showed high interest in health financing policy as one of the "reform pillars" included in the Strategic Plan 2014-19. It will be included with renewed relevance in the updated Strategic Plan 2020-24. HF is considered strategic to ensure sufficient funding for health policy, given the high dependence Mozambique has to fund its system, especially regarding to medicines.

Some partners have had a more intense technical and political involvement in health financing policy development, with different types of support (see table below).

Table: Partners' involvement in health financing policy in Mozambique 2014-20

	Areas of interest	Areas of support
WHO	Capacity development in HF	Training in HF (WHO Course for Lusophone countries)
	Benefit Package	Development of Benefit Package
	Costing	Costing of Strategic Plan - OneHealth
	Taxation for Health	Support to MoH to influence taxation of unhealthy prod.
P4H/GIZ/SDC	Policy development in HF	Resident HF advisor to MoH
	Alignment of HF narratives	Joint sessions on HF with partners, common narratives on HF
	Capacity development in HF	Capacity development, trainings MoH staff on HF
	Domestic Resource Mobilization	Liaison with MoF / Fiscal policy analysis (forthcoming)
WB	Efficiency	Studies on outsourcing, service delivery, last mile supply
	Policy development in HF	Supported HF development
GFF	Alignment of HF narratives	Participation in HF sessions
	Domestic Resource Mobilization	DLI 5 - Advocacy for increased internal resources to health
GFATM	Sustainability and Transition Policy	Technical work on fiscal space to ensure MoH contribution
ILO	Contributory approach to HF	Feasibility study for Social Health Insurance

Other partners interested in health financing but not so directly involved in policy developments are:

- UNAIDS: Joint group to assess fiscal space options for HIV sector
- ENABEL (Belgian Cooperation), which supports Finance and Administration at MoH with a Public Financial Manager Adviser
- UNICEF, which publishes yearly Budget Briefs
- DFID, which supports MoH at bilateral level and supports MoF in fiscal policy development

The P4H position

The health financing advisor/ P4H Focal Point started as a consultant/ technical position at MoH to support a specific technical process, while the coordination functions have been progressively assumed:

1. **Advise the Ministry of Health in the assessment of the economic, social and political implications of health financing policy reforms,** in areas such as:
    - Universal Health Coverage Policy, including Financial Protection
    - Health Financing Policy: Domestic Resource Mobilization (DRM), prioritization of State Budget to health, Social Health Insurance, pooling arrangements, user fees, taxation for health
    - Health economics: Costing of health services
    - Fiscal space for public health policies: Assessment of the macroeconomic and fiscal context for social spending and link with the Ministry of Finance and IMF

- Efficiency: Assessment of options to produce efficiency estimates

This has been done by producing analytical work that gives input into technical and decision-making meetings and includes training of technical staff to reinforce internal capacities.

2. **Support internal coordination at MoH in the area of health financing,** especially between the Planning and Health Economics Department and other relevant National Directions and Departments:
   - *Financial Management and Admin Department***:** On PFM-related topics, i.e. quantification and simplification of user fees in the health sector
   - *Public Health***:** Preparation of health-related taxation proposals
   - *Health Insurance Advisor to the Minister***:** Joint assessment of the proposal of a Social Health Insurance (SHI) scheme in Mozambique
3. **Support coordination between MoH and key Ministries, Departments and Agencies** to advance agendas in the area of health financing policy, i.e. in the following areas:
   - *Ministry of Finance: On the Prioritization of Health in the State Budget*
     Support the setup of the Technical Group on Health Financing MoH-MoF with regular meetings, joint analysis on budget and macrofiscal situation and advocacy for more funding to the health at high decision-making levels. *Tax Authority: On Taxation for health:* Joint assessment of health-related tax options.
   - *Ministry of Labor: Exploration of contributory mechanisms to fund the health sector*,
4. **Support the Ministry in the dialogue with partners in the area of Health Financing**:
   - Dialogue sessions to advance policy HF policy: Health Financing Technical Group (GTF), formed by MoH officials and key partners selected by MoH (WB, WHO, ILO).
   - Specific coordination with key partners: Funding requirements of the Global Fund (GFATM) and related analysis of macrofiscal situation and financing options.

5. **Align partners' support** in the area of health financing, by:
   - Producing and sharing information and knowledge to feed into the debate of Domestic Resource Mobilization in country – Updates on expenditure, health financing policy development, main areas of decision-making processes. Ad hoc meetings in the framework of the Health Partners Group (HPG).
   - Introducing partner's priorities, expectations and policy advise into the debate on health financing policy and strategic documents, i.e: Technical efficiency measures, performance-based financing.
   - Supporting the harmonization of partners in their dialogue with the Ministry of Health in the area of Domestic Resource Mobilization, i.e: Partners' sessions to co-produce the matrix of the health financing strategy.

The functions taken are in line with the drivers contained in the Accelerator 1 proposal of the Global Action Plan (GAP) for Healthy Lives and Well-being for All:

- Supporting appropriate **domestic allocations** for health
- **Evidence-based dialogues** between budget and health officials to accelerate fiscal reforms and mobilize more money for health
- Enhanced support for countries to **increase the efficiency** and effectiveness of health spending
- Enhanced support for countries to **improve Public Financial Management**
- **Increased and evidence-based consensus and knowledge** sharing about what works and what does not work in health financing policies for UHC
- **Greater utilization of joint funding mechanisms** to leverage additional external funds for health

In this context, it is important to recognize the added value of positioning a health financing advisor/ P4H Focal Point in covering this thematic area and supporting the advancement of the health financing for UHC Agenda. The **availability of such a dedicated resource** is not easily found in development agencies that fund positions in relation to projects. The multi-agency commitment to fund P4H Focal Points can ensure this resource.

5.2 Coordination structures in Health Financing

The Health Financing Technical Group (GTF) to establish a HF Strategy

MoH established a Technical Health Financing Group (*Grupo Técnico de Financiamento -GTF*) in 2014, to host the preparation of a Health Financing Strategy (HFS). This group was composed by MoH officials of different profiles (Planning and Health Economics, Finance and Admin, primary health, law, medicines, hospital management, etc.), other ministries' officials (Labor, Social Security, Economy and Finance, Public Administration), University, civil society and selected development partners (those which provided specialized staff to contribute to the strategic discussions: USAID, WHO, ILO and the World Bank). WHO led this group from the partners' side and reported to the Health Partners Group. At that moment, there was not a donor-only Health Financing group.

Parallelly, in 2014, MoH requested a resident long-term health financing advisor to P4H, to support the elaboration of the HFS. As the recruitment became a complex process, USAID contracted Deloitte and SDC contracted ThinkWell to support MoH and the GTF in elaborating the proposal. Several joint workshops were held in the period 2014-16, that allowed the advancement of a proposal of Health Financing Strategy early 2017.

The health financing advisor contracted by P4H/GIZ/SDC started in November 2017. In the first months, the principal task was to advance technical work to inform decision making inside MoH and in the GTF framework (detailed functions in the next section). Many internal and open meetings were held in the period 2017-19. Late 2019, all partners were invited to discuss the HFS proposal with MoH, so the GTF "restricted" setting lost its relevance. The HFS proposal was closed early 2020, with difficulties to discuss complex topics (SHI, user fees, inequalities), which remained largely unexplored.

The partners' Health Financing Group and the role of P4H

The P4H group in Mozambique was initially formed by founding organizations (WB, WHO, ILO, SDC).

The Health Financing group has been placed in the SWAp structure in the HPG, as a **PIMA subgroup** (Inside Planning, Monitoring, Investment and Evaluation), which is the strongest and most active working group, led by the National Director of Planning and team co-led by WHO and Canada, and in charge of all major planning processes (strategic plans, diagnostics, assessments, National Health Accounts, etc.). This organizational arrangement should work to jointly assess developments in health financing policy, such as the forthcoming presentation of the final draft Health Financing Strategy, and to in-depth discuss parts of it (e.g. user fees, financial protection, the prospects of increased internal funding).

6. Conclusions and recommendations

Health financing will always be a central field in health policy. Alongside ensuring material base to deliver services, health financing policy is interlinked with deep social, economic and political implications, including rights, deservingness, redistributive concerns and economic impacts.

Much has been advanced in recent years in Mozambique. Some areas have been analyzed and open for discussion, other are less debated but its relevance has been highlighted. The influence of international ideas is of utmost importance in Mozambique, as it has been in many other contexts when assessing policy options. In this regard, the Universal Health Coverage (UHC) framework and the recognition of public funding as main driver of inclusive improvements in health financing are useful guidelines for countries to design sustainable health financing systems.

The presence of an adviser is useful, as it makes more feasible to advance some agendas related to health financing. Given the abundance of external funding for health systems strengthening and limited absorptive capacity (alongside high transaction costs), specialized technical assistance in national institutions is an interesting tool to support policy development in an harmonized way.

The role of aligning partners' narratives on health financing is also crucial, as partners influence agenda setting and policy development, and these processes need to have common grounds and policy recommendations to national institutions.

References

Basu, S. Et al. (2012): *Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A systematic review*. PLoS Medicine.

Cabral, J. (2018): *Um estudo* sobre tempos *e movimentos nos Cuidados de Saúde Primários em Moçambique*. ThinkWell. Maputo

Chrisholm, Evans (2010): *Improving health systems efficiency as a means of moving towards Universal Health Coverage.* World Health Organization Geneva.

Friedberg, M. et al. (2010): *Paying for performance in primary care: Potential impact on practices and disparities*. Health Affairs.

Hongoro, C Kumaranayare, L. (2000): Do they work? Regulating for-profit providers in Zimbabwe. Health Policy and Planning 15(4)

International Monetary Fund (2011): *Raising revenues in developing countries*. Washington.

International Monetary Fund (2020): Economic Outlook. Washington and Rapid Credit Facility Report. Maputo.

INE – National Institute of Statistics (2015): *Household Budget Survey 2014*

Martinez-Franzoni, J and Sánchez-Ancochea, D. (2013): *The quest for universal social policy in the South.* Cambridge University Press.

Mathauer, I. Dale, E. Meessen, B (2018) Strategic purchasing for UHC: Key policy issues and questions. World Health Organization. Geneva.

McIntyre (2017): *What level of domestic health expenditure should we aspire for universal health coverage?* Health Economics, Policy and Law12:125-137

McPake (2013): *Two-tier charging in Maputo Central Hospital: Costs, revenue, and effects on equity of access to hospital services*. BMC Health Services and Research.

Mills, A, Hongoro, C, Broomerg, J. (1997): *Improving the efficiency of district hospitals: Is contracting an option?* Tropical Medicine and International Health. Vol.2 N.2

Ministry of Health of Mozambique (2016). National Health Accounts 2012. Maputo.

Tandon, A. Lisa Fleisher, Rong Li & Wei Aun Yap. (2014). Reprioritizing government spending on health: pushing an elephant up the stairs? *WHO South-East Asia Journal of Public Health, 3* (3-4), 206 - 212. World Health Organization. Regional Office for South-East Asia.

UNICEF (2019): *Fiscal space analysis*. Maputo.

Wagstaff, A. et al. (2017): *Progress on catastrophic health spending in 133 countries: A retrospective observational study*. Lancet.

World Bank (2015): Health Service Delivery Indicators. Maputo.

World Health Organization (2010): *Health systems financing: The path to Universal Health Coverage* World Health Report. Geneva.

World Health Organization (2018): World Health Expenditure Database. Online, updated 2018.

Yazbeck, A, Savedoff, A. Soucat, A. (2019): *The case against labor-based tax financing in low-and-middle income countries*. Health Affairs.