

CASE STUDY

## Decentralization Reforms in Mozambique: How This Has Shaped Health Financing Arrangements and Public Financial Management Practices in the Health Sector

June 2022

BREAKING NEW GROUND



[in](#) ThinkWell  
[@thinkwellglobal](#)  
[www.thinkwell.global](http://www.thinkwell.global)

## ACKNOWLEDGMENTS

The authors gratefully acknowledge feedback on earlier drafts from H el ene Barroy, Inke Mathauer, and Nirmala Ravishankar.

### Recommended citation:

Vilcu, Ileana, Salom ao Louren o, Egidio Cueteia, Yara Cumbi, Federica Fabozzi, and Amandio Manuel. 2022. *Decentralization Reforms in Mozambique: How This Has Shaped Health Financing Arrangements and Public Financial Management Practices in the Health Sector*. Case Study Series on Devolution, Health Financing, and Public Financial Management. Maputo, Mozambique: ThinkWell.

-----

This case study was developed with funding from the World Health Organization (WHO). WHO gratefully acknowledges financial support received from the Gesellschaft f ur International Zusammenarbeit (GIZ) through the Sector Initiative Universal Health Coverage and Gavi, The Vaccine Alliance through the Sustainability Strategic Focus Area. This case study is part of a series produced jointly by ThinkWell and WHO to explore the implications of devolution for health financing and public financial management in Burkina Faso, Indonesia, Kenya, Mozambique, Nigeria, the Philippines, and Uganda. This series sheds light on how health financing functions are organized within and impacted by the devolved system of government in a country. It also explores how devolution has shaped public financial management processes in the health sector, including budget development, approval, execution, and accountability.

For more information, please visit our website at <https://thinkwell.global/projects/sp4phc/>.

For questions, please write to us at [sp4phc@thinkwell.global](mailto:sp4phc@thinkwell.global).

## TABLE OF CONTENTS

Acknowledgments .....	2
List of Figures.....	4
List of Tables.....	4
Abbreviations .....	5
Introduction .....	6
Methodology .....	6
Country Context.....	7
Health Financing Landscape in the Context of Decentralization .....	10
Discussion.....	20
References.....	21

## LIST OF FIGURES

Figure 1. Distribution of health facilities by ownership and level by province, 2019 .....	10
Figure 2. Health spending by source, 2000-2017 .....	11
Figure 3. Health sector resource allocation in nominal and real terms, 2010-2020.....	12
Figure 4. Total government health budget allocation, 2017-2019 .....	12
Figure 5. Provincial and district budgets disaggregated by source of revenue, 2019.....	13
Figure 6. Main phases of the budget cycle for year n .....	15
Figure 7. Distribution of health expenditure by province .....	17
Figure 8. Budget execution rate in the health sector, 2010-2020.....	18
Figure 9. Flow of funds in the health sector in Mozambique.....	19

## LIST OF TABLES

Table 1. Key milestones in the decentralization process in Mozambique .....	9
Table 2. Key steps in budget process at national, provincial, and district levels .....	16

## ABBREVIATIONS

---

<b>CHE</b>	current health expenditure
<b>DDS</b>	District Directorate of Health
<b>DPPF</b>	Provincial Directorate of Planning and Finance
<b>DPS</b>	Provincial Directorate of Health
<b>FDD</b>	District Development Fund
<b>OOP</b>	out-of-pocket
<b>MEF</b>	Ministry of Economy and Finance
<b>MISAU</b>	Ministry of Health
<b>PES</b>	Economic and Social Plan
<b>PESOD</b>	District Social Economic and Budget Plans
<b>PFM</b>	public financial management
<b>PPFD</b>	District Planning and Financing Project
<b>PROSAUDE</b>	Mozambique's Common Fund of Support for the Health Sector, and vertical programs
<b>SISTAFE</b>	financial management system
<b>UHC</b>	universal health coverage
<b>WHO</b>	World Health Organization

---

## INTRODUCTION

**Over the past five decades, subnational government units in most countries around the world have assumed some level of decision-making authority** (Cheema and Rondinelli 2007).<sup>1</sup> This often occurs through devolution, a reform that typically involves the transfer of different government functions related to sectors, such as health, from the central government to subnational units. Devolution often entails changes to public financial management (PFM) rules, systems, and processes. In parallel, countries have also initiated health financing reforms, such as expanding publicly managed health insurance, eliminating user fees, and introducing performance-based payments to move closer to the goal of achieving universal health coverage (UHC). While national governments exercise a high degree of control over the design of health financing reforms, their implementation in devolved contexts is heavily influenced by local politics, policies, and processes. Subnational government units are often the main purchasers of primary health care services, exercising considerable control over the funds flowing to public facilities, including from user fees or insurance reimbursements.

**Public funds lie at the heart of sustainable health financing policy for achieving UHC** (Kutzin, Yip, and Cashin 2016). Globally, public financing accounted for approximately 60% of health spending in 2017 and increased faster than any other source of health expenditure over the preceding decade (World Health Organization 2019). Given public funding's growing role, governments and development partners increasingly recognize the importance of PFM to effective, efficient, and equitable health spending (Cashin et al. 2017; Barroy et al. 2019). Therefore, devolution and related PFM reforms can affect how public funds are allocated, used, and reported in the health sector.

**The World Health Organization (WHO) and ThinkWell jointly developed a series of case studies to explore the implications of devolution for health financing, with a deep dive into PFM issues.** The cases shed light on how health financing functions are organized within and impacted by each country's devolved system of government. They also explore how devolution has shaped PFM processes in the health sector, including budget development, approval, execution, and accountability.

**This case study explores how decentralization has affected health financing arrangements in Mozambique, with a focus on PFM processes in the health sector.** The decentralization process began with the introduction of economic reforms in the late 1980s, the opening of the political arena, and the end of the civil war in the early 1990s. The process is based on the administrative and fiscal decentralization under the 2003 law on local state bodies, and political decentralization in the context of creating local authorities (Law No. 2/97) and of the approval of the decentralization package in 2019 and 2020.

## METHODOLOGY

**ThinkWell and WHO jointly developed a set of questions to guide data collection in selected countries to answer the following overarching questions:**

- How are the three health financing functions—revenue raising, pooling, and purchasing—and related governance functions organized and affected by a devolved system of government in a country?
- What challenges related to devolved health financing exist and how do these affect progress toward UHC?

---

<sup>1</sup> The literature offers several typologies to distinguish between different forms of decentralization (devolution vs. de-concentration, administrative vs. fiscal vs. political decentralization), which are discussed in a separate methodology document.

- How do PFM processes unfold across government levels, and what is the role of subnational governments in allocating, spending, and reporting public funds for health?
- What is the role of health facilities in PFM processes?

**Information for the development of the Mozambique case study was collected through desk review.** The desk review entailed a purposeful review of documents and data that could be accessed online, including from the Government of Mozambique, international organizations, development assistance projects, and peer-reviewed literature.

## COUNTRY CONTEXT

**When Mozambique gained independence in 1975, the Portuguese colonial administrative structures were replaced by a new system of governance at national, provincial, and local levels consisting of districts and cities.** The country adopted a system of centralized administration as stated in the 1975 Constitution. In 1978, provincial governments were created according to Law No. 5/78. These were composed of a provincial governor, appointed by the president of Mozambique and by provincial directors representing each ministry. Provincial directors were appointed by their respective minister in consultation with the provincial governor and reported into both the line ministry and the provincial governor. At the same time, assemblies at all levels were created: provincial, district, and city. Although the assemblies were supposed to have full decision-making power, they did not because they existed under a single-party regime. At the district and city level, as of 1978, there was an appointed leader, the chairman of the District and City Executive Council, and members of the council selected by their respective assembly (Massuanganhe 2005).

**Mozambique took its first step toward decentralization in 1987.** It passed Law No. 2/87 whereby the national government worked closely with provincial governments in each of the 11 provinces to select a district to pilot measures to grant districts greater administrative and financial autonomy (Massuanganhe 2005; Forquilha 2020).

**In 1990, a new constitution was adopted that defined two additional types of local authority: municipalities in cities and towns, and village councils in rural areas.** The 1990 Constitution was further amended in 1996 to enshrine local governments (Law No. 9/96) (Table 1). Thirty-three municipalities were established in 1997. The number of municipalities gradually increased to 43 in 2008 and to 53 in 2013 (CLGF 2020). Municipalities have their own representative body, the Municipal Assembly, composed of members elected by proportional representation. They also have their own executive body, the Municipal Council, comprised of the president of the Municipal Council (also known as the mayor) and town councilors (their number varies depending on the size of the municipality's population). The mayor is directly elected by the population and nominates the town councilors. At least half of the town councilors must be drawn from the Municipal Assembly (Massuanganhe 2005).

**In 2003, the structure and organization of local state organs were defined and, when Law No. 8/03 was adopted, districts became the planning and budgeting unit.** The law represented an important step toward increasing autonomy of provinces and districts by giving the provincial governor and district administrator the power to merge sectoral directorates into multisectoral teams. Local consultative councils were also created to act as an interface between civil society and district authorities in the planning process (Massuanganhe 2005).

---

### ***District Planning and Financing Project in Nampula Province***

In 1998, the national government started implementation of the District Planning and Financing Project (PPFD) in Nampula Province to support efforts to decentralize planning and financing at the district level. Through this project, a District Development Fund (FDD) as well as consultative councils in each of Nampula's 18 districts were established. District and provincial staff were trained in planning and financing. Funded by the United Nations Capital Development Fund and the United Nations Development Programme, PPFD continued in Nampula Province until 2001, when it was further consolidated and implemented in Cabo Delgado Province. The PPFD ended in 2015 (UNCDF 2006; Mugabe 2012).

---

**As of 2005, each district received an investment budget of 7 million metical under the Local Initiative Investment Budget, later known as the FDD.** Districts, partners, and civil society welcomed this initiative as the Strategic Plans for District Development and the District Social Economic and Budget Plans (PESOD) could be put into practice with the involvement of local consultative councils. However, the way resources were allocated varied across districts, some choosing to fund enterprises. In 2008, the government decided that these funds were to be used for income generation, job creation, and food production. That left several PESOD planning activities without funding, and districts had to go back and plan without consulting the local councils. With the implementation of the new guidelines, districts also began managing microcredit lines. Funding was allocated to borrowers who presented projects in line with the purpose of the funds, such as income generation, job creation, and food production. They repaid the amount allocated with interest rates, which initially varied from district to district before being regulated. Not only did the borrowers have difficulty repaying the money, but many of the projects approved were not economically viable and were not clearly connected with Strategic Plans for District Development and PESOD (Forquilha 2020).

**The procedures through which functions and competencies are transferred from state bodies to municipalities were defined in 2006.** Decree No. 33/06 allows the national government to gradually decentralize provision, beyond basic infrastructure, of primary health care services, primary education, and other social services to municipalities. Before 2006, the national government was responsible for delivery and financing of social services, including primary education and primary health care services. The national government must indicate the transfer of specific responsibilities and the corresponding financial means on a yearly basis. However, the national government continued to be responsible for investments in those areas, providing municipalities with all related plans, projects, and programs for the transition phase (World Bank 2009).

**In 2018, the constitution was amended to state the three levels of decentralization with elected provincial, district, and municipal assemblies.** While provincial assemblies approve the provincial annual plan and budget, district assemblies can only approve the annual plan. Both the provincial and the district assemblies monitor implementation of their respective plans (SADOCC 2018). Moreover, the amendment changed the way mayors are elected and introduced indirect elections of provincial and district assemblies. Provinces have provincial decentralized governance bodies and state representation (Republic of Mozambique 2020b). A decentralization package, which calls for the election of provincial governors, was approved in 2019 and 2020 (Forquilha 2020).

**Table 1. Key milestones in the decentralization process in Mozambique**

<b>Year</b>	<b>Milestone</b>
1996	Law No. 9/96: amended the constitution, enshrined local government, and revised electoral arrangements
1997	Law No. 2/97: established municipalities in Maputo City and the 10 provincial capital cities Laws No. 4-6/97: established 10 new municipalities Law No. 10/97: established municipalities in the remaining 22 cities and 10 towns in the districts Law No. 11/97: established the financial framework for municipalities Gradual expansion of municipal governance to an increasing number of cities throughout the country and incremental transfer of competencies from the deconcentrated state to municipalities
1998	PPFD pilot started in Nampula Province
2002	Law No. 09/02 (financial management system called SISTAFE) <sup>2</sup> : provided overall framework for decentralized planning and PFM at provincial and district levels
2003	Law No. 8/03 (law on local state bodies): provided legal basis for deconcentration process in the district and provincial governments; districts became the planning and budgetary units
2006	Decree No. 33/06: established framework for transfer of functions and competencies from state bodies to municipalities
2008	Established 10 new municipalities Law No. 1/08: adopted new Municipal Finance Law (revoked Law No. 11/97) and revised the Municipal Fiscal Code
2012	Decentralization policy and strategy ratified by the parliament
2013	Law No. 11/13: established 10 new municipalities and 16 new districts Law No. 26/13: created new districts
2016	Law No. 3/16: created new districts
2018	Law No. 1/18: established the specific amendment of the constitution

<sup>2</sup> SISTAFE is the Government of Mozambique's financial management system where all on-budget expenditure is recorded.

Year	Milestone
2019	Laws No. 3-7/19: established the election of provincial governors
2020	Decree No. 2/20: established the principles and norms of organization, competencies, and functioning of the executive bodies of the decentralized provincial governance

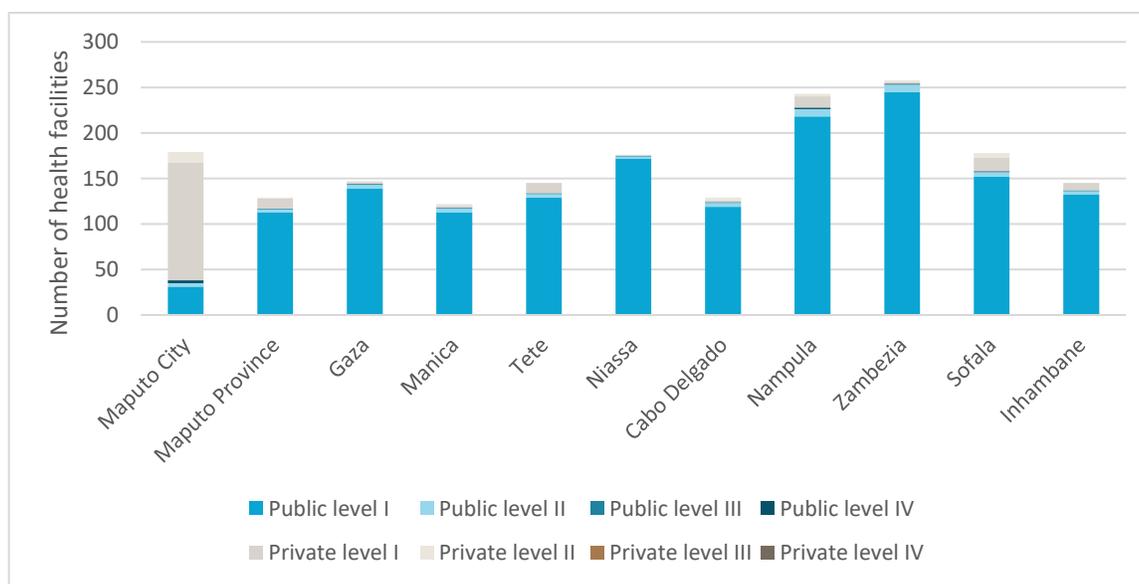
Source: Authors based on CLGF 2020; World Bank 2009; Massuanganhe 2005; Ministry of Planning and Development 2006

## HEALTH FINANCING LANDSCAPE IN THE CONTEXT OF DECENTRALIZATION

**The national government, provinces, and districts govern the health sector.** The Ministry of Health (MISAU) is responsible for developing health sector policies and strategies, coordinating and developing plans, mobilizing and allocating funds, monitoring implementation of plans, overseeing and auditing services, and coordinating with the national and international partners. The devolved body at provincial level, namely the Provincial Directorate of Health (DPS), is responsible for coordinating the development and implementation of provincial sector plans, monitoring progress and achievements, distributing resources, and providing logistical and technical support to district services. Districts manage health sector resources and health services delivery in their jurisdiction (MISAU 2013).

**Health provision in Mozambique is managed mainly by public sector facilities, which have the widest geographic coverage (Figure 1).** The public sector is structured into four levels of service provision. The primary level includes health centers and health posts (level I). The secondary level is comprised of district, general, and rural hospitals (level II), which typically serve more than one district. These constitute the first referral level for health services. The primary and the secondary levels, managed by districts, provide primary health services. The tertiary level consists of provincial hospitals (level III), operated by the extension of the national power at provincial level, namely the Provincial Health Services. Finally, central and specialized hospitals represent the quaternary level (level IV). The private sector includes for-profit facilities, mostly limited to urban areas, and nonprofit providers (MISAU 2013).

**Figure 1. Distribution of health facilities by ownership and level by province, 2019**



Source: Authors based on USAID 2019

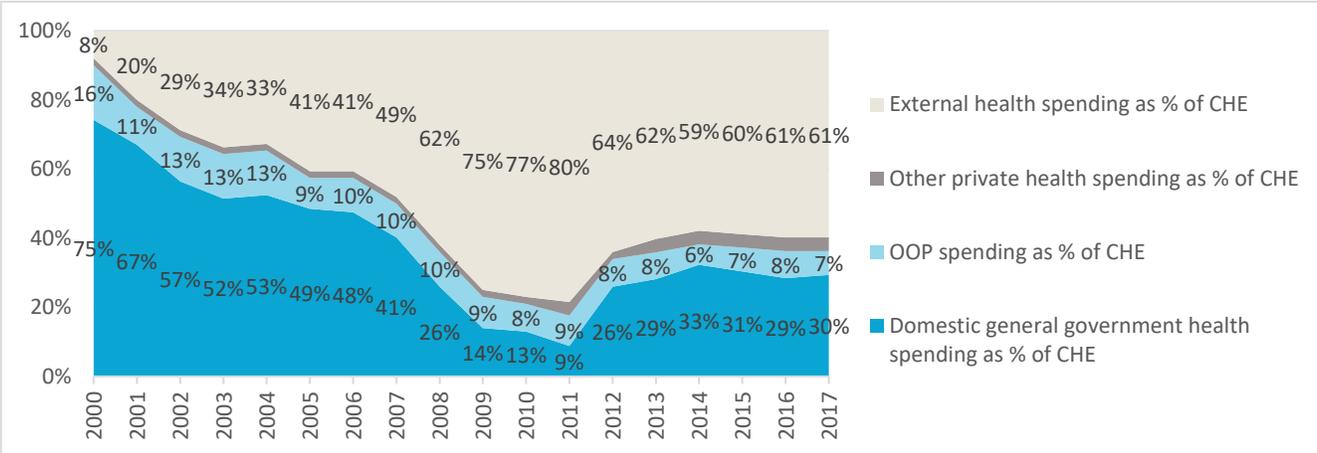
**How devolution has impacted the health financing functions, with a focus on PFM policies and processes, is described below.** The first function is revenue raising, which refers to how funds are collected and shared. The second is pooling, whereby funds are collected and managed by agencies on behalf of the population. The final function is purchasing, which refers to how agencies that pool funds pay for health services. Each is discussed from the district perspective in the next three subsections. A final subsection examines reporting, oversight, and accountability for health financing. Findings related to PFM processes are woven throughout.

**REVENUE RAISING**

**Sources of Health Spending**

**The share of health spending that is financed by government revenue has fluctuated over the past two decades.** Figure 2 shows the share of current health expenditure (CHE) financed by the following sources: government revenue, out-of-pocket (OOP) spending, other private health spending (this includes voluntary private health insurance spending by households as well as spending by private companies), and external financing. While government health expenditure as a percentage of CHE decreased from 75% in 2000 to only 9% in 2011, spending financed by donors increased from 8% to 80%. Although the government health expenditure as a share of CHE almost tripled in 2012 compared to 2011 and increased to 30% in 2017, Mozambique still relies heavily on external funding. OOP spending as a percentage of CHE decreased from 16% in 2000 to 8% in 2010 and fluctuated between 6% and 9% over the last decade.

**Figure 2. Health spending by source, 2000-2017**



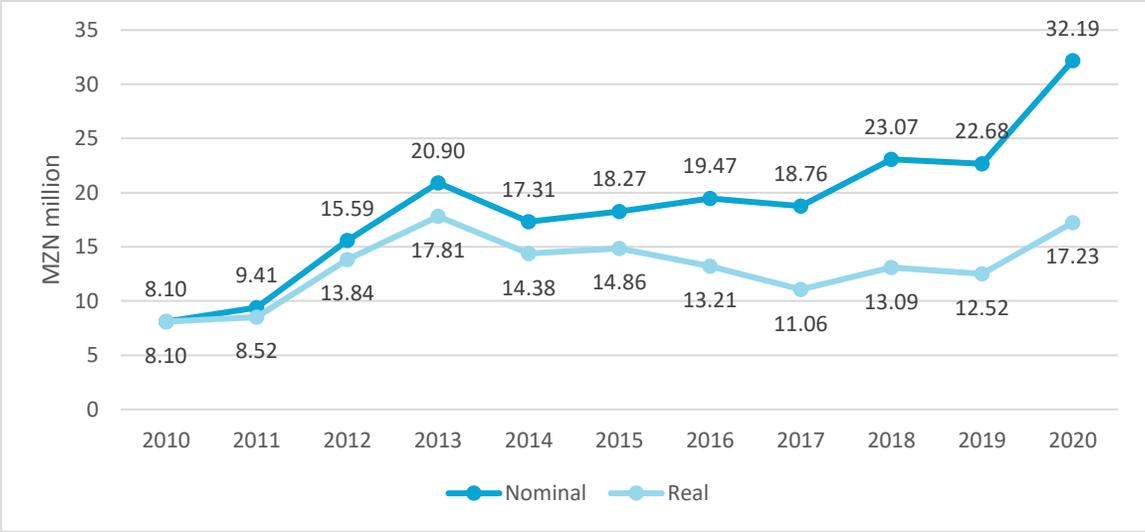
Source: Authors based on World Health Organization n.d.

**External resources are divided into funds for PROSAUDE, Mozambique’s Common Fund of Support for the Health Sector, and vertical programs.** PROSAUDE is a common fund mechanism for several donors—Switzerland, Ireland, Spain, Italy, and Flanders; the United Nations Population Fund (UNFPA); and the United Nations Children’s Fund (UNICEF)—involved in the health sector’s wide approach. Vertical programs’ funds consist of foreign investment in on-budget projects, funded by donors and implemented in collaboration with the Government of Mozambique (Health Policy Project 2016). In 2019, the donors’ commitments to PROSAUDE decreased, similar to the trend over the past five years as donors decided to reduce or cease support (UNICEF 2019).

**The total government health budget allocation has been erratic over time (Figure 3).** MISAU received the 40%-plus of the total government budget for health between 2017 and 2018, and the remaining share was

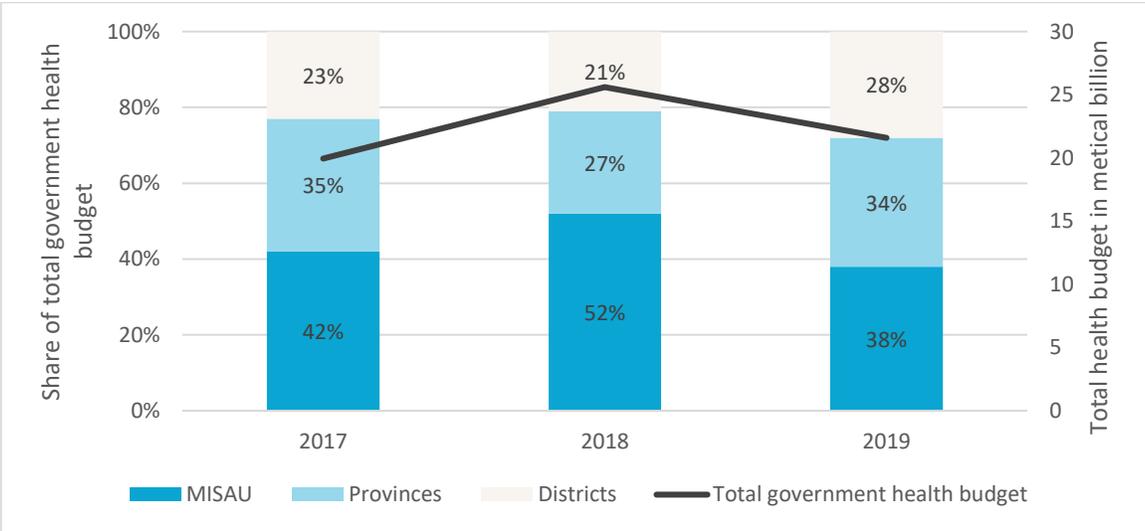
divided between provinces and districts (Figure 4). In 2019, MISAU received a lower allocation, while the budget allocated to provinces and districts increased to 34% and 28%, respectively.<sup>3</sup>

**Figure 3. Health sector resource allocation in nominal and real terms, 2010-2020**



Source: Observatório do Cidadão para Saúde n.d.

**Figure 4. Total government health budget allocation, 2017-2019**



Source: MOH Annual Budget Execution Reports

**Revenues at Provincial and District Levels**

Provinces derive their revenue from two sources: a block grant from the national government and own-source revenue. The national government allocates the block grant to each province based on population

<sup>3</sup> The rules for revenue sharing between the MISAU, provinces, and districts are not clear.

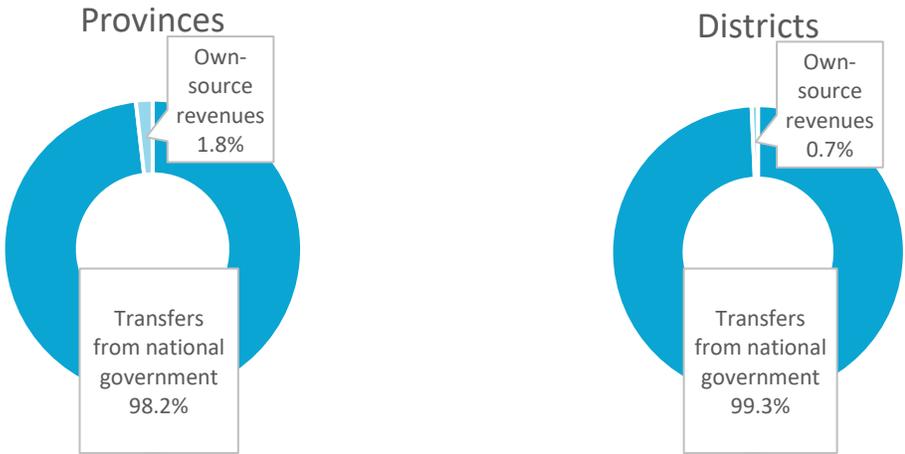
size (70%) and poverty index (30%).<sup>4</sup> Provinces generate own-source revenue from local taxes and fees (e.g., license fees on economic and commercial activities). They can also set specific and ad valorem tax rates as long as the rates are determined in accordance with general criteria such as equality and ability to pay (World Bank 2014; Republic of Mozambique 2020b).

**Districts receive block grants from the national government and can generate own-source revenue as well.** The national government allocates both the District Investment Fund and the FDD grants based on population size (30%), surface area (20%), own-revenue collection (20%), and poverty level (30%). Similar to provinces, districts generate own-source revenue from local taxes and fees (World Bank 2014).

**Provinces and districts also receive a health sector-specific grant, PROSAUDE, initially an unconditional grant that is progressively becoming a conditional grant.** While the national government retains 20% of the total PROSAUDE funds received from donors, it distributes the remaining 80% to provinces (16%) and districts (64%). The funds allocated to each province and district are determined by population (25%), activity (30%), beds per inhabitant (20%), acute child malnutrition (15%), and reverse population density (10%) (Manual de Procedimentos Para Implementação Do Memorando de Entendimento Do PROSAUDE III 2017).

**The transfers from the national government represent the main sources of revenue at both provincial and district levels.** In 2012, they accounted for 97.5% and 99.6% of the revenues at the provincial and district levels, respectively (World Bank 2014). The share of own-source revenue has not increased over time; in 2019, these accounted for 1.8% of the revenue at the provincial level and 0.7% at the district level (Figure 5). The low level of own-source revenue can be explained by the fact that taxes at these levels have not been subject to reforms, as in the case of municipalities. In addition, provinces and districts must share a proportion of taxes and fees with the central government, a disincentive to collect more revenues (World Bank 2014).

**Figure 5. Provincial and district budgets disaggregated by source of revenue, 2019**



Source: Authors based on Republic of Mozambique 2020a

**The Ministry of Economy and Finance (MEF), MISAU, and donors allocate funds across geographic areas and across health programs according to priorities.** The Provincial Directorate of Planning and Finance (DPPF) and the provincial governor, in collaboration with the provincial directorates, decide the allocation

<sup>4</sup> The poverty index takes into account consumption (30%), water and sanitation (30%), health (20%), and education (20%).

for each provincial directorate, including DPS. When resources are allocated to each sector, the budget execution of the previous years is taken into account as well as the inflation rate (MISAU 2012).

### User fees

#### **Health facilities in Mozambique have been collecting user fees for services for more than four decades.**

According to the law adopted in 1977, all inpatient and preventive health care services were provided free of charge, but outpatient consultations were subject to user fees. The level of fees varied across districts; provincial governors were able to make adjustments with approval from MISAU. In 1987, Mozambique adopted a new law that broadened the basis for charging, increased the level of fees, and allowed regular revisions of the fee levels. Initially, fees were set at 500 metical for inpatient care and 100 metical for outpatient care. Certain population groups (e.g., children, retired persons, unemployed, people with no means of subsistence) or diseases (e.g., tuberculosis, leprosy) were exempted from user fees. In 1996, the level of fees was revised: hospitals started charging 10,000 metical for inpatient services, and 1.000 and 500 metical for outpatient services in urban and rural areas, respectively (Lindelov, Ward, and Zorzi 2004).

**Most drugs for outpatient services are subject to fees.** All drugs for inpatient services as well as several basic drugs for outpatient services were provided free of charge; the rest were charged according to the price list approved by MISAU and the Ministry of Planning and Finance. Although price reductions depending on the individual or household income were established, the way to verify the income level was not clear. In 1985, the list of drugs for which people had to pay was expanded, a fixed-price charge per prescription in rural primary health facilities was introduced, and a formula for determining the drug prices based on actual costs was specified. In 1989, the MISAU approved a manual on drug charging, and the fixed fee in rural primary health facilities was increased to 500 metical. Drugs in other primary health facilities were charged according to the price list (Lindelov, Ward, and Zorzi 2004).

**Guidance on how to use revenue collected from user fees was provided in 1987.** The law introduced in 1977 established that fees collected for drugs must be transferred to the Central Medical Store. Ten years later, it was explicitly stated that the revenues collected from consultation fees should be used to support the operating costs of health facilities. According to a 2004 study (Lindelov, Ward, and Zorzi 2004), almost all facilities transferred the revenue collected to the District Directorate of Health (DDS). It is notable that these funds did not come back to the facility level. DDS transferred the revenues from inpatient and outpatient services to the DPPF. Once these funds were registered by the DPPF, they were transferred back to DDS where they were retained; in most cases, funds were transferred back in their entirety. DDS transferred the revenues from drugs to the Central Medical Store through the DPS. According to the 2004 study, although there was guidance on how to use the revenues from user fees, there was considerable variation across districts. In some districts, funds were supposed to be used only for buying food for patients, in others for contracting temporary personnel. Districts in Maputo City spent the largest part of revenue on maintenance (Lindelov, Ward, and Zorzi 2004).

**Currently, health facilities continue to collect user fees.** By law, user fees must be less than 65 metical (Health Policy Project 2016). In addition, children under five, pregnant women, people over 60 years of age, and those with disabilities continue to be exempted from user fees. There are also exemptions for treatment for tuberculosis, malaria, HIV, and chronic diseases. On the hand, although user fees represent a small amount, they still pose challenges to the population to access health services, especially when combined with transportation costs from remote rural areas (Lindelov, Ward, and Zorzi 2004; Rodriguez Pose et al. 2014). On the other hand, although user fees represent a small share of the total budget, it is an important source of revenue for facilities.

**Health facilities must remit revenues from user fees to the national government, but this rarely happens in practice, especially in the case of lower-level facilities.** This is mainly because these funds are not sent back to facilities. In theory, all primary and secondary health facilities are required to remit revenues from

user fees to districts, which transfer these funds directly to the single treasury account at the national level.<sup>5</sup> Health facilities designated as budget units, namely central, provincial, and specialized hospitals, are required to transfer the revenues from user fees to the single treasury account. They must submit a request to receive their money back.

### Budget development process

For the purposes of these case studies, the budget cycle is analyzed in terms of four stages: **budget formulation, budget approval, budget execution, and budget accountability**. The first two stages of budget formulation and approval are described here, while execution and accountability are discussed under “purchasing” below. **Figure 6** presents the main phases of the budget cycle in Mozambique. The fiscal year in Mozambique is the same as the calendar year.

**Figure 6. Main phases of the budget cycle for year n**



Source: Adapted from Hodges and Tibana 2004

**The budget formulation and approval process last for 12 months (Table 2).** Budget formulation starts with the preparation of the medium-term fiscal framework to determine the overall resource envelope and set the initial budget ceiling. MEF develops this framework for the next three years using information from all levels. In May year n-1, MEF communicates to each budget unit the initial budget ceilings and guidelines for the preparation of the Economic and Social Plan (PES) and the proposed budget for year n (Hodges and Tibana 2004). Although budget units have autonomy, the decision on their assigned budget ceilings depends on the institutions to which they are subordinate. Each institution prepares its year n PES and budget proposal and enters its budget proposal into the financial management system by the end of July year n-1. The PES and budget proposal of devolved bodies at the provincial level (DPS) are submitted for approval to the provincial assembly. The PES and budget proposal of deconcentrated bodies are consolidated into the national budget proposal that is approved by the national government and submitted to the parliament by mid-October year n-1. Once the parliament approves the PES and national budget (by the end of December year n-1), MEF informs the different levels. As the budget is always drastically reduced, adjustments and replanning are required to fit all the planned activities in the total allocated budget. This process takes place in January year n. While many believe that the national government reduces the government budget to provinces and districts when donor funding is available, there is no documentation to support this (Hodges and Tibana 2004; VillageReach 2016).

**Donors can provide direct funding to the district, provincial, and national levels.** The funds they can provide are discussed when planning for PES starts in May. Districts and provinces must inform the institution to which they are subordinate on the funds that donors agreed to give and the activities that will benefit from such funding (VillageReach 2016).

**The program-based budgeting approach has been introduced in 2008, but despite efforts to institutionalize it, it is not fully applied.** Classifications for all health services do not yet exist. Therefore,

<sup>5</sup> Although districts should transfer funds directly to the single treasury account, they should also submit records on user fees collected to DPS.

Mozambique uses a mix of economic, administrative, and functional classifications across all levels: national, provincial, district, and facility (MISAU 2013).

**Table 2. Key steps in budget process at national, provincial, and district levels**

No.	Step	Responsibility	Timeframe	Step applied to
1	Preparation of medium-term fiscal framework (year n to year n+2)	MEF	November year n-2 - May year n-1	National government and budget units (provinces and districts; central, provincial, general, and specialized hospitals)
2	Communication of ceilings and guidelines for development of year n budget and PES	MEF	31 May n-1	National government and budget units
3	Preparation of PES and budget proposal for year n	National government and budget units	31 July year n-1	National government and budget units <sup>a</sup>
4	Submission of consolidated PES and budget proposal for parliament's approval	MEF	15 October year n-1	National government and budget units
5	Discussion and approval of PES and budget for year n	Parliament	15 December year n-1	National government and budget units

<sup>a</sup> Districts' budget must be within the ceilings provided by provincial ministries of finances. Their PES and budget proposal include planning and budgeting of district and rural hospitals and primary care facilities and are consolidated into the PES and budget proposal of deconcentrated provincial bodies.

## POOLING

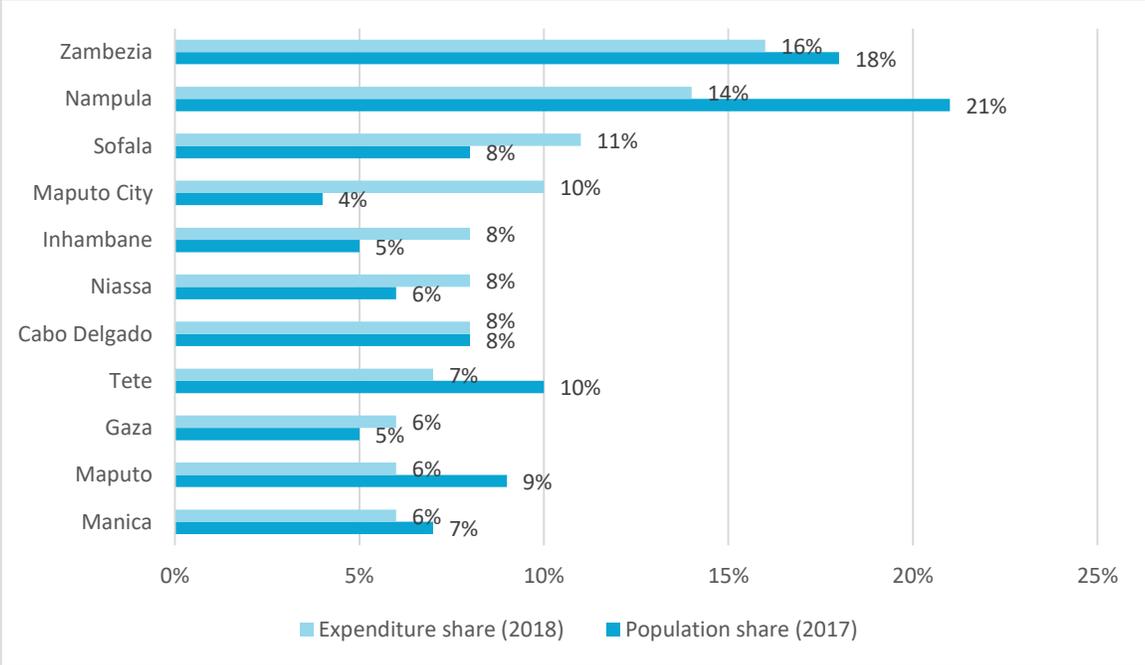
**Funds are pooled at the national, provincial, and district levels.** As shown in [Figure 4](#), MISAU has the largest share of the total health budget and uses these funds to finance its own operations as well as a range of vertical programs. Provinces have the second largest pool of funds to pay for investments and a substantial portion of operating expenses, as well as to purchase services from hospitals located at the provincial level. Finally, districts manage health service delivery under their own jurisdiction. Certain facilities can receive support from both the provincial and district levels.

**There is considerable variation in per capita revenue in all 11 provinces of Mozambique, ranging from less than 300 to almost 12,000 metical in 2014.** Maputo Province had the highest per capita revenue, even when Maputo City was excluded. If included, the per capita revenue in Maputo Province was above 74,000 metical in 2014. This is because the cities of Maputo and Matola are where the central government resides

and the Mozambican Tax Authority has a strong presence, but also where the majority of the country’s large enterprises are registered and pay taxes. Sofala had the second highest per capita revenue given its importance for trade with the landlocked neighboring countries. The lowest per capita revenue was registered in Niassa, Zambezia, Inhambane, and Gaza provinces (Weimer and Carrilho 2017).

**In 2014, the per capita spending ranged from about 800 to 2,100 metical across provinces.** The highest level of spending was in Cabo Delgado, Maputo, and Niassa, and the lowest level in Zambezia and Nampula (Weimer and Carrilho 2017). In 2018, there was still considerable variation in per capita expenditure, ranging from approximately 250 to more than 1,000 metical. Maputo City and Inhambane Province had the highest per capita spending. Despite having poor health outcomes, Zambezia, Tete, Nampula, and Manica provinces had the lowest per capita health spending (Primary Health Care Strengthening Program 2021). In the case of Zambezia and Nampula provinces, this contrasts with the high total health expenditure (Figure 7).

**Figure 7. Distribution of health expenditure by province**



Source: Authors based on Primary Health Care Strengthening Program 2021

**Health insurance is nascent in Mozambique.** Currently there are discussions to build a national health insurance scheme based on the existing scheme for civil servants. Civil servants contribute 1.5% of their salaries to a medical assistance fund. However, population coverage is unknown (Health Policy Project 2016).

**PURCHASING**

**Purchasing landscape**

**The three levels of the government (national, provincial, and district) share the costs of service delivery in the public sector.** MISAU pays for commodities and most of the capital investments and purchases services from central and specialized hospitals. Provinces purchase services from hospitals located at the provincial level, such as central specialized, general, and provincial hospitals, paying for health worker salaries and other costs through input-based budgets. Districts purchase services from district and rural hospitals and from primary health care facilities, paying largely for health worker salaries and operating

costs. Districts are also responsible for paying community health workers, and provinces and districts both undertake public health programs. Although both provinces and districts can contract private providers, they rarely do.

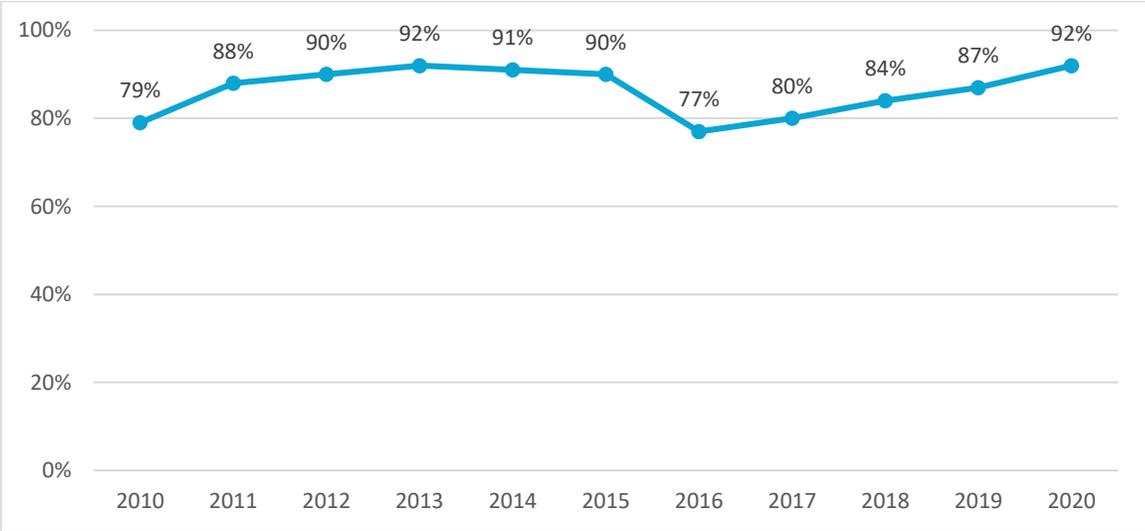
**Even if program-based budgeting was introduced in 2008, provinces and districts continue to pay for the various costs through input-based budgets.** Mozambique has experimented with performance-based financing to health facilities, mainly with donor support. These programs are centrally managed by MISAU.

**Budget execution**

**Once the parliament approves the budget, MEF can start releasing funds to the appropriate units.** All government funds for the national government and deconcentrated bodies are deposited into the central treasury account, while the funds for the devolved bodies are deposited into the treasury account at the provincial level. Both accounts are managed through SISTAFE. Budget units register their financial needs for each budget line in SISTAFE<sup>6</sup> based on the approved budget and PES. Upon completion of registration, funds can be released directly to MISAU and to budget units that have their own budgets and autonomy to execute them. Primary health care facilities do not have their own budgets; districts pay on their behalf (MISAU 2013; VillageReach 2016; MISAU 2012).

**The overall budget execution rate in the health sector in 2020 was 92%, higher by 5 percentage points compared to 2019 (Figure 8).** The level of budget execution has been less than 100%, mainly due to low execution of external investment expenditure. Such investments are subject to constraints and uncertainties in disbursements, including delays. For example, the execution rate of PROSAUDE funds is low and oscillating (65% in 2016, 80% in 2017, and 71% in 2018) (Primary Health Care Strengthening Program 2021). In 2018, disbursement of the largest share of PROSAUDE funds was done in the last two quarters, leaving insufficient time to implement activities and spend the funds (UNICEF 2019).

**Figure 8. Budget execution rate in the health sector, 2010-2020**



Source: Observatório do Cidadão para Saúde n.d.

**There is considerable variation in budget execution rates across national, provincial, and district levels.** For example, between 2015 and 2018, districts had consistent and high budget execution rates (above

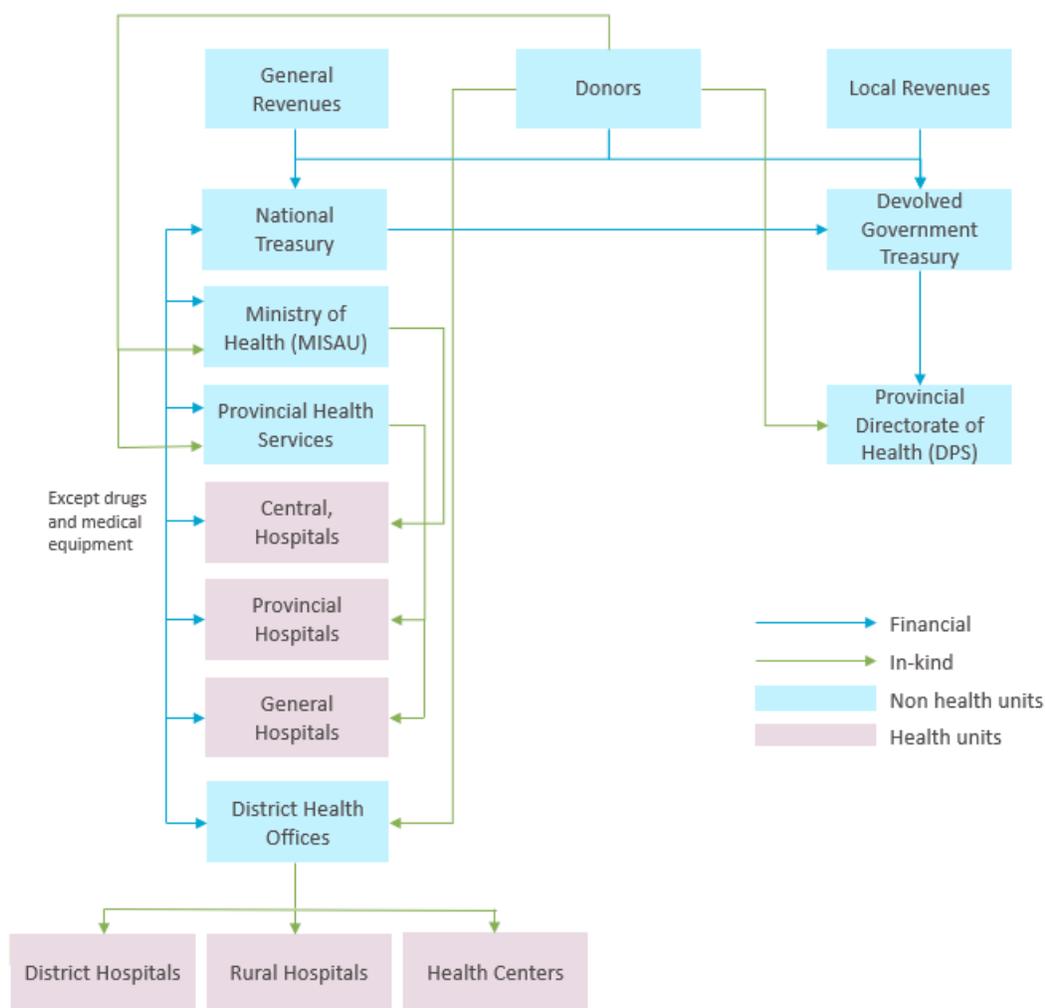
<sup>6</sup> SISTAFE classifies health expenditure into broad categories: general and specialized hospital services, public health services, and medicines, devices, and equipment. It also includes an unspecified health spending category that represented a third of the total health spending in 2018.

95%). In contrast, provincial budget execution rates declined from about 93% in 2015 to approximately 75% in 2017, but then recovered to almost 90% in 2018. The national government had the lowest execution rates, oscillating between about 70% and 80% over the same time period. This can be attributed to the very low execution rates of on-budget funds for vertical programs, which are executed mainly at the central level (Primary Health Care Strengthening Program 2021).

### Flow of funds to health facilities

The flow of funds in the health sector in Mozambique is complex (Figure 9). While all facilities receive in-kind transfers, only central, provincial and general hospitals receive financial transfers. Drugs and medical equipment are budgeted for and purchased by the Central Medical Store. Districts pay health workers salaries for the facilities under their management.

Figure 9. Flow of funds in the health sector in Mozambique



Source: Authors based on Lindelow 2006 and Law No. 16/19 of 24 September 2019

### Supplemental budgets and unspent funds

MISAU and all budget units can reallocate their budget during the year. Each of them can make up to six reallocations from government funds (half for operating expenses and the other half for investments). Reallocation can only be done within cost categories of the same aggregate (e.g., goods and services). Funds for salaries cannot be allocated to other categories and vice versa. Reallocation of external funds is

more flexible, but it needs to be in line with the current donor agreements or otherwise needs donor approval. Unspent funds—except eternal funds—in a given year cannot be carried over to the next year. This also applies to health facilities, which may request to reclaim some the funds.

## REPORTING, OVERSIGHT, AND ACCOUNTABILITY

**Deployment of the e-SISTAFE, Mozambique’s electronic financial management system, is not complete.**

The national government, provinces, and districts use e-SISTAFE for tracking health spending. In contrast, the digital system is only extended to facilities that are budget units.

**MISAU prepares the consolidated report for the health sector on a quarterly basis.** The report includes details of the budget execution of all budget units. While the MISAU and MEF are responsible for budget monitoring at the provincial and district levels, they share this responsibility with DPS and district directorates of health. In addition, MEF carries out internal audits at the central and provincial levels.

## DISCUSSION

**Provinces and districts in Mozambique rely extensively on transfers from the central government, while their capacity to raise local revenue remains limited.** The bulk of funds for provinces and districts are distributed through block grants that are determined based on complex criteria. However, this does not guarantee equitable health spending across subnational units.

**In 2018, Mozambique’s constitution was revised to create devolved bodies at the provincial level.** There is need for increased coordination between the devolved body, DPS, and the extension of the national power, the Provincial Health Services, to achieve health targets. Given that each provincial body develops its own budget and that the budget of districts is consolidated into the budget of the deconcentrated provincial body, there are bottlenecks in funding of primary health care facilities. This is because these facilities fall under the competence of the devolved provincial body, which sets health priorities. However, primary health facilities rely on financing from districts. Therefore, primary care facilities do not receive enough financial resources to provide good-quality services and to achieve the targets set at the provincial level.

**The decentralization process in Mozambique is not complete.** Districts are expected to be decentralized in 2024. In the meantime, there are often misalignments between the different subnational government levels, each one with its own budget and priority interventions. This affects health services delivery and achievement of health goals.

## REFERENCES

- Barroy, H, G Kabaniha, C Boudreaux, T Cammack, and N Bain. 2019. "Leveraging Public Financial Management for Better Health in Africa: Key Bottlenecks and Opportunities for Reform. Health Financing Working Paper No. 14." Geneva: World Health Organization.
- Cashin, Cheryl, Danielle Bloom, Susan Sparkes, H  l  ne Barroy, Joseph Kutzin, and Sheila O'Dougherty. 2017. "Aligning Public Financial Management and Health Financing: Sustaining Progress toward Universal Health Coverage." Health Financing Working Paper No. 17.1. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/aligning-pfm-health-financing/en/](https://www.who.int/health_financing/documents/aligning-pfm-health-financing/en/).
- Cheema, G. Shabbir, and Dennis A. Rondinelli. 2007. "From Government Decentralization to Decentralized Government." In *Decentralizing Governance: Emerging Concepts and Practices*, 1–20. Washington, DC: Brookings Institution Press.
- CLGF. 2020. "The Local Government System in Mozambique: Country Profile 2019-20." Commonwealth Local Government Forum.
- Expert Interviews. 2020. Conducted by Michael Chaitkin between August 5 and October 21.
- Forquilha, Salvador. 2020. "Decentralization Reforms in Mozambique. The Role of Institutions in the Definition of Results. EDI Working Paper WP20/MID08." Maputo, Mozambique: United Nations University World Institute for Development Economics Research.
- Health Policy Project. 2016. "Health Financing Profile: Mozambique." Washington, DC: Futures Group. Health Policy Project.
- Hodges, Tony, and Roberto Tibana. 2004. "Political Economy of the Budget in Mozambique (Unpublished)."
- Kutzin, Joseph, Winnie Yip, and Cheryl Cashin. 2016. "Alternative Financing Strategies for Universal Health Coverage." In *World Scientific Handbook of Global Health Economics and Public Policy: Volume 1 — The Economics of Health and Health Systems*, 267–309. <https://doi.org/10.1142/9200-vol1>.
- Lindelov, Magnus. 2006. "Tracking Public Money in the Health Sector in Mozambique: Conceptual and Practical Challenges." Washington, DC: World Bank.
- Lindelov, Magnus, Patrick Ward, and Nathalie Zorzi. 2004. "Primary Health Care in Mozambique. Service Delivery in a Complex Hierarchy. Africa Region Human Development Working Paper Series." World Bank.
- "Manual de Procedimentos Para Implementa  o Do Memorando de Entendiment Do PROSAUDE III." 2017. Maputo.
- Massuanganhe, Israel Jacob. 2005. "Decentralization and District Development: Participatory & Multi-Sectoral Framework for Decentralized Policies and Local Development Strategies Addressed to Millenium Development Goals. Consolidated Review of Case Studies, Regional Experiences, Best Practices and Evidences Based on UNCDF & UNDP Support in Mozambique." Maputo, Mozambique: UNDP Mozambique.
- Ministry of Planning and Development. 2006. "PPFD/PRODER Joint Review and Strategy Proposal for the National PPF Program Architecture. Final Report (Translation from the Original in Portuguese) Decentralized Planning and Finance Project." Maputo, Mozambique: Metier.
- MISAU. 2012. "Health Sector Review Report." Maputo, Mozambique: Ministry of Health.
- — —. 2013. "Health Sector Strategic Plan PESS 2014-2019." Maputo, Mozambique: Republic of Mozambique.

- Observatório do Cidadão para Saúde. n.d. "Budget Dynamics of the Health Sector in Mozambique: Focusing on Financing Sexual & Reproductive Health and HIV and AIDS Programmes." n.d. <https://www.observatoriodesaude.org/budget-dynamics-of-the-health-sector-in-mozambique-focusing-on-financing-sexual-reproductive-health-and-hiv-and-aids-programmes/>.
- Primary Health Care Strengthening Program. 2021. "Health Expenditures in Mozambique, 2014-2018." World Bank Group.
- Republic of Mozambique. 2020a. "General State Account. Year 2019. Volume I (Portuguese)." Maputo, Mozambique: Republic of Mozambique. <https://www.mef.gov.mz/index.php/documentos/instrumentos-de-gestao/-21/conta-geral-do-estado-cge/cge-2019/899-conta-geral-do-estado-2019-anexos-informativos-volume-i/file>.
- . 2020b. "Voluntary National Review of Agenda 2030 for Sustainable Development: Mozambique." Maputo, Mozambique: Republic of Mozambique.
- Rodriguez Pose, Romina, Jakob Engel, Amandine Poncin, and Sandra Manuel. 2014. "Against the Odds: Mozambique's Gains in Primary Health Care." London: Overseas Development Institute.
- SADOC. 2018. "Mozambique, February 13, 2018: Constitutional amendment proposes limited decentralization in 'unitary state.'" 2018. <https://www.sadoc.at/?p=1495>.
- UNICEF. 2019. "Budget Brief: Health. Mozambique 2019." UNICEF.
- USAID. 2019. "Overview of Private Actors in the Mozambican Health System and Rapid Assessment of the Supply Chain." Washington, DC: USAID.
- VillageReach. 2016. "Assessment of Financial Flows in Mozambique." VillageReach.
- Weimer, Bernhard, and Joao Carrilho. 2017. *Political Economy of Decentralization in Mozambique*. Maputo, Mozambique: Institute for Social and Economic Studies.
- World Bank. 2009. "Municipal Development in Mozambique: Lessons from the First Decade." Washington, DC: World Bank.
- . 2014. "Mozambique Public Expenditure Review: Addressing the Challenges of Today, Seizing the Opportunities of Tomorrow." Washington, DC: World Bank.
- World Health Organization. 2019. "Global Spending on Health: A World in Transition." Geneva: World Health Organization.
- . n.d. "Global Health Expenditure Database." Accessed June 17, 2019. <https://apps.who.int/nha/database/Select/Indicators/en>.