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# 2015 Health Budget Brief

## KEY MESSAGES

- In 2015 the Health Sector has been allocated MT 20.3 billion (US$ 580.9 million), representing nine percent of the total State Budget. This is an increase from the 7.8 percent share allocated in 2014. Nevertheless, the total resource envelope, including projected off-budget resources, falls MT 17.0 billion (US$ 487 million) short of the estimated MT 45.5 billion (US$ 1.3 billion) it will take to implement the PESS (Health Sector Strategic Plan) in 2015.
- The Mozambican Government has shown an increasing commitment to self-financing the Health Sector as the share of internal resources for health has increased from 45 percent in 2009 to a budgeted 70 percent in 2015.
- Despite substantial growth in recent years in the sector's wage and salary bill, there has been little progress to improve the health worker to population ratio.
- Despite decreased internal financing for Mozambique's response to HIV/AIDS, total resources, thanks to external donors, have grown over the past three years; however, a large funding gap persists, which threatens full implementation of the Government's Acceleration Plan.
- The Health Sector has significantly improved budget execution in recent years, achieving rates over 90 percent in 2012 and 2013, the two most recent years for which state accounts have been finalized. This is a big change from just a few years ago when it executed just 70 percent in both 2008 and 2009.
- Mozambique has worse health indicators than many African countries. This is likely explained by the fact that per capita expenditure on health is very low, especially in the provinces with the greatest need.

## Introduction

**The 2015 budget year in Mozambique is atypical.** Whereas the annual State Budget and Economic and Social Plan (PES) –the annual spending strategy for the sectors– are normally approved in Parliament by the 15th of December of the preceding year, the 2015 PES and Budget were not approved until the 23rd and 28th of April 2015, respectively. The four-month delay was due to the new government's tardy approval of its new Five Year Program (PQG), which is to guide public spending in the years to come. During the first four months of 2015, the 2014 State Budget was reinstated to pay salaries and operating costs, however no new investment projects were begun.

**The total 2015 State Budget is worth MT 226.5 billion (bn), which is equivalent to US $6.5 bn[1]. This budget is 6% lower than last years revised initial budget, in nominal terms.[2] However it is 24 percent higher than the actual budget of 2013[3].** While the volume of the 2015 State Budget is set to

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**Disclaimer:** UNICEF does not have access to e-SISTAFE (Mozambique's integrated financial management information system); therefore, all analysis was carried out with publicly available information. Where limitations were encountered, notes are made in the text. Additionally, there are some minor discrepancies between the totals presented in the 2014 Health Budget Brief and those presented in the 2015 edition. As new data sources became available, UNICEF revised its calculations; in this respect, it publishes the values in this edition believing these to be most correct.

1) An exchange rate of MT 35 = US $1 is used for all year 2015 calculations in this report.

2) All calculations are in nominal values, except when noted.

3) At the time of writing, the 2014 public expenditure accounts have yet to be finalized, meaning the totals published in the REO IV 2014 might not have captured all spending that will eventually be published in the CGE 2014. Because of this, the brief will often compare the 2015 budget with 2013 total expenditure, instead of 2014 total expenditure, because the 2013 accounts have been finalized.

Photo: ©UNICEF/Mozambique

**9%** is the Health Sector's share of the State Budget

decrease relative to last year, the budgeted share of internal to external financing has increased significantly from 65% internal/35% external in the 2014 budget to 75%/25% in the 2015 Budget[4]. This is due to a nominal increase in internal financing coupled with a nominal decrease in external financing. The recent growth trend in internal resources is partly the result of capital gains revenues from the country's extractive sector. Nonetheless, the Government has again planned a budget deficit for 2015, representing an estimated 11 percent of GDP. This is smaller than last year's deficit of 18 percent of GDP[5].

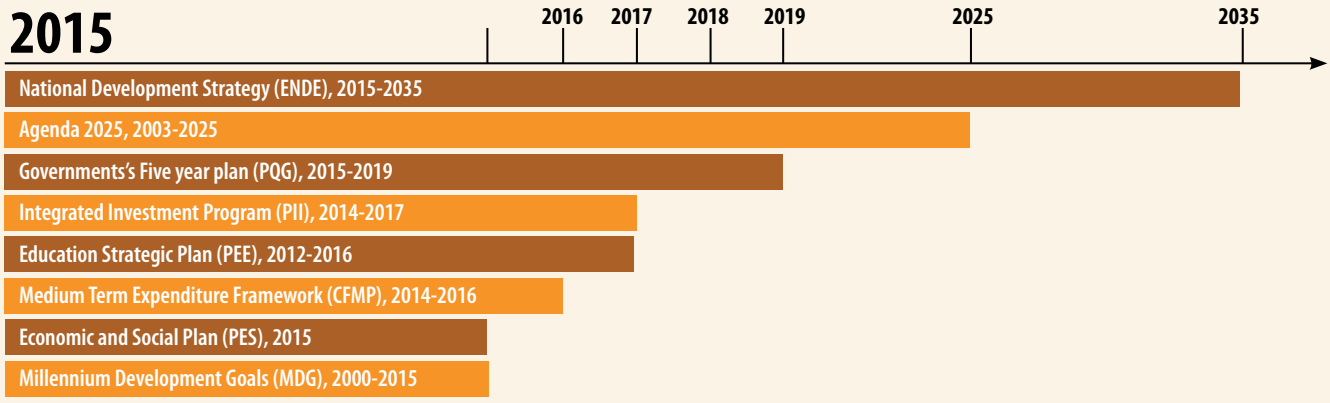
## 1. How is the Health Sector defined?

Before delving into the specifics of the Mozambican Health Sector, it is first important to define its structure. The Health Sector consists of 161 health entities that are organized along three territorial levels: central, provincial, and district.

The Sector is led at the central level by the Ministry of Health (MISAU) and supported by 11 Provincial Health Directorates (DPS) and 131 District Services for Health, Women, and Social Action (SDSMAS). The Sector composition also includes the Centre of Medicines and Medical Articles (CMAM), the National Council for the Fight Against HIV/AIDS (CNCS), three Central Hospitals, four General Hospitals, seven Provincial Hospitals, one District Hospital, and one Psychiatric Hospital. There have been no changes in the Sector composition compared to 2014.

**Health is one of seven priority sectors, whose planning and budgeting is governed by a framework of national strategies, most importantly, the Health Sector Strategic Plan (PESS) 2014-2019.** The Health Sector, along with the other priority sectors, forms the backbone of the Government's agenda for poverty alleviation, which is currently administered by eight planning and budgeting instruments *(see Figure 1)*. In short, the country seeks to develop human capital by investing in health infrastructure (i.e. hospitals and clinics), especially in rural areas; increasing the quantity and quality of health workers; and improving the response to endemic diseases. Specifically, the PESS lays out seven strategic objectives: (1) augment the access and use of health services, (2) improve the quality of health services, (3) reduce geographical inequalities in the access and use of health services, (4) better the efficiency of health services provided, (5) strengthen health partnerships, (6) increase transparency and accountability in how public resources are used, and (7) strengthen the Mozambican health system[6].

**FIGURE 1** Framework of strategic plans guiding the Health Sector




***Source:*** *Author's compilation.*

4) The growth in the share of internal resources is due to a concurrent nominal growth in internal resources from MT 153.1 bn in 2014 to MT 169.9 bn in 2015 and a decrease in external resources from MT 87.8 bn to MT 56.5 bn. Within the external resources category, there was a drop in both aid *(donativos)* and credits. [LOE 2014, *Documento da Fundamentação.* Quadro 3, Page 11. And LOE 2015, Page 3.]

5) Deficits in the State Budget are presented as the sum of internal/external credits *(créditos)* and external aid *(donativos)*. Considering just external credits, the deficit is 11 percent of GDP in 2014 and six percent in 2015. [Author's calculation from LOE 2014, Page 1. And LOE 2015, Page 1.]

6) MISAU. *Plano Estratégico do Sector da Saúde* (PESS) 2014-2019. Page. XV, Tabela 2.

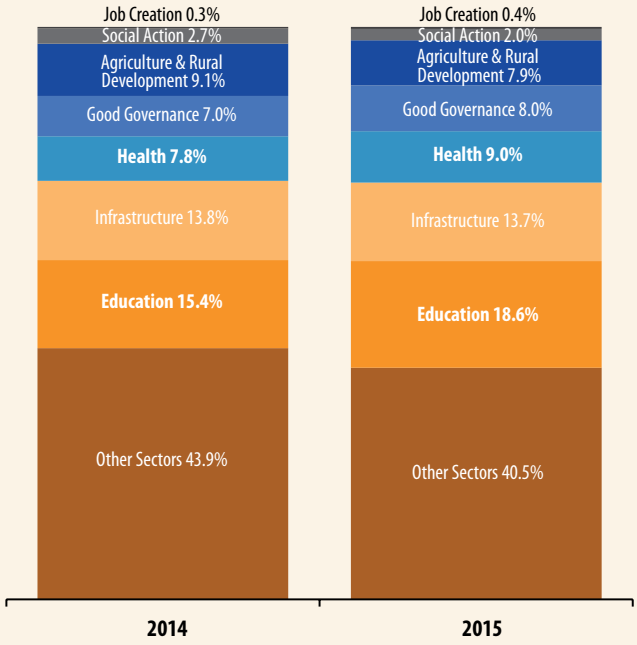
## 2. What trends emerge from the Health Budget?

**In 2015, the Health Sector was allocated MT 20.3 bn (US$ 580.9 million).** This signifies a five percent nominal increase compared to the Sector's 2014 revised[7] initial allocation, but a three percent decrease relative to 2013 Sector expenditure *(see Glossary for definition of terms).*

**The Health Sector's share of the entire State Budget grew from 7.8 percent in the 2014 revised budget to nine percent in the 2015 budget[8]** *(see Figure 2).* However, the 2015 budgeted share is 2.5 percentage points less than the 11.5 percent share recorded in 2013.

**Large variations in recent years between the initial allocation, revised allocation, and final expenditure reflect the positive trend of development partners to inscribe projects on the State Budget and Single Treasury Account (CUT)** *(see Figure 3).* Since 2012, the differences between budget allocations and expenditure are due to the practice of inscribing externally funded projects on the State Budget –but only after the State Budget has already been released– and then only accounting expenditure for some projects[9]. Although it has become challenging to gauge Health Sector expenditure from the initial allocations approved by Parliament (e.g. in 2013 expenditure according to state accounts was MT 5.2bn more than the initial offering), the commitment on the part of a select few donors represents a positive step forward for aid effectiveness in Mozambique.

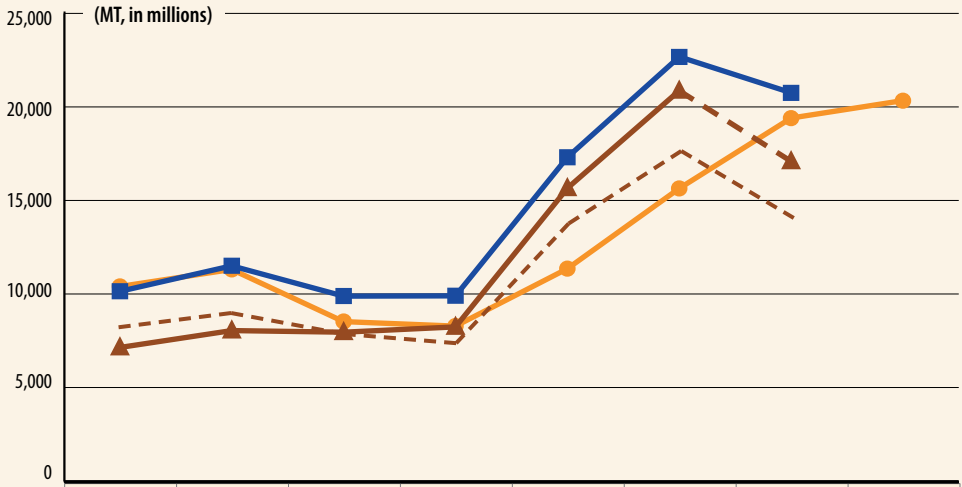
**FIGURE 2** Weight of the Health Sector and other priority sectors




***Source:*** *The 2014 shares are based on the LOE 2014 Revisto and the 2015 shares are based on the LOE 2015 and come from Sectores Estruturantes excel file provided by the Government. The Education and Health totals are the author's calculations from these sources.*

**Note:** The "Other Sectors" portion represents non-priority sectors: General Public Services, Defense, Security and Public Order, Economy, Environmental Protection, Housing and Collective Development; and Recreation, Culture, and Religion.

**FIGURE 3** Health Sector budgeting and expenditure




| | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014* | 2015 |
|---|---|---|---|---|---|---|---|---|
| Initial Allocation | 10 406,8 | 11 315,8 | 8 531,9 | 8 291,8 | 11 357,0 | 15 642,9 | 19 399,6 | 20 331,7 |
| Revised Allocation | 10 148,8 | 11 512,2 | 9 894,2 | 9 909,1 | 17 309,4 | 22 671,8 | 20 751,1 | |
| Expenditure | 7 149,0 | 8 051,5 | 7 964,6 | 8 248,2 | 15 659,7 | 20 868,7 | 17 097,8 | |
| Expenditure, inflation adjusted (CPI 2010) | 10 148,8 | 11 512,2 | 9 894,2 | 9 909,1 | 17 309,4 | 22 671,8 | 20 751,1 | |

***Source:*** *Author's calculations from CGE 2008-2013, REO IV 2014, LOE 2015.*

**Note:** In 2011, 2013, and 2014, the initial allocations were revised later in the fiscal year; the numbers in the figure for these years represent the revised initial allocations.
* The 2014 public expenditures account has yet to be finalized; in this regard, it is likely the totals will be larger than presented for the release of the CGE 2014.

7) In 2014, the State Budget was revised towards the end of the year, and the total amount was changed, reflecting changes in several sectors, including Health.

8) The Government represents slightly different shares for the Health Sector by using the total State Budget less debt-servicing payments as a denominator. Because the resolve to take on debt is a political decision and the resources used for interest payments on debts are public funds that could otherwise be applied elsewhere if not for debt, the author calculates the shares using the total State Budget *including* debt-servicing payments.

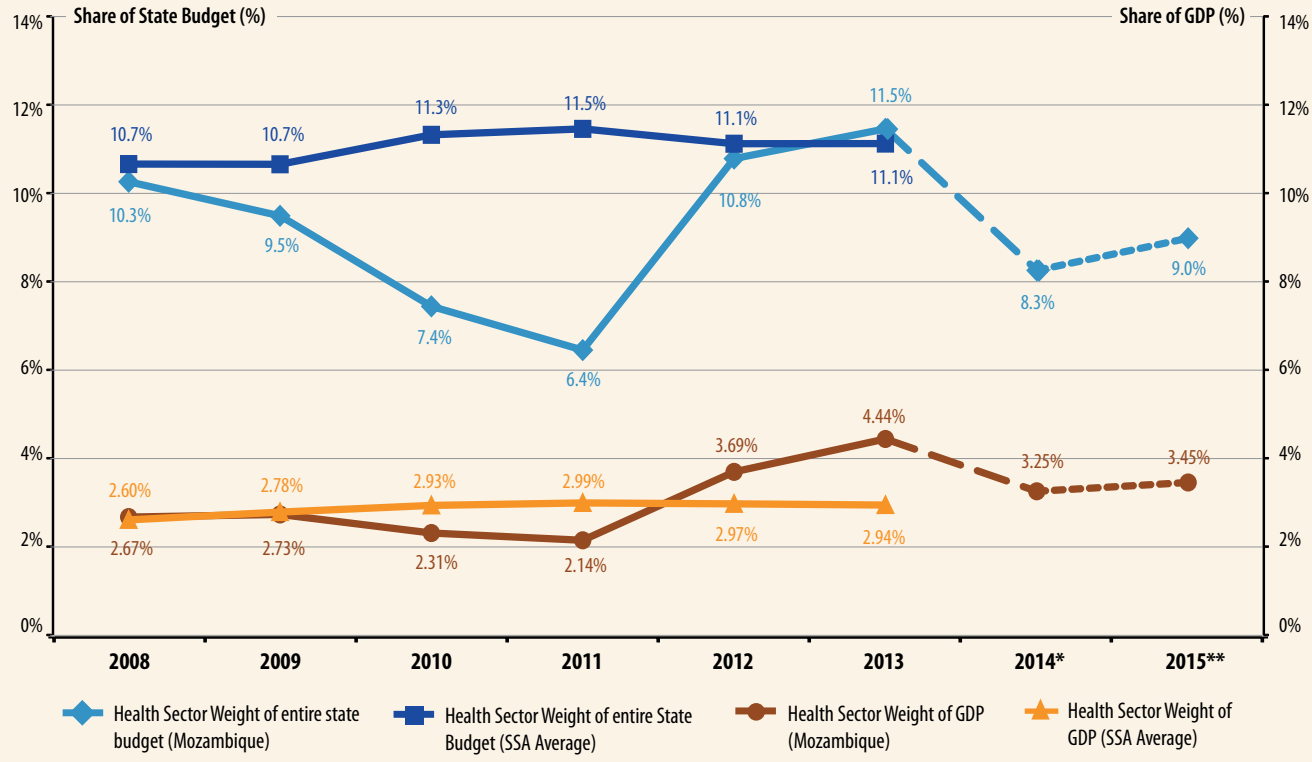
9) For certain development partners, projects are inscribed on the State Budget, however project funds do not pass through the CUT, and thus expenditure is not recorded. It is a Sector goal to place external funding on budget and on-CUT. Despite progress made towards this goal, much external funding of health activities in the country remains off-budget.


**70%** of the Health Sector Budget is financed with internal resources, much larger than the 45% achieved in 2009

**The Health Sector's 2015 budgeted share lags behind the proportions achieved pre-2008 and more recently in 2012 and 2013** *(see Figure 4).* The expenditure accounts have yet to be finalized for 2014; thus, it is to be expected that the 2014 Sector share will climb from its 8.3 percent value based on the 2014 State Budget Execution Report (REO) for the release of the 2014 General State Account (CGE)[10]. Moreover, given the recent trend of expenditure registering higher than the initial allocation *(see Figure 3),* it is possible that the 2015 share will be larger than projected in the 2015 State Budget Law (LOE).

**Despite diminishing shares for Health between 2008 and 2011, increases in 2012 and 2013 moved the trend back on par with Sub-Saharan Africa (SSA) regional averages** *(see Figure 4).* Over the past seven years, the Health Sector has traced an erratic trend as a share of the State Budget and GDP. In 2011, the Sector bottomed out at 6.4 percent of the State Budget and 2.1 percent of GDP before climbing to 11.5 percent and 4.4 percent, respectively, breaching the health funding thresholds of its peers.

**FIGURE 4** Trends in the weight of the Health Sector




***Source:*** *Mozambican Health Sector weights are the author's calculations from CGE 2008-2013, REO IV 2014, LOE 2015 and using World Bank's World Development Indicators (WDI) Open Data for GDP (Current LCU). The Sub-Saharan Africa (SSA) averages are WB WDI for "Health expenditure, public (% of GDP)" and "Health expenditure, public (% of government expenditure)".*

**Note:** For 2008 through 2014, the weight is calculated out of the total public expenditure, including financial operations and debt servicing. * The 2014 public expenditures account has yet to be finalized; therefore, it is likely these shares are larger than portrayed. ** The 2015 shares are initial budget allocations and not expenditure.

10) For the remainder of this report it is important to keep this point in mind: because state accounts have yet to be finalized for 2014, total expenditure will likely increase, predominately in the external component of investment for donor inscribed vertical health projects.

# 3. Where do the Health Sector resources come from?

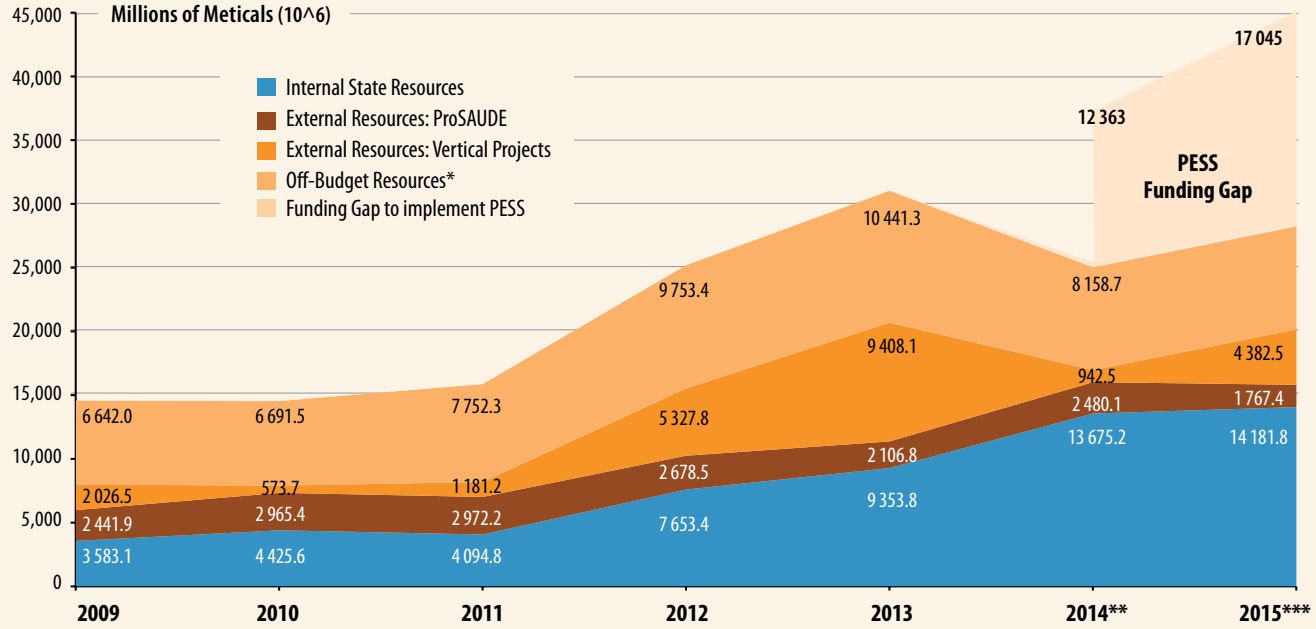
The Health sector is financed both by Internal and External Resources. Internal Resources are those that have been mobilized domestically through taxes, tariffs, duties, and credit. In Mozambique, Internal Resources are supplemented by General Budget Support[11]. External Resources consist of foreign aid, donations, and external credit. In the Health Sector, External Resources are sub-categorized into "Prosaúde" and "Vertical Project" funds. Prosaúde is the multi-donor Common Fund (FC) for health, and Vertical Projects are development partner projects inscribed in the Budget. A possible third category of funding for the Health Sector is off-budget vertical projects, however these resources do not pass through country systems and are not accounted for in the State Budget.

**The Mozambican Government has shown an increasing commitment to financing the Health Sector with internal resources** *(see Figure 5)*. The share of Internal Resources for health has increased from 45% in 2009 to a budgeted 70% in 2015, while the share of External Resources decreased from 55% to 30% in the same period. Nominally, Internal Resources grew nearly four times its value in just six years, from MT 3.6 bn (US $130 mn) in 2009 to a budgeted MT 14.2 bn (US$ 405 mn) in 2015.

**ProSaúde donor commitments for 2015 are worth MT 1.8 bn (US$ 55.6 mn), which is approximately MT 1.1 bn (US$ 30 mn) less than the 2014 commitments.** Nevertheless, in the context of the phase-out of other Common Funds (i.e. FC-ProAgri, FC-HIV/AIDS, FC-Apoio ao TA[12]), ProSaúde has remained an important financing mechanism for government-led health interventions. The group of 10 bilateral and multilateral donors, of which UNICEF is a member, has funded on average 22% of the Health Budget over the past six years. The importance of ProSaúde has been recognized by the involved parties, which have worked together over the past year to fine-tune program aspects, and thus expect a revised and simplified Memorandum of Understanding to be ready by November 2015.

**The Health Sector is far from mobilizing the resources required to fund the PESS.** According to a 2014 study that estimated the resource envelope required to implement the PESS[13], the Sector needs to efficiently spend MT 45.5 bn (US$ 1.301 bn) in 2015 to fund progress to reach the strategic objectives by 2019. The 2015 initial allocation falls MT 17.0 bn (US$ 487 mn) short of the benchmark *(see Figure 5)*. Moreover, the Sector came up MT 12.4 bn short last year, even when including projected off-budget expenditure. In order to address the PESS funding gap, the Health Sector must strengthen health partnerships –as described in PESS Objective six– with donors, engage the private sector, pursue innovative means of health financing, and review funding priorities.

**FIGURE 5** Health Sector resources: internal & external, on- & off-treasury




***Source: Internal and external state resources:*** *Author's calculations from the CGEs 2009-2013, REO IV 2014, and LOE 2015.* ***Prosaúde:*** *CGE 2009 (Quadro 6, pg. 48); CGE 2010 (Quadro 8, pg.38); CGE 2011 (Quadro 13, pg. 45); CGE 2012 (Quadro 13, pg. 44); CGE 2013 (Quadro 16, pg. 57); REO IV 2014 (Tabela 8, pg. 18); Health REO I 2015 (Tabela 2, pg. 6). Off-Budget: 2009-2012: World Bank Public Expenditure Review, Table 9, Page 71. 2013-2014: IFE, 2013. 2015: For 2015, the 2014 total was repeated.* ***Cost Estimate of the PESS:*** *"Estimated Resource Needs and Impact of Mozambique's Plano Estratégico do Sector Saúde," 2014-2019, Table ES1, pg.viii.*

**Note:** Internal State Resources: includes the Recurrent Costs and Internal Investment components of Health expenditure. **External Resources: Prosaúde:** includes the share of External Investment that is funded by the health donor's 'Common Fund'. **External Resources: Vertical Projects:** includes the share of External Investment for on-budget, donor-funded projects jointly implemented. * Off-budget health resources were obtained from IFE. ** The 2014 public expenditures account has yet to be finalized. *** Year 2015 represents the initial budget, while 2008 through 2014 represent expenditure. For the "Off-Budget Health Resources" category in 2015, the 2014 total was repeated to demonstrate a more realistic funding gap. The PESS was estimated to cost US $1,254 million in 2014 and $1,301 million in 2015.

11) General Budget Support (GBS) is aid given to the Mozambican Government from a group of 19 foreign governments (G19) in order to supplement internal resources for public spending through the State Budget.

12) Common Funds for Agriculture, HIV/AIDS, and Support for the Administrative Tribunal.

13) Health Policy Project. *Estimated Resource Needs and Impact of Mozambique's Plano Estrategico do Sector Saude,* 2014-2019. Table ES1, Page.viii.


Photo: ©UNICEF/Mozambique

# 4. How are Health Sector resources spent?

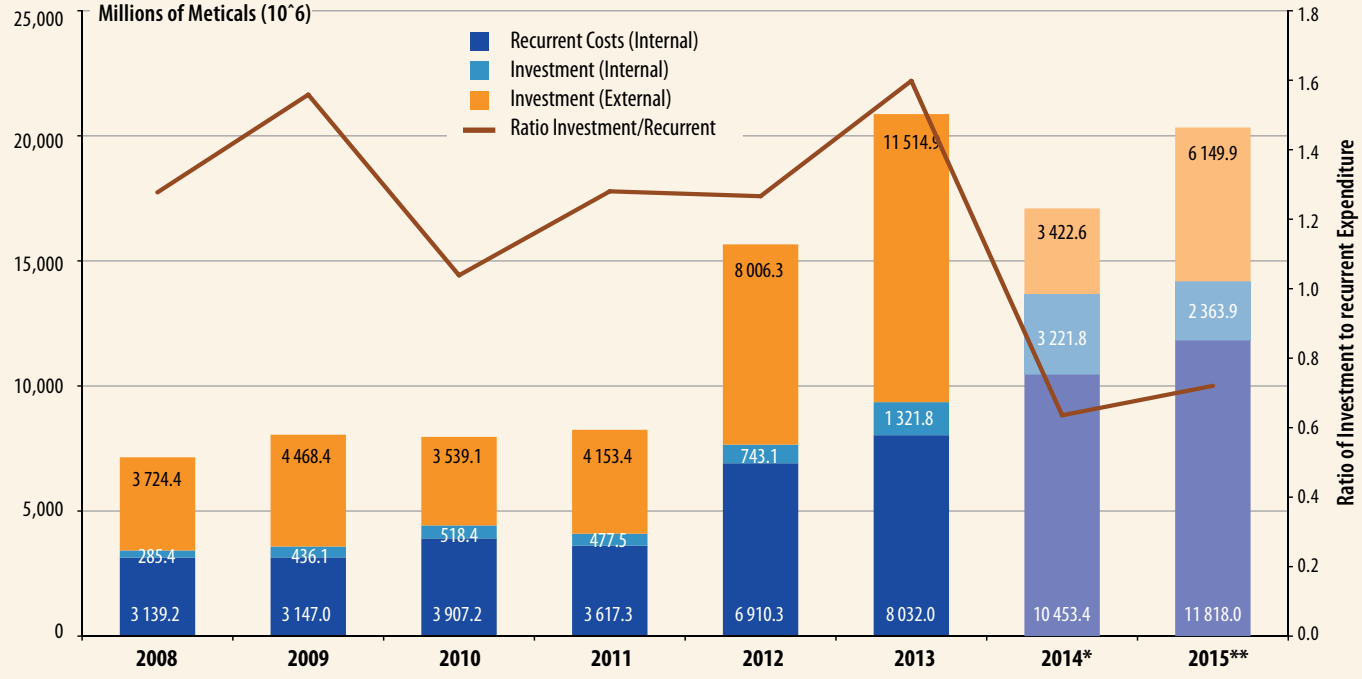
## 4.1 RECURRENT EXPENDITURE COMPARED TO INVESTMENT

Once health resources have been allocated, the individual institutions are responsible for their execution. Spent resources are accounted as either Recurrent or Investment. Recurrent expenditures are those needed to keep an institution "up and running," and include salaries/remunerations, purchase of goods (i.e. medicines), operating costs, and financial operations. Investment, on the other hand, concerns the funds spent to realize productivity and efficiency gains in the Sector (i.e. the construction of a hospital or the acquisition of new medical equipment)[14]. Recurrent Expenditure is financed by Internal Resources, while Investment is financed by both Internal and External resources.

**Between 2008 and 2013, 57 percent of total expenditure in the sector has gone to Investment spending (with internal and external financing sources)** *(see Figure 6)*. Although the 2014 accounts have yet to be finalized, internally financed Investment has grown nearly 150% from its 2013 value; the 2015 budget envisions a nearly 80% growth on the 2013 value.

**Despite progress incorporating vertical funds on-budget, a large portion of Health Sector funding remains off-budget.** In 2013, off-budget expenditure represented an estimated 33 percent of total sector expenditure, or a nominal MT 10.4 bn (US$ 360 mn); whereas in 2009, it represented an estimated 45 percent share or a nominal MT 6.6 bn (US$ 241 mn). The decreasing share of off-budget expenditure coupled with the corresponding increasing share of vertical funds, again, reflects the increasing tendency of donors to inscribe their projects on the budget. Nonetheless, to improve sector planning and ensure each health dollar is used effectively, further progress is required to incorporate off-budget resources into country systems in accordance with the 2005 Paris Declaration for Aid Effectiveness.

**FIGURE 6** Recurrent and investment expenditure




***Source:*** *Author's calculations from the CGEs 2008-2013, REO IV 2014, and LOE 2015.*

**Note:** * The 2014 public expenditures account has yet to be finalized. ** 2015 represents initial budget allocations and not expenditure.

14) However, it is important to note that the differentiation is not always rigorously followed as often expenditures in the investment category go for salaries, goods, and operating costs.
15) LEO 2015, *Documento da Fundamentação,* Page 25. Government of Mozambique. Programa Integrado de Investimentos 2014-2017, Revisto Julho 2014.

*The Health Sector is far from mobilising the resources required to fund its social and economic plan*

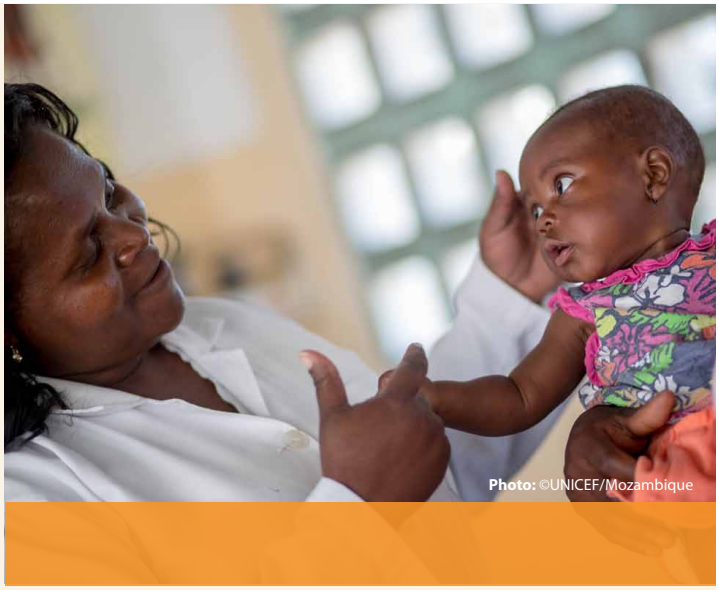
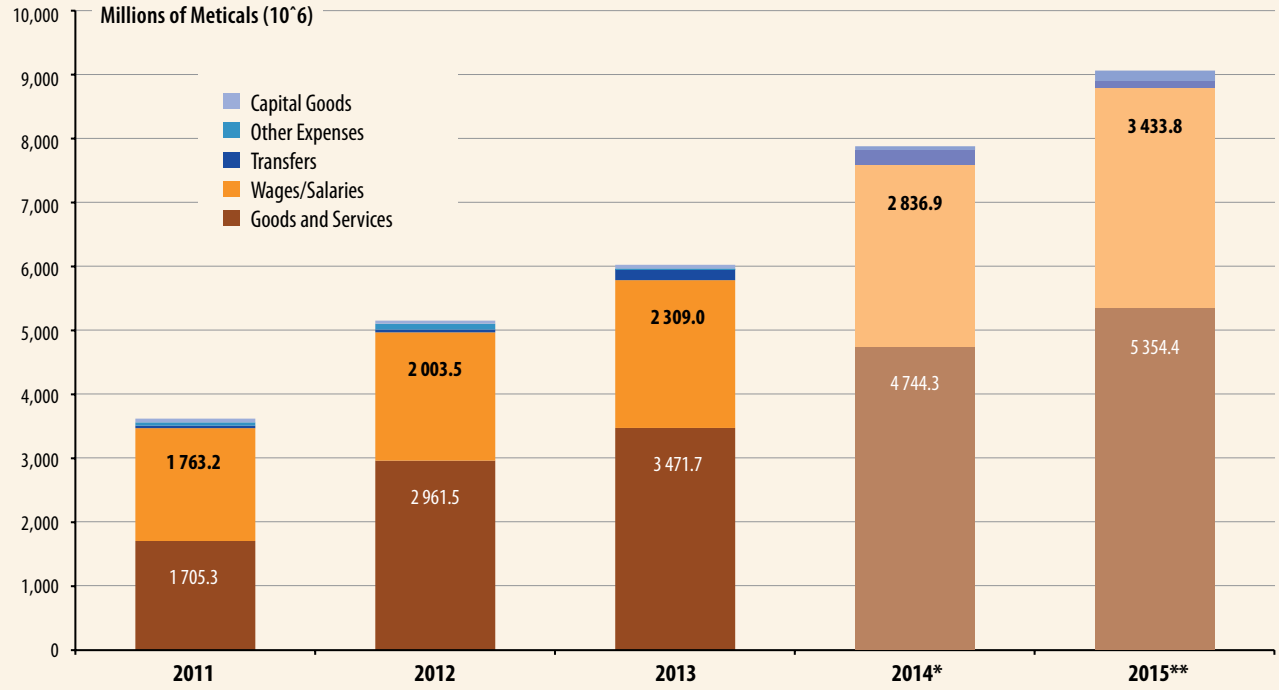


Photo: ©UNICEF/Mozambique

The large increases in externally financed Investment observed in 2012 and 2013 are again due to the effort by development partners to inscribe their projects on the State Budget. According to the 2015 State Budget, the principle health investment projects for the present year are the (i) continuation of the construction of the Quelimane Central Hospital and the (ii) construction of District Hospitals in Macia, Massinha, Mocimboa da Praia, Mopeia, Pebane, Montepuez[15]. Due to the delayed passage of the 2015 budget, the Sector will only have eight months, instead of 12, to execute these investment projects.

**The country's wage bill is growing faster in health and other priority sectors compared to non-priority sectors,** however, this has not been sufficient to respond to the need to recruit and retain quality public sector workers to improve the health worker to population ratio. Recurrent Expenditure has grown more than three times its value between 2008 and 2014 *(see Figure 6)* and is budgeted to continue to increase in 2015, predicated on an average annual 18 percent rise in wages/salaries *(see Figure 7)*. Despite the health sector wage growth, the ratio of physicians per 1000 people increased just slightly from 0.03 to 0.04 over the same time period, and the ratio of nurses/midwives per 1000[16] people increased just 0.34 to 0.41[17]. Much progress will need to be made to reach the PQG target of 1.13 health professionals per 1000 people. According to the World Bank's 2014 *Mozambique Public Expenditure Review*, the country registers below average health performance relative to its SSA peers, yet spends more on public sector wages than the SSA average. To improve efficiency, the report stresses the importance of managing demands for salary increases and reprioritizing the wage bill to strengthen the existing focus on the recruitment and retention of civil servants in priority areas such as health[18].

**FIGURE 7** **Elements of recurrent expenditure at the central and provincial levels**




***Source:*** *Author's calculations from CGEs 2011-2013, REO IV 2014, and LOE 2015.*

Note: The figure demonstrates trends in recurrent expenditure at the central and provincial levels; for lack of publicly available data, the figure does not include the recurrent expenditure for SDSMAS at the district level. In 2011, wages were deconcentrated from the provincial level to the district level. * The 2014 public expenditures account has yet to be finalized. ** The 2015 total represents the initial budget allocation and not expenditure.

16) World Bank. World Development Indicators. 2008, 2012 (most recent data).
17) Government of Mozambique. *Programa Quinquenal do Governo* 2015-2019. Quadro 1. Page 19.
18) World Bank, *2014 Mozambique Public Expenditure Review.* September 2014. Pages 14, 26, 29.

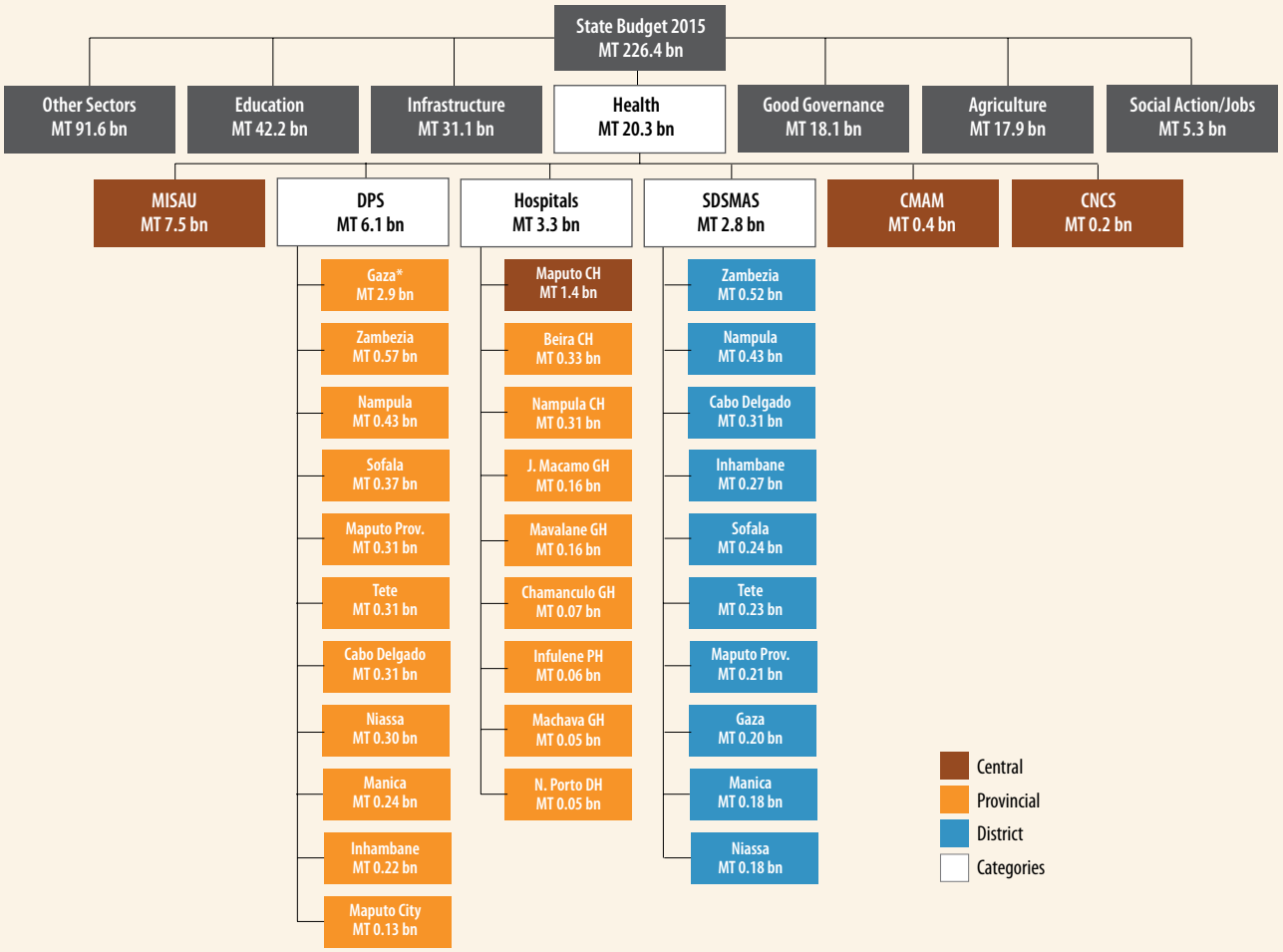
## 4.2 EXPENDITURE BY HEALTH INSTITUTION

**Of all the 2015 Health Sector budget, MISAU central office received the largest share, followed by DPS, Hospitals, and SDSMAS** *(see Figure 8).* MISAU, the institution responsible for leading the Health Sector, was budgeted MT 7.5 bn. Comparing the allocations to each Direcção Provincial de Saúde (DPS) and each Secretaria Distrital de Saúde, Mulher e Acção Social (SDSMAS), the bodies responsible for leading the Sector in the provinces and districts, respectively, the Zambézia Province receives the largest *nominal* total allocations[19]. The Maputo Central Hospital was budgeted MT 1.4 bn, approximately the equivalent allocation as all other hospitals in the country (with a unique UGB) combined.

**The inclusion of SDSMAS in the formal Health Sector composition[20] in 2012 was accompanied by a proportional decrease in DPS's share of the health budget[21].** The spending volume of DPS declined from a 30 percent share of the health budget in 2010 to a 13 percent share in 2013 *(see Figure 9).* Nonetheless, the figure can be a bit deceiving as there has been district-level health spending by SDSMAS since at least 2008. In fact, SDSMAS was budgeted MT 0.2 bn in 2008, MT 0.35 bn in 2009, MT 0.44 bn in 2010, and MT 1.2 bn in 2011[22]; however, it is unclear where those expenditures were registered before the district entity was formally included into the Health Sector composition in 2012.

**47%** of the Health Sector's allocations were at central level

**FIGURE 8** Organigram of health institution expenditure




***Source:*** *Author's compilation from the LOE 2015.*

**Note:** CH = Central Hospital, GH = General Hospital, DH = District Hospital, PH = Psychiatric Hospital, bn = Billion. *It is very probable that the initial allocation for DPS Gaza is a decimal mistake and thus should be MT 0.29bn.

19) An evident decimal error in the LOE 2015 has allocated the Gaza DPS a higher budget; however, once corrected –as is evident in the updated allocation in the REO I 2015– Zambézia has the higher nominal initial allocation.

20) The Health Sector composition is most easily tracked in the priority sector summary charts in Mapa I-1-1 in the CGEs and Mapa III-3 in the REOs.

21) According to the figure, the DPS share then grows to 19 percent in 2014 and 30 percent in 2015. This must be interpreted with caution as it is likely that as donor vertical project funds are inscribed on the budget under MISAU, the share of MISAU expenditure for 2014 and 2015 will rise.

22) These are the author's calculations from the 2008 – 2011 LOEs, Acompanhantes da Lei. Final district level expenditure is neither publicly available in the REOs nor the CGEs.

## 4.3 EXPENDITURE FOR THE CONTROL OF HIV/AIDS

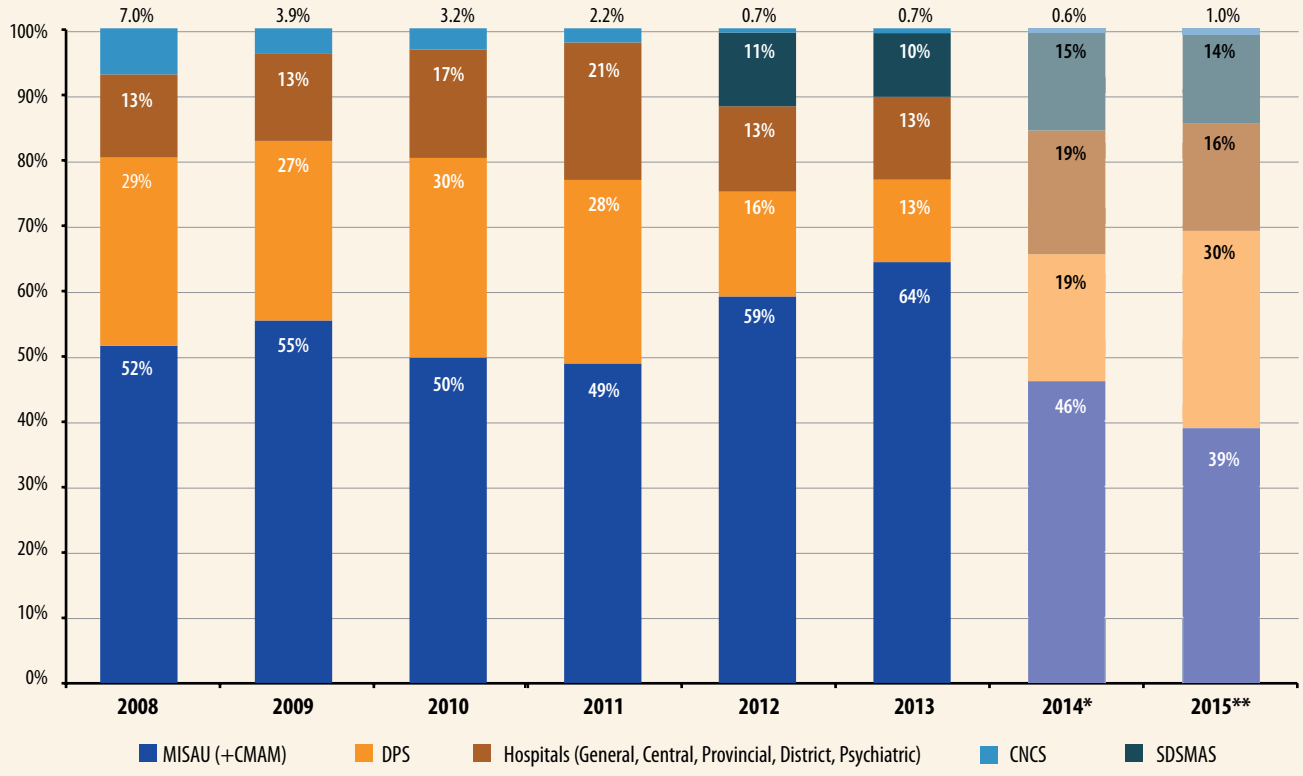
**Mozambique's fight against HIV/AIDS is largely funded by external development partners, notably The United States Government's PEPFAR program and The Global Fund** *(see Figure 10)*. Mozambique has the 8th highest HIV prevalence in the world, being home to four percent of all people living with HIV in the world. More than one in ten Mozambicans are infected. Nevertheless, of all the funds going towards HIV/AIDS interventions, only three percent came from Internal Resources in 2014. The remainder 97 percent came from external partner, including USAID's PEPFAR (72 percent), The Global Fund (15 percent), and the United Nations (including UNICEF), bilateral aid agencies, and other international organizations (ten percent). In fact, internal spending on HIV/AIDS has been decreasing over time. Expenditures by CNCS, the principle public institution responsible for HIV/AIDS response activities, have decreased from seven percent of the health budget (US$ 20mn) in 2008 to a budgeted one percent share (US$ 5 mn) in 2015 *(see Figure 9)*. This is principally due to the fact that the HIV/AIDS Common Fund –the once main funding mechanism for the CNCS and its provincial counterpart, NPCS– gradually decreased in volume before being formally abandoned in 2014. The CNCS is now funded through the State Budget.

**A significant funding gap threatens the Government's ability to scale up HIV treatment services in line with the Acceleration Plan for the Response to HIV/AIDS** *(see Figure 10)*.


Photo: ©UNICEF/Mozambique

There are an estimated 1.6 million people living with HIV in Mozambique. HIV/AIDs is the leading cause of death in adults, accounting for 40% of adult mortality, and the second leading cause of death for children (after malaria)[23] in the country. At the end of 2014, 67 percent of all adults, but only 48 percent of all children living with HIV were on antiretroviral therapy (ART)[24]. The Government, through its Acceleration Plan, aims to enroll 80 percent of people eligible for ART by the end of 2017 (almost 800,000 people).

**FIGURE 9** Weight of Health Sector components over time




***Source:*** *Author's calculations from CGEs 2011-2013, REO IV 2014, and LOE 2015.*

**Note:** In 2013, CMAM was deconcentrated from MISAU; for the sake of the analysis, MISAU and CMAM are considered together across the time series. * The 2014 public expenditures account has yet to be finalized; in this regard, it is possible that the totals are different than portrayed. ** The 2015 figures are initial budget allocations and not expenditure.

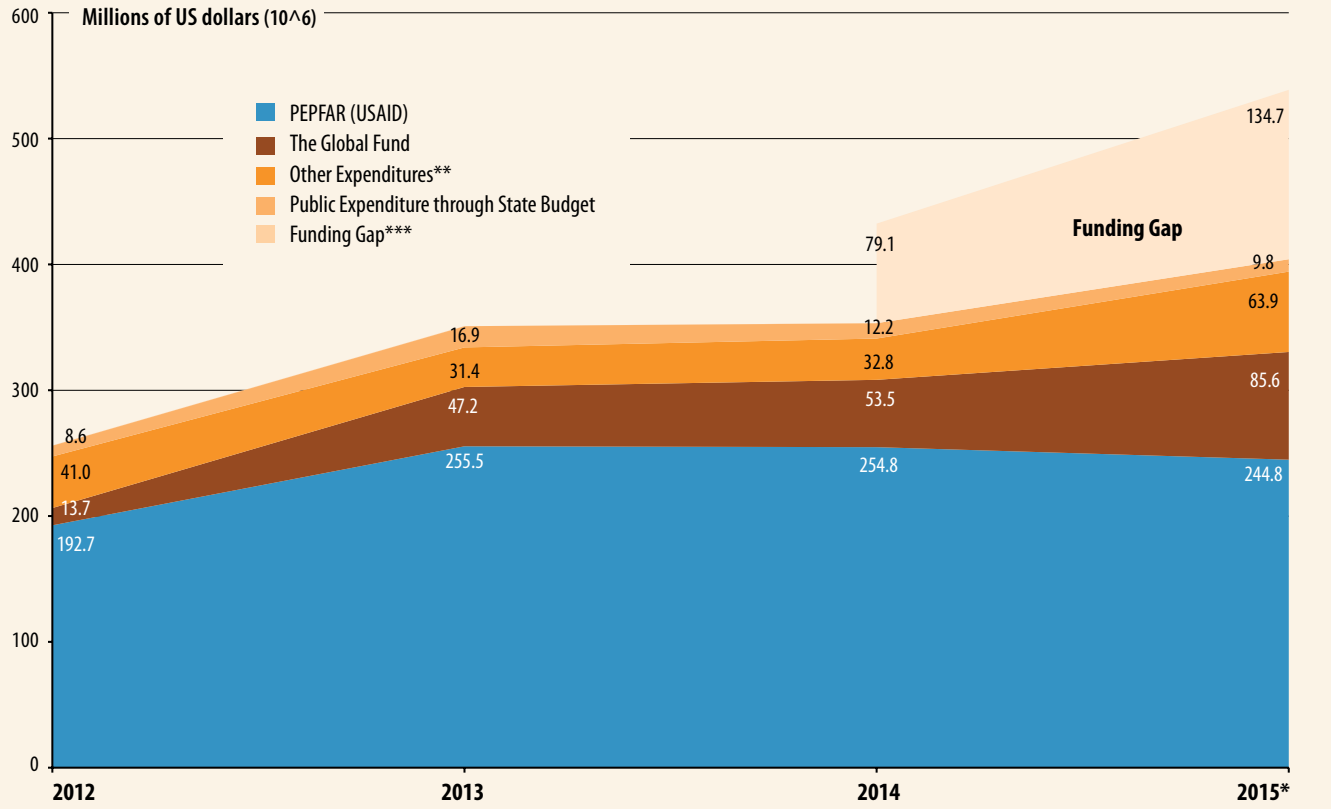
23) MISAU. *Relatório Anual das Actividades Relacionadas ao HIV/SIDA 2014*. Maputo, 2014.
24) UNAIDS. *The Gap Report*, 2014. Available at: [http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf].

Photo: ©UNICEF/Mozambique

*Mozambique has the 8th highest prevalence of HIV in the world. It is the leading cause of death in the country. However, the country's fight against HIV is almost entirely funded by donors*

These drugs are currently entirely covered by external aid. A serious financing gap –estimated to be as much as US$ 134.7 mn in 2015[25]– jeopardizes the health system's ability to fund ART, infrastructure for supply procurement, M&E surveys, additional health and community worker positions, HIV testing and counseling, behavioral change programs, etc[26]. While the State Budget cannot, at this stage, replace external aid in the fight against HIV/AIDS, given the burden of this silent epidemic, the Government should commit to significantly increase domestic financing for this area, as well as work with the donor community to develop a plan to mobilize further resources to fill the funding gap necessary to expand access to life-saving quality treatment and services.

**FIGURE 10** **Expenditure and budgeting for the fight against HIV/AIDS**




***Source: For years 2012-2014:*** *GARPR 2015 Narrative Report, Indicator 6.1, Tabela 14. For 2015: Author's calculations from the LOE 2015 and Global Fund "HIV Financial Gap Analysis and Counterpart Financing Table" Excel file.*

**Note:** * Whereas 2012-2014 represents expenditure, 2015 represents budgeting. ** "Other Expenditures" include spending realized by households, bilateral aid agencies other than USAID, development banks (grants), United Nations, and other international organizations. *** "Funding Gap" is the author's calculation based on Global Fund staff estimates of the cost of implementing the national multi-sectorial plan for HIV. According to The Global Fund's "HIV Financial Gap Analysis," the cost of implementing the National Strategic Plan is US $432 mn in 2014, $538 mn in 2015, $520mn in 2016, and $532mn in 2017.

25) The Global Fund. *HIV Financial Gap Analysis and Counterpart Financing Table,* 2015. It is worth noting that a July 2015 MSF briefing paper, "Defying Expectations," lists the funding gap at US $143 million.
26) Medecins Sans Frontieres (MSF). *MSF Briefing Paper: Defying Expectations.* July 2015. Table: "Register of Unfunded Quality Demand", Page 7.

*From spending just 70% of its budget in 2008, the sector has improved execution rates to reach 93% in 2013*

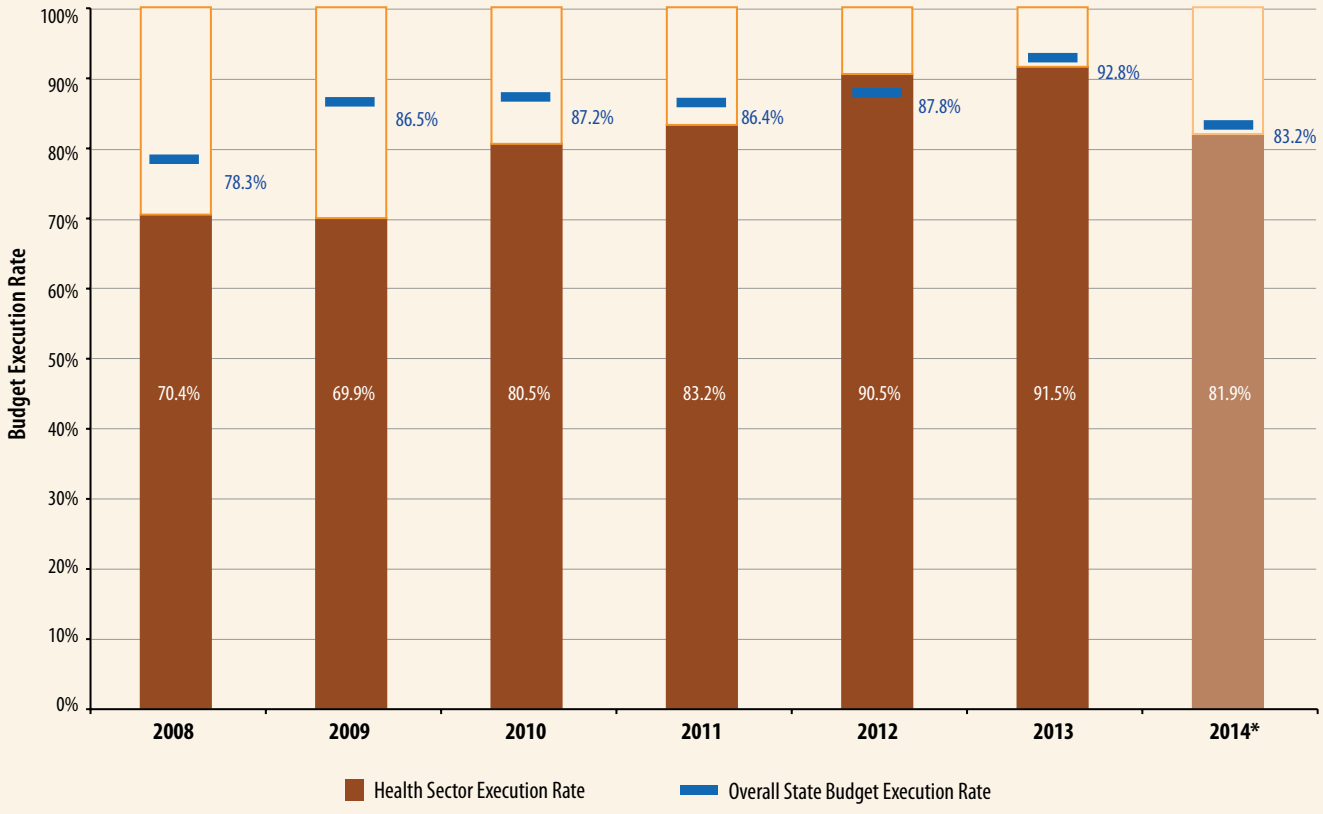

Photo: ©UNICEF/Mozambique

## 5. How well has the Health Sector executed its past budgets?

**Health Sector institutions have collectively improved budget execution rates in recent years to catch up to the overall State Budget execution rate** *(see Figure 11).* From spending just 70 percent of their budgets in 2008, Sector institutions have improved year-on-year execution rates to reach 93 percent in 2013. This might be due to the fact that many of the projects financed by cooperation partners are being inscribed in the budget and their execution might be bringing the overall execution rate up, as evidenced by Figure 3.

**Maputo Central Hospital and DPS Cabo Delgado were the health institutions at the central and district levels, respectively, that displayed the weakest execution rates in 2013, both executing just 74 percent of their budgets.** Despite low average budget execution rates in the 70s between 2008 and 2011, MISAU managed to execute 92 percent of its budget in 2012 and 93 percent in 2013; nonetheless, this is still under the 95 percent target laid out in Objective six of the PESS.

**FIGURE 11** Budget execution in the Health Sector




***Source*: *The State Budget execution rates:*** *CGE 2008 (Quadro 2, pg.21); CGE 2009 (Quadro 2, pg.28); CGE 2010 (Quadro 2, pg.22); CGE 2011 (Quadro 7, pg. 27); CGE 2012 (Quadro 6, pg. 28); CGE 2013 (Quadro 7, pg. 37); REO IV 2014 (Tabela 2, pg. 9).* ***Health Sector execution rates:*** *Author's calculation using CGE 2008-2013 and REO IV 2014.*

**Note:** The brown bars represent the Health Sector budget execution rate and the blue hash represents the entire state budget execution rate. * The 2014 public expenditures account has yet to be finalized; in this regard, it is likely that the execution rates will be higher for the release of the CGE 2014.

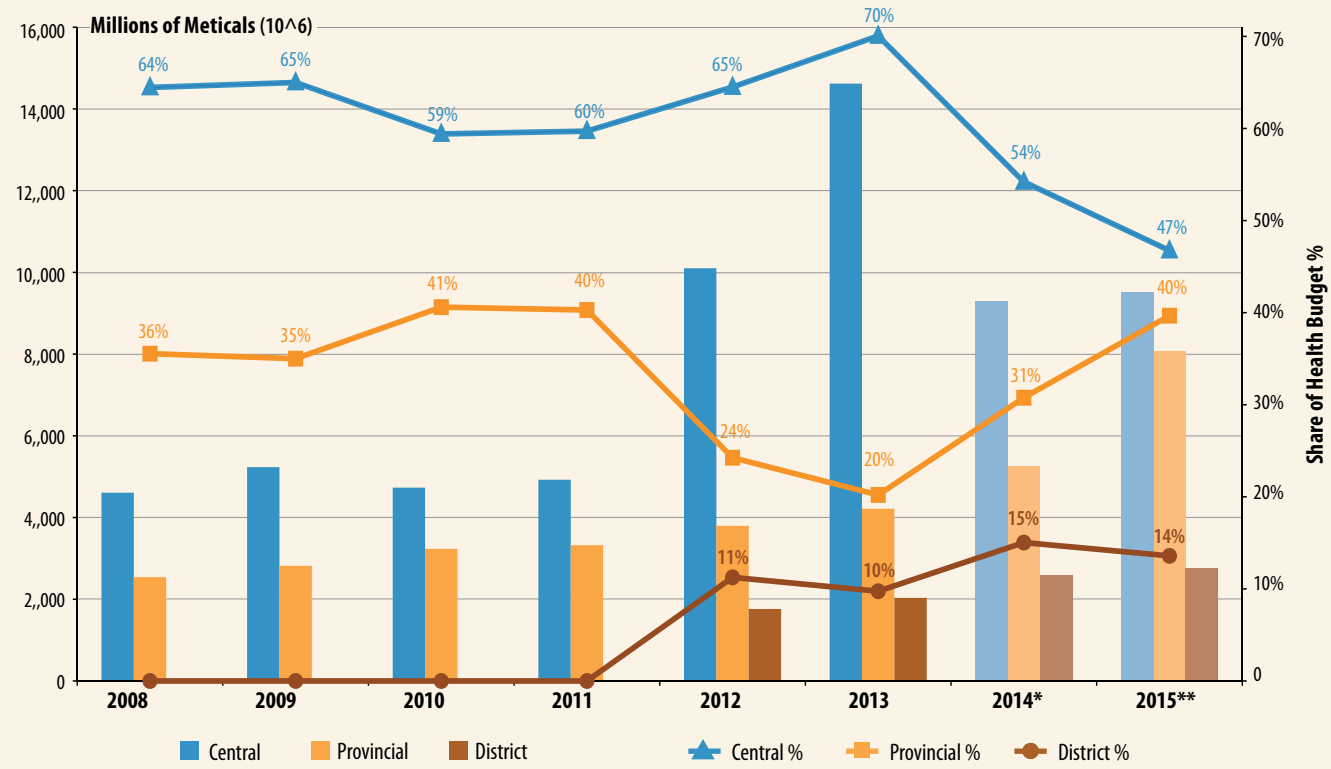
Photo: ©UNICEF/Mozambique

## 6. To what extent has the Health Sector deconcentrated?

**In 2012 and 2013 –the two most recent years for which the state accounts have been finalized– there is clear deconcentration from the provincial to the district level** *(see Figure 12)*. However, the growth in External Investment for the same two years at the central level implies more resources are being executed at the central level than ever before, in plain contradiction to PESS's second pillar, which stresses deconcentration to be at the heart of sector reform[27]. This, in fact, is more likely the consequence of the standard accounting practice to inscribe donor Vertical Projects under MISAU at the central level, no matter where they are being implemented. Nonetheless, the 2015 budget suggests a deconcentration of funding from the central level to the provincial level to counter the impression of centralization in 2012 and 2013[28].

**The Sector has been slow to deconcentrate the budget execution of various health institutions from the central level.** In 2013, CMAM and the Nacala Porto District Hospital were deconcentrated from MISAU and (presumably) DPS, respectively. However, no additional institutions have since been deconcentrated despite MISAU's Directorate of Administration and Finances (DAF) having identified the deconcentration of five subordinate central level institutions, 12 District Hospitals, and 14 Rural Hospitals as a priority for each of the past two years[29]. To give a perspective, there are 47 Rural Hospitals, 1233 Health Centers, and 157 Health Posts[30] that should eventually be deconcentrated, because autonomous budget execution often improves transparency and accountability.

**FIGURE 12** Expenditure by territorial level




***Source:*** *Author's calculations from CGEs 2011-2013, REO IV 2014, and LOE 2015.*

**Note: Central Level includes:** MISAU, CMAM, Maputo Central Hospital, and CNCS; Provincial Level includes: DPS, Provincial Hospitals, General Hospitals, Nampula and Beira Central Hospitals, Infulene Psychiatric Hospital, and Nacala Porto District Hospital; **District Level includes:** SDSMAS. SDSMAS was deconcentrated as a district level entity in 2012, CMAM was deconcentrated as a central level entity in 2013, and Nacala-Porto District Hospital was deconcentrated as a provincial level entity in 2013. * The 2014 public expenditures account has yet to be finalized. ** The 2015 figures are initial budget allocations and not expenditure.

27) MISAU. *Plano Estratégico do Sector da Saúde* (PESS) 2014-2019. Pages 47-49.

28) It is important to understand that deconcentration in the Health Sector from a central institution to a provincial or district institution is essentially devolution to a lower extension of the same single body, MISAU.

29) 2014 Health REO, Page 23; 2015 Health REO, Page 26.

30) Instituto Nacional de Estatística (INE). *Estatísticas e Indicadores Sociais, 2012-2013*. Page 39, Quadro 3.2.

# 7. How does the Health Sector address Mozambican health challenges?

## 7.1 CHALLENGES AT THE NATIONAL LEVEL

**On indicators for HIV/AIDS, Nutrition, Malaria, and Child Mortality, Mozambique underperforms the Sub-Saharan Africa (SSA) average on three of the four** *(see Figure 13)*. The country exhibits a higher incidence of chronic malnutrition/ stunting, malaria, and people living with HIV/AIDS than its peers on the continent.

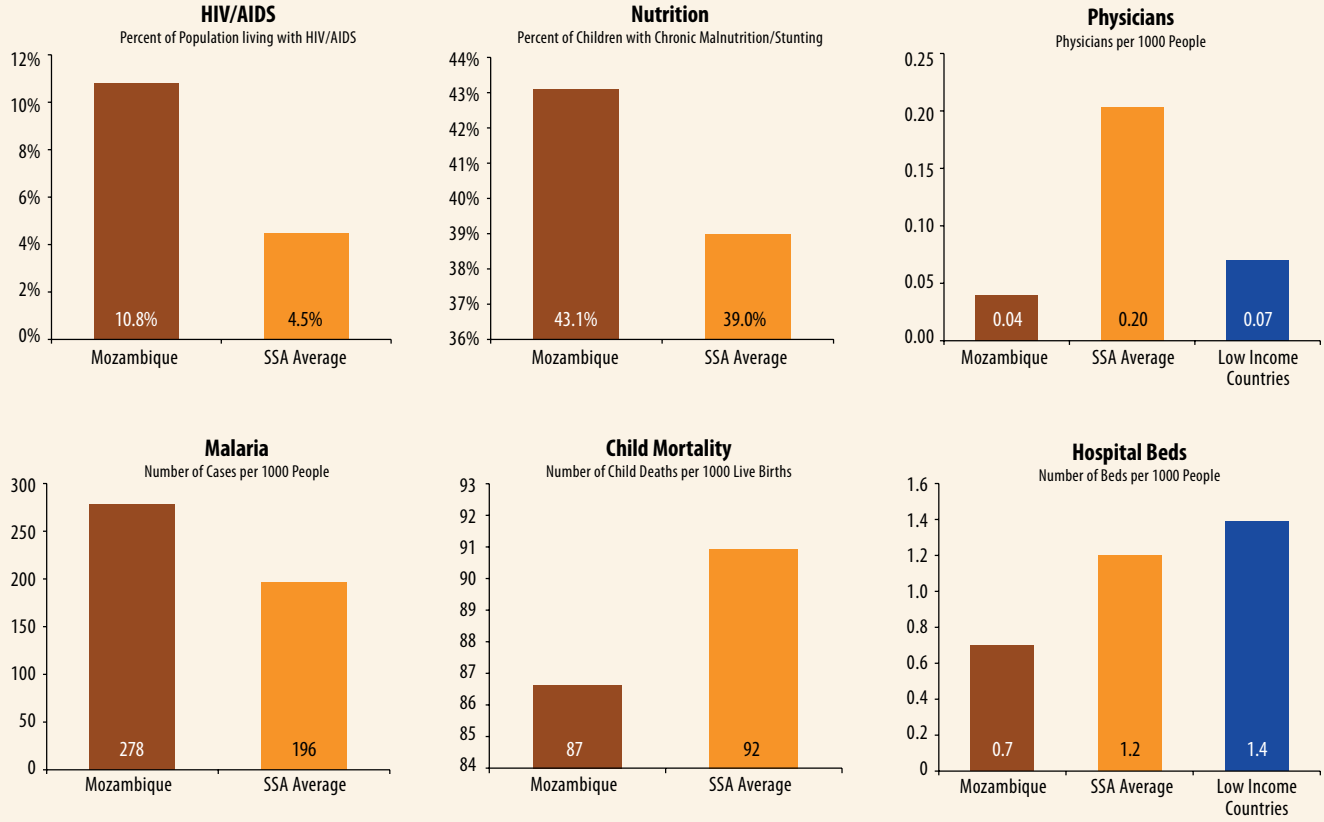
**Yet, in attempting to confront these challenges, Mozambique spends less per capita on health** *(see Figure 14)* **and has less health infrastructure compared to its peers** *(see Figure 13)*. The country spends just US$ 43 (MT 1,505) per Mozambican each year compared to the US$ 102 (MT 3,570) per capita SSA average and the US$ 237 (MT 8,295) per capita Southern African Development Community (SADC) average[31]. Although the volume of the Mozambican Health Sector was worth a greater share of the State Budget and GDP than the SSA average in 2013 *(see Figure 4),* its per capita expenditure was significantly less than the average due to the country's large total public spending to GDP ratio.

**1,500 MT**

Is how much Mozambique spends per person each year on health, compared to 8300 MT on average for SADC

For Mozambique to reach the SSA per capita average, it would have to spend MT 48.8 bn (US$ 1.4 bn), more than twice what it currently spends on health, clearly not possible given the lack of fiscal space at the moment. Due to its relatively low health spending in past years, the country is less equipped –in terms of health workers and hospital beds– than its peers to respond to the disproportionate public health and health care challenges.

**FIGURE 13** Performance on major health indicators relative to peers




***Source: HIV/AIDS:*** *WB WDI, 2013. Prevalence of HIV, total (% of population ages 15-49).* ***Malaria:*** *WHO Global Health Observatory Data Repository, 2012. Estimated Incidence per 1000 people (2012).* ***Nutrition:*** *WB WDI, 2013. Malnutrition prevalence, height for age (% of children under 5).* ***Child Mortality:*** *WB WDI, 2013. Mortality rate, under-5 (per 1,000 live births).* ***Hospital Beds:*** *WB WDI, 2013. Hospital beds (per 1,000 people).* ***Physicians:*** *WB WDI, 2013. Physicians (per 1000 people).*

31) Author's calculation based on the SADC country numbers in *Figure 14.*

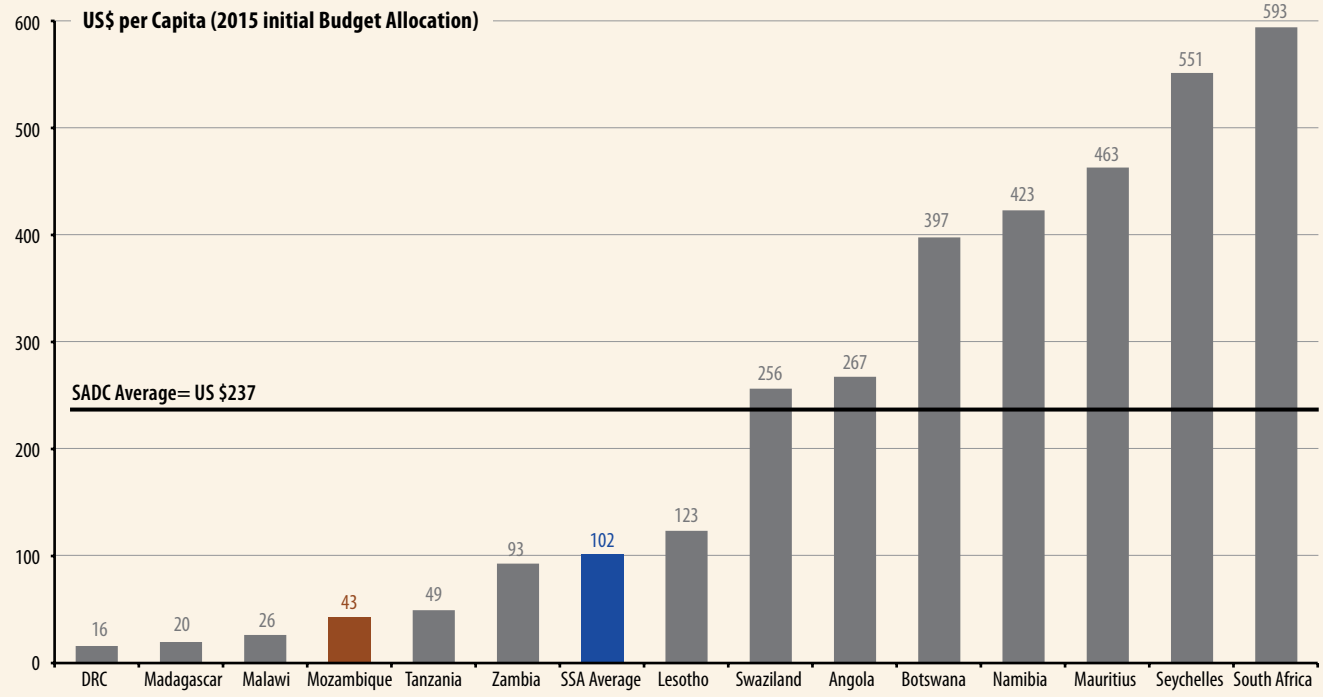
Photo: ©UNICEF/Mozambique

**Probable expansion of the country's fiscal space, due to expected revenues from the country's extractive industries and growth in non-extractive GDP, represents a great opportunity for increased priority sector spending, especially in the Health Sector.** According to UNICEF Mozambique's Situation Analysis Report on Fiscal Space (2014), assuming expected non-extractive GDP growth, all scenarios imply a substantial increase in absolute terms for the overall fiscal resource envelope. By 2023, following a 5.5 percent fiscal deficit rule over the period, the government would be able to spend nearly MT 325 bn in 2012 prices (compared to MT 150 bn in 2012) in an optimistic forecast and still MT 265 bn in a conservative forecast[32]. If managed effectively, this added fiscal space will go a long way to address the health infrastructure and personnel gap. However, since revenues are still a few years out, and because they are finite, the Sector must prioritize realizing efficiency gains as described in objective four of the PESS. For example, the provision of community-based interventions would bring health prevention and promotion services and basic care closer to communities and at lower costs[33].

## 7.2 CHALLENGES AT THE SUB-NATIONAL LEVEL

**The provinces with the lowest health performance indicators are among the ones that receive less per capita funds** *(see Figures 15 & 16)*. Nampula, which has the highest prevalence of child malnutrition and malaria, is the least per capita funded province. Zambézia, which has the highest child mortality rate, is the third least per capita funded. Meanwhile, Gaza has the highest prevalence of persons living with HIV/AIDS, yet is among the better per capita funded. Nampula was allocated just MT 243 per person (US$ 14)[34] and Zambézia was allocated just MT 264 per person (US$ 15). These per capita budgets, which exhibit little change from the previous year, fall especially below the SSA and SADC average per capita funding levels.

**FIGURE 14** Per capita health funding relative to peers



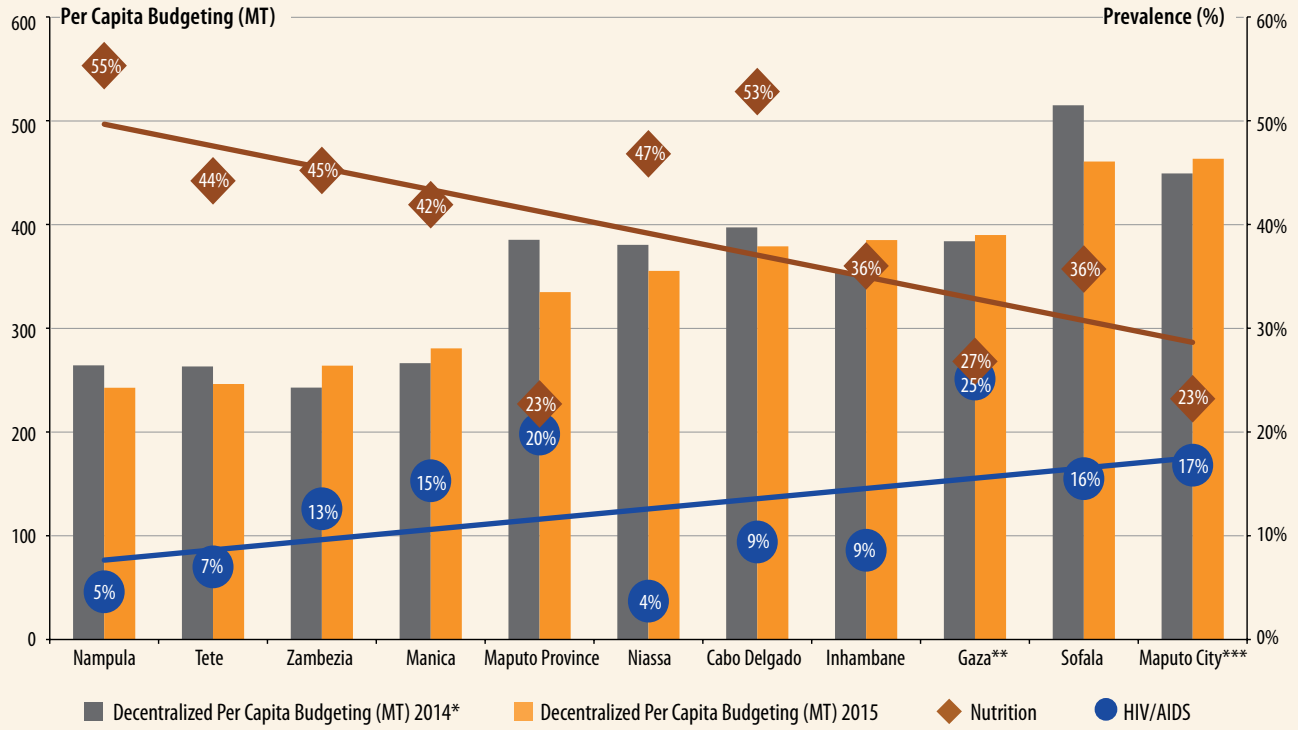

***Source:*** *WB WDI, Health expenditure per capita (current US$), 2013.*
**Note**: The per capita amount for Mozambique is author's calculation from the LOE 2015.

32) It is important to emphasize that the fiscal space expansion will be predicated on ODA resources and non-resource GDP growth. The report is keen to point out that resource income is not expected until 2020, during which it will be limited, until productive capacity is expanded into the mid-2020s. [UNICEF Mozambique. *Mozambique Situation Analysis: Fiscal Space and Financing Scenarios in the Context of the Resource Boom.* January 2014. Pages 43-45, 50].

33) World Bank. *2014 Mozambique Public Expenditure Review. September 2014.* Page 81.

34) For lack of publicly available information, these two per capita calculations do not factor in central level expenditures in the provinces. Calculation based on PPP conversion factor of 17.632. WBI, PPP conversion factor, GDP (LCU per international $).

**FIGURE 15** Per capita health funding by province relative to HIV/AIDS, nutrition indicators




***Source:*** *Per capita expenditure amounts are Author's calculations using the REO IV 2014 and LOE 2015 including just the district and provincial health institutions, organized by province. District population figures come from Mozambique's Instituto Nacional de Estatística (INE).* ***HIV/AIDS:*** *2009 Prevalence of HIV, total by province (% of population ages 15-49) from National Survey on Prevalence, Behavioral Risks and Information about HIV and AIDS in Mozambique (2009 INSIDA).* ***Nutrition:*** *2011 Malnutrition prevalence, height for age (% of children under 5) from IDS 2011, pg.156, Quadro 11.1.*

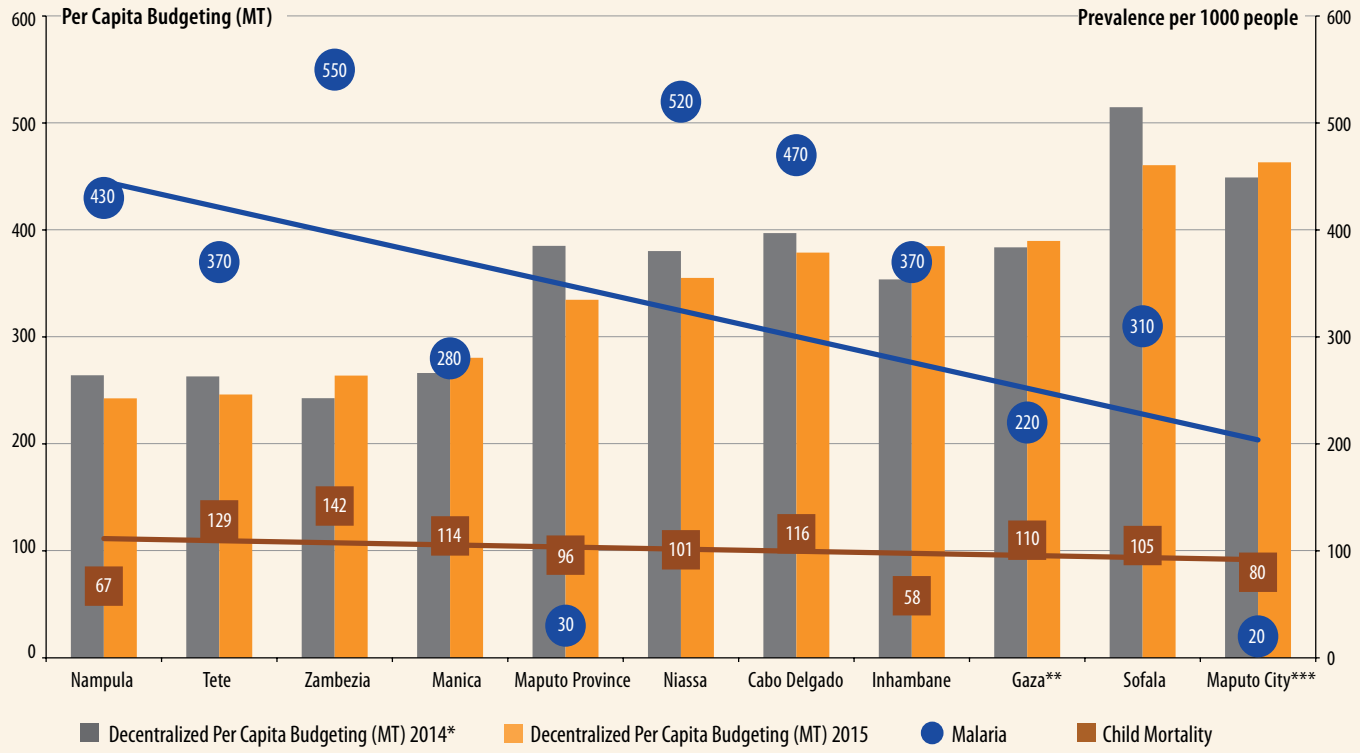
**Note:** The provincial per capita amounts are estimates due to limitations in available data, most notably because it is not possible to discriminate which portion of the central level budget goes to projects at the provincial level, and to what province. * For lack of publicly available data, the 2014 figures for SDSMAS are budget allocations and not actual expenditure. ** For 2015, the DPS initial budget allocation to Gaza was 2,800,768 thousand Meticais. Assuming this was an error, the author modified the figure moving the decimal one place to the left such that it would correspond to other allocations in other provinces. *** The health infrastructure in Maputo treats people from other provinces, notably extreme cases.

**In order to accelerate improvements in performance indicators and correspondingly achieve Sector goals, the Health Sector must target the neediest provinces with additional funding.** Despite Zambézia and Nampula having the highest nominal DPS and SDSMAS allocations in both 2014 and 2015 *(see Figure 8),* they are among the three lowest per capita funded provinces (they are the most populous provinces). The small allocations they currently receive are unlikely to reverse the geographical disparities as envisioned by PESS objective three. The Sector's various actors must work together to expand health infrastructure, staff, and services to rural areas where the most need exists, and where the most progress can be made in improving indicators to meet medium- and long-term goals.

## Conclusion

Over the past few years, after receiving less priority in the State Budget, the Health Sector has begun to receive a bigger share of the total resources. Yet, despite significant growth in the volume of Health Sector expenditure in 2012 and 2013, likely high spending in 2014, and the highest-ever initial allocation for 2015, the Sector is still far from addressing the PESS funding gap, reaching the average per capita funding levels of its neighbors, and realizing the efficiency gains necessary to accelerate progress on health performance indicators. Low decentralized spending, especially in marginalized provinces, significantly hinders this progress. Nevertheless, strong growth in the provision of domestic resources for health, improvements in Sector budget execution, and the growing tendency for development partners to place their interventions on-budget in order to improve Sector planning and fiduciary arrangements, create optimism for progress. The Mozambican Health Sector has a long way to go to catch up with its peers, nonetheless, the current trends create positive expectations for the future.

**FIGURE 16** Per capita health funding by province related to malaria, child mortality indicators




***Source:*** *Per capita expenditure amounts are Author's calculations using the REO IV 2014 and LOE 2015 including just the district and provincial entities, organized by province. District population figures come from Mozambique's Instituto Nacional de Estatística (INE).* ***Malaria:*** *Prevalence of Malaria for Children between 6 and 59 months, as determined by a Rapid Diagnostic Test (converted from percentage into a prevalence per 1000 people). Mozambique Inquérito Demográfico e de Saúde (IDS) 2011, pg. 192, Quadro 12.11.* ***Child Mortality:*** *Mortality rate, under-5 (per 1,000 live births). Mozambique Inquerito Demografico e de Saude (IDS) 2011, pg.116, Quadro 8.2. (Figures were converted into percentiles).*

**Note:** The provincial per capita amounts are estimates due to limitations in available data, most notably because it is not possible to discriminate which portion of the central level budget goes to projects at the provincial level, and to what province. * For lack of publicly available data, the 2014 figures for SDSMAS are budget allocations and not actual expenditure. ** For 2015, the DPS initial budget allocation to Gaza was 2,800,768 thousand Meticais. Assuming this was an error, the author modified the figure moving the decimal one place to the left such that it would correspond to other allocations in other provinces. *** The health infrastructure in Maputo treats people from other provinces, notably extreme cases.

## Glossary of Budget Terms

**Budget Execution (Execução do Orçamento):** Percentage of allocated funds spent out of the total allocation

**Deconcentration (Desconcentração):** Shifting autonomous budget responsibility from a more centralized level to the provincial or district level.

**Expenditure (Despesa Realizada):** Allocated funds spent on health investment, services, and products

**Initial Allocation (Dotação Inicial):** The first allocation of funds, approved by Parliament

**Revised Initial Allocation (Dotação Rectificativa):** A revised allocation of funds, approved by Parliament

**Updated Allocation (Dotação Actualizada):** The total funds that arrive at the disposal of a given health institution

## Acronyms

| | |
|---|---|
| bn | Billion |
| CGE | General State Account (Final Budget Report) |
| CMAM | Centre of Medicines and Medical Articles |
| CNCS | National Council for the Fight against HIV/AIDS |
| CUT | Single Treasury Account |
| DPS | Provincial Health Directorate |
| FC | Common Fund |
| GBS | General Budget Support |
| G19 | Group of 19 General Budget Support donating countries |
| HCM | Maputo Central Hospital |
| LOE | State Budget Law |
| MISAU | Ministry of Health |
| mn | Million |
| MT | Mozambican Metical (Local Currency) |
| NPCS | Provincial Nuclei for the Fight against HIV/AIDS |
| PESS | Health Sector Strategic Plan |
| PPP | Purchasing Power Parity |
| PQG | Government Five Year Plan |
| REO | State Budget Execution Report (Budget Update Report) |
| SADC | Southern African Development Community |
| SDSMAS | District Service for Health, Women, and Social Action |
| SSA | Sub-Saharan Africa |
| UGB | Beneficiary Management Unit, designates autonomous funds-receiving institutions in Budget |
| WB | World Bank |
| WDI | World Development Indicators |



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