Health Sector

April 2011

Budget Briefs 2011 # 3

This brief highlights key data from the Economic and Social Plan (PES) and the 2011 State Budget (OE), approved by the National Assembly in December 2010.

KEY MESSAGES

- **Total Envelope of Resources:** Even including the District Services for Health, Women's Affairs and Social Action (1,222 million meticais), the weight of the Health Sector is continuing to drop, and now accounts for about 7% of total expenditure.
- **Reduction in the External Component:** There was a general reduction of 15% in the external component for the sector. This can be attributed in part to a drastic reduction in the funding of the National AIDS Council (CSCS), the mandate of which was completely overhauled in 2011.
- **Recurrent Expenditure:** This includes the costs of the staff of the National Health System. Although the ratio between staff and population per province has increased in recent years, the per capita distribution of expenditure in the sector varies from one province to another.
- **District Allocations:** This year there has been a sharp decentralisation of resources to the provincial and district levels. The structure of the budget changed considerably for 2011, with recurrent expenditure registered directly at the level where it will be spent. Analysing expenditure at district level remains a challenge because District Services are grouped under clusters. For example, in the districts, the Health Sector is grouped together with women's affairs and social welfare.

DEFINITION OF THE SECTOR

The Health Sector is defined as the Health System (Ministry of Health, Provincial Directorates and Hospitals) and HIV and AIDS (National AIDS Council). This definition of is the same used in the dialogue between the Government and the Programme Aid Partners who provide direct budget support in Mozambique. The definition is also reflected in the Budget Execution Reports issued every quarter by the Ministry of Finance.

TRENDS

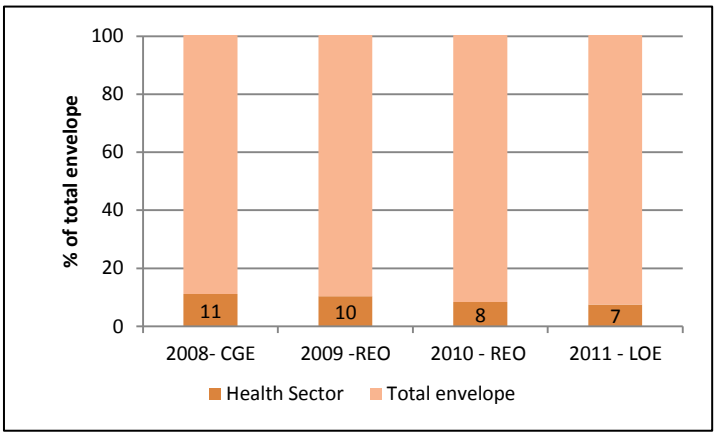
The total envelope of resources available for the Health Sector in 2011 is **9,312 million meticais** (or about **7%** of total expenditure, excluding debt servicing and financial operations).[1]

It is difficult to compare the evolution of the weight of the sector over the years because the composition of the sector changed in 2011. In 2011, the sector came to include the District Health, Women's Affairs and Social Welfare Services, which are equivalent to a total of 1,222 million meticais.

Even with the inclusion of these funds, there is a reduction of 1% in the absolute value allocated to the Health Sector between 2010 and 2011. When the impact of inflation is considered, this reduction is even greater: a decline of 14% between the two years.

Compared with other countries in the region, Mozambique is the only one that shows reduction in the weight of the Health Sector in the overall budget envelope.[2] Data from 2000 to 2007 show that while neighbouring countries increased expenditure on health, the opposite happened in Mozambique, where the expenditure on the sector fell from 17.9% to 12.6% over the same period (Table 1)

Figure 1: Evolution of the expenditure made and allocated to the Health Sector (2008-2011)



Source: CGE 2008; REO IV 2009; REO II 2010 and OE 2011

At the same time, external resources for the sector increased significantly in Mozambique between 2000 and 2007, rising from 26.4% to 57.8% (or US$ 72 million to US$ 296 million, in absolute terms). Malawi also displayed a substantial increase in the external component, with a corresponding increase in Government expenditure on health over the same period.

[1] Our calculation, to be confirmed with the National Budget Directorate (DNO)

[2] Zimbabwe and South Africa also display similar trends, but the weight of the difference – both in the reduction in the Government expenditure, and in the total of foreign aid to the sector – is very small.

How far does this increase in external funding for the sector influence the trend towards a reduction in general government expenditure in Mozambique and in health in particular? This is an important question that may explain the phenomenon of the vertical funds in the sector.

When partners provide support for the State Budget (OE), there is an expectation that the Government will continue to invest in the sector (that is, partner funds become "additional" to Government funds). This is to avoid the question of "fungibility" – that is, that when foreign funds enter, domestic funds are reallocated to other areas or to another sector. This question must be resolved in a practical manner to avoid the phenomenon of off-budget funds (funds that are not included in the OE).

Table 1: Comparison of the evolution of expenditure on the health sector – southern African region (2000-2007)

Countries of the region	General government expenditure on the Health Sector as % of the budget envelope		External resources for health as % of total expenditure on the sector	
	2000	2007	2000	2007
Zimbabwe	10.7	8.9	1.3	0.2
South Africa	10.9	10.8	0.3	0.8
Malawi	8.6	11.9	26.9	59.9
Mozambique	**17.9**	**12.6**	**26.4**	**57.8**
Botswana	6.9	13.00	0.5	4.0
Zambia	9.4	14.5	17.8	33.1
Madagascar	14.0	14.8	20.1	17.8
Tanzania	9.1	18.4	27.8	49.9

Source: WHO, World Health Statistics 2010

EXPENDITURE PER PERSON (US$)

The total annual per capita expenditure in the Health Sector is equivalent to about **US$ 13** – a figure much lower than that recommended by the Macro-economics and Health Commission (US$ 34) or by the World Health Organisation (US$ 60) as the minimum amount necessary to cover a basic package of interventions in the health area in developing countries.[3] It is important to note that this sum does not include off-budget investment in the sector, and that there are great variations among the provinces (more below).

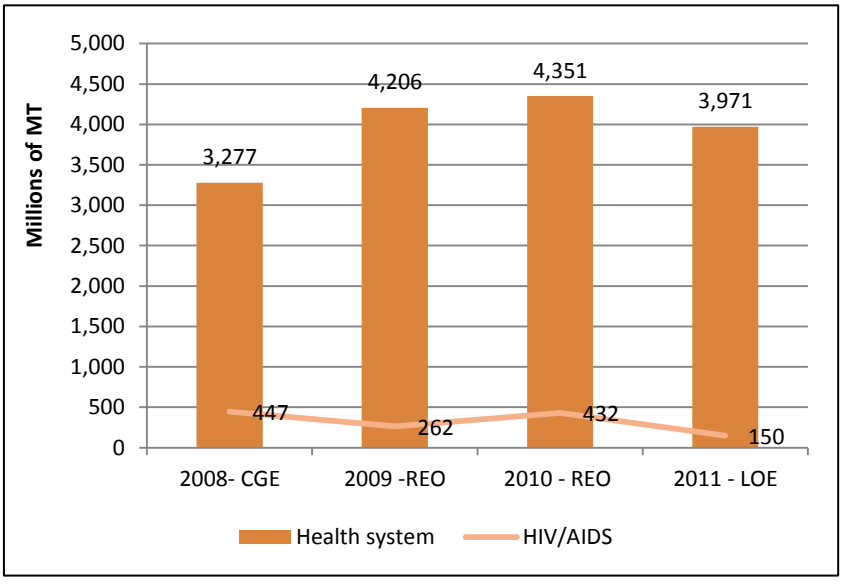
EXTERNAL COMPONENT IN THE SECTOR

Part of the observed reduction in expenditure in the Health Sector in 2011 is attributed to the external component, which has shrunk by about 15% since 2010.

With regard to the HIV and AIDS sub-sector, this reduction is still more striking, with a decline of about 65% between 2010 and 2011. This reduction is related to the shift in the role of the National AIDS Council (CNCS).

In 2011, the CNCS ended its role as the manager of funds intended for the sub-programme of activities in the fight against HIV and AIDS in the provinces and communities, and is now charged only with the coordination, communication, monitoring and assessment of the national response to the pandemic. Although this process began in 2009, the CNCS still disbursed funds in 2010. In 2011, this function is completely finished, leading to a reduction in the funds for the sub-sector as shown in the graph below.

Figure 2: **Expenditure on the Health System and HIV and AIDS, 2011**



Source: CGE 2008; REO IV 2009; REO II 2010 and LOE 2011

This does not mean that there was necessarily a reduction in the external funds allocated to the fight against HIV/AIDS. Rather, there was a change in the way in which the external funds are allocated. UNDP and UNAIDS set up a Rapid Response Fund to serve as a transitional mechanism, mainly for the disbursement of funds to community organisations. It is still not clear how this question of the disbursement of funds will be solved in the medium term in a sustainable manner.

[3] Mozambican Ministry of Health, EQUINET (2010)

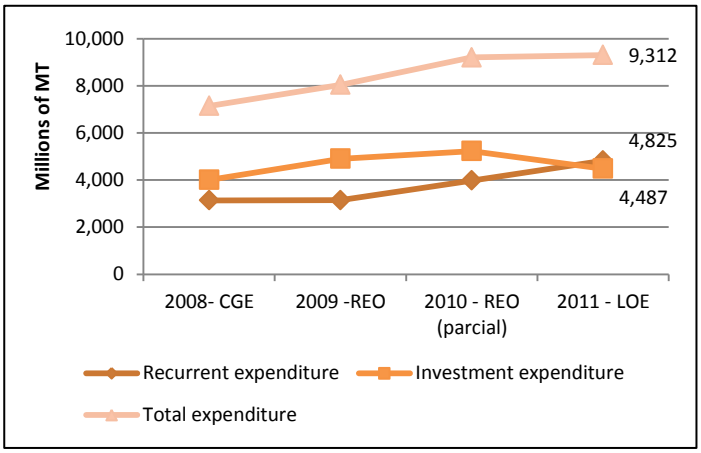
COMPOSITION OF THE EXPENDITURE

Figure 3 shows the evolution of the operational and capital expenditure since 2008. However, as mentioned earlier, it is difficult to make a comparison of trends in the sector with earlier years, because in 2011, the funds of the District Health, Women's Affairs and Social Welfare Services were added.

The **recurrent expenditure** is the state's running costs. These include, among others, staff costs. Mozambique has a general shortage of staff in the National Health Service. In 2009, there were only 1,042 doctors and 5,213 nurses in the country. This is equivalent to one doctor and 13 nurses for each 10,000 people.

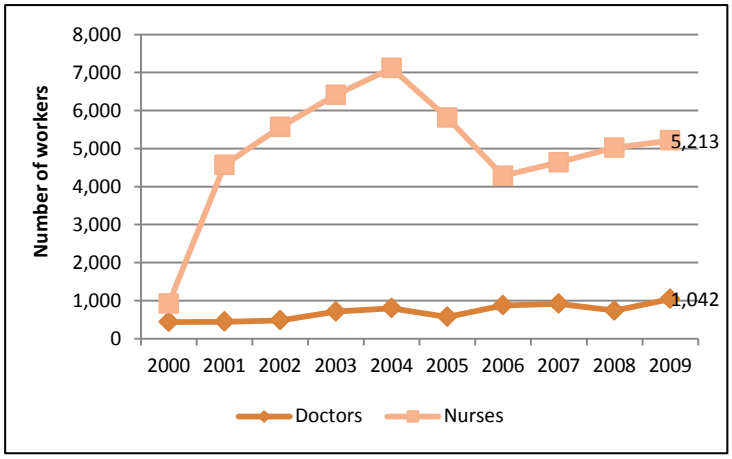
Between 2005 and 2008, the number of health workers increased in the most populous provinces. In Nampula, this number rose from 3,071 in 2005 to 4,436 in 2008. In Zambézia, there was a surge of health workers from 2,130 to 3,041 over the same period. The increase also includes workers with higher education. In Nampula, this figure rose from 62 to 117 between 2005 and 2009, while in Zambézia the increase was from35 to 79.

Figure 3: Evolution of the expenditure allocated and undertaken in the Health Sector, 2008 to 2011 (in millions of meticais)



Source: CGE 2008, LOE 2009, 2010 and 2011, REO IV 2009

Figure 4: **Evolution of the number of doctors/nurses, 2000-09**



Source: INE, 2009

person, while Nampula and Zambézia receive only US$ 3.

The same trend occurs when we add **investment expenditure**[4] and the **District Health, Women's Affairs and Social Welfare Services**. Niassa and Cabo Delgado (north), Sofala (centre), and Maputo City and Maputo province (south) receive on average US$ 8 per person – double the per capita average of the other provinces.

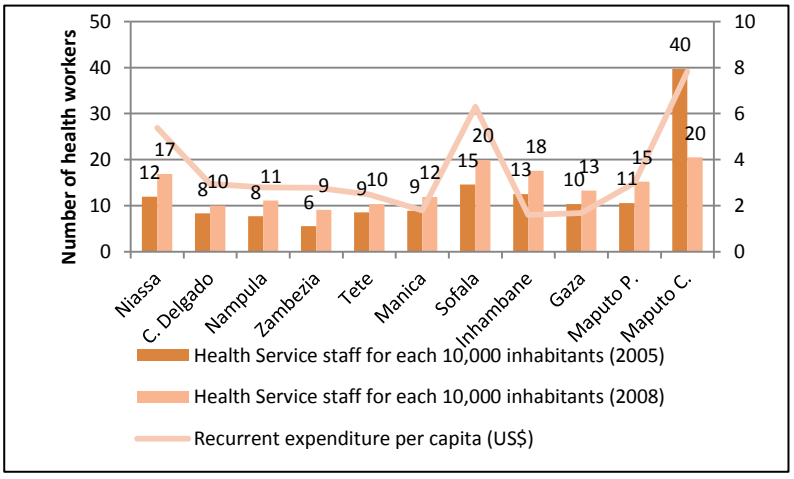
There is limited correlation between the distribution of Health Sector expenditure and the level of human development per province. For example, the child mortality rate varies across provinces. Zambézia has the highest infant mortality rate, but has a health expenditure of only US$ 4 per capita. The opposite happens in Maputo City with per capita expenditure of US$ 9 and the lowest mortality rate in the country. Cabo Delgado is an exception: it has a high rate of infant mortality, and expenditure per capita comparable to that of Maputo City (US$ 9).

Despite the increase in the absolute number of staff in the Health Service, the ratio between health service staff and population is still insufficient. For each 10,000 people in Zambézia province there were just 9 health workers in 2008. In Maputo City, there are 20 health workers for each 10,000 individuals.

Progress was observed in the distribution of Health Service staff in the provinces between 2005 and 2008. The number of health staff for each 10,000 individuals fell drastically in Maputo City and increased in all the other provinces. Is this more equitable distribution a result of the location subsidy provided by the Government?

The same trend is observed in the **recurrent expenditure** of the sector per province. In absolute terms, allocations for running costs in the most populous provinces are high. However, in per capita terms the situation is different. Maputo City receives US$ 8 per

Figure 5: **National Health Service staff for each 10,000 inhabitants, per province, 2005-8, and recurrent expenditure per capita in 2011 (in US$)**



Source: INE, 2005 and 2008, LOE 2011

[4] Investment expenditure in Mozambique reflects the series of expenses incurred in projects financed externally and where, through particular agreements with the donors/funding agencies of these projects, the Government also provides a small amount (known as counterpart funds) in order, for example, to pay national taxes.

DECENTRALISATION AND DECONCENTRATION

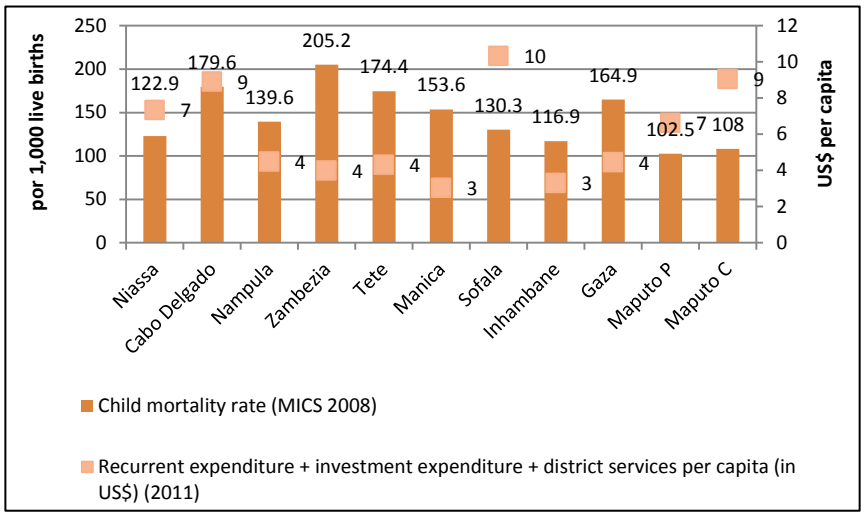
This year there was a sharp decentralisation of resources to the provincial and district levels. The structure of the budget changed considerably for 2011, with recurrent expenditure registered directly at the level where they will be spent. This is a positive trend and should be encouraged, not only for recurrent but also for investment expenditure.

There are two routes by which the provinces benefit from funds from the State Budget:

- **Provincial allocations** – allocations registered directly in the provinces: that is, which directly benefit the Provincial Directorates, which have their own organic classifier in the Budget. These allocations do not pass through the Central Ministry.
- **Central allocations** – funds controlled by central bodies (Ministries in Maputo), which represent the majority of financial expenditure in the provinces. That is, the sums are recorded in the central level budget, but the result of their expenditure benefits each province individually. However, the 2011 OE does not allow us to understand which part of the funds allocated at central level may eventually benefit the provincial level.

Additionally, in 2011 there was a considerable increase in allocations to districts. However, District Services are not separated by sectors. For example, the health sector is grouped together with women's affairs and social welfare. It is difficult to identify, in terms of the volume of resources, the specific part that belongs to each sector.

Figure 6: Infant mortality rate (2008) and capital expenditure per capita, per province (US$) (2011)



Source: MICS 2008, LOE 2011

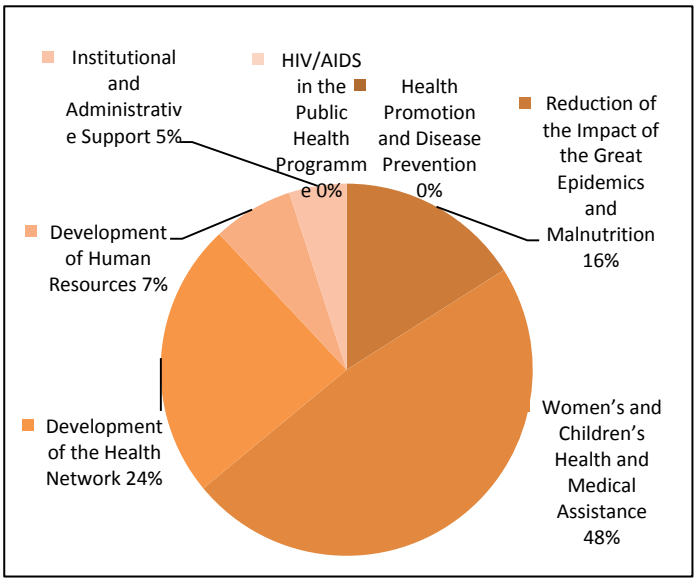
It is important that the sector expenditure at district level is structured in the same way as expenditure at central and provincial levels. This situation also adds to the discussion over whether or not there should be a sector classifier (not just priority sector) so that the inclusiveness and coverage of the budget can be better analysed.

PROGRAMMES OF THE SECTOR

The draft of the 2011 PES, unlike the versions of previous years, was designed in accordance with the Government's Five Year Programme (PQG) and not in accordance with the strategic pillars of the Action Plan for the Reduction of Absolute Poverty (PARPA).

The PES is based on a matrix where the programmes for different areas are detailed. However, not all the programmes are simultaneously reflected in the PES and OE, so linkages between the programmes and their respective costs are unclear. In any case, for those programmes where the cost can be verified, the Programme on Women's and Children's Health and Medical Assistance absorbs almost half the resources.

However, it is not possible to identify the value allocated to the programmes of Health Promotion and Disease Prevention, or the HIV/AIDS programme.



Programme according to the draft PES	Costs according to the draft OE
1. **Women's and Children's Health and Medical Assistance**: which consists of building relevant sector facilities, training courses on various matters for sector staff and opening of health care posts among other activities	2,048,957.19 MT (10^3) – Central level 4,712.17 MT (10^3) – Provincial level
2. **Reduction of the impact of the great epidemics and malnutrition**: which consists of the administration and extension of various types of treatment to target groups, namely women and children: also envisaged are training, communication and research activities	674,725.10 MT (10^3) – Central level
3. **Health Promotion and Disease Prevention**: which consists of setting up health committees, training village health workers, recruiting staff, expanding services and other treatments	Not identified in the 2011 draft OE
4. **Development of the health network**: which consists of building rural health centres, district, general and provincial hospitals as well as some rehabilitation of services in hospitals that are already functioning	856,569.97 MT (10^3) – Central level 173,299.55 MT (10^3) – Provincial level
5. **Development of human resources**: which consists of recruiting, placing and additional training of health professionals in the country	310,803.81 MT (10^3) – Central level
6. **Institutional and administrative support**: which consists of staff training, the installation of a stocks management system in the Supply Centres and Regional Warehouses, in establishing a strategy for the transport of goods; in building or expanding facilities, among others; and	20,016.91 MT (10^3) – Central level 209,729.97 MT (10^3) – Provincial level
7. **HIV/AIDS in the public health programme**: which consists of holding training courses to integrate 660 staff in a new approach to the disease, in setting up support groups, and in undertaking various research.	Not identified in the 2011 draft OE

The information contained in this brief has been taken from the Mid-Term Fiscal Scenarios issued annually since 2007, and from the draft OE for 2011 submitted by the Mozambican government to the Assembly of the Republic in September, and analysed and approved by the Assembly in December 2010. The Draft PES, the Explanatory Document, the Draft Budget Law, and the charts appended to the law were analysed.

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