# HEALTH FINANCING LANDSCAPE IN MOZAMBIQUE

SCOPING REPORT AHEAD OF THE 2023 NATIONAL HEALTH FINANCING DIALOGUE AND INTEGRATED REPORT OF THE AFRICAN UNION ALM DOMESTIC FINANCING TRACKER

APRIL 2023

Supported by:

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African Union

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AUDA-NEPAD
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## ACRONYMS

| | |
|---|---|
| ALM | African Leadership Meeting |
| AU | African Union |
| CHE | Current health expenditures |
| DP | Development partner |
| DPS | Direcção Provincial de Saúde *(Provincial Health Directorate)* |
| EAU | East African Union |
| e-SISTAFE | Sistema de Administração Financeira do Estado *(State Financial Administration System)* |
| GFF | Global Financing Facility |
| GOM | Government of Mozambique |
| HFS | Health financing strategy |
| HIV | Human immunodeficiency virus |
| IHME | Institute for Health Metrics and Evaluation |
| IT | Informatics and telecommunications |
| LNG | liquefied natural gas |
| MEF | Ministry of Economy and Finance |
| MOH | Ministry of Health |
| MTEF | Medium-term expenditure framework |
| NCDs | Non-communicable diseases |
| NCDI | Non-communicable diseases & injuries |
| NGO | Non-governmental organization |
| NHFD | National Health Financing Dialogue |
| NHS | National Health Service |
| NHSP (PESS) | National Health Strategic Plan |
| OOP | Out-of-pocket payments |
| PBF | Performance-based financing |
| PEPFAR | The United States President's Emergency Plan for AIDS Relief |
| PESOE | Plano Económico Social e Orçamento do Estado *(National Economic and Social Plan and Government Budget)* |
| PFM | Public Financial Management |
| PHC | Primary Health Care |
| PQG | Programa Quinquenal do Governo *(five-year governmental plan)* |
| SADC | Southern African Development Community |
| SDSMAS | Serviços Distritais de Saúde, Mulher e Acção Social *(District Services for Health, Women, and Social Action)* |
| SPS | Serviços Provinciais de Saúde (*Provincial Health Services)* |
| TB | Tuberculosis |
| UHC | Universal health coverage |
| UN | United Nations |
| UNOCHA | United National Office for the Coordination of Humanitarian Assistance |
| WASH | Water, sanitation & hygiene |
| WB | The World Bank |

## EXECUTIVE SUMMARY

**As a signatory to the African Leadership Meeting on investing in health (ALM) Declaration, Mozambique has reaffirmed its commitment towards domestic resource mobilization (DRM) for health.** The ALM Declaration provides Mozambique and other African Union Member States the mandate and guidance to strengthen national health financing budgets and structures. It specifically calls for increased DRM for health and to tackle existing inefficiencies in health budgets to create more effective and efficient health systems. It also reiterates Mozambique's commitment to a strong health system that is adequately and sustainably financed. To meet and track the ALM commitment objectives, the Southern African Development Community (SADC) and its partners are facilitating a National Health Financing Dialogue in Mozambique. SADC is collaborating with a range of partners to realize the national dialogues.

**This report, requested by SADC, provides background on Mozambique's health financing context and opportunities to inform its planned National Health Financing Dialogue (NHFD).** The report was prepared by ThinkWell through extensive research and discussions with national stakeholders to provide a comprehensive overview of the state of health financing in Mozambique, drawing on local context, progress, and commitments. Opportunities to support Mozambique to reach its commitments are identified, which may be used as a starting point in NHFD discussions.

**Mozambique is unlikely to meet several health-related SDG targets, despite remarkable progress in its health outcomes and indicators over the past few decades.** Since 2000, life expectancy has risen substantially, from 49 to 61 years. Concurrently, infant mortality rates dropped by 53% while under-five mortality dropped by 58%. Despite these achievements, the country is unlikely to meet the majority of health-related SDG targets, including those related to skilled attendance at birth, malnutrition, non-communicable disease-related mortality, and malaria and HIV elimination.

**The public health system is governed at three levels across decentralized government structures.** The Ministry of Health (MOH) oversees the health sector, handling policy strategy, coordination, funding allocation, and monitoring. Meanwhile, the Provincial Health Directorate (DPS) and the District Services for Health, Women, and Social Action (SDSMAS) have executive roles at the provincial and district level, respectively.

**The health system suffers from a number of challenges, including significant inequities in access to services and a lack of resources in general.** Most Mozambicans rely on the public health sector, which suffers from a lack of resources and limited service offering**.** The country's vast geography exacerbates access barriers and inequities for rural populations. While 97.9% of the country's urban population is able to access a health facility on foot in less than 30 minutes, for the rural population the corresponding rate is only 55.4% (National Statistics Institute, 2021). In addition, there is a low availability of health workers and pharmaceuticals.

**Mozambique is grappling with an economic and debt crisis, hindering its capacity to raise more domestic resources for the health sector.** Fiscal space is severely constrained by a high burden of debt servicing. Around 20% of the government's budget is financed through public debt, which demands high interest rates in the market. Despite these challenging circumstances, stakeholders recognize that the currently ongoing discussions on establishing a sovereign fund for LNG revenues offer a promising opportunity for the country to plan its shift towards increased domestic health financing.

**Nonetheless, there is a real need to increase domestic financing for health, with the share of public funds that is spent on the health sector falling below the SADC average.** From 2018 to 2020, SADC

Member States allocated an average of 8.7% of their government budget to health, already far below the 15% Abuja target, while Mozambique's rate was even lower at 6.4%. Public spending relative to GDP is also low, with Mozambique's rate (2%) being significantly below neighboring Eswatini's (3.5%), South Africa's (4.9%) and Zambia's (2.2%), while the country comes last among its neighbors in terms of absolute levels of per capita spending. Addressing these funding shortfalls is crucial to improve health system performance.

**Health budget allocation decisions lack evidence-based foundations, and the MOH's limited analytical capabilities undermine its ability to demonstrate its efficient use of resources.** In interviews, stakeholders expressed concerns that the MOH's budget requests lack evidence-based, bottom-up approaches and fail to align short- and medium-term activities with long-term strategies. The structuring of public budgets around input lines further hinders efficient fund allocation and use, as the MOH is unable to reallocate funds in response to health needs during a fiscal year. The MOH also experienced a decline in its budget execution rate in 2021, with the execution rate of external funds targeted to the central level being particularly low at 15% [17]. It would be important to build a deeper understanding of the causes of these low execution rates and identify solutions to improve fund utilization. In general, inadequate fund absorption is a common challenge across health sector programs, especially those with large commodity procurement requirements. For example, the country utilized less than 35% of the COVID-19 relief funds provided by the Global Fund before the grant expired [8].

**The proposed Health Financing Strategy (HFS) offers several options to increase health financing, such as health taxes and a social health insurance scheme.** The HFS provides a useful roadmap for the country, although it is presently only available in draft form and has been under review by the MOH since 2015. Finalizing and endorsing the HFS would be a critical step to maintain momentum, and some stakeholders have also expressed concerns that multiple rounds of review may weaken the document's strength and vision. One of the suggestions of the HFS is for the growing financial needs of the health sector to be progressively covered by domestic and on-budget donor funds. In addition, while the health sector financing coordination mechanisms are functioning well, there is a need to further engage the private sector to co-finance the value chain.

**Due to disparities in the allocation of funds across provinces, rural areas tend to have poorer health services.** While the raising of public health funds is largely centralized, the final distribution of funds and purchasing responsibilities is decentralized. The national government seeks to fairly allocate funds to provinces and districts based on a formula, although significant disparities in per capita health spending across provinces persist, likely hampering health system efficiency. On average, urban areas receive a larger share of resources than rural areas. Lower-level facilities provide the majority of care in rural areas and often face stockouts and a lack of equipment due to insufficient funding.

**There are also opportunities to improve efficiency at the facility level, particularly in terms of integration of services, addressing underutilization, and improving technical efficiency.** While service delivery has achieved a high level of integration at the primary health care (PHC) level, progress is uneven across disease areas. In addition, many health facilities and district hospitals are underutilized, and the scarcity of funding at the facility level leads to further inefficiencies. Research has also identified significant technical inefficiencies at the facility level, such as high absence rates, a lack of diagnostic capacity, and poor availability of essential drugs. The government's plan to establish a hospital in each

district has therefore raised questions from stakeholders about feasibility and cost-effectiveness, with suggestions to optimize existing infrastructure instead.

**Discussions are ongoing to increase pooling of funds through a national health insurance scheme, and its success would depend on its ability to include informal workers and efficiently target subsidies to those in need.** Such a scheme is planned to be expanded from the current scheme for civil servants, who contribute 1.5% of their salaries to a medical assistance fund. However, ensuring that health insurance expansion leads to a more equitable distribution of access to health services across diverse population groups will be critical, considering the significant portion of the workforce engaged in the informal sector. In such contexts, universal health coverage schemes are often more effective than voluntary health insurance schemes. In addition, stakeholders have noted that discussions have stalled since the previous initiative lead left in 2020, suggesting the need for a new champion to drive progress.

**Mozambique has a long-standing tradition of leadership in PHC, and a clear policy framework centered on PHC is in place.** The National Development Strategy (END) covers the period of 2015-2035 and is implemented in five-year governmental plans (PQGs) that define national priorities based on the ruling party's political platform. The current PQG, covering the period of 2020 to 2024, focuses on strengthening primary health care to effectively and efficiently deliver quality services. One area that may be improved is the operationalization of policy objectives, as historically there have been limited connections between long-term goals and priorities and short- and medium-term plans.

**The analysis presented in this report has yielded several points of discussion that may serve as a guide for Mozambique's upcoming NHFD (see Table 1).** These points reflect current and planned developments in Mozambique's health system. It is important to note that they should be considered as potential areas for discussion and are not intended to be strictly adhered to. The points of discussion are grouped according to the four pillars or outcomes the ALM Declaration aims to achieve: more money for health, more health for the money, equity in financing, and strengthened leadership and governance. These pillars provide a framework for identifying key issues and potential solutions to improve Mozambique's health financing system.

*Table 1: Potential discussion points by ALM Tracker Theme*

| Theme | Potential discussion points |
|---|---|
| Mobilize more money for health | — How can the government ensure that health financing is aligned with the government's priorities for the health sector, and that resources are allocated in a way that maximizes impact and sustainability? What steps can be taken to improve the transparency and accountability of health financing, and to engage stakeholders in the decision-making process?<br>— How and when can the MOH have an approved version of the Health Financing Strategy, which is meant to help guide decisions and discussions on health financing for Mozambique?<br>— How can Mozambique effectively incorporate global best practices in need-based budgeting, taking into account its advantages and drawbacks, when developing health budgets? Are there any data sources that could be used? And what sort of analytical and operational capacity would the MOH need to implement this? |

| | |
|---|---|
| | — The Health Financing Strategy proposes several options to increase health financing, including taxes on unhealthy products (sin taxes) and a social health insurance scheme. How could the introduction of such options be successfully realized in Mozambique, and who should be involved in the discussions?<br>— As government budgets are expected to rise in the coming years due to LNG extraction, how can the MOH and other stakeholders strategize to advocate for greater budget allocations to the health sector? What forms of evidence, such as investment case analyses and cost projections, will support such advocacy efforts?<br>— What fiscal and monetary policy incentives can be employed to encourage private sector investment into the health sector, thereby growing the overall level of health financing?<br>— The health financing strategy offers several implementation options. What measures should be used to assess which options should receive priority, and which ones are the most realistic solutions to implement in the short term? Which options present the lowest hanging fruits for achieving immediate gains in health financing? Therefore, what five resource mobilization options could we prioritize for the next ten years? |
| More health for the money | — What kind of analytical capabilities would the MOH need to better demonstrate the value and impact of health programs and services?<br>— The HFS identifies a number of challenges, including a fragmented supply chain with a high level of leakage, a lack of demand-led decision making for distributing health staff, and poor management of staff careers. How could these challenges be addressed? Have there been successful (local) initiatives in the past that could be introduced more widely?<br>— How can the public health system address the challenges of underutilization of health facilities and district hospitals, and optimize the use of existing infrastructure to achieve more health for the money?<br>— How can we incentivize good governance and service quality in the provision of health care services? Can performance-based payment mechanisms play a role in promoting better outcomes and more efficient allocation of resources? |
| Equity in health financing and service distribution | — What are the key challenges in ensuring that public health funds are distributed efficiently and equitably across provinces and districts in Mozambique? How can these challenges be addressed to better support the delivery of quality health care services to all Mozambicans?<br>— Numerous countries, and across various income levels, have achieved big improvements to their health system by pooling risks through health insurance schemes which target large parts of the population. What conversations must be held in Mozambique to develop and introduce such schemes or alternative risk-pooling options?<br>— There is ongoing debate regarding the accuracy of out-of-pocket estimates in Mozambique's National Health Accounts. Is it important to |

| | |
|---|---|
| | delve deeper into the additional expenses patients face while accessing care, beyond those currently documented? Is more detailed information available for certain regions in the country? If so, how do regional estimates compare to national estimates?<br>— What impact do user fees have on the efficiency and equity of the health care system in Mozambique, and how can the negative effects of user fees be mitigated while still ensuring the sustainability of the health care system? |
| Leadership, governance and coordination of health financing | — Mozambique has been strong in promoting primary health care in its policies, although it has not always been able to realize its goals. What challenges has this led to for the state of health care in the country? Do public officials consider policy goals to be realistic, and do they work actively towards realizing them?<br>— What kind of leadership is required to successfully advocate, endorse, and implement the Heath Financing Strategy?<br>— How can country ownership of developments in the health sector be ensured in light of its dependence on donor funds? How do planning efforts between the government and developments partners take place in practice? Is the government able to secure its priorities?<br>— The current five-year government plan (PQG) lists targets but these are not matched with ringfenced resources. Is the country able to work towards realizing these targets in practice? Could more explicit links between targets and the available resources be made for future plans?<br>— How is the collaboration between the government and non-governmental partners? Is there a common goal, and are all parts of the country being prioritized fairly? How can parliament, civil society (including local and international NGOs), and the private sector be better engaged in health financing coordination mechanisms?<br>— In the past, parliament has often made significant reductions to draft consolidated budgets. What impact has this had on the health sector? Are there ways to strengthen the argument for a certain level of resources, for example through increased use of evidence in budget discussions? |

Source: ThinkWell compilation based on comprehensive research and analysis.

## INTRODUCTION

**In 2019, African Union (AU) Member States signed the "Addis Ababa Commitment toward Shared Responsibility and Global Solidarity for Increased Health Financing Declaration", also known as the ALM Declaration.** The declaration was a key outcome of the African Leadership Meeting—or ALM in short form—titled *Investing in Health*, for which the AU convened Heads of States and Governments and global and regional health leaders on the February 9, 2019. The ALM Declaration is an initiative geared towards increasing domestic resources for health and reorienting health systems in Africa.

**The ALM Declaration provides Mozambique and other AU Member States the mandate and guidance to strengthen national health financing budgets and structures.** The Declaration specifically calls for increased domestic resource mobilization for health and tackling existing inefficiencies in health budgets towards financing more effective and efficient health systems. The declaration also calls for better collaboration between multi-sectoral actors—regionally and globally—to strengthen existing health systems in AU Member States.

**The ALM Declaration reaffirms Mozambique's commitment to a strong health system that is adequately and sustainably financed.** By joining the ALM Declaration, Mozambique joined in a demonstration of political will to place health financing at the forefront of development. It builds on Mozambique's past commitments, including the Abuja Declaration of 2001 on increasing government funding for health, the Addis Ababa Declaration of 2006 on community health in the African region, the 2008 Ouagadougou Declaration on primary health care and health systems in Africa; and the 2016 global commitments which gave rise to the Sustainable Development Goals.

**To meet and track the ALM commitment objectives, the government of Mozambique is leading a National Health Financing Dialogue (NHFD) with support from the Southern African Development Community (SADC).** SADC is collaborating with a range of partners, including the Global Fund, to support the Government of Mozambique to realize its national dialogue. NHFDs are an important part of country-level work to strengthen or refine domestic health financing strategies and interventions. For Mozambique, the NHFD comes at a crucial time as the country is navigating how it improves its health services with reduced fiscal space.

**This report provides background on Mozambique's health financing context and opportunities to inform its planned NHFD.** This report was commissioned by SADC and prepared by ThinkWell through extensive research and discussions with national stakeholders. These activities provided a comprehensive overview of the state of health financing in Mozambique, drawing on the country's socio- and macro-economic context, its past progress improving health systems and outcomes, and its goals for the future. Opportunities to support Mozambique to reach these goals were then identified, which may be used as a starting point in NHFD discussions.

**This report is structured around the four broad pillars or outcomes the ALM Declaration aims to achieve**. These four pillars are i) more money for health; ii) more health for the money; iii) equity in financing; and iv) strengthened leadership and governance. Each section sets out the key health financing issues under each objective and discusses current reform efforts, challenges, and opportunities of the Mozambican health system.

# COUNTRY CONTEXT

## SOCIO-ECONOMIC BACKGROUND

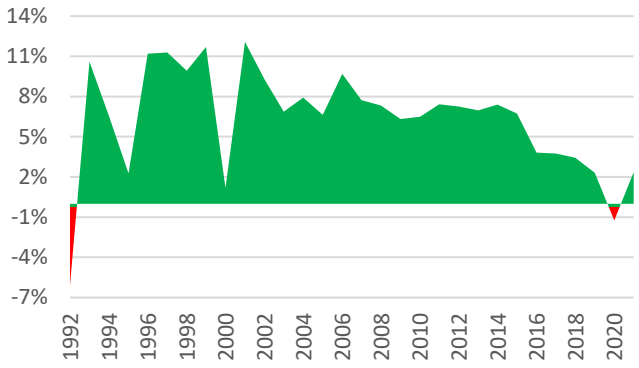
**Mozambique has a fast-growing young population with significant levels of poverty.** Growing at a rate of 2.88% per year, Mozambique's population of 32 million includes 13.6 million (43.68%) under the age of 15 [39]—compared to averages across all SADC Member States of 1.96% and 36.92%, respectively. An estimated 63% of the population live in rural areas, in which 9 out of 10 households survive on subsistence agriculture—comprising 70% of the country's workforce. The most recent national poverty assessments conducted in 2015 found that 46% of the population live in poverty and that 85% of those living in poverty reside in rural areas. The country is gradually urbanizing, rising from 32% to 37% of the population between 2010 and 2020, although this is still below the SADC average of 43% [20].

**The Republic of Mozambique is a multi-party presidential democracy that is decentralized at the sub-national levels.** As a unitary republic, Mozambique is headed by the President, who serves as head of state and commander in chief and is supported by a 250-member national Parliament (the Assembleia da República). The President is directly elected by an absolute majority and appoints a Prime Minister and a Council of Ministers who advise and coordinate the actions of state ministers. With the adoption of the new constitution, decentralization began in the 1990s which devolved powers to 11 provinces that are further subdivided into districts. Decentralization remained a priority in the new 2004 Constitution and the process of fully implementing the reforms is still underway.

## MACROECONOMIC BACKGROUND

**After the civil war ended in 1992, Mozambique was one of the fastest-growing economies in sub-Saharan Africa for nearly two decades.** As shown in Figure 1, annual economic growth averaged around 8% between 1996 and 2015, and poverty rates declined from 70% to 46%. The human development index rose considerably from 0.227 to 0.456, which moved Mozambique to rank 181st out of 189 countries. Adding to the optimism in the country, large reserves of offshore natural gas were discovered in 2012 in the northern Cabo Delgado Province, creating the promise of further economic growth. As measured by the Gini index, wealth inequality reduced between 1996 and 2008 (dropping from 53.6% to 45.6%), although it has since risen to 54% in 2014, and a significant proportion of the population continues to live below the national poverty line.

*Figure 1: Percentage annual GDP growth*

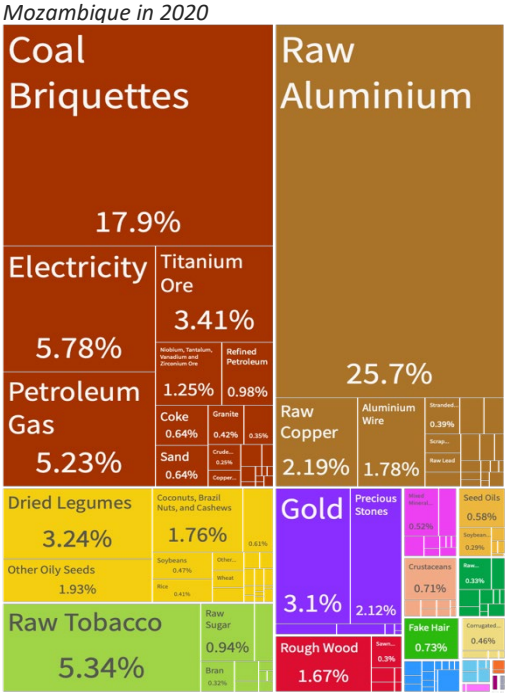



Source: [39]

**Mozambique's economic momentum stagnated in 2013 with the 'hidden debt' scandal serving as one of the first of several setbacks for the country.** In 2013, high-ranking government officials secured three loans for $2 billion and premised it on their optimism of generating liquefied natural gas (LNG) revenues. Equal to over 14% of GDP in 2013, the purpose of the loans was to revitalize the country's fishing industry; however, the fishing projects never materialized. When the scandal was uncovered in 2015, the International Monetary Fund (IMF) and the World Bank (WB) suspended their direct budget support mechanisms for Mozambique, which was followed by the scaling back of support from many development partners. As a result, the government was forced to cut back on spending dramatically and was saddled with large loan payments, a depreciating currency, high inflation, and reduced donor support.

**Economic growth continued to slow from 2015 as commodity prices declined.** The Mozambican economy is relatively dependent on export earnings. Exports accounted for 31% of GDP in 2021, compared with an average across Sub-Saharan Africa of 23%. More concerningly, Mozambique is highly commodity dependent, as shown in Figure 2. The decline in commodity prices for natural resources and agricultural products in 2015 combined with the effects of the debt crisis and population growth led to a drop in GDP per capita from a high of $674 in 2014 to $449 in 2020 [39], while general government consumption dropped by more than a third in real terms. As a result, the country's debt level has risen sharply and is currently among the highest in the world, at nearly 129% of GDP.

*Figure 2: Percentage breakdown of exports from Mozambique in 2020*




Source: [22]

**In 2017, a violent insurgency in the Northern province of Cabo Delgado created disruptions and delayed LNG production.** An Islamic jihadist organization began challenging the power of the government, attacking civilian targets, and disrupting essential services such as health, education, and water supplies. This also caused delays to the significant investments by energy companies to develop natural gas extraction. The United National Office for the Coordination of Humanitarian Assistance (UNOCHA) has estimated that the attacks on coastal districts in the province have displaced upwards of 700,000 people as of 2020.

**In 2019, two tropical cyclones hit Mozambique, causing widespread damage.** In March, cyclone Idai hit the central province of Sofala and caused widespread damage to four provinces, leaving nearly 2 million in need of support. In April, at the end of the rainy season when water levels had already increased, cyclone Kenneth, the strongest cyclone to ever hit the African continent, hit the Northern province of Cabo Delgado, causing three deaths, and leaving 374,000 in need. In total, five provinces were hit, which resulted in 650 deaths and an estimated $3 billion in damages and losses.

**In 2020, the country was then hit by the COVID-19 pandemic, resulting in partial shutdowns and further economic losses.** The President of Mozambique announced a state of emergency in March 2020 for 150 days, and increased restrictions in 2021 (a curfew and a ban on public and private gatherings were added to closures of borders, schools, and many commercial enterprises). Initial estimates suggest overall consumption of goods and services in the country dropped between 7% and 14% and that two million people may have been pushed into poverty. Due to the insurgency in the North, natural disasters, and the COVID-19 pandemic, an estimated 3 million people also faced high levels of food insecurity.

**As of 2020, Mozambique is the third poorest country globally; however, there is optimism for the future.** The IMF estimates that after a contraction in GDP of 1.2% in 2020, the country's economy made a strong recovery in 2021 and 2022 (2.3% and 3.7% in real terms, respectively), although inflation rates remain high at 11.3% as of 2022. Looking forward, the economy is projected to grow substantially as expected natural gas production begins in 2023.

## HEALTH INDICATORS AND BURDEN OF DISEASE

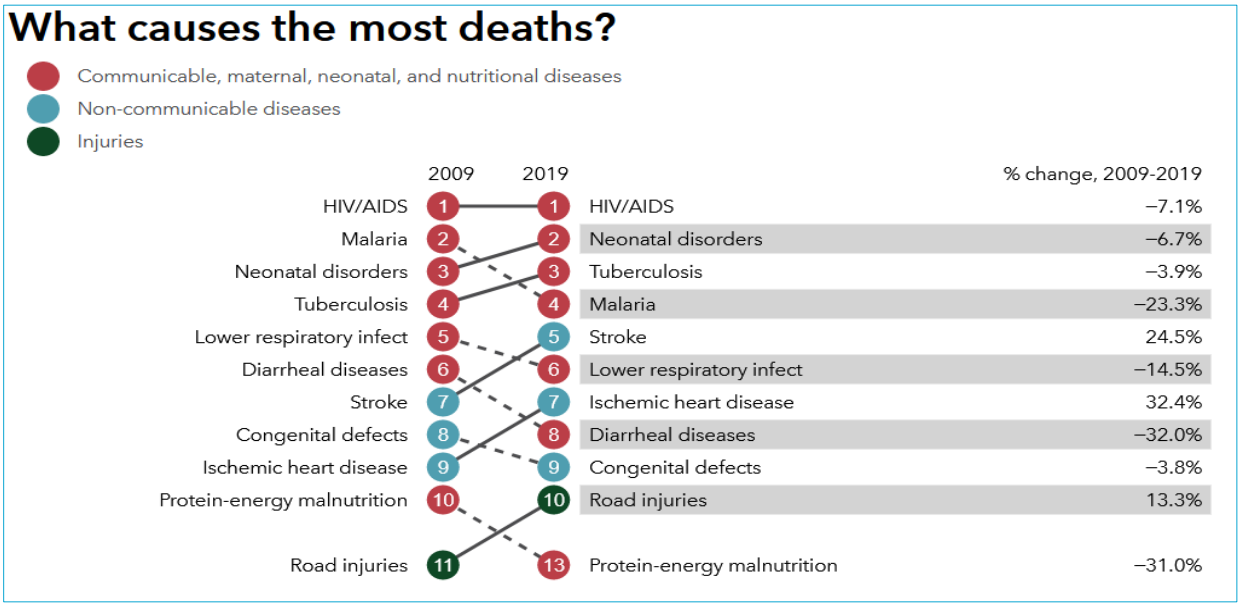
**Mozambique has realized significant gains in its health outcomes and indicators in recent decades.** Life expectancy in Mozambique increased substantially, from 49 years in 2000 to 61 years in 2020. During the same period, infant mortality rates dropped from 112 to 53 per 1,000 live births while under-five mortality rates dropped from 170 to 71 per 1,000 live births.

**Despite these gains, Mozambique's health performance remains poor compared to its neighboring countries.** Average life expectancy across SADC Member States is 64 years, significantly higher than Mozambique's 61 years. In addition, Mozambique's below-average performance is also reflected in its infant and under-five mortality rates, which are higher than in neighboring countries. In 2020, infant mortality rates per 1,000 live births in neighboring countries ranged from 42 (Zambia) to 26 (South Africa), much lower than Mozambique's rate of 53. This may partially stem from a lower attendance rate of skilled health personnel during births in Mozambique. Although data is not consistently available on an annual basis, most recent estimates show that Mozambique's skilled personnel attendance rate (73%) is lower than Malawi's (96%), South Africa's (97%), and Zimbabwe's (86%).

**Communicable diseases remain a significant source of the country's disease burden, although the relative burden of non-communicable diseases is increasing.** Figure 3 shows that HIV/AIDS continues to be the main cause of premature death, and is joined by other communicable, maternal, neonatal, and nutritional diseases to make up the top four causes. However, while all diseases of this category have seen their relative burdens reduce from 2009 to 2019, the relative burden of communicable diseases—strokes and ischemic heart disease in particular—has increased.

**Overall, Mozambique is unlikely to meet most health-related SDG targets.** While maternal mortality rates have fallen sharply from 412 in 2010 to 289 in 2017—a decline of nearly 5% per year—they must fall more sharply to meet the SDG target of 140 by 2030. Similarly, the country is currently off-track to achieving the SDG targets related to skilled attendance at birth, malnutrition, non-communicable disease-related mortality, and malaria and HIV elimination.

*Figure 3: Main causes of death in Mozambique, evolution 2009-2019*




Source: [10]

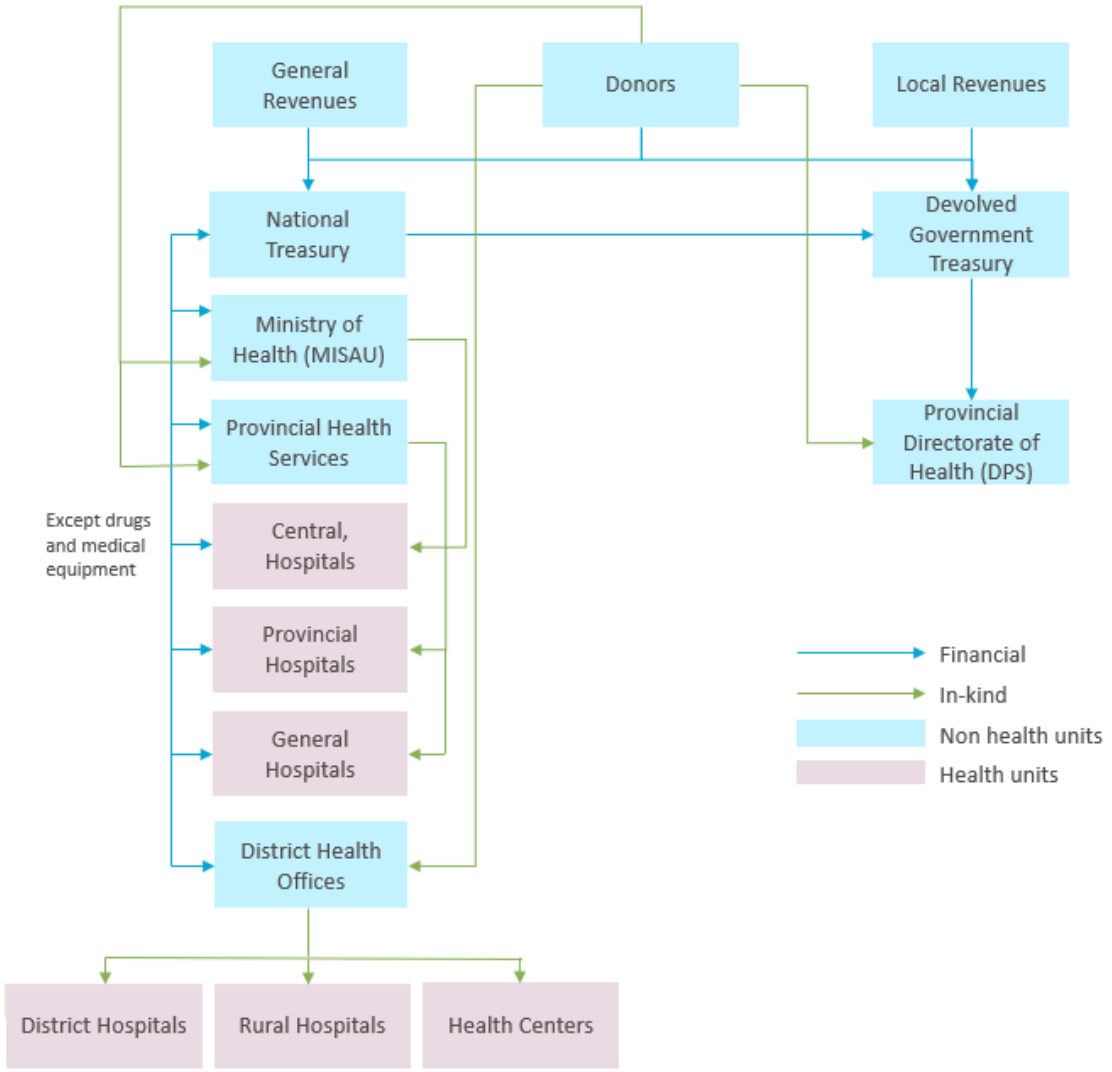
## ORGANIZATION OF THE HEALTH SECTOR AND CHALLENGES IN ACCESSING HEALTH CARE

**The public health system is governed at three levels across decentralized government structures.** The Ministry of Health (MOH) is the steward of the health sector and is responsible for policy and strategy development, coordination and planning, allocation of funding, and monitoring. At the decentralized levels, the Provincial Health Directorate (Direcção Provincial de Saúde or DPS) coordinates the implementation of provincial sector plans, distribution of resources, provision of technical assistance to districts, monitoring of progress and achievements, and are responsible for the PHC system and the Provincial Health Services system (Serviços Provinciais de Saúde or SPS). At the District level, the District Services for Health, Women, and Social Action (Serviços Distritais de Saúde, Mulher e Acção Social or SDSMAS) are tasked with managing health sector resources and overseeing direct service provision at level I and II facilities in their jurisdiction.

**Mozambique has a mixed health system of public, private for-profit, and private not-for-profit providers.** The MOH has defined four levels of facilities distributed across 11 provinces (see Figure 5): level I) Health Centers and Health Posts (approx. 1600); level II) rural, district, and general hospitals (approx. 60); level III) provincial hospitals (7); and level IV) central and specialized hospitals (4). Most of the facilities in the country are public (88%) and part of the government's National Health Service (NHS). In some areas not adequately covered by the NHS, independent community-level service providers aim to fill the gaps.

**The flow of funds in the health sector in Mozambique is complex.** While all facilities receive in-kind transfers, only central, provincial, and general hospitals receive financial transfers. Drugs and medical equipment are budgeted for and purchased by the Central Medical Store. Districts pay health workers salaries for the facilities under their management. Figure 4 provides an overview of the fund flows.

*Figure 4: Flow of funds in the health sector in Mozambique*

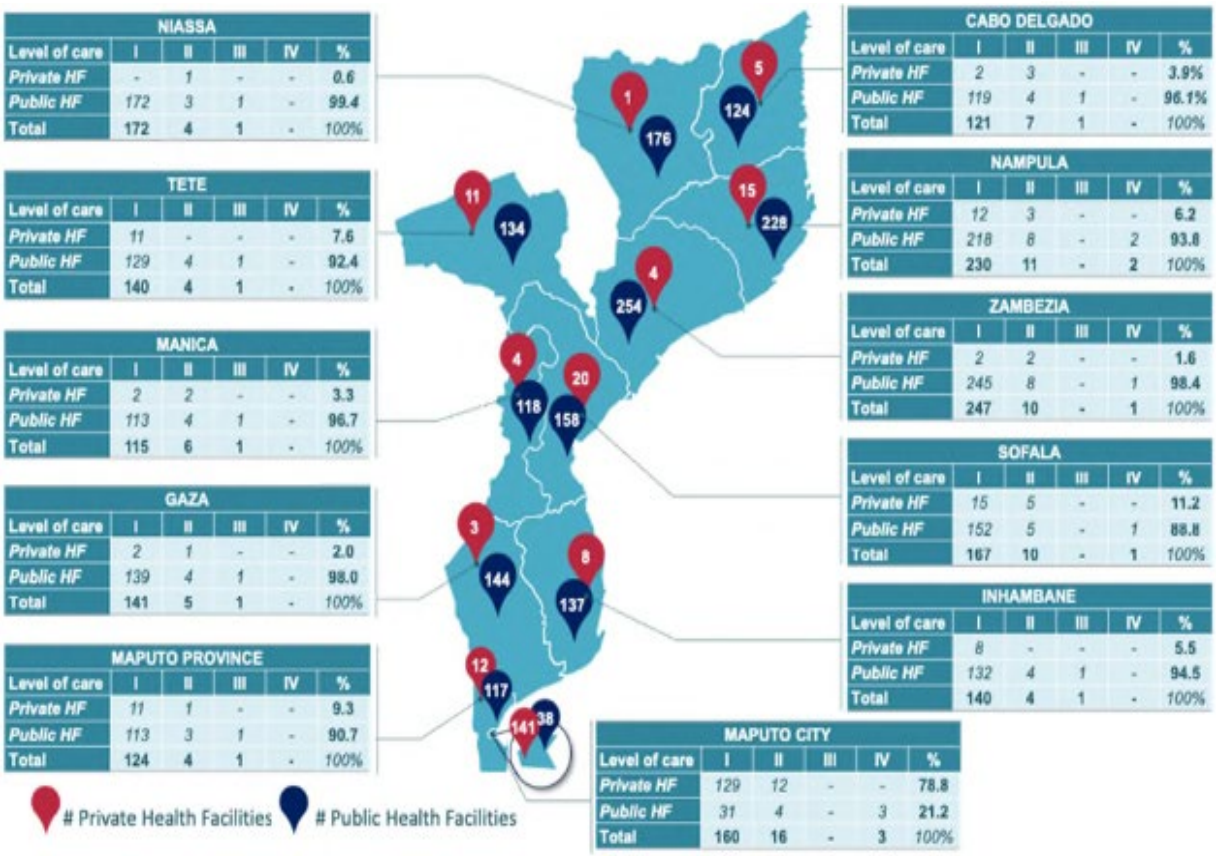



Source: [28]

**Mozambique's health system suffers from a number of challenges, including significant inequities in access to services.** The majority of Mozambique's population is reliant on the public health sector, which suffers from a lack of resources and limited service offering**.** Public facilities generally have poor infrastructure—only 50% of peripheral health centers have electricity and 60% have water supply [18]. Additionally, some services are more readily available than others: while 99% of facilities offer malaria services, only 66% offer adolescent health care.

**Mozambique's vast geography creates additional barriers to access and inequities for rural populations.** While the country has one health facility per 10,000 population, only half the global benchmark, they are mostly concentrated in urban areas. The more densely populated provinces of Maputo City, Maputo, and Zambézia have the greatest coverage of health facilities, whereas the sparsely populated provinces of Niassa, Gaza, and Cabo Delgado are the most underserved [18]. In addition, while 97.9% of the country's urban population is able to access a health facility on foot in less than 30 minutes, for the rural population the corresponding rate is only 55.4% [21].

*Figure 5: Distribution of health facilities by province and level*




Source: [31]

**A recent readiness survey of the health sector also noted challenges regarding the quality of infrastructure and equipment at facilities.** Such constraints are particularly relevant for the first referral level, the District Hospital. A high percentage of district hospitals have insufficient back-up systems for water, electricity, and communications, thereby limiting their ability to handle serious cases (which, in rural areas, often arrive late) [5]. Equipment and building maintenance are poor, due to a lack of technical capacity and funding [18].

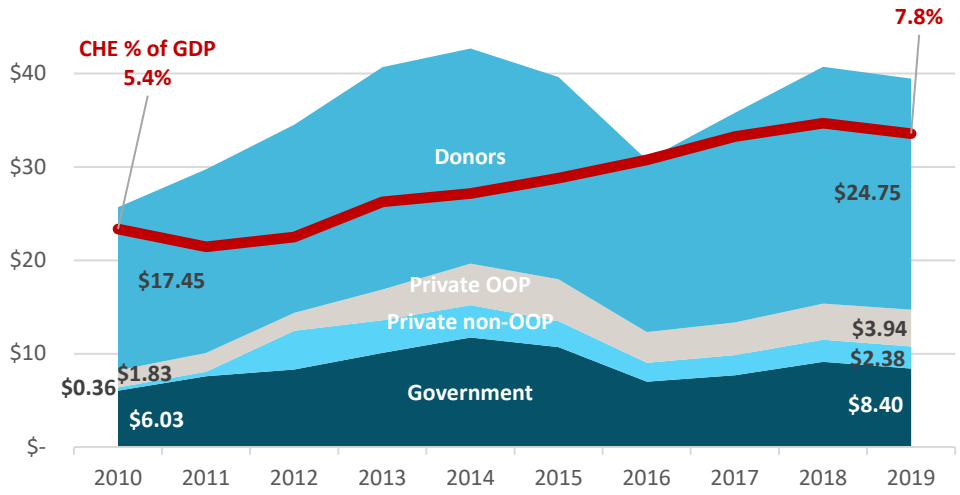
**In addition, the low availability of human resources for health (HRH) is a major constraint of Mozambique's health system.** Studies have indicated issues around low staffing levels, poor pay, and low productivity in health facilities [4, 6, 32]. While successive Strategic Plans for HRH have been developed to address the HRH challenges, the country's limited fiscal space makes it challenging to address the dual problem of scarcity and low salaries. Attempts have been made to address these challenges through performance-based financing experiments in four provinces by NGOs providing HIV services, although these are no longer implemented [7].

**The availability of pharmaceuticals and other clinical consumables is low due to budget constraints and challenges in distribution**. Funding for pharmaceuticals and other clinical consumables remains highly dependent on external funds. In addition, the country's large surface area and poor infrastructure makes it challenging to distribute goods, while warehousing constraints and slow procurement processes further hamper efficiency. As a result, PHC facilities often lack essential drugs [18].

## FINANCING OF THE HEALTH SECTOR

**Current health expenditures (CHE) in Mozambique have increased consistently relative to GDP in the past decade, partly due to increased private spending.** Overall, the WHO estimates that CHE per capita grew from $25.67 in 2010 to $39.46 in 2019 [33]. As a percentage of GDP, CHE grew by nearly 2.5 percentage points over the same period, although it did decline from 2018 to 2019. As shown in Figure 6, the largest sources of CHE are donor financing and government expenditures, which declined as proportions of CHE between 2010 and 2019 by 5.3 and 2.3 percentage points, respectively. Private expenditures for health, however, grew as a percentage of total CHE from 8.5% in 2010 to 16% in 2020.

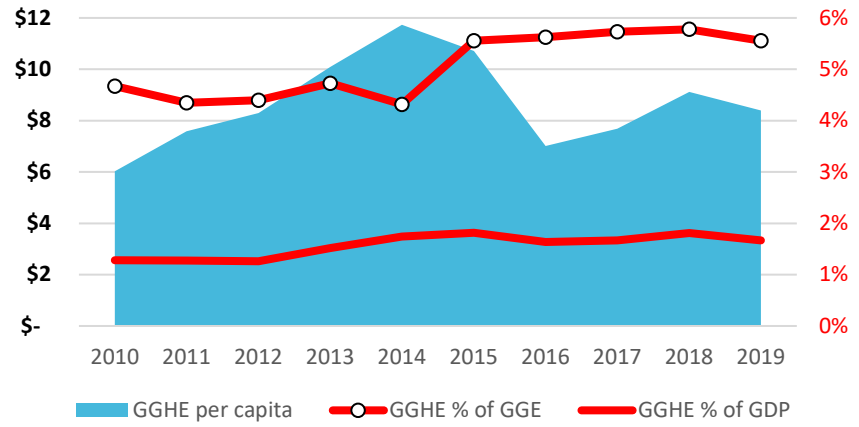
*Figure 6: Per capita spending in current $US by source and total CHE as a percentage of GDP from 2010-2020*




Source: [10]

**While the overall level of government spending on health has grown, it has varied widely on a per capita basis.** The government's sources of financing for health consist of tax revenues, natural resource revenues, borrowing and on-budget donor support mechanisms. Until the fiscal shocks of 2015, government spending on health rose almost twofold between 2010 and 2014, reaching an all-time high of $11.73 per capita. As the economy slowed and public debt rose, government spending on health dropped to $7.01 per capita, a cut of over 40%. As shown in
Figure 7, spending on health has remained relatively constant as a percentage of general government expenditure and of GDP, with only modest increases between 2010 and 2020. On-budget donor support to the health sector has been a significant source of financing in the past; however, after 2015, it has declined dramatically. In 2018**,** 79% of the government's budget for health came from domestic sources, while 21% came from donors channeling their support through the state budget. The relative consistency of government health expenditure as a percentage of the budget and GDP indicates that they are closely linked to the resources available to the government and the overall size of the economy.

*Figure 7: Per capita government expenditures for health and as a percentage of government expenditures and overall GDP from 2010-2019*

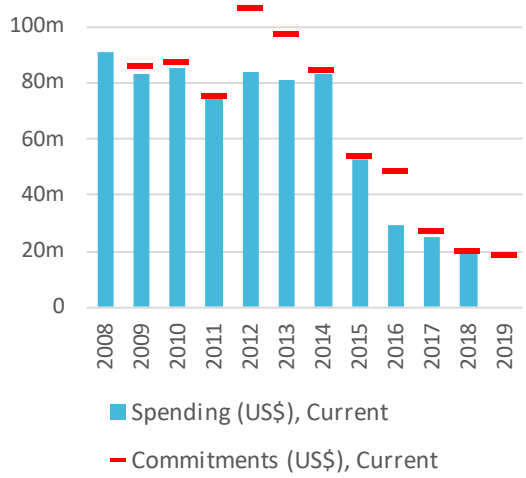



Source: [33]

**External funds constitute the largest source of health financing, which were primarily channeled to the government through the ProSaude fund until 2015.** Since independence, donor support to the health sector has been the largest source of financing, averaging over 60% of CHE from 2010 to 2019. The ProSaude fund (from the Portuguese acronym for "Common Support Fund for the Health Sector") is a multi-donor funding mechanism for several donors—including Belgium, Denmark, Ireland, Italy, the Netherlands, Spain, Switzerland, UNICEF, UNFPA, the United Kingdom, the World Bank-funded Global Financing Facility (GFF)—involved in the health sector-wide approach. ProSaude was established to respect the leadership of the MOH and aligned earmarked funding to its development priorities. However, contributions to the facility dropped sharply as details of Mozambique's hidden debt scandal emerged in 2015 (see Figure 8).

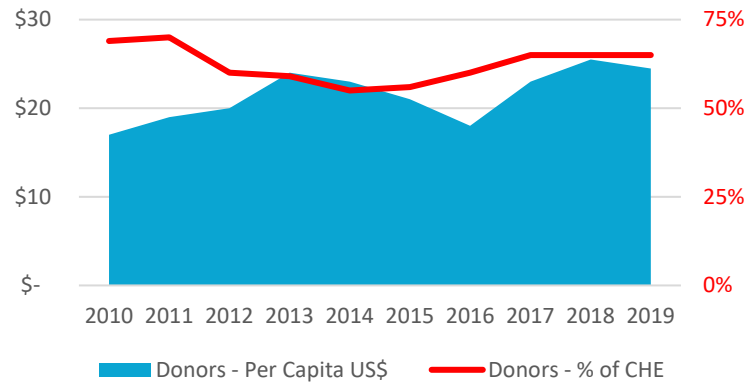
**As ProSaude contributions declined, external funds shifted primarily towards vertical programs.** A critical area of donor support has been the vertical programs responding to HIV/AIDS, malaria, and tuberculosis funded by the Global Fund and the US government. While the US government's funding is established through a bilateral agreement (nearly all of which is implemented off-budget through development partners), the Global Fund's support consists of both on-budget and off-budget grants to its principal recipients. Despite the declines in ProSaude contributions, donor support recovered in response to the displacement of large numbers in the North, the cyclones of 2019, and in response to the COVID-19 pandemic in 2020.

*Figure 8: Commitments and actual contributions to ProSaude from 2008-2019*




Source: [29]

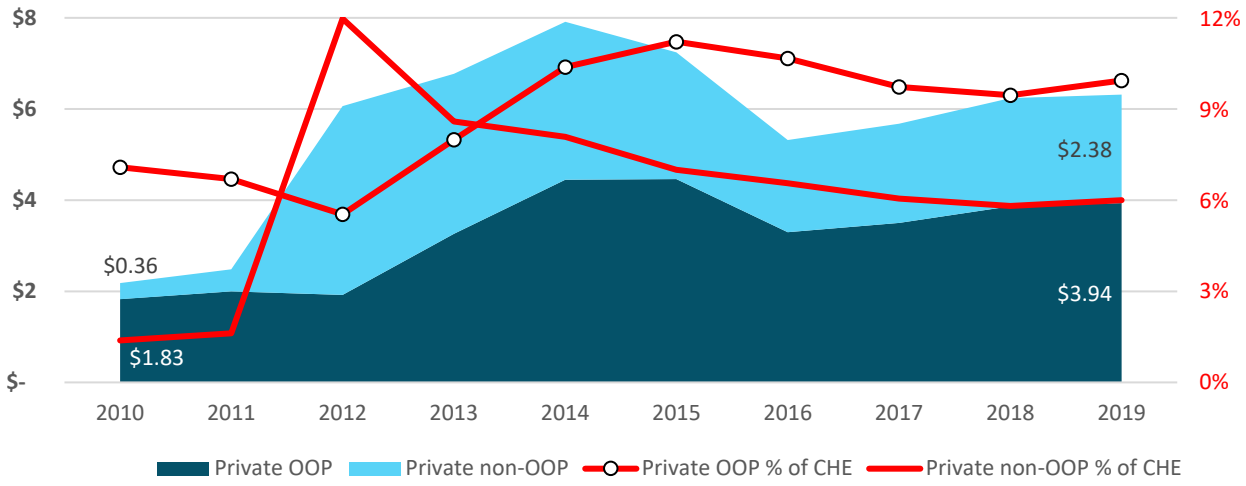
*Figure 9: Per capita donor financing for health and as a percentage of CHE*




Source: [28, 38]

**Out-of-pocket (OOP) expenses are a small but consistent source of health financing and an important source of revenue for many facilities.** Health facilities in Mozambique have been collecting user fees for over four decades, although legislation has gradually limited the amounts that may be charged. By law, user fees must be less than 65 meticais, while there are exemptions for children under five, pregnant women, people over 60 years of age, people living with disabilities, and for the treatment of TB, malaria, HIV, and other chronic diseases [9]. All drugs for inpatient services are provided free of charge while for outpatient services drugs that are not classified as basic are subject to fees. While health facilities must remit revenues from user fees to the national government, evidence suggests that this does not consistently happen, particularly at lower-level facilities [28]. There is therefore some contention on what level of OOP spending occurs in the country, with the NHA report of 2015 even noting that, although it was formally found to only comprise 11% of CHE, in reality it may be closer to 40% of CHE [12].

*Figure 10: Per capita private OOP and non-OOP expenditures and percentage of CHE from 2010-2019*




Source: [33]

## OUTCOME 1: MOBILIZE MORE MONEY FOR HEALTH

*Table 2: ALM tracker for Mozambique: Mobilize more money for health*

| | Indicators | Score |
|---|---|---|
| **Raise** | Year-on-year change in tax effort (a proxy of government's capability to increase domestic resource mobilization) | N/A |
| | Tax/GDP ratio (assess trends in tax revenue providing insight into attempts to reform and improve tax collection) [34, 25] | 28,5% (2019)<br>21.6% (2020)<br>23.6% (2021)<br>Δ (2019-20) = -24,2%<br>Δ (2020-21) = 9.2% |
| **Allocate** | Increased prioritization of health spending as the public expenditure grows (Change in GGHE-D/GGE) [35] | 7.1% (2019)<br>8.3% (2020)<br>7.9% (2021)<br>Δ(2019-20) = 16.9%<br>Δ(2020-21) = -4.8% |
| **Spend** | Ministry of Health budget utilization/execution rate [35] | 88% (2019)<br>93% (2020)<br>77% (2021) |
| | PEFA indicator: "Predictability of in-year resource allocation" [36] | Score: C |

Source: Calculations by ThinkWell Mozambique team.

### INCREASING REVENUES FOR HEALTH SPENDING

**Mozambique is currently in an economic and debt crisis, which constrains its ability to raise additional domestic resources for social sectors, including health.** Economic growth has slowed considerably since 2014, with the economy facing challenges related to its reliance on subsistence agriculture—which is prone to natural disasters—and declines in manufacturing activity. While natural resource extraction has grown in recent years, the resulting increase in government revenues has been limited. As a result of these circumstances, the government faces significant challenges to raise or even maintain its spending on social sectors.

**In addition, and although tax collection rates are above regional averages, fiscal space is severely constrained by a high burden of debt servicing.** Mozambique's tax-to-GDP ratio has consistently been above 20%, higher than rates seen in all neighboring countries except South Africa (23.3%). However, despite the relatively high levels of tax collection, public spending is even higher, with around 20% of the government's budget financed through debt. During the suspension of IMF support from 2016 to late 2022, the government was forced to borrow on the domestic market, which demanded higher interest rates. This led to reduced public expenditures on social sectors such as health and education, while cash flow issues led to delayed disbursements from the Ministry of Economy and Finance and an increase in spending arrears.

**A fiscal space analysis conducted by UNICEF in 2019 indicates that even in an optimistic scenario, the health system of Mozambique would continue to face funding gaps.** Even in the best-case scenario (strong GDP growth and increased donor support), the analysis predicts that the net growth in government spending on priority areas relevant to children (including health care) between 2017 and 2024 would be less than 10% [29]. This would be insufficient to address the significant funding gaps, considering that current CHE per capita at $39.46 would need to more than double to meet the WHO's benchmark for delivering a set of essential health interventions ($86 per capita).

**Despite the difficulties posed by the current circumstances, stakeholders are largely in agreement that the present moment presents a good opportunity to plan a shift towards increased domestic health financing.** Mozambique is actively considering the creation of a sovereign fund that would receive revenues from its liquefied natural gas production and be empowered to invest directly in social sectors. Given the health sector's significance to civil society groups, these deliberations represent a promising moment to push for greater domestic investment in health care.

**Mozambique's proposed Health Financing Strategy (HFS) includes several options to increase health financing, such as health taxes.** Although the HFS provides a useful roadmap for the country, it is presently only available in draft form and has been under review by the MOH since 2015 and has therefore not yet been formally endorsed and does not yet carry legal weight. Finalizing and endorsing the HFS would be a critical step to maintain momentum, and some stakeholders have expressed concerns that multiple rounds of review may weaken the document's strength and vision. In addition, while the health sector financing coordination mechanisms are functioning well, there is a need to further engage the private sector to co-finance the value chain.

**One of the options proposed is raising additional health taxes (taxes levied on unhealthy products, sometimes also called "sin taxes") which are earmarked for the health sector**. However, this would still require alignment between the MOH and the Ministry of Economy and Finance. For this purpose, the MOH may develop a compelling and well-structured argument on the benefits of health taxes, for which it can draw from the experiences of other countries. Health taxes have been successfully implemented in several SADC Member States, such as South Africa and Zimbabwe, and provide the dual benefit of additional tax revenue and reduced consumption of harmful substances. In addition, a Specific Consumption Tax, labelled ICE, is already being raised on certain products in Mozambique, such as alcoholic beverages and non-alcoholic beverages containing added sugars or sweeteners, and currently represent 1.3% of tax revenue in the country, as per Budget Execution Report of the Ministry of Finance.

**The HFS also proposes to launch a social health insurance scheme, although it does not specify a roadmap to implement it.** Careful planning is required to ensure that such a scheme is able to provide wide coverage to the population, considering that large parts work in the informal sector. Stakeholders have noted that discussions have stalled since the project's previous lead at the government left their position in 2020, with some feeling that a new champion is needed to drive progress. Lastly, the HFS does not propose to increase user fees as an additional financing source for the NHS, aiming to maintain current user fee levels and list of exemptions (user fees currently account for only 0.5% of NHS funding).

### ENSURING SUFFICIENT BUDGET ALLOCATIONS TO THE HEALTH SECTOR

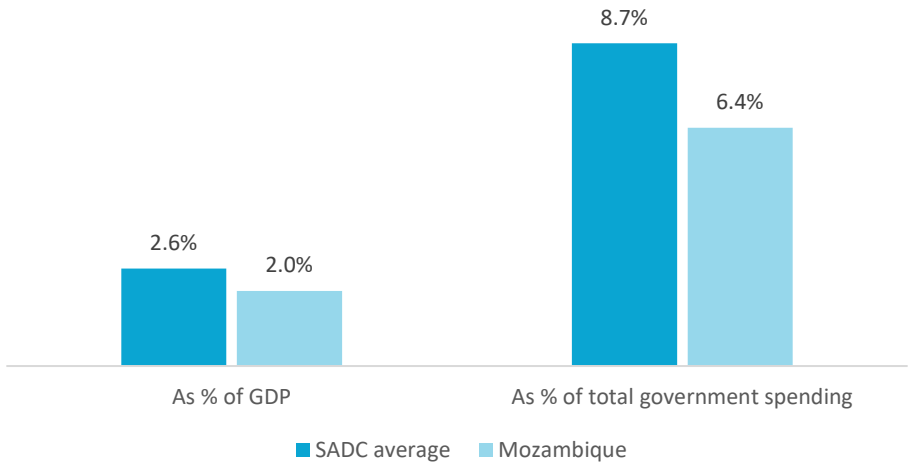
**Mozambique's domestic government health spending as a share of total government spending is far below rates seen in most neighboring countries.** In addition, government health spending is also modest relative to GDP, with Mozambique's rate (2%) being significantly below Eswatini's (3.5%), South Africa's (4.9%) and Zambia's (2.2%), while the country comes last in terms of per capita spending (see Table 3). Figure 11 shows that Mozambique's health sector spending also falls below the average across SADC Member States, underscoring the need to increase domestic resource mobilization for the health sector.

*Table 3: Domestic Government Health Sector Spending in Mozambique and neighboring countries, average 2018-2020*

| Country | Per capita (USD) | As % of total government spending | As % of GDP |
|---|---|---|---|
| **Eswatini** | 129.3 | 10.0 | 3.5 |
| **Malawi** | 10.3 | 8.7 | 1.8 |
| **Mozambique** | 9.8 | 6.4 | 2.0 |
| **South Africa** | 317.2 | 15.3 | 4.9 |
| **Tanzania** | 16.1 | 9.4 | 1.6 |
| **Zambia** | 26.6 | 7.2 | 2.2 |
| **Zimbabwe** | 19.4 | 5.7 | 1.0 |

Source: [33]

*Figure 11: Domestic government health sector spending in Mozambique vs. SADC, average 2018-2020*




Source: [33]

**However, estimates on total and public health expenditure in Mozambique often vary between sources due to different estimation methods, complicating analyses.** The main reason for such discrepancies is the country's dependency on foreign funding and the large proportion of this that flows off-budget. For instance, different estimates may be presented as "% of public financing for health" depending on whether the authors include (or were able to accurately estimate) external funds channeled as off-budget support. For example, in 2021, the MOH's expenditure report noted that foreign funding was reduced, while a budget analysis by UNICEF noted that a dramatic increase in external funding took place in order to maintain health services during the COVID-19 pandemic. Similarly, statistics in the draft HFS suggest a higher share of public funds is channeled towards the health sector than reported in the WHO's Global Health Observatory.

**As a result, estimates for CHE per capita currently range from $25 to $39.5, and the government is under pressure to increase its financing for health.** Even the upper limit ($39.5) is considered as insufficient in the country's HFS and in the Essential Services Package (ESP) publications. While the HFS

suggests an increase towards $58 per capita by 2030, the ESP suggests an increase of $16.6 to $21.1 is required by 2030 to deliver essential services. As part of its commitments linked to the PHC Strengthening program co-funded by the World Bank and the Global Financing Facility, the Government has previously agreed to increase the share of health among its total expenditures from the average of 8.5% in 2015-2017 to 10% in 2022 (forthcoming expenditure reports will confirm whether this has been achieved). However, some stakeholders argue that the government will likely struggle to allocate more funds to the health sector, in part due to the need to invest in other priority sectors for which external funding is less common, such as national security and climate change adaptation.

**The HFS suggests that the growing financial needs of the health sector should progressively be covered by domestic and on-budget donor funds**. The HFS suggests that domestic sources should cover 58% of health spending by 2030, the equivalent of $33.64 per capita; a significant increase from the $12 per capita spent in 2020 (see Table 4). However, even if these targets are met, they imply an allocation to health of 12% of government expenditure, which would still be below the 15% Abuja target. The costing projections of the HFS have been based on estimates for the NHSP (2019-24) and the ES Package (2030), which used the WHO's OneHealth methodology. The estimates for the availability of government resources were based on information from IMF and national institutions on the evolution of fiscal space and the overall economy. Table 4 summarizes these projections.

*Table 4: HFS, Projected evolution of health funding needs, and sources, 2020-2030*

| | 2019 | 2020* | 2025* | 2030* |
|---|---|---|---|---|
| Estimated costs of EHSP (per capita) | | US$51 | US$54 | US$58 |
| Per capita CHE *(Int + Ext funds)*: | US$39.46 | US$34 | | |
| % covered by Domestic sources | 21% | 32% | 42% | 58% |
| US$ covered by Domestic sources | US$10 | US$12 | US$22 | US$32 |
| Convergence to the Abuja target: | 12.0% | 16.0% | 12.1% | 11.9% |
| CHE (domestic) as % of GDP | 2.0% | 2.5% | 4.4% | 6.0% |

*estimates/forecasts. Source: [14]

**There is a need for improvement in the processes for health budget allocations, which often lack an evidence-based approach and rely on historical spending levels.** Stakeholders expressed concern during interviews that the MOH's budget demands are not grounded in evidence, and that there are inadequate plans to show how its short- and medium-term activities align with long-term strategies. The central allocation of funds is typically done at a high level, without a bottom-up approach that considers evidence to support program budgeting. A major issue in developing accurate health budgets is the absence of unit costs for services throughout the health system. Public budgets are usually structured around input lines, which further hinders the calculation and allocation of sufficient funds for the health system as the MOH is unable to reallocate funds in response to health needs during a fiscal year.

**In addition, the MOH's limited analytical capability hampers its ability to demonstrate the full and efficient utilization of its resources.** There is a lack of routine matching between existing data on service levels and resource use by the MOH [27]. In addition to complicating the MOH's role of managing health resources, it also makes it difficult to demonstrate the value of health programs and services, resulting in budget proposals often being reduced during the parliamentary process.

## ENSURING THAT HEALTH BUDGET ALLOCATIONS ARE SPENT EFFECTIVELY

**The MOH experienced a decline in its budget execution rate in 2021, as indicated by its annual reports.** While the execution rate remained high at 93% in 2020, it dropped significantly to 77% in 2021, which the MOH attributes to low execution rates for external sources of funding. It is important to ensure that budgets are executed efficiently and that funds are allocated and spent as budgeted, thereby allowing health systems to maintain and expand essential services, infrastructure, and workforce capacity. To optimize its performance, the MOH should seek to address the causes of its reduced budget execution rates and develop pragmatic solutions. In general, inadequate fund absorption is a common challenge across health sector programs in the country, especially those with large commodity procurement requirements. For example, the country utilized less than 35% of the COVID-19 relief funds provided by the Global Fund before the grant expired [8].

**The health sector's public financial management (PFM) procedures aim to empower provinces and districts by directly disbursing funds to them.** The Ministry of Economy and Finance (MEF) manages the approved state budget and disburses funds to government entities through the government's Single Treasury Account system. This process is electronically managed through the State Financial Administration System, known as e-SISTAFE (Sistema de Administração Financeira do Estado), which was introduced in 2002 to curb corruption and misuse of public funds. By leveraging e-SISTAFE, the MEF can directly allocate funds to the MOH, DPSs, and SPSs, as well as to central, provincial, and some district hospitals, thereby bypassing the normal hierarchy in the health sector.

**However, administrative delays hinder the actual disbursement of funds and frequently lead to a lack of funds in the first months of the year.** Government entities must request their allocated funds from the MEF, which can take up to two weeks for the transfer to the requesting government unit's bank account. This delay creates challenges for the public health sector, especially considering that unused funds from the previous year must be returned to the national treasury by the end of the fiscal year in December. Consequently, there may be limited or no funding available in January and February, while it may also lead to challenges in budget execution before the end of the fiscal year. To improve the effectiveness of health budget allocations, it is crucial to streamline the disbursement process and minimize delays, ensuring timely access to funds for public health facilities (for example, cost effective digital solutions may be explored and deployed).

**While direct funding from health donors to DPSs, SPSs and SDSMASs is considered in the annual planning process, such funds are usually managed outside of the government's PFM systems.** While developing the PESOE at each level of the health system during May to July, the government engages in discussions with donors to determine anticipated levels of support and areas of activity for the upcoming year. Districts must communicate their development partner commitments and activity areas to their respective DPS and SPS, which then consolidates this information and shares it with the MOH. To establish a direct funding link, development partners must sign memorandums of understanding with the relevant DPS, SPS and SDSMAS that outline the partnership details. Although the Government of Mozambique (GOM) prefers all partner funding to be managed through the e-SISTAFE system, many development partners bypass the system when providing direct support to subnational levels.

**As a result, there is a perception at district and provincial levels that their draft budgets are frequently reduced based on the level of committed partner funding.** To enhance the effectiveness of health budget allocations across the country, it would be beneficial to encourage development partners to

align their funding with the e-SISTAFE system and foster transparent communication between donors, the MOH, DPSs, and SDSMASs. This alignment will ensure better coordination and management of funds, resulting in improved health outcomes at all levels.

## MORE MONEY FOR HEALTH DISCUSSION QUESTIONS

- How can the government ensure that health financing is aligned with the government's priorities for the health sector, and that resources are allocated in a way that maximizes impact and sustainability? What steps can be taken to improve the transparency and accountability of health financing, and to engage stakeholders in the decision-making process?
- How and when can the MOH have an approved version of the Health Financing Strategy, which is meant to help guide decisions and discussions on health financing for Mozambique?
- How can Mozambique effectively incorporate global best practices in need-based budgeting, taking into account its advantages and drawbacks, when developing health budgets? Are there any data sources that could be used? And what sort of analytical and operational capacity would the MOH need to implement this?
- The Health Financing Strategy proposes several options to increase health financing, including taxes on unhealthy products (sin taxes) and a social health insurance scheme. How could the introduction of such options be successfully realized in Mozambique, and who should be involved in the discussions?
- As government budgets are expected to rise in the coming years due to LNG extraction, how can the MOH and other stakeholders strategize to advocate for greater budget allocations to the health sector? What forms of evidence, such as investment case analyses and cost projections, will support such advocacy efforts?
- What fiscal and monetary policy incentives can be employed to encourage private sector investment into the health sector, thereby growing the overall level of health financing?
- The health financing strategy offers several implementation options. What measures should be used to assess which options should receive priority, and which ones are the most realistic solutions to implement in the short term? Which options present the lowest hanging fruits for achieving immediate gains in health financing? Therefore, what five resource mobilization options could we prioritize for the next ten years?

## OUTCOME 2: MORE HEALTH FOR THE MONEY

*Table 4: ALM tracker for Mozambique: More health for the money*

| | Indicators | Score |
|---|---|---|
| **Efficiency** | Percentage of government domestic health expenditure (GGHE-D) spent on salaries/wages [35] | 55.4% (2019)<br>57.1% (2020)<br>56.8% (2021) |
| | Is the country participating in a pooled procurement initiative to access medicines and commodities at the best pricing available to them? | Yes, in a few instances |
| | Proportion (%) of pharmaceutical [public] procurement volume ($%) that is generic | N/A |
| **Effectiveness** | Percentage of total [public] health spending allocated to Primary Health Care (PHC) | 76% (2018) |
| | Percentage of government health expenditure that goes to medicines [35] | 35.6% (2019)<br>51.1% (2020)<br>56.4% (2021) |
| **Measurement and monitoring** | Does the country use a priority setting mechanism to allocate health resources? If yes, is this priority setting process used for: i) determining which medicines appear on their Essential Medicines List; and ii) determining a Minimum Benefits Package? | No[1] |
| | Is provider performance monitored? If yes, is performance monitoring linked to purchasing decisions? | Yes and no. While there are multiple quality metrics that are applied by the MOH and government agencies, they are not linked to purchasing decisions among all the main purchasers of health. |

Source: Calculations by ThinkWell Mozambique team.

### INCREASING EFFICIENCY THROUGH POOLING AND PURCHASING

**While the raising of public health funds is largely centralized, the final distribution of funds is decentralized.** General tax revenues are used to fund the national health budget, which is also supplemented by external budgetary support received through the ProSaude fund. The national government then allocates a block grant to provinces and districts based on population size, a poverty index, and (for district transfers only) surface area and the district's own-revenue collection. However, despite efforts to ensure a fair and equitable distribution of funds, significant disparities in per capita health spending exist across provinces, as discussed in more detail under Outcome 3. These disparities likely hamper health system efficiency.

[1] While Mozambique has established an Essential Medicines List and Minimum Benefits Package, the use of priority-setting mechanisms in health resource allocation, such as through cost-effectiveness analyses, is not institutionalized.

**Purchasing responsibilities are also decentralized.** At the national level, the MOH pays for commodities and purchases services from central and specialized hospitals, in addition to funding a range of vertical programs. Provincial governments purchase services from hospitals located at the provincial level, such as central specialized, general, and provincial hospitals, where they support health worker salaries and other costs through input-based budgets. Finally, district governments purchase services from district and rural hospitals and from primary health care facilities in their jurisdiction.

**In addition, a number of vertical programs operate in parallel to national systems, and their scope has grown since donors moved away from the ProSaude fund.** After the hidden debt scandal, some of the donors previously involved in ProSaude started channeling their contributions towards multilateral agencies. Although vertical programs seek alignment and coordination with the MOH, the unequal and/or inefficient allocation of funds and facilities remains a risk [1]. For example, the HIV Control Program funded by the US government—while engaged in joint planning efforts with the MOH—directly funds implementing NGOs. These NGOs, in turn, prioritize their collaborations with local health administrations on the basis of HIV-specific criteria. However, as the benefits of such collaborations span far beyond HIV reduction alone and improve the quality of health care in general, they may inadvertently lead to increased inequities in access to health services.

**Most of the public purchasing efforts are passive, and the use of incentives through the public budget is limited, relying primarily on historical allocations and input-based budget lines.** While results-based payments have been trialed in various donor-funded projects, they have not been institutionalized into the public health system, with a key concern among stakeholders being the high operational costs of such schemes. Trials include the multi-year experiment in two provinces for HIV Control indicators, a localized scheme for officers of the Central Pharmaceuticals Stores, and the currently on-going trial of "disbursement-linked indicators" as part of a PHC Support Project by the World Bank and the Global Financing Facility. As a result of the lack of incentives, there is a limited sense of accountability across the public health system, relying primarily on administrative and hierarchical structures.

**Mozambique's public health system also suffers from high administrative costs and efficiencies may be sought there**. The National Health Accounts from 2015 estimate that nearly one quarter of health spending in Mozambique is by government units in their role as stewards [11]. Although it is challenging to compare the share of health administrative costs across countries due to gaps in data availability and different methodologies, a 2013 study in OECD countries showed a range of 7.4% (United States) to 0.6% (Norway) [23]. Analyzing the source of Mozambique's high costs in this regard could identify efficiency savings which would free up resources to provide direct health care goods and services.

**The NHS is currently undertaking a number of efforts to improve efficiency and access to care.** In efforts to improve access, the NHS aims to simplify the user payment system, through standardization, regulation, and transparent management. In order to improve efficiency in allocation and utilization of resources, the NHS prioritizes improving performance measurement and planning tools and is looking to introduce strategic payment mechanisms to incentivize good governance and service quality.

**In addition, the HFS seeks to address health system inefficiencies to support the realization of UHC.** The HFS was developed pending dialogues between the MOH and development partners (2012-2021) and is part of the agenda for reform in the health sector. It has three main objectives for 2020-2030: i) facilitate universal access to quality services; ii) promote efficiency in allocation and utilization of

resources in the NHS; and iii) ensure sufficient and sustainable public financing for the NHS. The HFS proposes a list of interventions including the improvement of planning and budgeting mechanisms, the adoption of performance-based criteria in resource allocation, the continuous monitoring of technical efficiency at the facility level and experimenting with sub-contracting for non-clinical services.

**The HFS identifies a series of efficiency challenges related to the allocation and utilization of resources and suggests a list of interventions to respond to those.** Challenges include a fragmented supply chain for pharmaceuticals and a high level of leakage, a lack of demand-led decision making for the distribution of health professionals, and poor career guidance and unclear task descriptions for staff. Other challenges that prevent the NHS from fulfilling its goals include poor rural coverage, poor quality services, inefficiencies in the management of service provision and resources, and the risk for catastrophic OOP expenditures to access public hospital services when needed.

**Lastly, several ongoing and planned studies may offer additional insights into ways to enhance health system efficiency.** These studies include the Health Public Expenditure Review (conducted by the World Bank), a Cross-Programmatic Efficiency Analysis (spearheaded by the WHO), and an evaluation of financial gaps in realizing the Health Sector Strategic Plan. The findings from these studies may help inform policy decisions on health sector governance and funding as well as identify potential areas for further improvements in the future.

### INCREASING EFFICIENCY AT THE FACILITY LEVEL

**Service delivery has achieved a high level of integration at the PHC level, although progress is uneven across disease areas.** The health system has recently integrated HIV services with other types of care, including services for pregnant women, family planning, childcare, adolescent services and care for TB patients. In addition, linkages between facility services and community workers are in place, although their operationalization can be improved. However, PHC facilities are still lagging behind in adapting to the needs of patients with chronic non-communicable diseases (NCDs) [16].

**In terms of human resources, insufficient links exist between allocations and local health needs while inefficient structures and procedures often lead to demotivated frontline health workers.** Health worker production and allocation in Mozambique has historically been guided by health worker to population ratios at national, provincial, and district-levels and by standard health-team structures. Since similar sized populations may have different health care demands and health facilities may attend vastly different numbers of patients, this has led to staff allocations that don't correspond to needs. In addition, a combination of insufficient resources, remuneration, management structures that do not reward performance, highly centralized decision making, and poor HR management have resulted in highly demotivated and disempowered frontline health providers. Lastly, while the health care demands placed on primary care facilities have dramatically increased and changed over the last 30 years due to the HIV pandemic and an ongoing decentralization process, management structures, systems, and procedures have not kept pace. This has resulted in inefficiencies, poor quality of care, and long waiting times [26].

**In addition, many health facilities and district hospitals are underutilized.** Half of the facilities in the PHC network deliver only a few services per day, and the recently proposed standard team of professionals is unlikely to significantly improve productivity [2]. One level up, at District Hospitals, research has indicated low rates of utilization: i) rural District Hospitals only have around 14-15

admissions per thousand inhabitants per year; ii) 65% of District Hospitals undertook less than 1.5 surgeries per day (including caesarean sections); and iii) in nearly two-thirds of District Hospitals bed-occupancy rates were below 50%. While the Government plans to establish one hospital at each district, a more cost-effective option may be to optimize the use of existing infrastructure [2, 3], and in interviews some stakeholders also questioned the feasibility of funding such substantial infrastructure investments.

**The extreme scarcity of funding and resources at the facility level leads to further inefficiencies.** The lack of reliable and consistent supply of funds and inputs at the facility level represents a significant challenge in realizing technical efficiency, as it may lead to delays in treatment, increased risk of errors, lack of critical items, understaffing and a shortage of trained health care workers (*SARA, 2018*). This ultimately results in a decline in the overall quality of care provided at health facilities and increased costs for the health care system.

**Research has also identified significant technical inefficiencies at the facility level.** The World Bank's Service Delivery Indicators survey, which was based on data from 2014, revealed low caseload per professional, high absence rates in urban areas (28.3% in health centers and 33.2% in hospitals), a lack of diagnostic capacity among professionals, and poor availability of essential drugs [32]. Additionally, studies have found that many ancillary workers in large hospitals do not have proper job descriptions [25], while workers in health centers were found to only use 2-4 hours daily for clinical work [4].

### MORE HEALTH FOR THE MONEY DISCUSSION QUESTIONS

- What kind of analytical capabilities would the MOH need to better demonstrate the value and impact of health programs and services?
- The HFS identifies a number of challenges, including a fragmented supply chain with a high level of leakage, a lack of demand-led decision making for distributing health staff, and poor management of staff careers. How could these challenges be addressed? Have there been successful (local) initiatives in the past that could be introduced more widely?
- How can the public health system address the challenges of underutilization of health facilities and district hospitals, and optimize the use of existing infrastructure to achieve more health for the money?
- How can we incentivize good governance and service quality in the provision of health care services? Can performance-based payment mechanisms play a role in promoting better outcomes and more efficient allocation of resources?

## OUTCOME 3: EQUITY IN HEALTH FINANCING AND SERVICE DISTRIBUTION

*Table 5: ALM tracker for Mozambique: Equity in health financing and service distribution*

| | Indicators | Score |
|---|---|---|
| **Equity in service utilization** | Access to RMNCH service by wealth quintile [2] | Q1 (poorest): 56.6%<br>Q5 (richest): 95.8% |
| | Full immunization coverage among one-year olds, by wealth quintile | Q1 (poorest): 52.7%<br>Q5 (richest): 85.1% |
| **Equity in financing** | Are Benefit Incidence Analyses (BIA) of public spending in health carried out routinely with good quality data? | No |
| | Concentration of resource pools (assesses the level of fragmentation in the health financing system) | Limited. State and on-budget funds pooled. Various donors provide off-budget support. HIV funds alone may count for a third of current spending, and are almost entirely off-budget |
| **Financial protection** | Medical Impoverishment (proportion of population pushed below poverty line ($3.65/day)) by OOPE [37] | 1.6% (2014) |
| | Key drivers of OOP and progress | Currently, limited Essential Services Package but most services are free of charge. Access to hospital-level care is low |

Source: Calculations by ThinkWell Mozambique team.

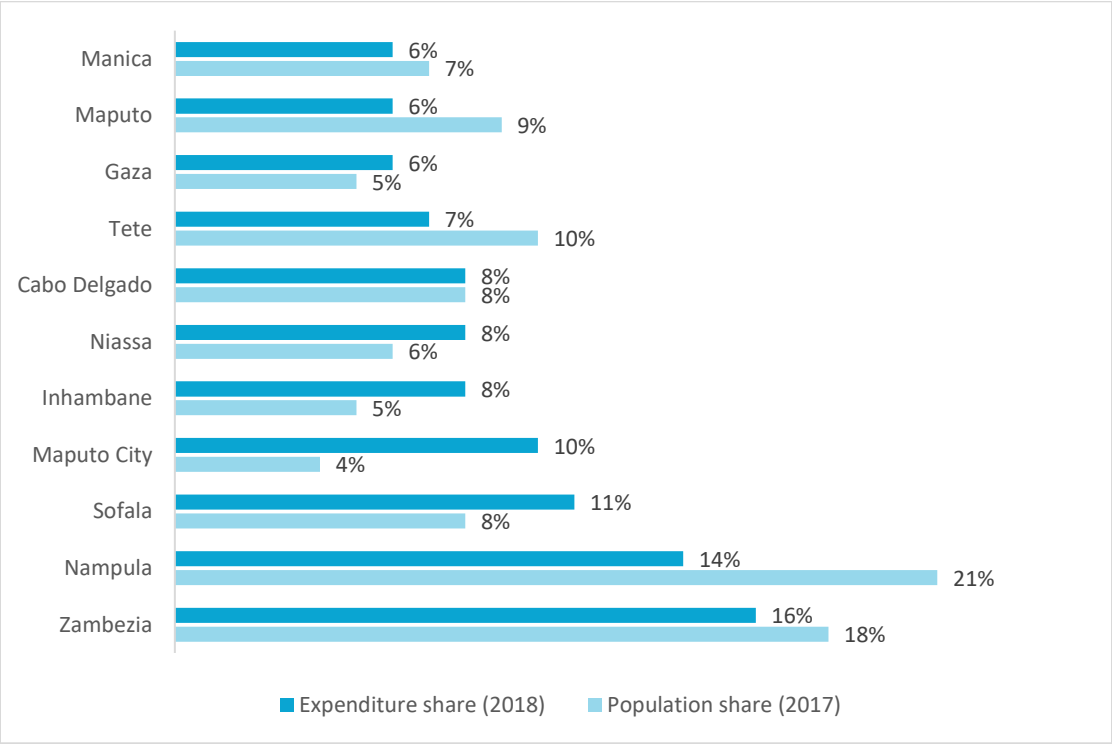
### EQUITY IN RESOURCE ALLOCATION

**In 2018, per capita spending on health varied widely across provinces, ranging from 250 to over 1,000 meticais.** The highest per capita spending was recorded in Maputo City and Inhambane Province, while the lowest was in Zambezia, Tete, Nampula, and Manica, despite the poor health outcomes in these provinces (see Figure 12) [24].

**The disparity in per capita health spending between provinces can be attributed to the unequal distribution of infrastructure and human resources.** A concentration of large hospitals in certain areas and an inadequate distribution of health care personnel both contribute to this inequality [4]. In addition, the allocation of large funds for HIV control may also play a role in the unequal distribution of spending across provinces [16, 17].

[2] Figures from: Ministério da Saúde (MISAU), Instituto Nacional de Estatística (INE), ICF Internacional, 2015. Inquérito de Indicadores de Imunização, Malária e HIV/SIDA em Moçambique 2015. Maputo, Moçambique. Rockville, Maryland, EUA: INS, INE e ICF International.

*Figure 12: Distribution of health expenditure and population by province*




Source: [28]

**Although the Central Treasury distributes funds for the NHS to provinces on the basis of a formula, a lack of up-to-date information distorts the link between actual needs and assigned budgets.** The Central Treasury allocates shares of the State Budget to each province based on their population size and poverty rates as well as the number of facilities and beds. However, because statistics on these criteria are not updated regularly, budget allocations often reflect mostly historical rates of usage. While some inequities have been addressed through political interventions, such as the prioritization of Niassa Province, others persist, such as Nampula and Zambézia, which jointly account for one-third of the country's population yet remain under-resourced [13]. Additionally, as transfers from the Treasury are not ringfenced for health, local health administrations are often forced to advocate for the continuation or expansion of their resource allocations.

**The lack of funding leads to stockouts and a lack of equipment, particularly for lower-level facilities, which provide the majority of care in rural areas.** Surveyed facilities from a World Bank report showed that only 42.7% of facilities had all priority drugs in stock and not expired. Additionally, only 34% of surveyed facilities met the minimum infrastructure requirements (clean water, improved sanitation, electricity). The network of district hospitals, or level II hospitals, are generally poorly equipped and inefficient, with many hospitals not stocked with functional equipment such as refrigerators and vaccine packs. Only 78.8% of rural facilities met the minimum equipment requirements, compared to 83% of urban facilities. Additionally, only 74.6% of hospitals in general met the equipment requirements, compared to 79.3% of health centers. Lastly, only 42.7% of all priority drugs were available among the surveyed facilities (42.6% rural and 43.9% urban). Lower tier facilities had lower levels of drug availability, with 31% of priority drugs available at health centers compared to 66.2% at first-level hospitals.

**In addition, research has indicated that urban areas in Mozambique receive a larger share of resources than rural areas.** A study analyzed government and donor spending from 2008 to 2011 and found a significant disparity in per capita health expenditure allocation across different regions, which could not be explained by regional differences in the burden of disease. It also found that government spending tended to be primarily targeted towards the richer quintiles, while donor spending primarily reached the middle quintiles. These findings suggest that the allocation of health resources—as in place from 2008 to 2011—may not be effective in addressing the health needs of the entire population, and that measures may be needed to ensure a more equitable distribution of resources [1]. New research into this area may verify whether improvements have been realized.

### EQUITY IN POOLING AND PURCHASING

**Health insurance is still in its early stages of development.** There are ongoing discussions to establish a national health insurance program based on the current scheme for civil servants, who contribute 1.5% of their salaries to a medical assistance fund. However, the extent of coverage among the population is uncertain [9].

**Ensuring that health insurance expansion leads to a more equitable distribution of financing across diverse population groups will be critical.** This is especially important in Mozambique, where a significant portion of the workforce is engaged in the informal sector. In such contexts, mandatory health insurance schemes are often more effective than voluntary social health insurance, as they are better able to include vulnerable populations. By making health insurance mandatory, all individuals, including those in the informal sector, can be covered, thereby reducing financial hardship and improving equity in access to health services.

**In general, the decentralized pooling and purchasing and varying levels of provincial revenues and spending are likely to negatively impact equity.** As noted earlier, provincial governments purchase services from hospitals located at the provincial level while district governments purchase services from district and rural hospitals and from primary health care facilities in their jurisdiction. Due to the higher per capita levels of health spending seen in some provinces (see Figure 12), inequities due to purchasing are likely to occur.

**In addition, purchasing by local health administrations is often based on historical trends and allocations instead of actual health needs and costs.** Health centers within each district are funded according to staffing, number of visits, and pharmaceuticals, although these may no longer accurately reflect demand for health care in their area. In addition, the unit costs for providing services (whether at the primary or hospital level) are not yet fully understood.[3] These circumstances make it hard for facilities to respond to increased health demands, particularly in areas where public budgets are lower.

[3] A study on unit costs for HIV services has been sponsored by USAID, and the technical report was expected to become public at the end of 2022.

## FINANCIAL RISK PROTECTION AND LEVELS OF OUT-OF-POCKET EXPENDITURE

**Although levels of out-of-pocket expenditure are low, this may partly be due to barriers to access and/or informal payments.** Mozambique's health system charges low user fees for essential care and households do not generally face catastrophic costs when accessing health services. However, it has been noted that the low OOP estimates may be related to potential financial barriers to accessing specialist services, which charge relatively high user fees, as well as informal payments at various levels of service delivery [14]. The NHA report of 2015 even noted that, although OOP spending was formally found to only comprise 11% of CHE, in reality it may be close to 40% of CHE [12].

**In general, the underutilization of health services in Mozambique raises questions about the interpretation of its levels of OOP spending.** Although OOP expenditures appear to be low, this may be partly due to the low utilization of health services, with an average of less than 1.5 curative visits per capita per year [13]. This low demand for services may stem from the lack of access and long distances to reach health care facilities. Mortality surveys reveal alarmingly high death rates at home, with around 80% of adult deaths occurring there, and trauma victims often dying en route to a hospital, suggesting that they are unable to receive essential emergency treatment when needed [16, 19].

**User fees are an important source of health financing, but verifying the consistent implementation of exemption policies for vulnerable populations remains challenging.** The majority of health facilities (97%) charge user fees, although there are several exemptions, including for individuals with chronic diseases, the elderly, children under 5 years of age, pregnant and lactating women, as well as for all preventive services such as communicable disease testing and treatment. Additionally, almost half of the facilities waive fees for those living in poverty. Hospitals generally exempt more groups from user fees compared to health centers. While these exemptions aim to ensure access to health services even for the most vulnerable, only 10% of facilities in the country openly share their financial information with the community. This lack of transparency makes it difficult to determine the extent to which user fee exemptions are consistently followed.

## EQUITY IN HEALTH FINANCING AND DISTRIBUTION DISCUSSION QUESTIONS

- What are the key challenges in ensuring that public health funds are distributed efficiently and equitably across provinces and districts in Mozambique? How can these challenges be addressed to better support the delivery of quality health care services to all Mozambicans?
- Numerous countries, and across various income levels, have achieved big improvements to their health system by pooling risks through health insurance schemes which target large parts of the population. What conversations must be held in Mozambique to develop and introduce such schemes or alternative risk-pooling options?
- There is ongoing debate regarding the accuracy of out-of-pocket estimates in Mozambique's National Health Accounts. Is it important to delve deeper into the additional expenses patients face while accessing care, beyond those currently documented? Is more detailed information available for certain regions in the country? If so, how do regional estimates compare to national estimates?
- What impact do user fees have on the efficiency and equity of the health care system in Mozambique, and how can the negative effects of user fees be mitigated while still ensuring the sustainability of the health care system?

## OUTCOME 4: LEADERSHIP, GOVERNANCE AND COORDINATION OF HEALTH FINANCING

*Table 5: ALM tracker for Mozambique: Leadership, governance and coordination of health financing*

| | Indicators | Score |
|---|---|---|
| **Leadership** | In line with the ALM Declaration, has the government expressed in policy and/or legislation its commitments to: a) prioritize increased domestic investment in health; b) improve the effectiveness of health spending; c) strengthen efforts to improve the efficiency of financing; and to better align d) development partner and e) private sector efforts to national, regional and continental priorities? | a) No<br>b) Yes [National Health Policy]<br>c) Yes<br>d) Yes<br>e) No |
| | Is there an up-to-date health financing policy statement guided by goals and based on evidence? | The Mozambique Health Financing Strategy 2020-2030 was drafted based on evidence but still not approved by the relevant authorities |
| **Governance and coordination** | Head of State/Government has a formal mechanism to (a) improve collaboration between MoF & MOH and other ministries on health financing and (b) ensure that MoF & MOH coordinate partners' alignment with national plans and budgets? | Yes, TWG |
| | Worldwide Governance Indicator (WGI) | 11$^{th}$-32$^{nd}$ percentile |
| **Data systems** | Is health financing information systematically used to monitor, evaluate, and improve policy development and implementation? | In part |
| | World Bank: Statistical Capacity Indicator (SCI) score | 62.2 (2020)<br>[scale 0-100] |

Source: Calculations by ThinkWell Mozambique team.

### COUNTRY LEADERSHIP

**Mozambique has a long-standing tradition of leadership in PHC.** The country made significant contributions to the 1978 Alma-Ata Conference, including on essential medicines, middle-level professionals, integrated services, and village health workers. In recent years, as the country has issued several policy documents to reflect decentralization and the growing role of the private sector, PHC has retained a central role, including in the NHSP, the ESP, and the HFS. More recently, in 2021, PHC was reemphasized as the cornerstone to achieving the National Health Policy, the Public Health Law and the creation of a Community Health Sub-System within the MOH.

**However, the operationalization of policy goals has been poor, with limited connections between long-term goals and priorities and short- and medium-term plans.** This lack of coherence is exacerbated by the scarcity of resources, with development partners potentially influencing prioritization and having access to more updated and analyzed information than the Planning department of the MOH. The MOH's technical capacity, in particular, may pose a greater challenge to effective planning than the limitations of the country's health information system.

**Balancing country leadership with the involvement of development partners results in frequent technical working groups and joint evaluations.** This delicate dynamic is especially tested when planning exercises involve multiple development partners with big budgets but differing agendas, as seen in the preparation of yearly and multi-year plans for HIV and TB control, involving the Global Fund, PEPFAR, and other entities including the World Bank and UN agencies. The MOH and the NHS heavily rely on these partners, limiting their ability to lead discussions.

## GOVERNANCE AND COORDINATION

**At the national level, Mozambique has a clear policy framework that is centered on primary health care.** The 2004 Constitution of Mozambique grants citizens the right to medical and health care within existing laws. The National Development Strategy (*Estratégia Nacional de Desenvolvimento – END*), covering the period of 2015-2035, includes health as fundamental to development and focuses on reducing morbidity among the population. Key among the objectives is the expansion and improvement of programs that work to eradicate major diseases, especially HIV/AIDS, TB, and malaria. The END is implemented in five-year governmental plans (Programa Quinquenal do Governo - PQG). The current plan covers the period of 2020-2024 and focuses on strengthening primary health care to effectively and efficiently deliver quality services. Priority actions include an array of clinical objectives but do not include any mention of the domestic resources required to achieve those actions.

**On a yearly basis, the government develops an Economic and Social Plan as part of the annual planning and budget process.** The annual planning process occurs simultaneously at each level of the health system. With support from the MOH, each decentralized district SDSMAS creates its plan for the upcoming fiscal year. This plan is submitted to their respective DPS at the provincial level, where it is consolidated with plans from other districts in the province and the provincial level plan before being submitted to the MOH. As described in greater detail below, the resources allocated to the health sector are consistently much less than what was originally planned for at each level. There are also typically delays in receiving the initial funding at the beginning of the year, which further makes implementation of the PESOE at each level difficult.

**The MOH and non-governmental partners have increased their collaboration to handle the growing amount of external funds and technical assistance.** They hold joint planning and evaluation meetings every other year, including the development partners who provide off-budget financing for health. Coordination with implementing partners, particularly international NGOs, takes place mostly at the local level, although international NGOs must abide by agreements made between the MOH and their primary funders. These agreements often focus on geographical priorities (e.g., high rates of HIV among young girls or high levels of family poverty that warrant pilot projects to prevent school dropouts), short-term solutions to human resource needs (which can often lead to long-term problems such as brain drain and the sustainability of pilot solutions), and division of responsibilities between facility and community activities.

**At the health sector level, the MOH is guided by the Health Sector Strategic Plan 2014-2019/Extension 2024, which plays the role of coordinating health policies and programs.** The vision of the plan is to "progressively achieve UHC enabling all Mozambicans, especially the most vulnerable groups, to enjoy the best health possible at an affordable cost to the country and its citizens…". The mission of the plan is to produce and provide "more and better essential health services, universally accessible, through a

decentralized system…" utilizing the core principles of PHC, equity, quality, partnerships, community involvement, research, technology innovations, integrity, transparency, and accountability. To achieve more and better health care services and a reform and decentralization agenda, it defines seven strategic goals as detailed in Table 1. These strategic goals are used to guide the development of technical guidance to the provinces and districts in their development of annual PESOE plans.

*Table 7: Strategic goals of the Health Sector Strategic Plan 2014-2019 / Extension 2024*

| Strategic Goals | Intervention Areas | Expected results |
|---|---|---|
| **1: Increase Access and Utilization of Health Care Services** | Expansion of the PHC health system, strengthen referral systems, intensify health promotion activities, expand prevention and strengthen outreach. | Increased utilization, number of health providers, and facilities with co-management committees. |
| **2: Improve Quality of Services Provided** | Humanization of patient care; develop norms, standards, and protocols; ensure sufficient HRH, strengthen logistics systems, and integrate accreditation systems. | Lower hospital mortality increased IMCI and reduced drug stockouts. |
| **3: Reduce Geographical Inequalities between Population Groups in Access to and Utilization of Health Care Services** | Develop needs and equity-based resource allocation formulas for financing, HRH, and drugs. | Reduced per capita inequity in financing, HR distribution, and utilization. |
| **4: Improve Efficiency of Service Provision and Utilization of Resources** | Developing a minimum package of health services, implement mechanisms to improve clinical performance, identify inefficiencies, and mobilize additional resources for the minimum package. | More facilities implementing the MPHS/B/CEmOC, improved resource allocations at the provincial level, budget execution, and lower inefficiency. |
| **5: Strengthen Partnerships for Health based on Mutual Respect** | Improving intersectoral collaboration, review mechanisms to improve civil society involvement in the design, and implementation of M&E of health policies and programs, develop a strategy for PPPs, strengthen DP relationships to rebuild mutual trust and strengthen MOH leadership. | Increased MOUs with relevant MOG sectors, increased forums with CSOs, increased PPPs, a higher proportion of external funds on-budget<br>NGO inclusion in the PESOE process. |
| **6: Increase Transparency and Accountability in how Public Goods are Used** | Strengthen accountancy and procurement systems, a communication strategy for sharing political decisions and sector performance, and effective mechanisms for civil society participation in monitoring the use of public resources. An expected result of these interventions will be increased expenditure as a percentage of the approved health sector budget. | |
| **7: Strengthen the Mozambican Health System** | Implement the institutional reform acceleration plan and strengthen the health system by focusing on decentralization and the district level. | |

## BUDGET FORMULATION PROCESS

**The government planning cycle is based on Five-Year Government Plans (PQGs) that define priorities for the country drawn from the ruling party's political platform.** Guided by the PQA, the government develops a set of annual planning documents translating the vision from the PQA into concrete plans for the year. These include a three-year rolling medium-term expenditure framework (MTEF) with anticipated sector budget ceilings and a National Economic and Social Plan and Government Budget, or PESOE (Plano Económico Social e Orçamento do Estado), inclusive of all sectors, and a state budget that defines sector-specific budget ceilings. Similar to the national planning cycle, the MOH guides the sector

through a Health Sector Strategic Plan (or the PESS - Plano Estratégico do Sector de Saúde), although the cycles at the national level and for the health sector are not aligned.

**The annual planning process is conducted simultaneously across Mozambique's decentralized levels.** The planning process begins in April, nine months before the start of the new fiscal year on January 1st. The district, province, and national levels conduct their annual planning simultaneously in line with the goals and priorities set forth in the PQA and sector-specific guidance. For the health sector, the MOH, guided by the PESS, guides the development of a sector-specific MTEF and establishes technical guidelines for provincial and district-level development of annual plans. The MOH has also established a set of deadlines and planning support teams to ensure that districts and provinces are able to develop their plans on time and to an acceptable level of quality. The annual district plans are aggregated at the provincial level, which are, in turn, aggregated at the national level by the MOH before submission to the Ministry of Economy and Finance (MEF). The MEF consolidates all the plans across sectors and submits the draft PESOE and budget to the Parliament for approval.

**Parliament always makes significant reductions to the draft consolidated budget before it is approved, requiring a reworking of plans.** After the development of the plans and budgets by the districts, provinces, and the MOH, which are consolidated and submitted by the MEF in August, Parliament undertakes a review and makes its final approvals in November or December. Following approval, the finalized amounts in the state budget are not communicated back to the MOH, DPSs, and SDSMASs until early January, at which point each level must undertake a replanning and budgeting process to align their plans with what Parliament approved. Mozambique may explore digital solutions for budget planning, approval, and allocations in order to reduce delays, increase communication (e.g., auto notifications), and guide such processes.

### LEADERSHIP, GOVERNANCE AND COORDINATION DISCUSSION QUESTIONS

- Mozambique has been strong in promoting primary health care in its policies, although it has not always been able to realize its goals. What challenges has this led to for the state of health care in the country? Do public officials consider policy goals to be realistic, and do they work actively towards realizing them?
- What kind of leadership is required to successfully advocate, endorse, and implement the Heath Financing Strategy?
- How can country ownership of developments in the health sector be ensured in light of its dependence on donor funds? How do planning efforts between the government and developments partners take place in practice? Is the government able to secure its priorities?
- The current five-year government plan (PQG) lists targets but these are not matched with ringfenced resources. Is the country able to work towards realizing these targets in practice? Could more explicit links between targets and the available resources be made for future plans?
- How is the collaboration between the government and non-governmental partners? Is there a common goal, and are all parts of the country being prioritized fairly? How can parliament, civil society (including local and international NGOs), and the private sector be better engaged in health financing coordination mechanisms?
- In the past, parliament has often made significant reductions to draft consolidated budgets. What impact has this had on the health sector? Are there ways to strengthen the argument for a certain level of resources, for example through increased use of evidence in budget discussions?

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