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Political economy of the health sector in Mozambique

Towards an understanding of its features, dynamics and challenges

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AJA	Annual Joint Assessment
ATM	*Autoridade Tributária de Moçambique* (Mozambican Tax Authority)
BAG	Budget Analysis Group
DAH	Development Assistance to Health)
DFID	Department for International Development
DNEAP	*Direcção Nacional de Estudos e Analises de Politicas* (National Directorate for Studies and Policy Analysis
DPS	*Direcção Provincial de Saúde* (Provincial Health Directorate)
Frelimo	*Frente de Libertação de Moçambique* (Mozambique Liberation Front)
GF	Global Fund
GNP	Gross National Product
HIV	Human Immunodeficiency Virus
IHME	Institute for Health Metrics and Evaluation
INE	*Instituto Nacional de Estatística* (National Statistics Institute)
MDM	*Movimento Democrático de Moçambique* (Mozambique Democratic Movement)
MISAU	*Ministério da Saúde* (Ministry of Health)
MoH	Ministry of Health
MP	Member of Parliament
MT	Metical (national currency)
NGO	Non-Governmental Organization
NHS	National Health Systeme (Systema Nacional de Saúde)
NSA	Non-State Actors
ODI	Overseas Development Institute
OE	*Orçamento do Estado* (State Budget)
PAC	*Plano de Acção Consolidado*Consolidated Action Plan
PAP	Programme Aid Partners
PDA	Power and Change Analysis
PEDD	Plano Estratégico de Desenvolvimento do Distrito (District Strategic Development Plan)
PES	*Plano Económico e Social* (Annual Social Economic Plan)
PESOD	*Plano Económico e Social e Orçamento do Distrito* (District Social Economic & Plan and Budget)
PESS	*Plano Estratégico do Sector da Saúde* (Health Sector Strategic Plan)
PFM	Public Finance Management
PHC	Primary Health Care
PNS	Política Nacional de Saúde (National Health Policy)
PRE	Structural Adjustment Programme
PROSAUDE	*Progama do Sector da Saúde* (Health Sector Common Fund Programme)
RENAMO	*Resistência Nacional de Moçambique* (Mozambique National Resistance)
RSS	*Revisão do Sector da Saúde* (Health Sector Review)
SB	State Budget
SDSMAS	*Serviços Distritais de Saúde Mulher e Acção Social* (District Health Directorate)
SISTAFE	*Sistema de Administração Financeira do Estado* (State Financial Administration System)
SNS	*Sistema Nacional de Saúde* (National Health System)
SWAp	Sector Wide Approach
TOR	Terms of Reference
UGB	*Unidade de Gestão Beneficiária* (Budget Management Unit)

UN	United Nation
US	United States of America

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Executive Summary

1. Political economy analysis is concerned with understanding the societal and economic dynamics and effects arising from the different forms and qualities of political and economic control over resources (capital, labour, soil and sub-soil and marine resources, budgets, etc.) and modes of capital accumulation. As such, it examines the distribution, access to, and distribution of benefits of economic activity including that of the state via its public finances, i.e. it examines the economic and power relations between different sections, strata and classes of society.
2. Analyzing the public health sector in Mozambique from this angle, implies examining its structure, financing, policies and outcomes with regard to the societal actors which, on the one hand, determine the allocation and the distribution of resources, and the policies and management approaches they employ, and, on the other, those, i.e. the 'public', in whose name the services are produced, provided and distributed, and who benefit from and pay for these services, directly (via fees) or indirectly, via taxes.
3. One key underlying assumption of the present analysis, arising from a number of epidemiological studies, is that health services and outcomes are highly correlated with the degree of (in)equality of a society. From this point of view one can say that the more equal the allocation and distribution of resources (investment, land, labour, technology) and income from them, and the more equitable public services, including health, are distributed among social strata and across the territory of a given country, the better the collective health of that society is.
4. The present analysis is based on a review of general literature, specific sector related documents and interviews of 19 persons intimately associated with the health sector and public financial management. Firstly, it looks briefly at the structure and dynamics of the predominant political power i.e. that of the Frelimo party, which is perceived as a result of political settlements among sections of the elite associated with the control of the state and the country's wealth. This includes access to various sources of wealth, such as capital in its various forms, rents and public finances (budgets, taxes and expenditure). 'Clientilist' political settlement implies the distribution of part of that wealth (rents, budgets, etc.) among 'clients', which sustain the ruling coalition and maintain it in power via elections and loyalty. Certain indicators for a socio-economic conflict potential are noted, arising from a tendency of perceived or *de facto* exclusion of increasing segments of the population (e.g. in urban areas and in areas of mineral extraction or large-scale agro- forestry projects) from access to and benefits of resources distributed by the patron to the client. Health is considered to be one of these critical areas. As recent 'social earthquakes' demonstrate, such conflict potential can turn violent, if it is not adequately addressed.
5. Concerning health in general, and the National Health System (NHS) in particular, a change of approach and ideology is noted, which varies with the political settlements within the party along its history. While in the immediate post- independence era the health policy was 'free health for all', and great effort was made to reverse the inherited urban-biased and hospital-based curative care, at present, while emphasis on public health providers is maintained, private providers, some linked to the elite, are emerging, mainly in urban area. This reflects social-economic stratification and a

differentiation process attributable to economic growth, the generation of mineral and other forms of rents (aid), etc. Yet, the socialist NHS established at the time of Independence together with the National Health Policy reformulated in 1995 has not been adjusted to the socio-economic changes of the last two decades, i.e. the period after the Rome Peace Agreement of 1992.

6. Concerning the financing of the health services, the study produces evidence for the following trends:
   - Government spending on the health sector is declining in relation to overall budget expenditure;
   - The domestic per capita expenditure in the national health budget is delinked from (increasing) per capita revenue from domestic sources;
   - Financing of the health sector via the state budget is outdone by financing from external resources. In 2011 alone the contribution to the health sector from the US Government sources was equivalent to the aggregate of budget allocations coming from both the domestic budget and from the contribution of the PROSAUDE donors;
   - The financing of the health services coming from private households is also slowly increasing;
   - Mozambique's health sector financing can be considered an exception from a worldwide trend which shows declining foreign support for health while domestic allocations increase.
7. The dominance of foreign aid in the health sector has mixed effects on outcomes. While progress in expanding health services and implementing programmes targeted on certain diseases via 'vertical funding' is notable and, partially attributable to donor support, the predominance of health donors has also less desirable effects: it maintains the country's health sector on the continued benevolence of donors, overstretches the institutional capacity of the sector concerning management and coordination and leads to its fragmentation, given the multiple and diverse approaches to management, reporting and monitoring. It also incentivises a 'brain drain' of health staff from the NHS to donor funded health projects due to salary differentials. One can rightfully speak of the phenomenon of 'Dutch disease' in the health sector, i.e. 'Too much wealth managed unwisely'.
8. The aid rent promotes forms of rent seeking, notably in its illicit form of corruption and non-transparent procurement, also in the health sector. One case in point is the budget for pharmaceuticals, the single most important spending programme in the state budget, where various scandals have become public in 2011, leading to a rupture of supplies of health units with certain medicines, and for certain provinces.
9. The budget allocation of expenditure for the NHS produces highly unequal effects. The central level (which manages the procurement, storage and distribution of drugs) benefitted, in 2009, from about 75% of the resources, with the rest for provinces and districts. In geographical terms, the distribution is highly distorted, with population-rich provinces receiving relatively less. This distribution pattern has various reasons, one of them being the incremental approach to budgeting, which carries forward the stark historical inequalities. Government is aware of these patterns and attempts to remedy the horizontal distribution pattern.
10. Despite political decentralization rhetoric, its effects on health services and their endowment with resources seem minimal. The study produces some evidence that

the District Services for Health, Women and Social Action (SDSMAS) and health units at district level have lost autonomy in managing of and accounting for their budgets. This is partially attributable to the fact, that they do not have the status of Management Units in e-sistafe, the Mozambican Public Finance Management (PFM) system?. Evidence suggests that these units occasionally lack not only medicines supposed to come from the centrally managed pharmaceutical sector, but also financial resources for acquiring services and goods, as well as for paying salaries. The adverse resource circumstances at sub-provincial level impact negatively on health outcomes and may be seen as a push factor for the brain drain mentioned above and a tendency by patients to seek health services at the provincial hospitals. A more rigorous and bold decentralization not only of functions, but also of resources and their management mechanism linked to e-sistafe are seen as necessary ingredients to boost the sector's performance at local level.

11. The study corroborates evidence produced elsewhere, notably by the Health Partners Group, for the proposition that the health sector's major challenge is its management of financial and human resources, not so much its financing. Triggered by the exit of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) from the PROSAUDE Partners in 2008 and an external audit of the 2009 accounts, the full dimension of the management challenges gradually have become clearer. The main causes are seen to be insufficient internal control mechanisms, lack of public external audits, human resource constraints in the Departments of Administration and Finance (retention, capacity), inefficient and non- transparent procurement, amongst others.
12. Another challenge lies in adequately reflecting, in the national health policy, the differentiation of health service providers which emerges as a result of the social stratification processes alluded to above. In the words of one insider of the NHS, the system is on its way to revert to a *de facto* class system, as it was in colonial days. The study produces some evidence for this assertion, which underlines the need to adapt the NHS and health policies to these dynamics, notably by providing a regulatory framework (so far absent) for private and semi-private health service providers, and by addressing the issue of user charges for health services, not only from a cost recovery point of view, but also from that of social justice.

13. The study draws some preliminary conclusions, which are forward-looking in nature:

    a) The political economic macro framework, i.e. power relations and economic and distributional dynamics as well as their consequences for governance, policies, etc., need to be seen as a given, at least in the short to medium term perspective. They are a result of foundational factors of Frelimo rule in Mozambique and will only change in the long term. This requires a sober assessment and understanding, without illusions, of the health sector's political and economic framework conditions, their dynamics and socio-economic consequences in relation to distributional factors and governance.
    b) Based on the analysis of evidence, it seems that the single most important factor to positively influence the health sector and its outcomes is the efficient, effective and transparent management of its resources: human, budgetary, assets, pharmaceutical pool, etc. The health partners Annual Joint Assessment

(AJA) report for 2010 flags the management issue, as does MISAU's input paper on health financing for health sector review. The fact that a sizable 37% of the sector's resources are spent on the management and administration of the public health programmes suggests that there are enough reserves for increasing management efficiency.

c) Efficient and effective management depends, to a large extent, on a clear regulatory and policy framework, which sets strategic and operational objectives, defines options and addresses issues of viability and sustainability of the health system. Thus, the necessity of a clear policy and regulatory framework reflecting the dynamic and socio-economic changes affecting the sector becomes obvious, also from a management perspective. The study has produced some powerful arguments which support the need of reform of the sector – a view shared by almost all persons interviewed.
d) Since the overwhelming and increasing dependence on foreign funding of the health sector has negative effects on the sector's structure, political economy and sustainability, a review of the sectors financial base is called for. It would be necessary to look at soft modalities of reducing donor dependence, e.g. via intelligent exit strategies, but, more importantly, at health sector financing from domestic resource. The sector's funding would need to be re-linked to the domestic revenue generation dynamic and income distribution patterns. Especially tax revenue is likely to pick up via expected taxation of megaprojects and mineral extraction operations. On the other hand, rising private incomes in urban areas could be tapped into for health sector financing especially if associated with health insurance schemes.
e) Taking into consideration the new dynamic and leadership qualities in MISAU, and its commitment to improve management and address policy issues, the study concludes, that at present a window of opportunity for raising and discussing some of the pertinent issues addressed in this paper with government – an opportunity that should not be missed.

1 Introduction

Context

The present study was commissioned by the Department for International Development (DFID) in Mozambique. As a piece of independent research on the political economy of the health sector, it is considered to inform DFID's health sector support programme for the period 2012-2016 and to lead to more in-depth inquiries of Mozambique's health sector. The latter has witnessed a number of institutional, management, financial and governance challenges in the past few years, including a change in leadership considered important for the sector.

In Mozambique, DFID has been supporting the health sector strategic plan ever since it was approved in 2007 through sector budget support (PROSAUDE II). £34 million will have been disbursed to the Ministry of Health by the time this phase of funding closes in June 2012. The relationship with MISAU has been very positive, with DFID as focal partner for the health partner group from 2008-2010. DFID is now working on the next stage of their funding (2012-2016) for the health sector.

Objective

The objective of this consultancy is to inform the development of a health sector support programme for the Government of Mozambique and to highlight particular political economy challenges and opportunities that DFID Mozambique should take into account in supporting PROSAUDE[1].

Political economy of health

The analysis of the political economy in the health sector can conceptually be framed in different ways. One way of doing this is by examining the change of epidemiology, bio-medical characteristics of human bodies and occurrences in human life cycles (e.g. fertility, morbidity or mortality), as resulting from interventions by institutions of the health sector, under changing societal, economic, environmental and cultural conditions. This approach is often poverty-focused and is based on the underlying assumption that institutional changes inside and outside the health sector, such as steady economic development, the expansion of the market economy, rule of law, democracy and gendered empowerment, etc., lead to improvement of well-being and health in societies, if the institutional interventions (plans, programmes, service providers, etc.) are 'right' and dispose of sufficient financial and human resources and capacities as well as an adequate policy framework. That way, fertility and mortality rates are deemed to eventually decrease, infectious diseases contained and other progress in combating poverty and disease can be achieved (O'Laughlin, 2010: 7).

O'Laughlin and other authors have, however, strongly argued that the poverty focus on health is not sufficient to explain changes in health and well-being in societies. Instead they have suggested a focus on inequality, citing studies which 'have shown, that holding

[1] See TOR, Annex I

absolute poverty levels constant, health outcomes are worse for those who live in non-egalitarian societies than for those who live in egalitarian societies'. They thus conclude that unequal societies are also sick societies (O'Laughlin, 2010: 8[2]).

From that point of view, individual and collective health is determined by the social, economic, relations of power over resources (capital, labour, land, technology etc.) and people in the spheres of production, distribution and consumption. Depending on the theoretical perspective, these relations can be analyzed by looking at, for example, the 'fiscal sociology' (Schumpeter) of the public finances and state budget[3]. Another way of examining socio-economic inequality is class analysis in the Marxian tradition[4] which qualifies the relations of production, distribution and consumption between classes and strata owning the means of production and those providing labour and other resources, i.e. between capital-owning classes on the one hand, and workers and peasants on the other. This approach includes also the (global and national) spatial geographical pattern of capital accumulation in its analyses (Harvey, 2006). A third approach, preferred by the authors, is that of analysing the distributional outcomes of political settlements of dominant political and economic elites, notably in clientilist and rent-seeking political settings in Africa end elsewhere[5] (Khan, 2010). Seen from these angles, individual and collective health, and the effectiveness, quality and coverage of health systems reflects the power and class relations of a society emanating from predominant patterns of capital accumulation, the way and degree to which the state is constructed and instrumentalized by the ruling class alliances and from more, or less, encompassing socio-economic and distributive policies of the ruling elites. Health is thus an outcome of the dynamics between ruling elites, the state and society, reflecting struggles and alliances between them (O'Laughlin, 2010: 12). In other words, individual and public health is, to a large degree, determined by socio-economic relations and distribution patterns of wealth, even from an epidemiological point of view (Wilkinson and Marmot, 2006; Marmot, 2005).

Methodology

From the foregoing it should be clear, that an analysis of the political economy of the health sector needs to examine determinants both exogenous and endogenous to the sector. Concerning the former, it would take into consideration, for example, the structure of power and the state; the commanding heights of the economy, its dynamics and ownership patterns, the predominant type of labour and labour relations, the structure and sources of the budget (revenue and expenditure, etc.) and the spatial distribution of centres of capital accumulation and private and public investment including the urban/rural divide in health

2 O'Laughlin makes particular reference to the work of the British epidemiologist Wilkinson, whose work has focussed on the relationship between social inequality and health in a society. See: Wilkinson, 1996. 2005.

3 i.e. the analysis of the relationship between social classes and strata that, through their taxes, etc., finance the budget in relation to those who benefit from the spending (See: Schumpeter, 1991).

4 See: Smelser, 1973.

5 With Khan and others, we define rents as forms of income of individuals, (public and private) enterprises and corporate organizations (including political parties), which is not the result of work / labour or generation of surpluses and use values, but rather a result of strategic (geographical) advantages or (mineral) or financial resources, including foreign aid. Rent-seeking both in its legal (lobbying, contributions to parties) and illegal forms (bribes, nepotism, etc.) is 'the expenditure of resources and effort in creating, maintaining and transferring rents (Khan; Jomo, 2000: 70). The rent is distributed by a patron to groups of 'clients' – via client networks organized by the patron and the offering of certain benefits in exchange for their political, organizational, etc., support aimed at guaranteeing and stabilizing this system and maintaining the patron in a position of power and access to the sources of rent (Khan, 2010).

service provision. Among the endogenous factors to be examined are change processes concerning the institutions of the health sector (service providers, administration, etc.), its regulatory and policy framework, the (vertical and horizontal) planning and allocation of its financial and human resources as well as their management, the training and professional focus of health personnel. Using these criteria, the relationship between inequality, policies and approaches to health provisioning and health outcomes can be better understood over time.

The methodology prescribed for this study takes into consideration the very distinction between exogenous and endogenous determinants of the sector alluded to in the previous paragraph[6]. Given the time constraints for its elaboration, the study, however, cannot examine all aspects of both dimensions in depth, and the dynamics arising from each, for the health sector and its performance. Thus, it rather represents a broad analytical sketch of the political economy of the sector, with more focused and penetrating research of selected aspects to be following the present study, according to the TOR of this study. The performance of the health sector in Mozambique, i.e. the impact it produces on individual and collective health and the containment and / or and/or eradication of diseases and their relation to the political economy is only touched upon, a more rigorous analysis not being possible in the present context and under the given time constraints.

In structuring the study, specifically the main chapter (Chapter 3), we applied methodological elements of the Power and Change Analysis (PDA) approach designed by ODI in collaboration with the Netherlands Institute of International Relations Clingendael. It contains strong elements of political economic analysis, notably what concerns the 'foundational factors'. A PDA exercise for Mozambique was conducted in 2008 for the Foreign Ministry of the Kingdom of the Netherlands (ECORYS, 2008).

The authors based their analysis on desk-based research and the study of literature (see Annex 3: Bibliography), as well as, on information obtained through interviews of practitioners and experts in government, institutions of the health sector, the donor community, as well as social scientists and consultants (see Annex 2).

The findings and conclusions of the report do not necessarily reflect the opinion of DFID but are solely attributable to its authors as are potential errors and omissions.

[6] An analytical framework for understanding the political economy of sectors and policy arenas, Overseas Development Institute, 2005.: www.**odi**.org.uk/resources/download/2989.pdf

2 Political economy of Mozambique: the macro context

2.1 History and Politics

The political settlement (Khan, 2010)[7], i.e., the distribution of power between relevant groups in Mozambican society in general and within the predominant political party, Frelimo, to secure economically sustainable distribution of benefits, has been changing throughout the post-independence era, but with some continuities. Immediately after Independence in 1975, the ruling coalition of the 'generation of freedom fighters' ('*Geração 25 de Setembro'*) has changed from one ideologically claiming a broad peasant and worker-based alliance, to one which includes new actors such as administrators and bureaucrats with little or no credentials from the armed struggle ('*Geração 8 de Março'*), and, more recently, business people, etc. However, the control of the state, the non-negotiable core of political settlements, has basically remained in the hands of changing coalitions. The dominance of the immediate post-Independence coalition was founded on a strong centralist ideology, reflected also in the economic model of central planning, with the state as the main economic agent and the sole social services provider, combined with a political model of popular participation through the party apparatus called "democratic centralism" and a strong charismatic leadership of the former freedom fighter Samora Machel. The demise of this model of 'vulnerable authoritarian coalition' (Khan), due to external destabilization (in the context of the Cold War), internal dissatisfaction, economic failure and civil war, challenged the ruling party monopoly and led to the redefinition of the underpinnings of the political settlement, and to what Khan refers to a 'weak dominant party coalition' (Khan).

The perceived loss of the political monopoly of the Frelimo party over people and territory during the 16 years of civil war coupled with the internal contestation that complemented its external causes, as well as the internal political and economic reforms in the 1980s, did not necessarily mean the separation of the state from the economy and from the party. It was reshaped in many ways by the leadership of the day. Thus Chissano, who inaugurated the new era of 'weak dominant party coalition' after the death of Samora Machel in 1986, when he took over the leadership of the party and country, complemented the leadership with members of a group of administrators and technocrats as well as representatives of hitherto marginalized ethnicities in order to balance the ideological leaning and territorial representativeness of the regime and to signal a new era. He also has been systematically involved and possibly has initiated the process of co-optation of non-party members, which would eventually be the hallmark of the ruling elite coalition-building tactics. The privatisation of the state enterprises as part of the economic recovery programme launched in 1987 has mainly benefited the former *nomenklatura* and contributed to ease the way to the new market economy and to relegate members of the former Marxist-Leninist sub-elite to the second plane, also to assure increasing donor support from western countries and the Bretton Woods institutions. This would also allow some new economic elites to emerge (e.g. in banking and parastatals), under the control of the ruling party. However, despite the

[7] Recently a number of studies on Mozambique have been conducted using this theoretical framework. See: (Buur, 2011, Buur et.al. 2011).

liberal rhetoric underlining the principles of market economy, economic reforms and privatisation, a national bourgeoisie did not emerge automatically, due to a combination of factors, among them, a lack of capital and entrepreneurial skills. The absence of an effective and efficient domestic capitalist class, the control of the state by the party, the practise of seeking opportunities for generating and distributing rents, and the abundance of donor support (a form of strategic rent), explain to some extent why the state remained the main player– despite the liberalization. This dynamic also was reflected in the social sectors such as education and health, although private initiatives (universities and clinics) had begun to emerge. The economic and political liberalization and privatization, as well as a high dependence on foreign aid were accompanied by an increasingly pervasive rent-seeking behaviour, epitomized by saying "*o cabrito come onde está amarrado*" ('the goat eats where it is tied'), the popular code for corruption. This ranges from petty corruption of the public servant to 'grand corruption' of the top of the political and administrative hierarchy involving procurement and large scale public contracts, public concessions, natural resources concessions, etc.

The end of the civil war in 1992, following negotiations between Frelimo and the Renamo guerrilla movement, and the approval of a new constitution in 1990, paved the way for the first general elections in 1994, and, to some extent a realignment of the dominant party coalition, without, however, giving the opposition access to, and control over, sources of rent and state power.

Throughout the last 18 years, in the context of the democratisation process, the country has slid from what was considered a bipartisan system (with initially a third small coalition, *União Democrática*[8]) in the 1994 founding multiparty elections, to a predominant party system, with Frelimo close to an absolute majority in Parliament, in tcharge of the government and the state, with a dwindling parliamentary representation of Renamo. MDM, a small party created with a political base in Beira municipality in the centre of the country emerged as a Renamo break-away group in 2008. At present it holds 8 MP seats in parliament and provides the mayors in Beira and Quelimane.

The Frelimo predominance is a result of the deficient separation of powers, party and state and permeates all the administrative structures from the central government to the local governments, and also the municipalities, with only few exceptions. Its main architect, Armando Guebuza, was elected Frelimo's secretary general in 2002, and since then consistently undertook the revitalizing of party structures from central down to the local level, and extending the clientilist downward trend?. This process followed the recognition of an 'almost-defeat' for Frelimo by Renamo in the 1999 general elections. Guebuza's government, elected in 2004 with a comfortable margin in the presidential and legislative elections, vigorously furthered the process of deconcentration through the enactment of regulations aimed at operationalizing the deconcentration law of 2003. This went hand in hand with a clientilist distribution of resources to the local level, through a fund ('*Sete Milhões*') aimed at supporting local economic initiatives and livelihoods – at the cost of financing public infrastructure, its initial vocation (Forquilha and Orre, 2011). His electoral and organizational successes, together with strategic thinking and aggressive business behaviour, gave Guebuza the opportunity to also use the party and state for pursuing his

[88] Democratic Union – a coalition of three small parties.

own business interests. At present, these span a broad range of sectors, including transport and harbours, fisheries, manufacturing, construction, real estate, consultancy, electrical energy and natural/mineral resources[9]. The concentration of wealth and businesses in the hands of the president, his family and allies, together with his style of governing has fuelled criticism in his party and the urban and rural society at large, for who poverty and inefficient and corrupt public services is a daily reality. Thus, to some extent the anger flaring up in a violent 'social earthquake' in September 2010, following the increase of prices for fuel and social services, is attributable to increasing socio-economic inequality for which the president is made responsible: in those demonstrations pictures of Guebuza's were burned, a school bearing his name was ransacked and some demonstrators accused him of amassing wealth at the expense of the people. Within the ruling elite, because of the rigorous party discipline, the criticisms of Guebuza have been more muted, but nevertheless unmistakably clear[10]. Apart from divisions around the 'sharing of the cake', ideological differences that had remained dormant seem to re-emerge. Historic figures belonging like Guebuza to the 'generation of freedom fighters' ('*Geração 25 de Setembro*'), such as former party secretary for ideology and propaganda, Jorge Rebelo, and the former Frelimo vice-president, Marcelino dos Santos, strongly criticize the capitalist leaning of the current regime as well as the uncritical attitude of party followers. A certain contradiction also exist in the process of decentralization, which despite some deconcentration and devolution, is also experiencing some re-centralization (Chiziane, 2011, Weimer, forthcoming).

Since 2004, with its two landslide electoral victories (with 2/3 two-thirds of the valid votes in the 2009 elections), Frelimo's hegemony has been only challenged at the municipal level, with defeats in the municipality of Beira and, more recently, in Quelimane (the fourth biggest city). The defeat in the Quelimane by-elections followed the premature, politically enforced resignation of the former Frelimo mayor.

In a context of the ruling party predominance, and amidst the decline of Renamo, the historical rebel movement-turned-party and a new and inexperienced MDM, the present regime's true political opposition is mainly within the ruling party. Despite the public denial of the existence of internal party factions, public positioning of historical figures show that the party is no longer the pursuer of a single ideology. In this context, the attempt of the current leadership to control the state and the economy by using his political power as head of state and chairman of Frelimo, to consolidate own economic interests and the loyalties underpinning them, is being opposed by some factions in the party. However, this opposition is seen as basically aiming at securing control of resources for the maintenance of their own clientilist networks, and not necessarily to pursue a common inclusive goal or more encompassing interests with regard to other (local, regional, social) stakeholders. In other words, we see an emerging competition between patrons, or in terms of political settlement theory, of a kind of a 'competitive clientilism' (Khan). It will be these competing and at some point contradictory interests that will shape the outcome of the political settlement that is due to be forged, still this year, at the forthcoming 10th Congress of the Frelimo party.

[9] See http://mg.co.za/article/2012-01-06-mozambiques-mr-guebusiness.

[10] Wikileaks realised communications of the US embassy to its government alleging former president Chissano, a minister and a businessman lambasting Guebuza's tendency to monopolize business opportunities.

2.2 Economic Structure

According to INE (National Statistics Institute)[11] in 2009, the Mozambican economy featured a primary sector accounting for 26.3% of the GNP (including extractive industries), low industrialization (manufacture contributes 12.8% to the GNP) and an increasing growth of the tertiary sector (services, commerce, banking, etc.), contributing more than 40%, with an overall positive growth (albeit increasing inflation in recent years) and macroeconomic stability recognized by the IMF, donors and investors. The impacts of external shocks (global financial crises, increase volatility of fuel and food prices, etc.) could be contained, so far, notably via fiscal subsidies. With the discovery and exploitation? of large reserves of mineral and energetic resources, the country has witnessed the inflow of massive Direct Foreign Investment. Yet, according to Castel-Branco & Ossemane (2010), the pattern of economic growth in Mozambique is heavily concentrated on a few sectors and enclaves, hinging on a limited set of products, services and firms, mainly those of the energy and extractive sector, all of which depend on exports markets. Due to the extractive nature of the economy, the domestic capitalist classes' accumulation is based on the rents of this sector and the economy is heavily dependent on external capital inflows with the tendency to generate negative net capital flows (exported capital is higher than imported capital). The authors consider that this model of accumulation causes not only capital flight but also structural inequalities in the capitalist development across the different regions of the country (Castel-Branco and Ossemane, 2010: 143). If we consider only the illicit capital outflows resulting from the difference between the country's source of financial flows and the recorded use of funding, as well as from under-invoicing exports and over-invoicing of imports, Mozambique is estimated to have lost 1.1177 billion USD between 2000 and 2008 (GFI, 2008: 26). It is among the 15 of the top 20 African countries with cumulative illicit outflows (GFI, 2008: 14).

A distinctive feature of the Mozambican entrepreneur class, stemming both from the history of its creation and the structure of the economy, is that a considerable part of it still keeps a close link to the state, and sometimes with a regular public service job, be it in the public administration, in a parastatal or in a regulatory agency. The lack of legal provisions concerning conflicts of interest allows for the persistence of this state of affairs. Bargaining between the elites through the networks of relations tied together by the setting of a dominant party, favours rent-seeking behaviour and less investment in productive activities (DFID, 2011).

2.3 Implications for Social Sector and the Health Sector

The somewhat contradictory, hardly irreconcilable ideas of various parts of the political elite on how to ensure access to the resources that underpin the changing political settlements also resonate in the social sectors in general, and in health in particular. Whereas some parts of the elite continue to argue for a fair distribution of health services and access to them across the socio-economic strata and the urban-rural divide – a classical responsibility of a

[11] www.ine.gov.mz links "Produto Interno Bruto, Óptica da Produção" and "Principais Produtos de Exportação (1994-2009)".

welfare state - others have embraced the liberal free market approach in which access to health services is a question of individual income and purchasing power. Due to the demand for quality health services, and the deficiencies of the NHS to adequately meet this demand, many Mozambicans and resident foreigners with sufficient purchasing power, members of the ruling elite included, have systematically resorted to neighbouring South Africa to get good health services, which signals a good economic opportunity. Throughout the last two decades, Mozambique has thus generously contributed to the development of the health sector of Mpumalanga province and particularly the city of Nelspruit (the same logic is true for other services such as retail trade and car-servicing). This has been pointed out as one of the stimuli for the now booming health private sector emerging in Mozambique, notably Maputo City. The landscape of private health service providers is changing from an initial limited number of simple single-business clinics or small cooperative-style clinics, to sizeable private investment in specialized clinics and health centres, and private hospitals. As in other economic areas, these new investments are directly or indirectly linked to the political elite[12].

Although Buur and Baloi (2009) argue that through the donor-supported poverty agenda the ruling elite has found a way to continue pursuing the core Frelimo socialist values in the social sectors, it is also important to take into account that Frelimo is no longer a homogeneous party, since there are different and divergent, sometimes openly contradictory interests that influence policies or established practice in the sector. For example, the former health minister's intent to dismantle cost covering ways of health service provision like "Clínica Especial" in the Maputo Central Hospital (HCM) designed to complement the increasingly meagre resources of the public hospitals and ensure better health services to the emerging middle-class, can hardly be detached from the then minister's business interest in private health service, being one of the owners of a private clinic. Other contradictions are related to the continuous brain drain from the public health sector to private service providers and donor-funded projects in the sector, due mainly to poor working conditions and low and often irregular salaries in the former. It is striking that sectors such as Finance[13] and Justice have been successful in negotiating remuneration packages, which are more attractive than those of the rest of the public service, including the health sector. Given the need for a good public health system and taking into consideration the historic Frelimo concern with more egalitarian health services and better territorial coverage it is surprising that the sector has not used core principles to improve the working and salary conditions of an estimated 30,000 personnel in a priority social sector, not only with regard to Millennium Development Goals (MDG), but also the national development and poverty reduction agenda. It is the more surprising that this should happen at the time of tenure of a government, whose leader ascended to power with the strong support from the liberation struggle veterans, defending the egalitarian principles allude to above. However, times have changed. The words of retired general Chipande, the man credited with firing the first shot that signalled the beginning of the liberation struggle in Mozambique: "we fought for liberty, so we are entitled to get rich", might epitomize the contradictions that seem to plague not only the health sector.

[12] see Annex 4: A brief sociology of the private health sector

[13] e.g. the National Tax Authority (*Autoridade Tributária de Mozambique*- ATM)

However, with reference to the afore-cited recent analyses (Buur; Baloi, 2009), it is important to acknowledge the continuities of some of the core socialist ideas, which still underpin the concern of policy makers of providing decent and fairly spread basic health services to the population. From a political settlement point of view, the provision of free health services continues to be part of a kind of social pact with the broader (non-elite) citizenry. In that sense, criticisms of the management practices and decisions of the former minister of health merit a more cautious questioning: some of those criticizing his actions, notably members of the bureaucratic rent-seeking elites within the health sector, were part of the previous coalition ('weak dominant party' scenario). Thus part of their opposition to and criticism of the former health minister is surely motivated by their loss of benefits that flowed to them in the context of the more *laissez-faire* approach under the Chissano coalition, benefits they were understandably attempting to regain. As one interviewee put it: "some of the most vocal critics [of the former health minister] were critics not for the best reasons; they were opposing the minister because they were part of the scum that plagued the sector".

As in the overall process of privatization, the health sector will not escape being shaped by the dynamics of blurred lines between private and collective interests, the overlapping of the bureaucratic and entrepreneurial roles of members of the elite and the internal political settlement dynamics of the dominant party system. In this regard, in an 'emerging globalized market' like Mozambique and with an emerging but weak and unconsolidated middle-class, the economic viability of the private health service will depend to a considerable degree on circumventing the existing market institutions and/or resorting to the political influence and control over the state to 'adjust' the 'rules of the game' provided for by the sector's institutional architecture and general and sector-specific legislation. Such adjustments may be formal and informal and may take the form of tax exemptions and privileges, and legal waivers, manipulation of public procurement rules and even illicit access to resources such as pharmaceuticals. This dynamic is not only at work at the top of the range of health sector providers, but also at lower echelons. The corrupt link between hospital pharmacies on the one hand, and unlicensed 'private health practitioners' who apply medication end even injections with drugs siphoned off from the hospitals, or the selling of '*comprimidos de duas cores*' (antibiotics) illegally acquired from the public health's drug pool and sold at informal and formal municipal markets at high unit prices is, unfortunately also a feature of the Mozambican informal 'public- private partnership' in the health sector[14].

[14] These observations are derived from some 'quick and dirty' research by one of the authors in Vilankulo municipality, which included conversations with one owner of a market stall selling drugs and a person, whose employee, a night-watchman, rained as a paramedic in the army, works as an informal 'medical practitioner' administering injections, antibiotics and drugs known as 'limpa todo' and 'para logo'(diclofenac), allegedly acquired from the hospital pharmacy. It is common knowledge that a whole truck load of pharmaceuticals 'disappeared 'from the Vilankulo hospital pharmacy towards the end of last year.

2.4 Trends

It could be said that, formally, the future of the health sector depends on the strategic planning exercise currently taking place in the Ministry of Health; its outcome will define the vision and the mission of the public health sector *vis-à-vis* the profit and non-profit private sector. The decisions that will shape the sector's core business will in the final analysis, however, be influenced, to a large extent, by the political clout of the interested parties engaged in the booming private health providers in urban areas, which is becoming an important player in the process of economic accumulation that underpins the political settlement. However, the electoral dynamics and the growing political contestation of the lack impact of the pro-poor policies are posing a serious challenge to the ruling elites in the sense that they need to be seen to improve the effectiveness and coverage of social services, health included. One of several possible outcome scenarios could be a stricter accentuation of the urban-rural divide: i.e. between a private service providers catering for the needs of urban clients and patients, and public ones for the rural and peri-urban demands. Also a 'Chinese solution' could be part of that scenario: the proliferation of low-cost private health shops and clinics owned and run by Chinese citizens in major and smaller towns as well as the informal 'medical' practitioners alluded to above points to the existence of a market, which is not being catered for by either the high cost private clinics and hospitals, nor the public ones of the NHS.

In this context, the genuine decentralization of the NHS system is another key concern, from the point of view of its financial and managerial challenges, but also from the resource side. The expansion and decentralization of the health network, either private or public, certainly will face major constraints in the limited number of qualified human resources available to the sector. These could easily be overstretched if measures are not taken to increase the output of training and education programmes in health, at all levels, and to improve the service conditions for retaining them, especially in the public sector. This would require the allocation of the necessary additional resources.

The reform of the health system and policies also implies new challenges arising from the foregoing political settlement analysis, since the contradictions stemming from competitive clientilism *vis-à-vis* a political position aimed at reflecting electoral demands and risks in social and health policy and programmes will be magnified. The accommodation off popular demands and thus public electoral support will need to be ensured by through the expansion and improvement of public services, including in health.. An extra effort will be needed to keep the dominating elites together.

At this point in time, the health sector is at a critical juncture and faces policy dilemmas: it needs to reconcile different and sometimes contradictory interests? within the elite and between private and public interests. To make things even more complex and difficult: the credibility and political survival of the ruling elite depends to a large extent on the effectiveness of the delivery of public goods and services by the overall system and that of the social sectors in particular. Some of the necessary solutions to resolving the dilemmas might come from the strategic planning currently on course. But looking at the sector from a broader angle and taking into consideration the foundational factors of Mozambique's political economy, and the nature and options of intra-elite political settlement, the decisive

answers to this conundrum will come from the decisions on the Frelimo theses on the social areas to be discussed in the forthcoming 10th Frelimo Congress in Pemba, in September 2012, and from the selection, on the same occasion, of the new party leadership and the presidential candidate for the 2014 elections.

3 Health sector: features, determinants, change

In this main chapter of the report, we first look, in a selective way, at some of the structural features which determine the political economy of the health sector: the historical heritage, spending patterns and donor dependence. Thereafter we examine, in some depth, what we call the 'rules of the game', specifically under aspects of their change and reform needs, with a focus on the normative and policy framework, and on decentralization. Other important aspects such as the institutional relationship between MISAU and other state actors important to the health sector such as the Ministry of Finance, the Ministry of Public Service and the Auditor General cannot be dealt with in this study for time constraints. Concerning the equally important procurement in the health sector, we only can, for the time being, refer to a previous study commissioned by DFID (2011). In the third section we look at the 'Here and Now' of the health sector, namely the management of the crises arising from what became known as the 'pharmaceuticals scandal' under the mandate of Ivo Garrido as Health Minister, and the exit of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF). In this context we also look at the initiatives undertaken by the new minister concerning a strategic review of the sector.

3.1 Structural aspects

3.1.1 Historical aspects, changing ideologies and approaches

At Independence in 1975, the then Frelimo political alliance under Samora Machel's leadership endeavoured to not only correct the economy, its structure, model of accumulation and distribution of the colonial state, but also to dismantle ('*escangalhar*') and replace the state administration for that purpose. The implications for the health sector were threefold: it was considered a priority sector with free health services and quality for all citizens; it attempted to narrow the wide gap in service coverage, access to health, etc., between urban and rural Mozambique; and it brought all health providers (public and mission hospitals) under one national umbrella, that of the state, in a unitary, highly centralized National Health System (NHS) (*Sistema Nacional de Saúde* SNS), moulded after the Soviet model. This 'sought to achieve universal, free access to basic health services, centrally planned according to strict norms with the goal of delivering services of uniform quality in all parts of the [country]' (Balabanova *et al.* 2004).

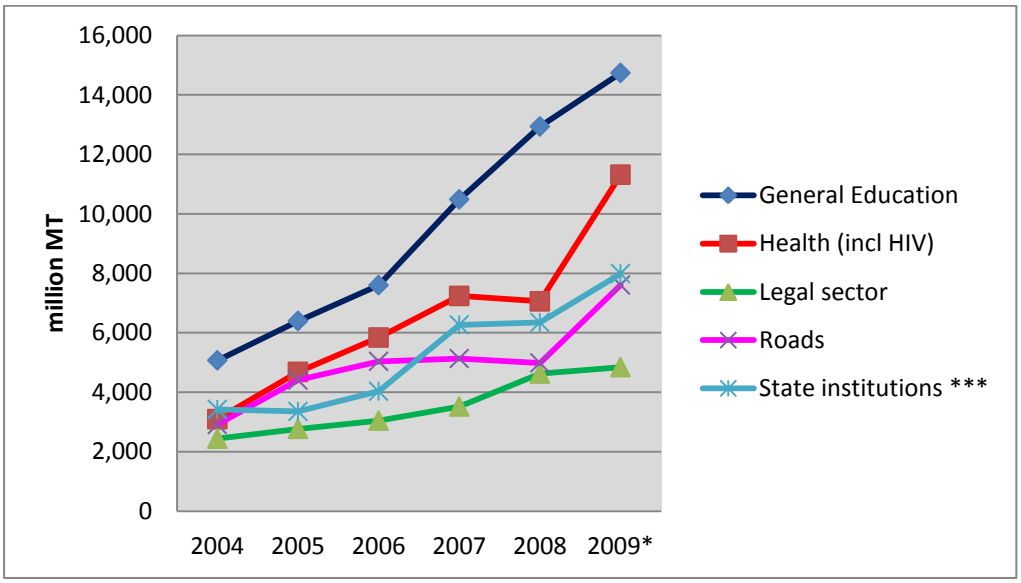
For various reasons, such as the destabilization cum civil war (1977-1992), the introduction of a market economy and the privatization of state assets within the framework of the structural adjustment programme (PRE) of the economy from 1986 onwards, as well as a severe economic and fiscal crisis, the initially successful health system (O'Laughlin, 2010), its political ideals, and policies found themselves in a less and less conducive socio-economic and political environment, negatively affecting the outcomes of the sector. While the two cornerstones of the health sector – the state- dominated, centralized SNS and the 'free

health for all citizens' dogma – remained largely untouched, a new health policy (*Politica Nacional de Saúde* PNS) was introduced in 1995[15]. Besides dividing for health sector into three sub-sectors, (the public, private and community), it specifically addressed the financing of the health sector via the state budget, with the donor support and common funds meant as being 'complementary' to governments own efforts. It also stressed the introduction and eventual increase of user fees for patients in order to broaden the sector's own resource base. More recently a changing ideology has been noted, together with the emergence of private health providers in urban areas: health is seen less and less as an essential and basically free public service provided by the state, to which the public is entitled (even when paying fees and charges for its use), but rather as an economic activity and way to make money and rents. While the proliferation of private clinics, notably in Maputo and other urban areas is a recent phenomena, as is the dramatic increase of external funding to the sector, the normative, regulatory and policy framework has not been adjusted to the changes. Thus, an adjustment of the health policy and its supporting vision, mission and options for service provision and funding is overdue.

3.1.2 Health, budgets and spending patterns

Health spending in absolute terms has increased over the years, both as a percentage of GDP and the total budget (Umarji, 2011: 1). The sector continues to be the second most important 'priority sector' (after education) in terms of spending. The following Figure shows the evolution from 2004 to 2009 in a comparative perspective. The trend of growth of the health budget continued for the period 2009-11 (Umarji, 2011).

Figure 1: Health spending in comparison to selected sectors, 2004-09 (executed, in million MT)



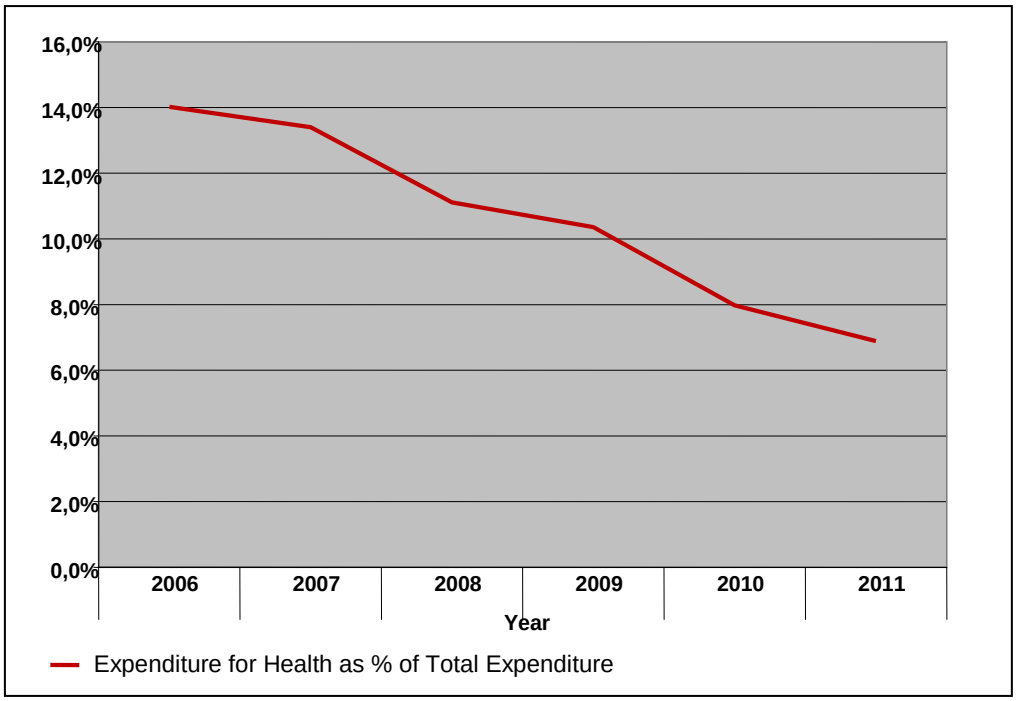
Source: based on Sal & Caldeira/Ximungo, * Budget projection, **Presidents Office, Parliaments, Defence and Security, Foreign Ministry and others

[15] Approved by Council of Ministers with Resolution No. 4/95

However, the picture is quite different, once the spending pattern is analysed in relative terms[16]:

- Health spending grew considerably less than overall spending. While total budget grew by 12.8 % per annum on average between 2006 and 2008, the health budget decreased by an annual average of 1.5% during that period.
- The ratio between health spending and total spending (both in nominal terms), decreased from 14% (2006) to 7 % in 2010 (see Figure 1 below).
- The executed budgets for health are consitently lower than the planned budgets over these years and vary considerably more from year to year than overall spending.

Figure 2: Health expenditure as % of total expenditure, 2006-11

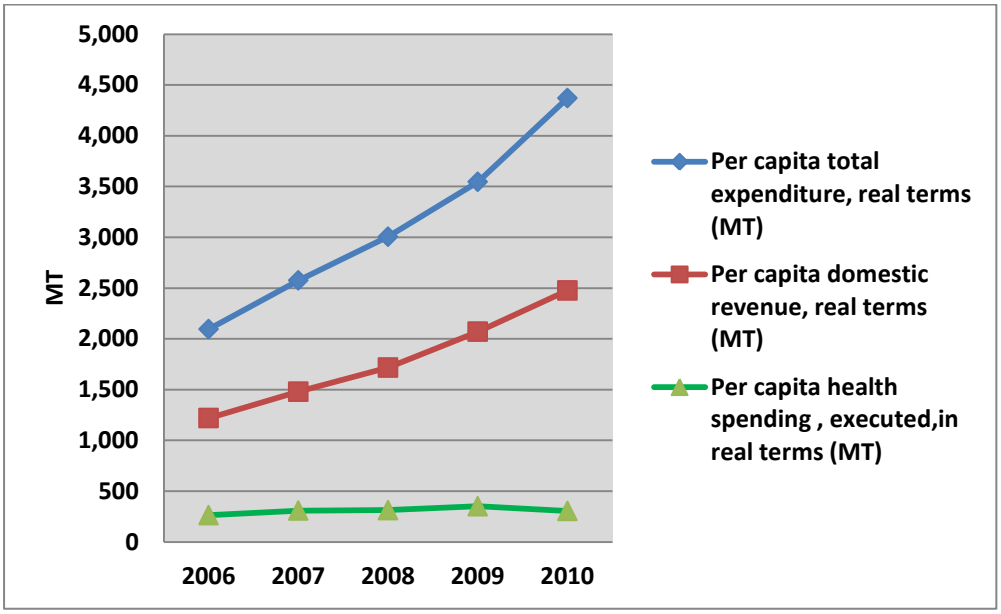


Source, BAG 2011

As Figure 3 demonstrates, the sector's spending dynamic is delinked from the overall growth dynamic of the government expenditure and revenue generation:

[16] See, for example: Anon, 2011; BGA, 2011; Umarji, 2011; Sal e Caldeira and Ximungo, 2009, McCoy and Cunamizana, 2008

Figure 3: Per- capita revenues, health and overall spending, 2006-2010 (in MT)



Source: based on data from ATM, INE and BGA, 2011[17]

Based on interviews and the review of studies, we suggest two main interlinked reasons for the stagnation/decline of government's health spending relative to overall spending and to revenue generation:

a) Massive financing of the health sector by government's international partners, either via PROSAUDE, (i.e. based on the philosophy of the Paris Declaration and its implementation mechanisms) and via vertical (project) funding, mostly with funding from the US government. This issue of the 'aid rent' further discussed below.
b) The absence of an adjusted or newly formulated health policy or framework, which, substituting the 1995 National Health Policy, would define priority spending areas, and criteria for distribution, address issues of economic viability and sustainability of the sector, and possibly introduce hard budget constraints.

These factors, notably the 'aid rent' have adverse consequences for the sector: they promote opportunistic behaviour regarding health financing, lead to the delinking of health expenditure from economic growth and revenue trends, and pose challenges to governance (e.g. rent seeking, corruption and lack of accountability) as well as the long term economic viability and sustainability of the sector. Especially the latter point was stressed by a number of interlocutors. The outcome may eventually constitute a phenomenon known as 'Dutch disease' in the health sector, i.e. 'too much wealth managed unwisely'[18], with negative consequences for the allocation and mobility of human resources, and productivity of the health and other sectors.

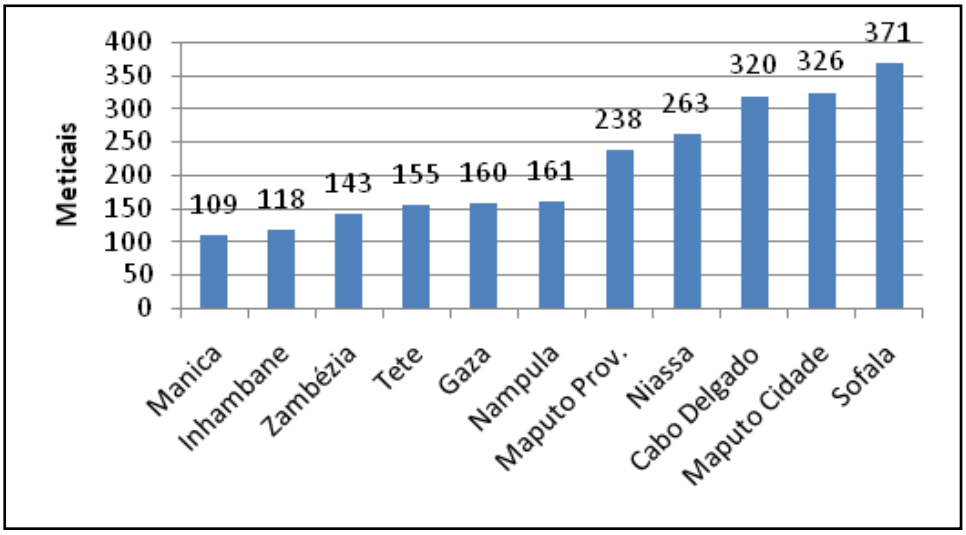
[17] Assumption for the calculation: annual averaged inflation rate as published by INE, population growth rate of 2,4% per annum, based on 2007 census data.
[18] Christine Ebrahim-zadeh, Back to Basics. The Dutch Disease, in Finance and Development, March 2003, Volume 40, Number 1. http://www.imf.org/external/pubs/ft/fandd/2003/03/ebra.htm

3.1.3 Regional disparities and equity issues:

It has been evident that health spending on a per capita basis has been 'exceptionally unequal across provinces' (McCoy and Cunamizana, 2008: 12). A recent report suggests that spending patterns vary with installed human resource capacity rather than with need as determined by factors such as population density, per capita number of hospitals and hospital beds, indicators of poverty and Severe Health Deprivation (SHD), etc. (Anon, 2011: 15). This may explain, that, for example, Niassa province, with a low population number, has substantially higher allocations than population-rich provinces such as Nampula and Zambezia [19], which are 'constantly losing out';in the case of Zambezia, per capita health expenditure averaging 3.73 USD versus 5.7 USD for the country as a whole (McCoy and Cunamizana, 2008: i).

The following table shows that the horizontal, i.e. geographical, pattern of spending has not substantially changed, a conclusion confirmed by other studies (Sal&Caldeira and Ximungo, 2009).

Figure 4: Per Capita health spending by province (in MT)



Source: Umarji, 2011

What are the causes of this spending pattern? We consider both technical and political factors.

The main interlinked technical factors are:

- Planning (PES) and budgeting (OE) are not systemically integrated. Thus, new or a change in priorities cannot easily be reflected in the budget and budget execution cannot easily be monitored from a strategic and policy perspective.
- The budget is elaborated in an incremental way, based on previous allocations – which do not necessarily reflect the real cost of producing and running a certain

[19] Between 2003 and 2006 the average factor was 2.5. (Mc Coy; Cunamizana, 2008:12)

public or administrative service, e.g. a rural hospital ('incremental budgeting'). These costs may vary considerably from province to province. Through incremental budgeting initial distortions in the allocation of resources are permanently carried forward and are difficult to change. A solution would be a zero budgeting approach, an 'extraordinary one-off budget exercise' (McCoy and Cunamizana, 2008: 21) coupled with a costing exercise, which would allow the readjustment of the distribution pattern for resource allocation.

- Lack of effective intra-sector coordination and bargaining between spheres/domains (e.g. central and provincial '*âmbito*'). According to one interviewee, the high transaction cost, lack of leadership and preponderance of central domain interests in relation to provincial ones worked together to prevent a stronger taking into account provincial interests in the budgetary process in health.

The political reasons are associated with the geography and sociology of power, which produced few centres and sub-centres of capital accumulation with major social and technical infrastructure, and fiscal, administrative, etc., authority, or, in other words, with core state functions. Mozambique is no exception from the general rule in Africa's vast territorial states that these core functions of the state, were, and continue to be, restricted to few such centres including the capital city, notably along the coast (Herbst, 2000). This is, obviously, dovetailed with the colonial mode of capital accumulation and extractive, export-oriented mineral and agricultural economy, the structure of which continues to characterize the Mozambican political economy (Mosca, 2005; 2011; Castel-Branco and Ossemane, 2010), despite Frelimo's early political coalition's attempts to rectify the inherited structure and to dismantle ('*escangalhar*') the (central and local) state for this purpose, an attempt, which largely failed and led to the taking over of the state by the various Frelimo coalitions governing the country since Independence (ECORYS, 2008, Sumich, 2010).

In such a setting, the periphery, i.e. provinces and districts or the rural areas – home to a thriving 'unobserved economy', which provides food and income to the vast majority of Mozambicans – is relegated to the function of providers of land, agricultural commodities and labour, unless a radical decentralization and redistribution policy coupled with a transformation of predominant mode of capital accumulation is forthcoming, both of which need to include local/regional political elites in the political settlements, or, in other words, a more encompassing interest by the ruling coalitions. Neither a radical decentralization project with substantial transfer of powers and resources to the local state has happened (Weimer, forthcoming), nor has the transformation of the inherited economic structure taken place (Castel Branco, 2010), let alone the empowerment of local elites and their inclusion in central political settlements. As a recent case study of Nampula province shows, the health sector is not dissociated from this pattern: whilst Nampula province is the second most important province in terms of GDP contribution, it is among those provinces with the low indicators with regard to health services and with below average per capita health spending, despite part of the local elite having been co-opted (Macuane *et al.* forthcoming). This may explain the province's electoral and political volatility in the past. One insider of the health sector interviewed for this study, suggests, that the political volatility in Nampula and other resource-rich provinces may increase,, to the extent at which, the Mozambican political economy continues to attract major investors in the mineral and agricultural extraction business, on the one hand, without, however, increasingly sharing the proceeds

with the population through improved employment, living and social conditions, including better health services. The interviewee drew parallels with the political violence and class struggles in the 19th century Germany (Interview).

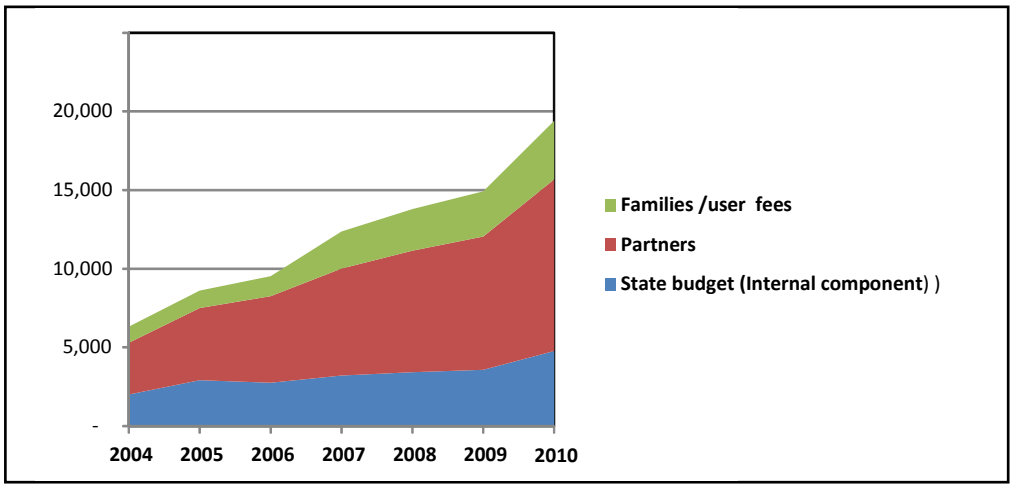
The government is aware of the detrimental effects of present horizontal resource allocation and looks at ways to redress it, not only in the health sector. One proposal elaborated in the Ministry of Planning and Development (MPD) seeks to redefine the criteria for provincial budget allocation and the midterm fiscal projections (*Cenário Fiscal de Médio Prazo- CFMP*) through the use of a redefined and re-calibrated composite poverty index (in whose composition health carries a weight of 20%) as one of the two criteria in the allocation formula, weighing 30%. The other criterion is the relative provincial population size weighted at 70% (Rosenfeld, 2012). If adopted, the formula would ensure a more need-based and a more equitable, predictable and transparent allocation of the provincial investment budgets as well as that for goods and services in the recurrent budget. It would also enhance and simplify provincial planning and would represent a major step towards genuine decentralization.

3.1.4 Donor dependence

The high degree of donor dependence of the sector, its causes and consequences has already been flagged above. In this section we present a more detailed analysis of external support. We start with the discussion of the global dimensions of external support in relation to other sources of funding.

The following figure, showing the financing of the sector by source of funding, illustrates the trend of the past years:

Figure 5: Financing health expenditure by source of financing (nominal values), in Million MT



Source: Anon, 2011:

The Figure shows a drastically growing dependency of the Mozambican health budget on foreign aid; in 2010 more than 70% of the funding to the sector was provided by a total of 26 health donors (Umarji, 2011: 1). The equally growing contribution of individuals/families to the health budget merits its own analysis, which goes beyond the context of this paper.

Table 1 provides a rough estimate of the volumes by source, of financing and the modalities of their delivery and management[20].

Table 1: Health sector- Donor dependence and management diversity

Source of Finance	Volume of finance (estimate for 2011),		On / off Budget, CUT*, CGE**	Management via PFM (e-sistafe)
	in million USD	In %		
State budget (incl DBS)	160	24	On	Yes
PROSAUDE	100	15	On	Yes
US Government	340	52		
-PEPFAR Via CDC	80		Off	No
-PEPFAR Via USAID	180		Off	No
-Via NGOs, in kind	80		Off	No
Global Fund (GF)	50	8	Partially until 2008	Until 2008
Others (incl. UN)	10	2	Off	No
Total	**660**	100		

Source: compiled by authors on the basis of Anon, 2011 and interviews

* CUT (*Conta Única de Tesouro*) = Treasury Account; **CGE (*Conta Geral do Estado*) = Annual Accounts

By far the largest partner is the US Government, whose contributions are roughly equal to the Government's and PROSAUDE's combined. We also note that external support basically takes two modalities of delivery and management: firstly, support to the budget via PROSAUDE and managed, to a large extent, via the national PFM system; and secondly, funds managed outside the Mozambican PFM system, stemming predominantly from the US Government, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), and others). There is, however, a grey zone, where the Mozambican PFM system is partially used, and the government (represented by MINEC and MINFIN) is at least informed about aid volumes (interviews)[21]. A considerable part of the US funding is delivered and administered by 'contractors' and 'subcontractors' (companies, NGOs, universities), using their own financial management and procurement systems, but drawing, to a considerable extent, on Mozambican human resources. There is general agreement by the interviewees that this weakens the human resource base of the Mozambican health system, with the low salary scales in the NHS providing a push factor for the migration of health staff to the donor-

[20] It is emphasized that these are rough estimates, taking into consideration, that no reliable data is available- a point repeatedly made by various interlocutors.

[21] A study on 'off budgets' conducted in 2005 concluded that 29% of all resources in the health sector are 'off annual budget', 60 % 'off Treasury Account ' and 40 % 'Off Annual Accounts' Cabral et.al., 2005. The consultants were informed about the intention of USAID to consider a pilot project using On Budget on CUT modality from 2013 onwards (Interview).

funded projects. The relative wealthy US supported off-budget projects are often called upon to bridge financing gaps of the health sector, notably in the case of salaries for nursing staff at provincial level (Interviews).

The so called 'Vertical Funds' provided for by US agencies and the GF are targeting specific diseases. In terms of delivery and management modalities, they are part of the second category of funding agencies. A third, and less conspicuous modality of delivery, is technical assistance to MISAU, basically by UN agencies.

From this analysis five conclusions can be drawn:

- The **dependency rate** on foreign finance has **dramatically increased**. A study conducted back in 1999 already concluded that donors took on an increasingly proactive and determining role in the sector, with the Ministry of Health relegated to the place of a 'receptive and reactive' partner (Paviagni and Durão, 1999: 243). This dynamic produced the paradoxical effect of the Programme Aid Partners in the health sector themselves complaining about having taken over the role of government[22]. Yet, the alignment with government approaches and systems and the predictability of their financial contributions still leaves a lot to be desired: a recent evaluation of the PAP's performance showed, that 11 out of 14 indicators were only partially met or not at all (Castel-Branco *et al.* 2010).
- The health sector is **highly fragmented** in terms of interests, projects, modalities, etc.
- The plurality and coexistence of many actors and projects with different delivery and management approaches puts a tremendous **strain on the available national capacity** for coordination, reporting, management in general, and, on health personnel in particular. The considerable salary differential between NHS and health projects has a brain drain effect on the NHS. It is assumed that a considerable number of professionals among the 15% of the total human resources which left the sector in 2010 have been absorbed by donor-funded projects and programmes. With regard to medical doctors in urban areas, it is standard practice that they split their time of service between public hospitals (in the mornings) and private clinics (afternoons) (Interview).
- Although the aid effectiveness agenda resulting from the Paris Declaration and its implementation mechanisms, such as the Joint Review process, pool funding for the sector (e.g. via PROSAUDE replacing the former Provincial Health Fund and the Pharmaceuticals Fund) and the establishment Health Partner Group (HPG) enhanced considerably the **coordination between government and PROSAUDE partners**, the degree of complexity has increased together with the transaction cost of coordination. Part of this is attributable to the unpredictability of external funding for the sector. According to experienced insiders, the degree of complexity and 'confusion' has grown to such an extent, that coordination has been replaced by an unregulated *laissez faire* (*deixar andar*) and a deteriorating of the 'state of health of the health sector' (interviews).

[22] Parceiros dizem estar a assumir papel de Estado na área da saúde''. O País, 11 March, 2011. http://www.opais.co.mz/index.php/sociedade/45-sociedade/12795-parceiros-dizem-estar-a-assumir-papel-de-estado-na-area-da-saude.html

- The health sector's **sustainability is threatened**, as observed above. Already in the late nineties a study concluded that the increasingly donor supported sector was being constructed on 'shifting sands' (Pavignani and Durão, 1999).

Finally, the Mozambican health sector's continued and pronounced dependence on foreign aid[23] coupled with a declining relative weight of the allocation of own resources is a certain exception from the general trend observable elsewhere in the developing world. It has recently been concluded that domestic health funding is growing and far more dynamically than the Development Assistance for Health (DAH), which has also increased during the past few years, but at a slower rate due to global economic recession (IHME, 2011). Seen from this angle, Mozambican policy makers face the task to minimize the risk and impact posed by a potential and possible sudden funding gap and its effects on the outcomes produced by the NHS. As the authors of the study note, 'policymakers will need to carefully assess the trends in resource flows to decide where and how spending can have the maximum impact on population health' at this crucial point in time, when the deadline of the MDG is approaching fast.

3.2 Rules of the game: the need for reform

3.2.1 National Health System and Health policy of 1995: adjustments to new realities?

All interviewees are more or less in agreement concerning the need of putting the Mozambican health sector on more solid ground which would be achieved by the formulation of a new national health policy and eventually the reform of the NHS. Both need adjustment with regard to the changes which have taken place during the past decades and to be able to face the political and economic challenges with which the health sector is confronted today. This sub-section examines five aspects which sustain the argument in favour of a new policy, if not the reform of the health system as a whole.

Socialism and free health for all?

Firstly, it is worth a look at the NHS. During much of the Mozambican health sector's life since independence, the 'rules of the game' were defined by the NHS, its configuration in spatial and hierarchical terms, its planning and accounting methods, its work ethics, professional standards, management and training of human resources. Having been constructed under a ruling Frelimo coalition espousing socialism and, as a consequence having been severely targeted and damaged by Renamo's war strategy, it has survived the war and the introduction of the market economy coupled with the privatization of state enterprises.

[23] According to the IHME report, Mozambique is on rank 8 of the list of the top 30 country recipients of DAH accumulated index for 2004 to 2009.

The National Health Policy of 1995 introduced new elements to reform the NHS, e.g. the introduction of user fees but did not question the NHS's fundamentals, which were moulded after the Soviet system. One of its essential building blocks has been, until today, accounts of intra sector input-output relations, typical for socialist central planning. In this system, the state and its various departments of the health system act both as suppliers (sellers) of goods and services and as well as demanders (buyers). Thus, in the National Health Accounts (*Contas Nacional de Saúde*), one unit, e.g. a hospital, may appear as both a financing (selling) agency and as a service providing (purchasing) agency, (Anon, 2011: 7). With the introduction of new PFM systems and decentralization in the wake of Public sector reform there are certainly other potentially more efficient forms of managing the flow of resources to the health sector and its various territorial and functional units and services.

Functional division of labour or conflict of Interests?

A second argument has to do with the efficient and transparent separation of functions in health management and service delivery. In the NHS, the distinction between the financing function and the service function in the health sector is blurred, since both functions theoretically and practically remain in one hand, that of the central government, with serious consequences not only for distributional issues and the allocation efficiency, but also for accountability. Even for insiders of the Mozambican health system who were interviewed, the separation between policy and regulatory functions of the central government level (i.e., the MISAU) and the executive branches and units of the sector (e.g. hospitals) – one of the central objectives of the public sector reform (PSR) – becomes increasingly blurred. In recent times, notably during the mandate of the previous health minister Ivo Garrido, there has been a perceived convergence and concentration of three functions in the leadership of the health ministry: that of policy maker, of executing and of financing agent. Given the increasing role of party politics in public policies, a fourth function, that of a 'political gatekeeper' on behalf of the predominant party needs to be included (interview). As a result, in the perception of some interviewees not only a recentralization and a politization of the health sector has happened, but also its 'dismantling' (*escangalhamento*), with nobody being held accountable, notwithstanding the dismissal of the previous health minister.

Thirdly, in the opinion of a number of interviewees a health sector reform and formulation of a new policy would need to address both the increasing diversity of actors and service providers and providers recognized but not reflected in policy, the increasingly donor-financed and driven programmes and projects, which sideline the government. It would also need to address MISAU's relationship and institutional interaction with three other national key players, who co-determine health outcomes in Mozambique: the Ministries of Finance, that of Public Service and the Auditor General. Finally, health insurance companies as well as health care schemes and units for workers of major international companies involved in mineral extraction need, also, to find their place in a new regulatory framework.

Towards a health system of classes?

A fourth argument is related to the social change and differentiation process, which has been taking place in Mozambique since the end of the 16 year civil war. Mozambican society

has become more stratified and increasingly reveals a class nature: a small, very wealthy class of citizens directly linked to the ruling national political elites, dominates the economy and demonstrates features of a '*comprador bourgeoisie'i*.e. a part of the national elite with strong alliances with foreign investors, multinational companies, banks, etc. It includes the President and his family which has substantial stakes in businesses in almost all sectors (Hanlon and Mosse, 2010)[24], key members of the Frelimo elite associated with public enterprises and others associated with trade oligopolies (Buur, Baloi and Tembe, 2012). At the bottom of the social hierarchy we find a presumably growing 'mass' of Mozambicans, rural and urban, to whom donor-supported government policies aimed at poverty reduction have produced little meaning (Macuane, 2012) and practical effects, taking into account stagnating indicators used for measuring poverty (DNEAP, 2010). A growing, predominantly urban middle class with some purchasing power appears to rest on an economic base which is volatile to price shocks and inflation, effects of speculation with land and insecure conditions of tenure and employment associated with projects, diplomatic missions and international business. More frequent occurrence of social unrest, demonstrations and labour action are indicators of social struggles for a more equal distribution of wealth.

The impact of these change processes is reflected in the health sector, which also undergoes a differentiation process: according to a medical doctor interviewed, a 'class system' of health service providers is remerging, in correspondence to the differentiated purchasing power of the various strata and segments of society. A simple taxonomy would distinguish four classes of service providers, in urban areas[25]:

- Private hospitals, whose ownership is linked to the elite and who cater for wealthy patients, national and foreign alike, with access to foreign exchange;
- Private wards in central hospitals (*clínicas especiais*), with preferential access to medical services, doctors and equipment; services are most often invoiced in USD put payable in MT (at highly unfavourable exchange rates);
- Special services and rooms in public hospitals, negotiated on a private basis with health staff, and to be paid with by extra fees or 'surcharges' (in MT)
- Ordinary services for ordinary people. In the words of an insider, this represents what in colonial times was referred to as '*Enfermarias Indígenas'* (native wards).

We may want to include in our analysis the medical facilities in neighbouring South Africa, notably in Nelspruit, the capital of Mpumalanga Province, which caters for and depends to a considerable extent on patients of the Mozambican elite and foreigners resident in Maputo[26], as well as the traditional health practitioners (*curandeiros*) both in urban and rural areas, outside the NHS. Thus we arrive at what appears to be realistic picture of the stratified nature of the health providers for Mozambique.

[24] See also the recent article in the South African newspaper Mail and Guardian by Luis Nhachote
: Mozambique's 'Mr Guebusiness', Jan 06 2012. http://mg.co.za/article/2012-01-06-mozambiques-mr-guebusiness.
[25] For further details see Annex 4: a Brief sociology of health service providers
[26] One interviewee, intimately familiar with this matter, pointed out to the consultants that most of the services are over-invoiced and paid for directly by the Mozambican state, in case of senior civil servants and managers in the state and parastatal administrations, causing an outflow of foreign exchange. According to this source, the private clinics in Nelspruit depend on the Maputo market for their survival.

All of the institutions charge the patient for the services they provide, on various scales. Thus the actual practice overtook the erstwhile dogma of 'free health for all '. It has run its course and has been substituted by one which relates services of a public good to a price to be paid, like in any public or private service such as water supply, household waste collection, etc. It is this aspect, i.e. a scaling of fees for various scales and qualities of health services, which a reform of the health sector and a new health policy needs to take into consideration.

The experience of the pilot project of the (public) *Polana Caniço* Hospital in Maputo, run by a Spanish NGO before it was again taken over by Government under the Garrido mandate, demonstrates that a decent and popular health service of good standard including training of doctors in family medicine (interview) does not need to contradict a cost recovery approach via user fees: a case study shows, that it managed to recover almost 80 % of its running costs (Christie and Ferrara, 1999: chapter 2.5.1).

It is noteworthy that various forms and practices of rent seeking, legal and illegal, occur at all levels, including embezzlement and extortion of money at the lower levels of public health, commonly known as small scale corruption. This means that an extra tax or monetary value is paid, resulting from the incongruence of demand and supply in the sector as well as illicit practices. This 'corruption fee' in the form of bribes, etc., has regressive taxation effects: 'the very poor suffer the most from this corruption when they fail to receive the services they require or are forced to pay a greater percentage of their income to access services that should be provided free or at a lower fee' (USAID, 2005).

Is there a role for Non-State Actors (NSA)?

A last argument stems from the recognition that the increasing role of private sector health service providers and of NGOs lacks a regulatory framework, which a health policy should provide. Some interviewees see a window of opportunity for a stronger role of NSA and communities, local health committees, etc., to be included in a new policy framework, for reason of (participatory) monitoring of health outcomes and stronger lobbying for social groups gradually marginalized from decent health care by the socio-economic dynamics of development. In the view of the Medical Association and others, the impetus for the reform of the health sector and the policy should come from civil society, taking into account the political lethargy of government on these matters.

3.2.2 Decentralization vs (re)centralization

The most relevant for poverty reduction and human development, and a more equitable distribution of health services and access to health is, in a historical dimension, the local level. At this level a large part of all health staff is affected and the health system can be proud of having achieved to allocate at least one medical doctor in each of the country's 128 districts. This, however, is not matched by a commensurate level of financial resources: only 11% of the health budget (2011) is allocated at local level (Anon, 2011: 15), and many units often lack medicines, funds for the purchase of services and goods as well for the salaries of nursing staff.

From the beginning of the 1990s a number of donors channelled aid directly to the provinces, developing a process of "twinning" large agencies and provinces. In the same period a number of initiatives took place to address capacity and equity issues in the sector. Donors and MoH put in place coordinating mechanisms leading to the creation of common funds – Pharmaceuticals, Provincial Common Funds (FCP), etc. The FCP was distributed based on clear criteria for resource allocation, including provincial poverty profiles. With the development of the SWAp process and PROSAUDE, direct support to the provinces declined, common funds were merged in the PROSAUDE, but requirements such as the allocation criteria addressing equity issues were not integrated in the "new mechanism". Thus, the delivery and management of resources to the local level is plagued with difficulties and challenges of governance (interview).

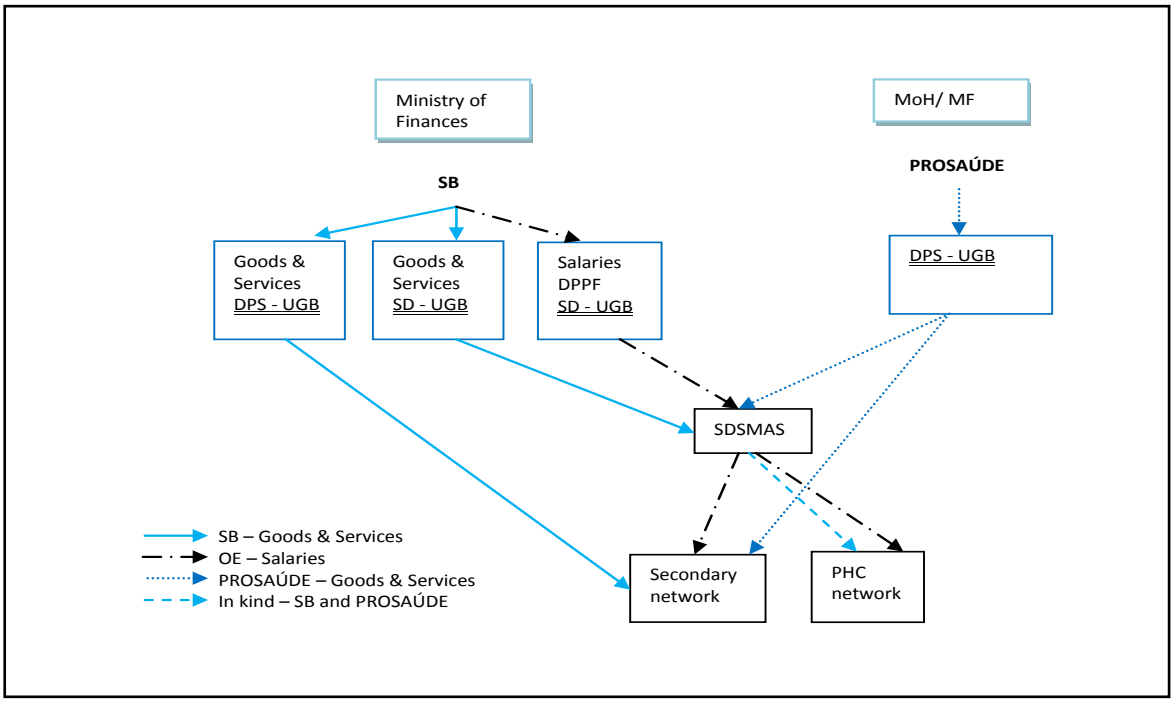
Institutional setting

Regarding health system management, the local level is represented by the district health authorities (SDSMAS). This corresponds to the last and lowest level of the national system and it has a more direct role in service provision trough the primary health care (PHC) network, the health centres and health posts. The SDSMAS have the responsibility to run and manage all health facilities in the district and *autarquias*(municipalities). The management team at this level is in charge of managing resources allocated through: i) the district government – *Secretaria Distrital* for the State Budget Funds (SB), ii) the health sector at provincial level, the PROSAUDE funds and iii) an increasing number of project aid funds. The SDSMAS, as all other district sector authorities, is not a budget management Unit (UGB[27]) in the sense of e-sistafe. As such, SB funds are managed globally as government district budget. Management problems that result from this setting negatively affect service delivery.

At the district level, besides the PCH network, some districts have secondary level health units – Rural, General and District Hospitals. These health units are labelled as autonomous by the SDSMAS; this adds further organizational, planning and management complexities. Furthermore, formally they are considered UGB, but in practice, in most provinces they get their funding both from the Provincial Health Directorates – DPS (SB – goods & services and PROSAUDE) and from SDSMAS (SB – salaries). The Figure below illustrates the flow of funds to the health sector at district level.

[27] Unidade Gestora Beneficiária

Figure 6: Flow of Funds to the District Level – Salaries and Goods & Services



Source: Cumbi, 2011

Concerning the municipalities, these have legally enshrined responsibility for primary health care, and institutional rules have been approved to produce the transfer of the human and financial resources to them (Decree 33/2006 of 30 August). However, this has not happened as yet, much to the dismay of some mayors. Thus, the health facilities in the municipalities are subordinated to either the 'Representative of the State' and the Health Directorate of the Town (*Direcção de Saúde da Cidade*) in major towns and cities (Anon, 2011) or the SDSMAS in smaller municipalities. As such, they are treated as any other health centres and health posts and do not have individual budgets.

PFM and health: Decentralization, recentralization, effectiveness and governance

Decentralization is in the case of health, confined to deconcentration and delegation. It has given more responsibility to the institutions at the local level, without, however, being accompanied by the necessary degree of autonomy in planning, programming, budgeting and budget execution, which has been retained at higher levels. For example, a study undertaken in 2009 concludes that more than 75% of the budgets of health, education and agriculture were budgeted and spent at the central level, despite the need of those sectors to be particularly close to the community and beneficiaries (Erskog and Rasmussen, 2009).

In fact, the erstwhile relative autonomy of the SDSMAS in budget execution and accounting has been curtailed. This has led, institutionally speaking, to a fractured health service delivery system at local level resulting from a lack of reconciliation between the (territorial) decentralization of functions and responsibilities, on the one hand, and that of allocation and management of resources via e-sistafe on the other. The possibility which e-sistafe opens up for more effective budget execution and control are not fully applied to promote

better performance of the decentralized health service delivery units; they are not yet tailored in such a way to make them congruent with their management needs.

The adverse consequences of this dynamic for the health sector can be illustrated with a couple of examples:

1) With the decentralization and the SWAp process, the **SDSMASs have lost most of the autonomy in the management and accounting of their expenditure**. The management of the accounting process including that of providing supporting evidence (invoices, receipts, etc.) is still done at the sector level, but the replenishment of justified funds is done only after all sectors have correctly accounted for their expenditure. Given different levels of capacity in financial management, (the health sector has better skills) there are delays due to the lower performance in the other sectors[28].This creates critical situations in the sector, which deprived of SB for the acquisition of inputs (parts, fuel for referrals, food for inpatients, etc.), sees the execution of its core business partially jeopardized. There are a number of telling examples underlining the inefficient flow and management of funds: a newly built hospital without equipment (in Gorongosa) or the lack of resources, in 2010, for almost nine month, for acquiring goods and services for health in the Districts of Nhamantanda and Dondo (interviews). Information gathered from Sofala and Cabo Delgado provinces indicate that in some instances the situation has reverted to the level of the 1990s, with the districts resorting to NGO funding and accumulating debts due to the delays and unpredictability of the SB funds.
2) The partial loss of autonomy has in some cases also led to the **underreporting via e-sistafe and thus retention of own revenue (fees from patients)**, in an attempt to mitigate against the lack of resources for the purchase of goods and services[29]. A solution could be to extend (or reinstall) the autonomy in financial management to the SDSMASs by turning them into UGB and even executive units, thus coherently decentralizing resources, planning, financial management and accounting. From a technical point of view, e-sistafe allows the possibility to provide local health units with or district primary health care with earmarked base funding or conditioned funding for capital and recurrent expenditure and for targeted support by donors[30]. The question is whether there is enough political will at central level, not only in MISAU, to use those opportunities which the core instrument of the Mozambican PFM system offers.
3) The exclusion of SDMASs from budget management has also implied **low execution rates of SB funds**, one of the criteria used by the MPD/MF for resource allocation.
4) While the decentralization policy recognizes local governments (both **districts and *autarquias***) important role in planning and budgeting for effectively executing public services at the local level, their role is very limited. The fact was already mentioned that municipalities have not received the resources for executing their attributed functions in

[28] "... No mesmo âmbito de diálogo a nível de Governo, procurar garantir um "estatuto especial" às DDS´s com fim a evitar a penalização do sector saúde na recepção de fundo pelos atrasos nas justificações de fundos de outros sectores." **(**Joint Review 2009 for 2008 - Anexo V: Relatórios dos Grupos de Trabalho)

[29] This happens even at central hospitals. The reported own revenue of HCM (Maputo Central Hospital) for the year 2011 is equivalent to the amount its *Clínica Especial* is generating in one week (Anon 2011: 12),

[30] The programme and sub-programme codes in the classification system that e-sistafe offers provides for budgeting and managing programmes at district level. Functional codes would allow for the costing of the budget structure of (sub) programmes and sectional codes would permit development of standard charts of accounts, cost centres etc. for budgets of health units such as hospitals at local level. Contrary to education, the health sector has not made use of the programme opportunities e-sistafe provides (Interview).

primary health care – a point of contention between some of them and central government. The role the districts play in planning, via the PESOD and PEDD, also has little effects, mainly for three reasons. Their planning exercise takes place at the same time as that of the central and provincial units. This means that the local plans are only reflected in provincial and national plans, if any, with a considerable delay. And, as already stated, the planning instruments, including CFMP and PES, are neither organically linked to the budgetary process and sistafe nor are budgets costed, although e-sistafe would provide a technical solution to do so.

Decentralization: Governance challenges

The loss of relative autonomy of the SDSMAS in managing and accounting for their resources points to governance challenges associated with deconcentration, including in the health sector, which is seen by some analysts as an extension to lower levels of government of the clientilist system of the distribution of rent by Frelimo, and as such an extension of central political control despite the decentralization rhetoric (Buur, 2009; Forquilha and Orre, 2011)[31]. The consultants were informed, that some District administrators visited by a joint field mission of the Decentralization Working Group undertaken end of 2011 with the aim of assessing decentralization in the health sector, complained about the change of purpose of the *Orçamento de Investimento de Iniciativa Local* (OIIL), commonly known as "*7 Milhões*". While up to 2007, the Fund was destined for the construction of public infrastructure, including health facilities. The redefinition as a fund for livelihood and income generation via a credit scheme in 2008, deprived the district governments from access to (own) resources for social sector investment beyond that coming from the sectors themselves.

The consultants also noted the reporting of complaints about lack of transparency concerning the allocation criteria for social sector spending and investment at the health system's primary and secondary level vs. investment in buildings of the District Administration, which apparently have higher spending priority than infrastructure in health or education. Other complaints noted, partially corroborated through other interviews and media reports, concerned the lack of information flow from Provincial and District governments to the health units at local level and insufficient coordination and bargaining between them; the apparent existence of ghost staff in the health sector receiving salaries pocketed by others, abusive use of operators of e-sistafe at district and provincial level[32] to the detriment of the health sector, etc.

The emerging picture is that of decentralization rhetoric on the one side, but little action, administrative, management, etc., to make it work for the sector. As one insider put it: 'in recent years, MISAU only had central level interests at its heart, never those of the provinces, let alone districts' (interview). This tendency has politically been underlined by President Guebuza's *Presidência Aberta and Inclusiva* (PAI). A recent study demonstrates the political benefits of that approach, but also questions its potentially adverse effects of its

[31] A critical legal analysis provides indications of a recentralization. See: Chiziane, 2011.

[32] Seis funcionários da Saúde condenados em Manica. O País, 25/11/11. http://www.opais.co.mz/index.php/sociedade/45-sociedade/17799-seis-funcionarios-da-saude-condenados-em-manica.html.

'parallel intervention' approach on planning and budgeting processes in both their territorial and functional dimensions (Leininger, 2011).

In concluding we suggest, that the state of affairs at the district level, i.e. the SDSMAS's endowment with human, financial and medical resources and sufficient management capacities and good practices, may not necessarily correspond to their needs and the demand profile of the sector's clients. Thus it is not surprising that the latter tend to increasingly avoid this level of service providers and seeking instead, the health services at central, provincial or general hospitals. The effect is an increasing demand and overcrowding at those units, greatly affecting the capacity to implement health programmes and the quality of care provided.

3.2.3 Accountability challenges of the sector

Lack of a sound and clearly identifiable policy in the sector is posing problem to accountability, since, as one interviewee explained, each minister has the leeway to determine the course of action of the sector. Some interviewees pointed out that broad policy issues, such as the pursuance of the Millennium Development Goals, have sometimes disguised the lack of a policy based on national concerns. Regional disparities and equity issues, though discussed now and then, are not adequately reflected in policy debate at all levels and fora. There is no clear policy sustained by measurable targets to be achieved. The GoM and PAP, as well as MoH and the HPG monitoring and evaluation mechanisms do not include equity indicators. The budget approved in parliament does not take into account issues such as provincial and rural vs. urban distribution of resources. The excessive reliance on external funds is considered a high risk, and a contradiction in terms, taking into account that the health sector is amongst the priorities in the fight against poverty that has been defined as a top priority by the government and the political elite. According to an interviewee, this issue is among the main concerns being debated in the process of designing the new sector strategic plan.

The lack of a clear policy direction is considered to be undermining the institutional memory, morale and motivation of the sector staff, since new proposals of reforms are cynically seen as another wave brought in by a minister and doomed to fade away as soon as a new minister is appointed, and no one is held accountable for what happens in the sector. Institutional memory is also seriously affected by high staff turnover, new and fashionable international agendas, both in government institutions as well as in donor agencies.

This setting has also influenced the levels of accountability in the sector and particularly the fight against corruption, which has been historically perceived as serious in the sector. In this regard, a study carried out by CIP (Centre of Public Integrity) in 2006, concludes that corruption in the health sector is founded on the relations of demand and supply of health services between the health system and the public. In this regard all the actors of the sector can potentially be involved in some kind of corrupt practices. Thus, the most frequent practices are: nurses demanding payment of bribes, medical staff using public facilities and resources to attract clients for the their private clinics or to provide private consultations and treatment; procurement agents accepting kickbacks to grant public contracts; pharmacy staff deviating pharmaceuticals to the black market (Mosse and Cortez, 2006). The study

also points out to cases of grand corruption in the procurement for public works and import of pharmaceuticals, and illegal supply of medicines to private pharmacies, which charge a much higher price in comparison to the public sector pharmacies, thus gaining large profit margins, a conclusion confirmed by one interviewee. The causes of corruption are identified as low salaries, weakness of the internal control mechanism (mainly the inspection) and the pervasive thin line between public and private activities.

The diagnosis of the health sector was used to design an anti-corruption action plan of the sector, in collaboration with CIP but, paradoxically, its implementation was not monitored, due to the dismantling of the General Inspection in the mandate of Minister Garrido (ACS, 2009).

Taking into account the issues identified during this work, the situation did not change much in the sector since the 2006 study. Accountability problems still persist, and the main sources of corruption are remain the same.

3.3 Here and Now

3.3.1 Finances and drugs: challenges to management

Two interrelated events in the past year revealed the dimensions of the management challenges the NHS, in general, and MISAU, in particular, are facing. The first was an external audit of the 2009 accounts for PROSAUDE II, and Central, Provincial and Global Fund Programme produced by the audit company KPMG, issued in June 2011. It revealed considerable weaknesses, notably regarding internal audit and a substantial non-reconciled closing difference between of receipts and payments.

The second was the widely publicised crisis of the supply of pharmaceuticals, when the media reported in 2011, that over a period from March to July, drugs worth at least 2 million USD had expired in MISAU's central pharmaceutical warehouse CMAM in Maputo ; the public hospitals in Zambezia province had run out of drugs and large quantities of drugs had disappeared from the pharmacy of the Nampula central hospital[33]. A request to donors by the Minister of Health in March 2011 for an additional amount of 25 million USD for restocking of drugs was turned down with the argument that government would first have to address and resolve the pending issues of the 2009 audit results before the PROSAUDE donors would consider any further funding commitments[34].

Already in 2008, GF had left PROSAUDE with the argument, that the funding principles of GF could not be aligned with the PROSAUDE approach, which is aligned with the national PFM systems and that sufficiently effective internal control mechanisms in MISAU were lacking.

[33] See various reports in the daily editions of O Pais on these matters.

[34] Doadores e Ministério da Saúde não se entendem. 29/07/2011. http://www.opais.co.mz/index.php/sociedade/45-sociedade/15534-doadores-e-ministerio-da-saude-nao-se-entendem.html

An audit of the 2008 accounts and the aforementioned one for 2009 led a specific assessment by GF come to the conclusion that a considerable two digit million USD amount was not specifically accounted for, in line with what was stipulated in the grant agreement with GF, and that there was no compliance with the requirements for reporting, and procurement among others (GF, 2011).

These events revealed a number of structural weakness concerning financial management and accounting, which were in one way or another conformed by the interviews conducted for this study. They can be summarized as follows:

- Absence of an effective internal audit system, despite the organizational structure of the Department of Administration and Finance (DAF) in the National Directorate for Planning and International Cooperation (DFC) in MISAU foreseeing such a unit;
- Inadequate external audits due to lack of capacity of the General Auditor's Office in the Administrative Tribunal (TA);
- Inadequate accounting and reporting procedures including documentation for supporting evidence for expenditure;
- Lack of a quality databases for financial flows in the sector which makes Public Expenditure Tracking (PETS) virtually impossible;
- Insufficient allocation of human resources and lack of retention capacity in DAF, as well as lack of support to DAF from DPC to which it is subordinated.

Specifically concerning pharmaceuticals whose annual budget was, in 2009, the single most important government expenditure item in the e-Sistafe list of government programmes (Erskog and Rasmussen, 2009), the crises brought to light major problems concerning:

- The supply and distribution chain management of pharmaceutical;
- Management of storage and stocks, including the security of warehouses;
- Inadequate and transparent procurement procedures, often conducted by junior personnel without professional experience, due to brain drain and deliberate removal of experienced personnel by the former minister;
- Lack of training of supply chain and stock managers (interviews; Grant Thornton, 2011).

For one of the interviewees, intimately familiar with the NHS, the Pharmaceutical sector is and has been one of the most corrupt sectors in the system, to the detriment of regular and adequate supplies of all hospitals with drugs, one of the key determinates for health outcomes. From this angle the drugs crisis in 2011 appears as the tip of an iceberg. It might also explain minister Garrido's option to renovate the personnel in this area even "desperately" resorting to junior professional. In another insider's opinion, 'the major challenge is that MISAU does not understand that management (all management dimensions including financial management) is an important part of their weakness as an institution and that better service delivery will only be achieved if management processes are in place, well-used and refined over time'.

A fiduciary risk assessment, taking into consideration the conclusions of Public Expenditure Financial Assessments (PEFA) of the health sector in general (Lawson *et al.* 2008) and that in Cabo Delgado province in particular (Umarji *et al.* 2009), confirm, by and large, the above reading of the management challenges in MISAU and the NHS (Umarji, 2011). However, they see progress in addressing these issues by MISAU staff, including a task force for managing the pharmaceutical crisis. Progress is specifically noted on the implementation of the Consolidated Action Plan (*Plano de Acção Consolidado* PAC) of April 2011, agreed upon between the health partners (MISAU, 2011b). By December 2011, 44% of the total of 56 agreed activities aimed at resolving the crises triggered by the 2009 audit report were concluded, 41% ongoing and 14% not yet accomplished.

This progress, the strict regime of producing monthly reconciled account reports by MISAU and submitting them for counterchecking to the international health partners on a bi-monthly basis agreed by the health partners, as well as a satisfactory progress report on pharmaceuticals, enabled some of the international PROSAUDE partners to gather 'sufficient confidence' for committing continued funding. The trigger mechanism for disbursement will be further progress in the clarification of the pharmaceutical accounts (interview).

Summarizing the conclusion of this section and widening at the same time the horizon of the present analysis, the general study by IHME cited above coincidentally concludes, that transparency, accountability 'are as critical to health outcomes as is the need to 'continuing to providing solid evidence on DAH's contribution to accelerate health progress' [35]

3.3.2 Reform initiative by government

One could be inclined to say, that the dimensions of the management problems brought to light by the crises, sketched above in some detail, may have been a blessing in disguise. The new Minister replacing Ivo Garrido and his team seized the crisis as an opportunity to exercise leadership and have the management issues addressed in such a way that the progress noted above was made possible, especially concerning the PAC implementation. This has been recognized and appreciated by the international health partners, who acknowledged in their extraordinary meeting on 13 December 2011 'the ownership, transparency and all the measures the MISAU is putting in place to improve management'[36], even if some doubts about the sustainability of the new DAF dynamic and the human resource situation in the department exist.

But the new leadership of MISAU goes further with its reform initiative. The Ministry is currently preparing the Strategic Plan for the Health Sector (PESS) for the period 2013-2018, and the discussion of the roles of the various service providers, as well as the funding of the system, are among the topics being considered (interview). Part of this process is the Health Sector Review (RSS), which attempts to produce a comprehensive and objective assessment of the sector, with the international partners invited to participate and contribute[37]. Due to

[35] ppt presentation of 'Financing Global Health 2011: Continued growth as MDG deadline approaches' by Christopher Murray and Michael Hanlon, IHME, January 19, 2012. Institute for Health Metrics and Evaluation. University of Washingtom.

[36] Minutes of the meeting.

[37] A draft paper on finances used in the present study, cited as Anon 2011, is already an output of the RSS.

time constraints the team has not had the opportunity to meet with the commission created to design the strategic plan to have more details about the strategic issues being discussed. Hence, in the second phase of this work a meeting with this group is strongly recommended.

4 Conclusions and further considerations

4.1 Conclusions

On the basis of the foregoing analysis, four major conclusions, which are **forward-looking** in nature, can be drawn.

4.1.1 Realistic assessment vs. expectations

The first one is that one needs to have a realistic, sober view of the health sector in Mozambique and its perspectives for improvement, including via donor support. If collective and individual health outcomes vary indeed with more or less socio-economic equality, as suggested by Wilkinson and others, then the path towards improved, broad based health in Mozambique, notably public health, faces an uphill effort: the social stratification and differentiation process which the Mozambican society is undergoing and which is caused, to a large extent, by the predominance of an economic accumulation model based on resource extraction and rent-seeking that is not necessarily accompanied by commensurate human development. On the contrary, it has a tendency to impoverish large parts of the population, if not corrective fiscal and distributional measures are undertaken, e.g. in the sense of welfare state measures. With the present configuration of the political power structure and its control of the commanding heights of the political economy and the state, question marks need to be placed on the likelihood of distributional measures and their possible effects success.

The same argument is true for a political economy in which legal and illicit practice of rent-seeking and corruption is seen to be pervasive. Concerning corruption, there are no fast and technical remedies in a setting where salaries in the public service, and particularly in the health sector, are generally very low and the legal system, to which the Auditor General Office in the Administrative Tribunal belongs. Under these circumstances it seems more promising to support initiatives which aim at raising the stakes for, and reducing the confidence of the parties involved in corrupt transactions, as suggested by literature (Lambsdorff, 2007). This may not only imply more frequent and rigorous independent, external audits and stricter control mechanisms for funds provided to the health sector, but also encouragement to NSA and Civil Society, the media, research institutes, etc., to engage in monitoring of the sector, its finances and outcomes.

From the perspective of a donor engaged in supporting the health in Mozambique there is pretty little that can be done to influence, or even change, the dynamics of the macro-context in which the sector operates, excluding 'strong' measures such as exit or hard conditionality, which may contradict principles of political correctness in the business of cooperation and/or own principles underpinning it. In other words, the present framework conditions need to be accepted as a point of departure, and expectations concerning fast success in achieving improved health outcomes need to be readjusted.

4.1.2 Efficiency of management

Given the conclusions arising from the foregoing analysis, it is somewhat impressive that, given the challenges the sector is facing in terms of policy, complexity, donor dependence, management and governance, the sector's outcomes and overall performance seems to be improving, according to the PAF monitoring criteria[38] (MISAU, 2011) and study results, although, in comparative perspective, the overall level of health outcomes is still low with the health status of the Mozambican population remaining 'lower than average for African countries and by international standards' (Visser-Valfrey and Umarji, 2010: 7). The NHS has shown its robustness and capacity to deliver early on, even under considerable strain (O'Laughlin, 2010; Cliff *et al.* 1986). The professionalism, competence and motivation of the health staff, with other words, the sectors collective social capital, seems to be one of the key factors responsible for the positive outcomes, despite circumstances such as low salary scale and irregular salary payments[39], lack of staff and brain drain, which affects it adversely[40] (interview). The AJA for 2011 comes to similar conclusions concerning the human resource capacity, notably concerning delivery of basic health care package (MISAU, 2011a: 28). Others see the move to the SWAps with Common Funds as one of the key causes for the improvements achieved (Visser-Valfrey and Umarji, 2010: 9). Assuming that the data sustaining these conclusions are reliable[41], the challenges the health sector is facing are, in principle, related to the effective, efficient, transparent and accountable management of its resources rather than to any other factor discussed above. A recent study by DFID corroborates this conclusion from the angle of procurement (DFID, 2011). The health partners AJA report for 2010 raises the management issue as does MISAU's input paper on health financing for health sector review. It states that a staggering 37% of the sector's resources are spent on the management and administration of the public health programmes (Anon, 2011:7).

The new minister and his team have recognized the management challenges and consequently reinforce the financial management and monitoring capacity in the ministry's DAF.

From a strategic donor perspective, supporting Mozambique's health system aimed at improving its performance and addressing equity issues would therefore imply strategically supporting all efforts to improve the management efficiency. This would need to address factors within the sector (such as, support to DAF, internal control and comprehensive Management Information and Reporting System – MIS) and outside the sector (e.g. support to MINFIN, TA), i.e. to improved PFM specifically for the sector. Facing such a challenge

[38] 'In comparison with previous years, and taking into account the 28 indicators for which there is information, the assessment of the sector's performance registers an improvement... assessment the indicators that reached the respective targets went from 53% in 2008 to 66.6% in 2009 and 71% in 2010'(MISAU, 2011a: 8).

[39] In December 2011, medical doctors threatened a strike for reasons of delayed salary payments. Source: *O País*, 13/12/2011.

[40] According to the minister of health, in 2010 12 % of the approximately 30,000 health professions on the government's payroll left the NHS, 'in search for better opportunities'. O País, 11/3/2011. . http://www.opais.co.mz/index.php/sociedade/45-sociedade/12795-parceiros-dizem-estar-a-assumir-papel-de-estado-na-area-da-saude.html

[41] Some of the interlocutors raised doubts about the veracity and reliability of the data.

would need to recognize a possible loss of overall dynamic in the evolution of the Mozambican PFM system as a whole recently diagnosed (De Renzio, 2011).

4.1.3 Health sector and policy reform

Since efficient and effective management depends to a large extent on a clear regulatory and policy framework, which sets strategic and operational objectives, defines options and addresses issues of viability and sustainability of the health system, the necessity of a clear policy and regulatory framework reflecting the dynamic and socio-economic changes affecting the sector becomes obvious. The analysis above produced some powerful arguments which support the need of reform of the sector – a view shared by almost all persons interviewed. They also agree that a reform or a new policy would need to cover both private and public service providers. Although it is not clear at present where the driving forces and alliances for a health sector reform would be located, there is a strong feeling among a number of interviewees that NSA and civil society would need to have – and to be given – a major role in a review of the present policy determinants, which are not adjusted to today's socio-economic challenges within and outside the sector. From that angle, a health donor might need to explore the possibilities and opportunities for supporting and empowering NSA for a stronger engagement in the sector. However, this would have to be balanced also with the concerns raised about the credibility of civil society in Mozambique, which is seen as dominated by donors and mostly created and managed by part of the urban elite. An alternative to complement these gaps of the civil society could be strengthening the parliament capacity to improve its understanding of sector problems, such as the consistency of its policies and meaningful formulated budgets to address country and sector major shortcomings.

4.1.4 Health financing

The analysis in section 3.1 showed the overwhelming dependence on foreign funding of the health sector and the effects this has on its fragmentation and sustainability. Thus, it is urgent to not only address the issue of health sector financing by looking at ways and soft modalities of reducing donor dependence, e.g. via intelligent exit strategies, but, more importantly, health sector financing from domestic resource. As we have seen, health sector funding has been completely delinked from the domestic revenue generation dynamic, which is likely to pick up via expected taxation of megaprojects and mineral extraction operations (EIU, 2012). On the other hand, funding from private households also has increased considerably. And lastly, there are hidden funding reserves in the form of rents and the 'corruption fee' for health services, extracted in the various forms at virtually all levels of public service providers.

Supporting the health sector and its reform, thus, would include also supporting the elaboration of a viable health funding approach, including addressing the issues of user charges commensurate with cost recovery, conditioned tax grants for the sector and social and health insurance.

Finally, taking into consideration the new dynamic and leadership qualities in MISAU alluded to above, we conclude, that there is an opening and opportunity for raising and discussing at least some of the issues and conclusions the present study has produced – an opportunity that should not be missed.

4.2 Further considerations

4.2.1 Risk and opportunities

There are some risk and opportunities for the support of the health sector mentioned throughout the report, summarised as follows:

Opportunities:

- The new leadership seems to be an opportunity for change, due to its political will and more cooperative working methods;
- The crisis in the sector can be a good opportunity for change, since the perception that the system is not efficient and effective, opens the opportunity for the necessary reforms.

Risks:

- Weak accountability and management systems that lead to pervasive rent-seeking practices that contribute to perpetuating the lack of accountability in the sector;
- The constraints of the decentralization process and their implication on the capacity of the local level to manage resources and deliver services;
- Lack of a policy that can define a long-term vision and work as guidance for the capacity development efforts and also for the consideration of the support to the various actors, according to the roles they play in the system;
- Fragmentation of the support to the sector, despite attempts to adopt more joined-up mechanisms of funding.

4.2.2 Further research questions

Since this report is an initial approach to the political economy of the health sector, it is worth presenting some key research questions and areas that should merit some attention in the forthcoming stages of the sector analysis.

The first area is related to the conundrum related to the missing link of the relatively good performance of the sector *vis-à-vis* all the problems pointed out. As mentioned in the conclusion, the sector faces challenges but its performance has been good is some areas, such as child mortality. Whilst an assertion of this nature might be responded to with the argument that the successes of the areas are consistent with the policies carried out, the insight for this study would suggest the opposite. Therefore, a critical analysis on the

determinants of the sectors' successes and its sustainability is important. This analysis could also address the point raised by O'Laughlin (2010) about other interdependent aspects that contribute to the positive improvement of the sector, such as improvement in urban sanitation, economic growth, better nutrition and sorting out of land conflicts.

Research on allocation of funds to regions deprived of the system and how to improve the access to the system in the areas were commercial provision would not be feasible, should also merit a deeper analysis, as the second area of research. As the system is leading to a second phase of its liberalization, with a growing role of the non-state actors in service provision, analysing the conditions for ensuring access to health services to the population is key for its effectiveness.

The third area of research could be the examination of the roles that the various private and informal service providers play, and the funding of the sector, taking into account the intricate relations between the intervening actors and the formal and informal mechanisms of funding that already exist. Finding sustainable ways of funding the sector is important for its long-term survival and for changing the current paradox of being a national priority sector but with strong participation of the external funding. In this area, issues as joint-management (*co-gestão*), cost-recovery and private mechanisms of health funding, such as social security and health insurance could be considered.

Further suggestions for research on the political economy of Mozambique's health sector can be gleaned from the exploratory research inquiry of Mozambique's health sector cited in this study (O'Laughlin, 2010).

5 Annexes

5.1 Terms of Reference

Terms of Reference for Political Economy and stakeholder analysis of the Health Sector in Mozambique

Objective

1) The objective of this consultancy is to inform the development of a health sector support programme for the Government of Mozambique and to highlight particular political economy challenges and opportunities that DFID Mozambique should take into account.

Background

2) DFID Mozambique has been supporting the health sector since 2007, through sector budget support, technical assistance to the Ministry of Health (MISAU) and projects through NGOs. Through the approval of the bilateral aid review for health in October 2010, DFID decided to continue this funding for another five years.
3) DFID will be exploring different ways of engaging in the sector. Sector budget support (PROSAUDE) will be made more effective by the possible introduction of either a performance tranche or a results compact into PROSAUDE. There are also discussions with other partners about the creation of a pool for more alignment of technical assistance (TA) by partners and greater control of funding for TA by MISAU. A project co-funded with other donors on demand side financing to increase institutional deliveries and use of family planning services in several provinces will also be implemented.
4) There have been significant staff changes in MISAU in the last 18 months including a new Minister of Health, a new Permanent Secretary and at least four new national directors. The new Minister of Health has a different leadership style from the previous Minister focusing on more transparency and open communication with donors. As a result, the health inspector general has been reinstated in MISAU with provincial representatives recruited and strengthened. The Minister of Health is also interested in attracting back some of the qualified staff that the sector has lost in the last five years.
5) In 2010, MISAU experienced problems in public financial management and the procurement, distribution and supply of pharmaceuticals. Partners and the relevant departments are working on medium and long term solutions to build capacity and systems to ensure these problems do not happen again. One of the consequences of has the restructuring of several departments. For example, the Administration and Finance Department is seeing internal changes while the Central Warehousing (CMAM) is being given more autonomy and independence.
6) MISAU will be drafting their new strategic plan (2013-2017) next year. In light of this a health sector strategy is being undertaken. To compliment the review, sector

budget support (PROSAUDE) partners will be conducting an evaluation of the sector looking at the last 5 years in the first quarter of 2012. The findings from this study can feed into the evaluation and ultimately the new health strategic plan.

Scope

7) This consultancy will have to phases. Phase 1 producing an overview of the political economy of the health sector. Phase 2 will build on this analysis and focus on the delivery chain within the health sector (with a possible focus on drug supply) down to the point of service delivery.
8) This work will focus on providing additional input to DFID to understand the risks and challenges that need to be considered in programme design and implementation in the Health Sector.
9) Phase 1 of the work will take place during December and January over a period of a total of 25 days. The consultants will gather relevant information, undertake detailed analysis and produce a short report on the political economy of the health sector in Mozambique.
10) Phase 2 will take place from February and will require a separate contract and Terms of Reference. This will build on the results of this study.

Tasks

11) In Phase 1 the consultants should:

    a. Do a literature review of the health sector focusing on ideologies, values and change processes and how these have influenced ways of working and norms.
    b. Interview key informants that interact with the health sector (including MISAU officials, ex-MISAU officials, donors, private health providers, political parties, non-government organisations) noting their incentives and interests in relation to the health system; when and how stakeholders might support or block reforms to develop a more effective system; whether certain groups can be positively influenced; and the existence or not of key reform champions.
    c. Assess how historical legacies, structural factors, government change processes, power relations and ideologies and values affect norms and ways of working in the health sector.
    d. Examine the relationships between different players and how different players influence the policy process, including influence on the way formal policies are implemented.
    e. Understand (or document perceptions of) where corruption and rent-seeking is most prevalent in the health system (at local and central levels).
    f. Understand how decisions are made within the Ministry of Health in relation to key policy areas.

Phase 2 will be a more comprehensive analysis of the incentives and motivations that exist within the system, especially at decentralised levels.

Method

12) The work of Phase 1 will be based in Maputo. It will include:

a) Analysis of literature on the health system and of other available information.
b) Discussions with key informants from government, private sector, non-government and donor stakeholders. Interviews should explore the informants own interests and their views on others' interests. Suggested interviewees would include

I. Government: Senior figures in Ministry of Health plus former officials now working for donor agencies.
II. Private sector: Selection that covers private clinics; companies with/without links to Frelimo, associations (e.g. CTA/ ACIS), international/national companies.
III. Non-government: Key academics and media representatives; civil society organisations.
IV. Donors: Netherlands, WB, Denmark, EU.

c) Production of documents including analysis detailed above.
d) The Stage 2 of the ODI Analytical Framework for Understanding the Political Economy of Sectors and Policy Arenas should be used as a guide to frame the interviews and analysis (see Annex 2).

Outputs and deliverables

13) The consultants will produce a report of not more than 15 pages covering the issues outlined above for internal DFID use.
14) A 3 page summary report in English to be shared with other partners in the health sector. This should be framed as a 'strengths and weaknesses' analysis.

Timeframe

15) Phase 1:

I. The consultancy will be conducted over 25 days in December/January (divided between 2 consultants). DFID will provide some logistical support for setting up meetings.
II. Initial briefing with DFID in early January about the structure of the structured interview questions.
III. A draft report (in English) by the 20th January. DFID will provide comments on the drafts by the 24th January.
IV. The consultancy will be completed by the 27th January.
V. DFID and the consultants will then discuss Phase 2 of the consultancy once Phase 1 is concluded, and on the basis of the findings.

Reporting

16) The overall coordinator for this consultancy is Etelvina Mahanjane, Health Adviser, DFID Mozambique, Deborah Nhandamo, Programme Assistant will be managing the contract and logistics. Mark Smith, Senior Governance Advisor, DFID Mozambique will provide technical input from a political economy perspective.

Skills and experience

17) Consultant(s) should have expertise in political science and political economy analysis. They should have in-depth understanding of the functioning of Mozambican state and political institutions.
18) The consultant(s) is/are expected to speak and write both English and Portuguese.
19) It is envisaged that this work is carried out by 2 consultants, one of whom should be the designated Team Leader. The Team Leader will be responsible for dividing the tasks and putting together final documentation.

Audience and Dissemination

20) The main report will be an internal DFID document. However, a summary report (in English) will also be produced for sharing with other partners.

Annexes:

1. Avaliação Conjunta Anual (ACA), 2010.
2. An analytical framework for understanding the political economy of sectors and policy arenas, Overseas Development Institute, 2005. Online: Available at: www.**odi**.org.uk/resources/download/2989.pdf

5.2 List of persons interviewed

	Name	Function	Institution
17 January			
1	Bridget Crumpton	Advisor, Health Sector	DFID
2	Etelvina Mahanjane	Programme Officer, Health Sector	
19 January			
3	António Mussa	Director (ex Provincial Director of Health, Nampula, Zambézia, Inhambane)	ICAP, Maputo
4	Francesca Bruschi	Coordinator Decentralization Working Group	Italian Cooperation
5	Bela Matias	First Secretary (Social Sectors)	EU Delegation
6	Geert Haghebaert	Attaché, Health Sector	
7	Dr Mathias Schmauch	Orthopedist	HCM,Clínica Sommerschield
20 January			
8	Nicole Mc Hugh	Development Specialist, Social Sectors	DCI
9	Jonas Chambule	Health Programme Advisor	
10	Lisa Nelson	Mozambique Country Director	CDC- Global AIDS Programme (GAP). Centres for Disease Control and Prevention (CDC)
11	Nandy Heurtoux	Financial Controller, Health Support Programme	EKN
12	Dr. M. Concepción Valls	Director (Ex Director of Polana Caniço Hospital)	Asociación para Salud Integral Y el Desarrollo Humano (ASIDH)
23 January			
13	Mariano Lugli	Exceutive Coordinator,	Médecins Sans Frontières (MSF) Switzerland
14	Dr Sam Patel	Clinical Director	Clínica Sommerschield
24 January			
15	Dr. Aurélio Zilhão	Presidente, (ex Health Minister) Director	Ordem dos Médicos ISCISA
16	Dr. Marcelino Lucas	Permanent Secretary	MISAU
25 January			
17	Gertrudes Machatine,	Financial Advisor, Health (Ex National Director of DPC, MISAU)	CHASS-SMT, Reforço do Sistema de Saúde/

28 January			
18	Hans Erskog	Financial Advisor	DANIDA
30 January			
19	Joaquim Durao	Consultant	MISAU, Central dos Medicamentos

5.3 Selected bibliography

Anon, 2011. *Revisão do Sector da Saúde – Área de financiamento*. Esboço final, *06 Dezembro 2011*

BAG (Budget Analysis Group), 2011. *Breve análise das tendências nos orçamentos do sector da saúde no período 2006/11*. 17 de Outubro de 2011

Balabanova Dina, Martin McKee, Joceline Pomerleau, Richard Rose, and Christian Haerpfer, 2004. "Health Service Utilization in the Former Soviet Union: Evidence from Eight Countries". In: Health Service Research, 2004 December, 39: 1927–1950. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361106/

Buur, Lars, 2009: The politics of gradualismo: popular participation and decentralised governance in Mozambique, in: O. Törnquist / N. Webster / K. Stokke (eds.), Rethinking popular representation, New York: Palgrave Macmillan, 99–118.

Buur, Lars, 2011. *Mozambique Political Settlement Analysis from a Dominant One-Party State towards Competitive Clientelism?* Unpublished

Buur, Lars and Baloi, Obede, 2009. *The Mozambican PRSP Initiative: Moorings, usage and future*. Copenhagen: DIIS Working Paper 2009:35.

Buur, Lars; Baloi, Obede; Tembe, Carlota, 2012. *Mozambique Synthesis Analysis: Between Pockets of Efficiency and Elite Capture.* DIIS Working Paper 2012:01. Copenhagen: Danish Institute for International Studies.

Cabral, Lidia, Cumbi, Amelia, Dista S. and Vinyals L. 2005, *Estudo sobre os fluxos financeiros "off-budget" no sector Saúde*. Maputo, Mozambique: Republic of Mozambique Ministry of Health, Ministry of Finance, and Ministry of Planning and Development.

Castel-Branco, Carlos, Nuno, Ossemane, Rogério C.; Amarcy, S., 2010. *Moçambique: Avaliação Independente do Desempenho dos PAP em 2009 e Tendências de Desempenho no Período 2004-2009*. Maputo, Instituto de Estudos Sociais e Económicos (IESE). April 2010.

Castel-Branco, Carlos; Ossemane, Rogério, 2010. "Crises cíclicas e desafios de transformação do padrão do crescimento económico em Moçambique". in: de Brito, L., Castel-Branco, C.; Chichava, S., Francisco, A. (Eds), 2010. *Moçambique: Desafios 2010*. Maputo, IESE.

Chiziane, Eduardo, 2011. *The trends of recentralization of the administrative power in Mozambique. Foreword by Professor Gilles Cistac*. Universidade Eduardo Mondlane. Imprensa Universitária

Cliff J, Kanji N, Muller M. 1986. "Mozambique Health Holding the Line". *Review of African Political Economy* 36: 7–23.

Christie F.; Ferrara P.R., 1999. *The Social Context of the Health Care in Mozambique - Volume 5*. Maputo: Management Sciences for Health and Ministry of Health.

Cumbi, Amélia J, 2011. *Revisão de apoio à Província de Cabo Delgado pela medicusmundi*.

de Renzio, Paolo, 2011. - Can Donors 'Buy' Better Governance? The political economy of budget reforms in Mozambique. Instituto de Estudos Económicos e Sociais (IESE). Cadernos IESE Nº 09. http://www.iese.ac.mz/lib/publication/cad_iese/CadernosIESE_09_PRenzio.pdf

DFID (Department for International Development), 2011. *O Processo de Aquisições (Procurement) em Moçambique: Economia, instituições, reforma e desafios*. Maputo: DFID.

DNEAP (Direcção Nacional de Estudos e Análise de Políticas), 2010. *Poverty and Well Being in Mozambique: The Third National Assessment*. Maputo: National Directorate of Poverty Analysis and Studies, Ministry of Planning and Development.

EIU, 2012. *Country Report Mozambique* . London, Economist Intelligence Unit. January 2012

Erskog, Hans; Rasmussen, Peter E., 2009. *Analysis of External Funds Registered in the State Budget 2009.* Draft (Unpublished)

Forquilha, Salvador e Orre, Aslak, 2011. "Transformações Sem Mudanças? Os Conselhos Locais e o Desafio da Institucionalização Democrática em Moçambique". *In* Luís de Brito, Carlos Castel-Branco, Sérgio Chichava, António Francisco. *Desafios para Moçambique 2011.* Maputo, IESE.

GF (Global Fund to Fight Aids, Tuberculosis and Malaria), 2011. *Audit of Grants to Mozambique. Debrief to Health Partner Group.* 08 December 2011. PPT

GFI, 2008. Illicit financial outflows from Africa: Hidden resources for Development. Washington. Global Financial Integrity (GFI). http://www.gfintegrity.org/content/view/300/154/

Grant Thornton, 2011. *Review the Ministry of Health Financial Report & Statements – Prosaúde II and Global Fund for 2009 August 23rd -September 23rd 2011*. (unpublished)

Harvey, David, 2006. *Spaces of global capitalism. Towards a theory of uneven geographical development*. London, New York. Verso.

Khan, Mushtaq, H.; Jomo, Kwame S. (Eds.), 2000. *Rents, Rent-Seeking and Economic Development: Theory and Evidence in Asia*. Cambridge University Press.

Khan, Mushtaq Husain, 2010. *Political Settlements and the Governance of Growth-Enhancing Institutions.* University of London. School of Oriental and African Studies. July 2010. http://eprints.soas.ac.uk/9968/1/Political_Settlements_internet.pdf

IHME, 2011. Financing Global Health 2011: Continued growth as MDG deadline approaches. Institute for Health Metrics and Evaluation. Washington University. http://www.healthmetricsandevaluation.org/publications/policy-report/financing-global-health-2011-continued-growth-mdg-deadline-approaches

Lambsdorff, Johan Graf, 2007. *The institutional economics of corruption and reform. Theory, Evidence and Practice.* Cambridge University Press, Cambridge, UK.

Lawson, Andrew; Umarji, Mariam; Guilherme, João; Chachine, Célia, 2008, *Avaliação da Gestão de Finanças Públicas em Moçambique 2006 (Usando a Metodologia PEFA): Relatório Preliminar.* Relatório feito para o Ministério das Finanças, UTRAFE e PAPs. http://www.pap.org.mz/downloads/final_report_pefa.pdf

Leininger, Julia, 2011. *Accountability through Dialogue: the Presidência Aberta e Inclusiva in Mozambique: Executive Summary.* Brefing paper 6/2011. *Deutsches Institut für Entwicklungspolitik (DIE)*.

Macuane, José Jaime, 2012. "Os desafios epistemológicos no combate à pobreza: Redes e aprendizado de políticas públicas no contexto do PARP". Maputo, IESE, forthcoming.

Macuane, José; Salimo, Padil; do Rosário, Domingos; Weimer Bernhard, forthcoming**.** A governação provincial entre o Estado central e local: O caso de Nampula. IESE

Marmot, Michael, 2005. "Social determinants of health inequalities", in: Lancet Vol. 365, March 19, 2005: 1099–104.

Martinez, Javier, 2011. *Review of Health Partner Engagement with the Ministry of Health, Mozambique*. UKAid / HRDC. Draft 31 May 2011

Mc Coy, Simon; Cunamizana, Imarciana, 2008. *Provincial Budget Allocations in the Health, Education and Water Sectors*. An Analysis, 2003-2007. MPD, National Directorate of Studies and Policy Analysis. Discussion papers No 58 E.http://origin-www.unicef.org/socialpolicy/files/Mozambique_Provincial_Allocations.pdf

MISAU, 2011a. *X Avaliação Conjunta Anual (ACA X) do Desempenho do Sector de Saúde*. Maputo, 9 de Março de 2011, Ministério da Saúde.

MISAU, 2011b. *Ponto de Situação da Implementação em Abril 2011. Plano de Acção Consolidado (PAC) para o desenvolvimento operacional do nível dos Sistemas de Gestão Internos nas áreas de Planificação, Finanças & Aquisições, Recursos Humanos e Auditoria | Controlo Interno*. *Versão Final. 20/04/2011*

Mosca João, 2011. *Politicas Agrárias de (em) Moçambique (1975-2009).* Prefácio de Mário da Graça Machungo. Maputo. Escolar Editora.

Mosca, João, 2005. *Economia de Moçambique. Século XX.* Prefácio de Jochen Oppenheimer. Lisboa. Instituto Piaget.

Mosse, Marcelo; Cortez, Edson. 2006. *A corrupção no sector de saúde em Moçambique. Centro de Integridade Pública*. Documento de Discussão , No 4. http://mocambique.fes-international.de/downloads/CIP%20Doc%204.pdf

O'Laughlin, Bridget 2010. *Questions of health and inequality in Mozambique*. Cadernos IESE nº 4/2010.

Pavignani, Enrico: Durão, Joaquim R., 1999. "Managing external resources in Mozambique: building new aid relationships on shifting sands?" In: Health Policy and Planning, 14(3): 243–253.

Rosenfeld, David, 2012. Criteria for Territorial Allocations. The case of Mozambique. UNICEF Mozambique Policy Brief 1/2012

Sal e Caldeira; Ximungo Consultores, 2009. *Análise do Impacto da estrutura da despesa sobre o desenvolvimento económico e as condições de vida em Moçambique*. Versão Final, Dezembro de 2009.

Schumpeter, Joseph Alois, 1991. *The economics and sociology of capitalism.* Edited by Richard Swedberg. Princeton, New Jersey : Princeton University Press.

Smelser Neil, (Ed.), 1973. *Karl Marx on Society and Social Change. With selections by Friedrich Engels*. University of Chicago Pres. Heritage of Sociology Series.

Sumich, Jason, 2010. The Party and the State: Frelimo and Social Stratification in Post-socialist Mozambique. in: Development and Change**,** Volume 41, Issue 4, July 2010**:** 679–698.

Umarji ,Mariam; Makda, Sadya; Paulo, Arsénio, Lalá, Aly, 2009. *Avaliação do Sistema de Gestão de Finanças Públicas na Província de Cabo Delgado 2008. Aplicação da Metodologia PEFA – Despesa Pública e Responsabilidade Financeira. Relatório Preliminar. Relatório para a Direcção Provincial do Governo da Província de Cabo Delgado e Agência Espanhola de Cooperação Internacional para o Desenvolvimento (AECID*). No place, November 2009.

Umarji, Mariam Bibi, 2011. *Short Fiduciary Risk Assessment of Health Sector in Mozambique. Final Report.* Maputo, MB Consulting. June 2011.

Visser-Valfrey, Muriel; Umarji, Mariam Bibi, 2010. *Sector Budget Support in Practice. Case Study. Health Sector in Mozambique*. ODI / Mokoro, July, 2010

Weimer, Bernhard, forthcoming. Towards a decentralization strategy in Mozambique: *Keeping it vague?* Junctures, paths, outcomes. Maputo, IESE.

Wilkinson, Richard G.; Marmot, Michael, (Eds.), 2006. *Social determinants of health*. Oxford University Press, 2006.

Wilkinson, Richard, 1996. *Unhealthy societies. The afflictions of inequality*. London. Routledge.

Wilkinson, Richard, 2005. *The Impact of Inequality: How to Make Sick Societies healthier.* New York. The New Press.

5.4 A brief sociology of health service providers

The current health system comprises a set of formal and informal structures and relations between service providers that can be grouped hierarchically in six classes of services:

- Treatment abroad for the elite, paid with own resources, or exceptionally for ordinary citizens when proper treatment is not available in the country, but depending on the approval of the National Medical Board ("Junta Médica"). In the particular case of the treatment approved by the *Junta Médica*, funded through public resources and with the services normally provided by the South African Health system, there's an impression that prices have been lately inflated, posing concerns about its sustainability.
- Private units (examples: ICOR/ Trauma Clinic) – these units are part of the booming health private sector, and serve normally urban mid-classes. In some cases public servants have also access to these services paid through state funds. The status of some of these units is ambiguous. For example, ICOR is registered as a non-profit unit and was created to provide cardiology services without commercial gains, but it also provides general medical services at market prices, which is considered an unfair competition by other private clinics.
- Private units in public units (Clínicas especiais) – those units have been from a conversion of the senior public officials and diplomat services that existed before the liberalization of the sector in the 1980s. In the case of the diplomats, these services were paid in foreign currency at market prices. The idea was to create a service that could suit the needs of the emerging mid-class, and at the same time collect revenues to fund the broader public service and provide opportunities for the health personnel to have extra revenues. However, according to an interviewee, lack of objective criteria on who could be eligible to work in the *Clínicas Especiais* triggered some jealousy and criticism from the health staff. Criticisms also came from the general public, which bitterly realized that better quality of public health services could just be in the next door of the same hospital. These concerns probably influenced or at least justified Minister Garrido's intention to shut down these clinics, which only failed in the Hospital Central de Maputo.
- Semi-private services in public institutions (special rooms and special consultations) – these services are aimed at those who can afford paying a little bit more to get a quality of service better than the ordinary services to the wider public. Public servants are among the clients of these services.
- Health units which are part of the NHS but managed by non-profit organizations – these units, such as the Polana Caniço Health Center (and now hospital also), once managed by an NGO (jointly with the public sector) before fully taken over by the ministry again under the Garrido era) and the Chicuque Hospital, in Inhambane province, run by a faith-based missionary organization, provide services regarded as of good quality, on a cost-recovery basis, charging a service fee slightly higher than of the public sector, but considered affordable to people of low income.
- General low quality hospital for 'indigenous' Rural/local – this comprises the services for the general public, generally in deteriorated conditions and weak quality of services. The measures taken by former Minister Garrido have improved the quality of some of these services, but general problems, such as lack of medicine and the

brain drain, due to the difficult relation of the health staff with the minister poses problems of sustainability of these gains in the quality of services. One interviewee noted that unless there is a clear policy for funding the costs of the health sector, the stratification of the health service based on income, as described in this typology, would make this popular service to resemble the infamous colonial "indigenous infirmary", reserved for the lower strata of the population before the independence.

- informal, non licensed, often ambulant 'private health practitioners' linked to informal , illicit networks of pharmaceutical supplies from the HNS and vendors of drugs local markets;
- private health shops, 'pharmacies' and clinics of 'Chinese traditional medicine' in peri-urban areas.

The heterogeneity of the system but at the same time the fluidity of the funding of its services, since public officials can also go both to private clinics and abroad or resort to their right to use the public service based on the contribution to the system that is withheld from their salaries, poses questions about the proper ways of funding the system. In the case of public health units, it also poses problems of equity, since there is a perception that public resources are being used for private gain. These are some of the challenges that the sector faces in organizing the system.

Some information on Private Hospitals in Maputo City

Disclaimer: *the information above is based solely on interviews and regarding the formal ownership it would need to be confirmed through legal commercial documents. Some factual information would need to be cross-checked as well.*

1. **Trauma Centre**
   Partnership between Zimbabwe Tycoon Billy Rautenbach[42] and Guebuza family (late brother of President Guebuza, and one of Guebuza's sons). Dr. Sibone Mocumbi (son of former Premier and Foreign Minister Pascoal Mocumbi) works there as medical doctor. Former Director Solanki, sacked under unclear circumstances, fled the country. Present Director: ex medical Doctor from Groote Schuur Hospital, Cape Town.

2. **Maputo Private Hospital**
   60 % of shares with LenMed (South Africa based, with strong links to Asian / Muslim culture), 40% with Mozambican investment company link to a Frelimo General Director: Isidora Faztudo (PCA of Cervejas de Moçambique, MP for Frelimo)
   Cooperation with ISCTEM (João Leopoldo, Rector, and President of CNE; ex Rector: Ivo Garrido) which is linked to Aga Khan economic interests (Delta Trading, etc.).
   Links to Clínica/Laboratório Raio X (Av. Tomás Nduda) of Yacub Omar.

[42] A highly controversial Zimbabwe multimillionaire, allegedly with close links to President Mugabe and ZANU PF, holds vast business interests in Africa and elsewhere, including in mining in Katanga Province / DRC (CAMEC) resulting from financial support for Zimbabwe's military intervention in favour of Laurent Kabila. CAMEC had previously partnered with the GoM in the failed PROCANA biofuel scheme in Massingir/Gaza province. http://www.facebook.com/pages/Billy-Rautenbach/140403642653463

3. **Clínica Sommershield**
   First private Hospital in Mozambique. Shareholders: Maria and José Natividade (formerly NATAIR Air services). Clinical Director: Dr. Sam Patel. Initially operated together with Dr. Bugalho, Aires Fernandes and Igor Vaz as partners. The latter three moved out taking over Clínica Cruz Azul and founding own specialized clinics (Dr. Bugalho: Clínica Mulher) due to policy differences with the majority share holders over pricing of services and access of poorer people to the Clínica.)

4. **Clinicare**
   Initiative of Yunus Assane (Beira) in partnership with BIM and Portuguese interests.

5. **Clínica 222**
   Owners: Dr Ivo Garrido (ex Health Minister) and wife. Has contentious issue with owner of building over rent; a court case is pending.

6. **ICOR**
   Linked to *Nomenklatura*. Official statute as non-profit organization (*sem fins lucrativos),* provides the hospital with tax exemption, But, de facto: a private hospital, with good profit situation, in which all medical doctors are employed on a full time basis (which is not the case in most of the private hospitals).
   Status as non profit organization forces clinic to make occasional free treatment/operations of poor children by renowned specialists, often accompanied with widespread publicity campaign.

7. **Clínica Especial / Hospital Central de Maputo (HCM)**

The HCM is the major public hospital in the country and thus part of NHS. It receives annually a major share of the annual budget. It operates the only private ward which survived Garrido's drive of closing all private wards in central hospitals. They were seen by Garrido as strong competitor to private clinics.

- Highly profitable: 30 – 40 beds at 100 USD / day (without treatment and medical services);
- Advantageous for HCM, because it generates own income and means for investment in medical equipment etc. and binds medical doctors to HCM, as well as satisfying an existing demand.
- rent seeking seems to be common practice. Income generated by Clínica Especial allegedly was shared in the past with senior functionaries in MISAU to the tune of more than 15.000 USD / month). A major challenge at HCM is its tendency to have 'more doctors than nurses' due to low pay for the latter which leads health support staff to look for better job opportunities; Medical doctors work at HCM in the morning period, providing services to private clinics in the afternoon period.