

CRC 1342 No. 25

Social Policy **Country** Briefs

Mozambique



Fernanda Farinha

The Health Care System in Mozambique



Global Dynamics
of Social Policy CRC 1342



Deutsche
Forschungsgemeinschaft

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CRC 1342 Social Policy Country Briefs, 25

Edited by Gabriela de Carvalho and Antonio Basilicata

Bremen: CRC 1342, 2022



SFB 1342 Globale Entwicklungsdynamiken von Sozialpolitik /
CRC 1342 Global Dynamics of Social Policy

A04: Global developments in health care systems and long-
term care as a new social risk

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[DOI <https://doi.org/10.26092/elib/1603>]

[ISSN 2700-4392]

Funded by the Deutsche Forschungsgemeinschaft

(DFG, German Research Foundation)

Projektnummer 374666841 – SFB 1342

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THE HEALTH CARE SYSTEM IN MOZAMBIQUE

Fernanda Farinha*

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1. COUNTRY OVERVIEW



Source: <https://ontheworldmap.com/mozambique/> (Accessed: May 11, 2021)

- » Sub-Region: Southern Africa
- » Capital: Maputo
- » Official Language: Portuguese
- » Population size: 31,255,435 (UNdata 2021; 2020 value)
- » Share of rural population: 63.5% (UNdata 2021; 2019 value)
- » GDP: 15.291 Billion USD (World Bank 2021; 2019 value)
- » Income group: Low Income (World Bank 2021)
- » Gini Index: 54 (World Bank 2021; 2014 value)
- » Colonial period: 1505-1975 (Portuguese colony) (CoW 2021)
- » Independence: 1975 (CoW 2021)

2. SELECTED HEALTH INDICATORS

Indicator	Country	Global Average
Male life expectancy (2019)	54	70.6
Female life expectancy (2019)	61	75
Under-5 mortality rate (per 1000 live births), 2019	74.2	37.7
Maternal mortality rate (per 100,000), 2017	289	211
HIV prevalence (15-49 years), 2019	12.4	0.7
Tuberculosis incidence (per 100,000), 2017	361	130

Sources: World Health Organization (2021); M&S (2020); UNAIDS (2019); M&S (2017); World Bank (2021)

3. LEGAL BEGINNING OF THE SYSTEM

Name and type of legal act	Decree-Law 1/75
Date the law was passed	29 of July 1975
Date of de jure implementation	1975

Brief summary of content	<p>Health as a citizen's right and the responsibility of the State.</p> <p>Unified and centralised health system to cover the whole country and population.</p> <p>Preventive medicine as a priority over curative medicine; services must be integrated at the primary level.</p> <p>Abolition of private health services (for-profit and not-for-profit).</p> <p>Traditional medicine was ignored and sometimes treated with hostility as it was seen as representing backward views.</p>
Socio-political context of introduction	<p>Country independence from Portugal's rule in June 1975 was the critical factor.</p> <p>FRELIMO's policies guide the development of the health system. Addressing the inherited racist and urban bias of the healthcare system was a key political objective.</p> <p>No civil society and/or other stakeholders were involved. Decisions were made at the top of the political hierarchy.</p>

4. CHARACTERISTICS OF THE SYSTEM AT THE INTRODUCTION

a. Organisational structure

The NHS was heavily centralised regarding allocation of financial resources (funded totally by the central government), human resources (allocation of technical and managerial staff throughout the country made at central level) and technical and policy decisions (treatment and other protocols defined at the central level).

The Ministry of Health (MoH) ran the NHS. Specialised departments at the central level dealt with specific areas of health: medical assistance (hospital care), preventive health, pharmacy (drugs and medicines), human resources (including the training of health professionals below university level), planning, and the administrative and financial departments. This structure was replicated at the provincial level, within the Provincial Health Directorate (PHD) and at the district level in a slightly different way. Regarding accountability, primary care health facilities reported to district level health government authorities, secondary and tertiary level to the provincial health directorates and quaternary level facilities to the central organs of the MoH.

NHS encompassed four levels of care: primary level (health posts and health centres, a few with maternity wards), secondary level (district and general hospitals with some inpatient care), tertiary level (provincial hospitals) and quaternary level (central hospitals in 3 regions: north, centre, and south).

Health care facilities were very poorly equipped and resourced: most health centres and posts did not have basic equipment (laboratories and X-ray) or medical doctors. Most existing technical and professional health staff (Portuguese citizens) left Mozambique after independence. Doctors from Eastern Europe, USSR, China, Cuba recruited through bilateral cooperation agreements and others from Western countries complemented the local staff, particularly in provincial hospitals and the Maputo (the country's capital) central hospital.

Practical priority within the NHS was given to the expansion of service (establishing new health centres, especially in rural areas), to mother and child health preventive and basic curative care, community education and sanitation, and immunisation. Also, identification and treatment of endemic diseases such as malaria, tuberculosis and leprosy were defined as a priority.

The NHS was open to all citizens and residents in the country. In 1977, the Free Medicine Act (Law No. 2 of 27 September 1977) made preventive health as well as inpatient services free. Other services were paid at a basic fee of US 22 cents (7.5 escudos) (MdS, 1978, p. 123).

The Defence Ministry ran a parallel military health service, with clinics and 1-2 hospitals.

» Coverage

In 1978 there were 747 health facilities, the great majority primary health posts and centres. Probably more than half of the population, which lived in rural areas, lacked access to modern health services. Health prevention activities, such as immunisation services and health education, were carried out through mobile units and covered a larger proportion of the population.

b. Provision

Of the 747 health facilities in place in 1978, less than 40% (278) provided inpatient care. There was a total of 12,170 beds (including maternity ward beds), representing 1.1 beds/1000 (MdS, 1978, p. 66).

At that time, there was one medical doctor per 38,600 inhabitants, with a total of 285 doctors, of which two-thirds were expatriates. There were 2,390 nurses and midwives (430 were midwives) (MdS, 1978, p. 66).

This level of staffing heavily influenced the access and quality of health care. To increase access, the MoH initiated a large training program to train nurses, midwives, curative and preventive agents, laboratory technicians, etc. This training was implemented directly by the MoH through four regional training institutes established for that purpose (Noormahomed et al., 1990, p. 28). It also adopted a policy to recruit, train and place community health workers to increase service outreach.

c. Financing

The health budget was US \$ 38.8 million, representing 12.9% of the total state budget in 1977. It corresponded to US \$ 3.5 per inhabitant. In 1978, the budget totalled US 43 million, corresponding to 11% of the State budget and US \$ 3.8 per inhabitant. (MdS, 1978, p. 65).

The NHS was financed mainly by the State budget. The Ministry of Finances allocated a budget to the Ministry of Health at the central level. This budget was then allocated to the provincial health departments, which in turn were distributed to the district health services. Health care facilities' budgets were managed by district health authorities. The decision was always made top-down. Later in the 1970s, small donations started to be received from a few international agencies and donors for particular activities (ex: immunisations and public health education campaigns); also, many foreign medical doctors and other health professionals contracted at the beginning of this phase were paid by their own countries and organisations.

d. Regulation

The MoH was responsible for elaborating health legislation under the guidance of the governing political party. There was little or no participation of any other stakeholders. The MoH prepared laws and by-laws and submitted them to the one-party parliament or the Council of Ministers for approval.

With international technical assistance, MoH developed an intense effort to normalise and standardise procedures and protocols, including medical treatment protocols for the most common illnesses, the first of which came in February 1977 (MdS, 1978, p. 57). It also developed a list of essential medicines, with a clear definition of who, within the NHS, could dispense them (MdS, 1978, p. 122). This standardisation was important in a context where most health care providers (nurses, medicine technicians, etc.) had a quite low level of basic education, and professional training and purchase of medicines were made only by the MoH.

5. SUBSEQUENT HISTORICAL DEVELOPMENT OF PUBLIC POLICY ON HEALTH CARE

a. Major reform I

Name and type of legal act	Law 26/91
Date the law was passed	31st of December 1991.
Date of <i>de jure</i> implementation	Implementation started gradually later in 1992. Laws, decrees, diplomas were revised a number of times during the following 20 years to accommodate changes in the context and stakeholders' interests.
Brief summary of content	Law 26/91 opened space for private and community ownership of health care facilities. It defined the scope of the new private and community health services; the requirements for opening a private facility; it indicated that the private sector should complement the public sector and follow up norms and technical procedures approved by the MoH. The law forbade discrimination based on gender, race, ethnic group, religion, and place of birth.

Socio-political context of introduction	<p>Changes in policy were the result of pressures from private interests within the country and the tendency towards privatisation was promoted and supported by international organisations and donors.</p> <p>After the liberalisation of the health sector, a number of health professional associations were established to defend specific professional groups as well as associations of private health services.</p>
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- » Law 26/91 allowed private (for-profit and not-for-profit) and community (traditional and alternative medicines) clinics, hospitals, health professionals' training institutes, transportation services, etc. Posterior legislation regulated the functioning of private pharmacies. The 26/91 law was followed by a series of other laws, by-laws, and regulations, such as the Decree 9/92 that regulates the provision of health care by private entities and the Presidential Decree 11/95 that establishes the new structure of the Ministry of Health to accommodate private sector health.
- » In 2006, the Law 3/2006 established the Order of Doctors as an independent institution to defend the medical profession. The Order is responsible for the accreditation of medical doctors who work in the private sector, advising the GoM on medical education, and disciplining medical doctors. In addition, a number of other health professionals' associations (nurses, laboratory, pharmacy professionals, etc.) were established to defend particular interests using the opportunity created by this cadre of legislation.

6. DESCRIPTION OF THE CURRENT HEALTH CARE SYSTEM

a. Organisational structure

The MoH is the custodian of the Mozambican health sector and oversees all public, private and community health facilities in the country. The public sector provides the great majority of modern health services to the population and ran 1674 health care facilities throughout the country in 2019. The provision of services continues to be organised in four levels of attention: primary care, with 1609 health centres that offer preventive and basic curative services and are the first point of contact between citizens and the NHS; 51 general and rural hospitals that are the first level of referral and deliver inpatient care and some surgical services; 7 provincial hospitals based in the provincial capital cities that provide general as well as more specialised care. Seven central and specialised hospitals comprise the quaternary level and are the last level of care and referral. (MdS, 2020, p. 9)

The public sector, the NHS, continues to be highly centralised and is directly and tightly controlled by the GoM. The Ministry of Finance allocates budgets to the MoH at the central level. Its structures at the provincial level allocate the budget to the provincial directorates of health and district authorities of health. District health authorities have some autonomy in allocating health staff to health facilities under their responsibility. With the exception of tertiary and quaternary level hospitals that have some autonomy to manage the budgets allocated to them, all other health facilities' budgets are managed by the district health authorities. Fees for services charged by health facilities of all levels are handed into financial authorities and cannot be used directly by health facilities to improve their own services. In general, devolution of powers through decentralisation is extremely limited in the country. A handful number of municipalities are starting to manage their own primary care services as a pilot experience.

In urban areas, private sector services mushroomed during the initial 10-15 years after the approval of the law but slowed down afterwards. There are now 224 clinics and hospitals (30 hospitals), 63% in the capital city (Maputo) (MMEMS, 2019, p. 17, p. 18). Most private services are clinics, pharmacies, and laboratory services, but there are a few hospitals providing surgery and specialised care. The sector caters to around 4% of the total population (MMEMS, 2019, p. 19).

The NHS is open to all residents in the country. There are clear provisions in the law to prevent discrimination based on gender, race, ethnic and religious group, both for the public and the private sectors.

» Coverage

Percentage of population covered by government schemes	Majority
Percentage of population covered by social insurance schemes	Not applicable
Percentage of population covered by private schemes	Around 3%
Percentage of population uncovered	Not available

Theoretically, the Government of Mozambique (GoM) schemes cover the whole population, but there are on average 17,514 inhabitants per health care facility, and citizens travel on average 12.3 kms to reach a facility. There are wide differences within the country regarding access to health care: geographic coverage can go from one facility per 750km² to another facility per 8km². (MdS, 2020, p. 12). Due to distance from facilities and costs (mostly indirect costs such as transportation, time, and corruption fees), it may be difficult for a significant proportion of the population to access health care when they need it. In 2007, the MoH estimated that around 30% of the population had no access to the NHS (MdS, 2007, p. 24) when there were 1338 health facilities (MdS, 2007, p. 9). A national household survey carried out by the GoM in 2014/15 refers that 90% of citizens seeking care interviewed mentioned using the NHS (as cited in MMEMS, 2019, p. 18).

The quality of care is quite poor. In over 70% of the country's 154 districts, the hospitals do not have a functioning X-ray machine and/or a laboratory and/or an operating theatre. Also, over 40% of the districts do not have a pharmacy outside the health facilities managed by the NHS (Garrido, 2020, p. 11).

Private insurance covers around 3% of the population (MMEMS, 2019, p. 14). It is concentrated in larger cities and responds to the needs of a small part of people engaged in the formal economic sector.

b. Provision

There were 2556 medical doctors, 14325 nurses and midwives (includes 6175 mother & child nurses) in the public sector in 2019; with a ratio of 8.7 doctors/100,000, 28.5 nurses/100,000, and 52.6 mother and child nurses/100,000 women of reproductive age and children <5y (2019) (MdS, 2020, p. 17). Data for the private sector is not available.

There were 21,651 beds in the public sector in 2019, of which 9042 are maternity beds. Ratio beds per inhabitant are 0.74 beds per 1000 inhabitants (and 1.29 beds per woman of reproductive age) (MdS, 2020, p. 17). No data is available for the private sector, but the number of beds is small.

In 2019, there were 1.56 consultations per inhabitant, varying across provinces from 1.15 to 2.65 (MdS, 2020, p.22).

c. Financing

The state sector health budget in 2019 was around US \$ 480,000,000 representing 8.8% of the state budget and 3.4% of GDP. In US \$, this is a 34% reduction from 2018, when the health budget represented around 12% of the state budget and 3.8% of GDP (UNICEF, 2019, p. 3-5). The reduction was primarily due to the devaluation of the local currency (Metical) against the US Dollar.

In 2019, 79% of the Health Sector Budget (public sector) was funded from domestic sources, and 21% from foreign sources. Expenditure on medicines corresponds to about one-third of the sector's total budget. This budget composition is a major departure from the last decade's trend, during which the structure was 60% and 40%, respectively, from domestic and foreign funds. Foreign support is provided via Common Fund (28%), Vertical Funds (29%), credit (26%) and in-kind (medicines, 17%). (UNICEF, 2019, p. 6)

The Ministry of Health budget is also highly concentrated in the central organs. In 2016, the central organs (based in Maputo city) received 45,2% of the state funds for health, the provincial level 13.5%, and the district health authorities 14.9% (UNICEF, 2016, as cited in Gironés et.al., 2018, p. 19).

Data for citizens and health insurance contribution to the whole health sector is not available. Civil servants contribute 1.5% of their basic salary to a health assistance fund that is then distributed to public health facilities through the state budget.

d. Regulation of dominant system

The health sector is regulated by the MoH, a department of the central GoM. The MoH is responsible for implementing a public NHS, licensing and controlling the health care private care services, elaborating policies, and regulating, licensing, and inspecting the exercise of the pharmaceutical activity, among others.

The Medicines Regulatory National Authority (ANARME), established in 2017 (Law 12/2017 dated 8 September 2017), is responsible for regulating, supervision, inspecting, and sanctioning medicines, vaccines, and biological products for humans and health use. There are a number of other regulatory systems: The Ministry of Science, Technology, Higher and Technical and Vocational Education is responsible for licensing and supervising medical training institutions; the National Authority for Professional Education regulates and certifies the education of professional training institutions in the country. There are a large number of other regulations established by municipalities and government departments that are common to the establishment of all types of private activities.

The NHS defines services to be provided according to the level of care. At the primary level, there are general clinic consultations for the most common adult and children's illnesses (especially endemic illnesses such as malaria, tuberculosis, and HIV/AIDs) maternal and child health (including family planning, pregnancy check-ups, delivery assistance, immunisation, weight control, nutrition supplements), basic medicines delivery and health education. Patients pay a small fee for services, and that fee includes medicines (around US \$ 9 cents, in 2019).

At the secondary level, the NHS provides general medicine, gynaecology and paediatrics services, small surgery, basic X-ray, lab services, and inpatient care. Other specialised clinical services are provided at the tertiary level and quaternary levels. More specialised diagnosis means and treatment services (e.g., MRI) are only provided at the quaternary level and in a few private health care clinics. Referrals to the Republic of South Africa hospitals, in particular for surgery, cancer among others, are used by those who can pay for it.

7. CO-EXISTING SYSTEMS

Beyond the NHS, there are private clinics, hospitals, laboratories, and pharmacies, addressing the needs of a small segment of the population: those from a middle-class background who directly pay the services they receive and employees of a number of businesses (as well as international and non-profit organisations) residing in the main cities. The private sector is quite expensive, fragmented, and curative biased. Most services provided are in the fields of general medicine, gyn-obstetrics, paediatrics. There are a few facilities providing specialised care in the fields of cardiology, neurology, orthopaedics. For some who can afford private health care, recourse to South African hospitals complement local resources and is used due to being less expensive (in general) and better equipped and staffed.

Traditional medicine covers the majority of the population. It is used in the absence of modern health services and/or conditions for which modern medicine is seen by the population as ineffective. The MoH has had since the 1990s a traditional medicine department, and it established in 2010 the Institute of Traditional Medicine, with the responsibility of bridging the two sectors, monitoring Traditional Medicine, and promoting research and training on relevant issues (Ministerial Diploma 52/2010, dated 23 of March). There has been a nationwide association of traditional healers (AMETRAMO) since the 1990s.

8. ROLE OF GLOBAL ACTORS

Global actors play a particularly important role in supporting the health sector, in particular the public NHS, through funding an important proportion of its budget and activities and providing technical assistance for policymaking. The proportion of external support to the health budget has been decreasing during the past years and went from 49% in 2016 (MMEMS, 2019, p. 14) to 21% in 2019 (UNICEF, 2019, p. 3). A key factor for this decrease in support is the loss of credibility of the GoM due to the scandal related to the "hidden debts".

Donors have three main vehicles to support the sector: (i) contributing to a common fund (the PROSAÚDE) that is managed quite autonomously by MoH, (ii) providing funds for specific programs and activities (Vertical Funds) where they have some control over funds and activities; (iii) and providing in-kind support (mostly used for supply of medicines). Using the last two vehicles, in particular the second, enable funders to have a significant influence

over the MoH agenda and has been the preferable channel for a few donors. The MoH established a coordination mechanism with its donors and has carried out annual joint evaluations of its performance in which funders and civil society actors participate. This has been used as an opportunity for influencing by external actors.

The main funders of health activities in Mozambique are the government of the USA (with a quite large program in HIV/AIDS), the Global Fund to fight HIV, tuberculosis and malaria, the United Nations, the Canadian cooperation, UK, Ireland, amongst others. There are a number of international non-governmental organisations providing direct services at the local level within the cadre of programs externally funded and approved by the government.

9. LIST OF ADDITIONAL RELEVANT LEGAL ACTS

Lei 12/2017. Lei de Medicamentos, Vacinas e Outros Produtos Biológicos para o Uso Humano. I Série. No. 141. 8 de Setembro de 2017

Resolução 4/2017. Estatuto Orgânico do Ministério da Saúde. I Série. No. 82. 26 de Maio de 2017.

Lei 6/2016. Lei da Educação Profissional. Boletim da República. I Série. No. 71. 16 de Junho de 2016.

Diploma Ministerial 40/2004. Regulamento Geral dos Hospitais. I Série. No. 7. 18 de Fevereiro de 2014.

Lei 24/2009. Lei do Exercício da Medicina Privada. I Série. No. 38. 28 de Setembro de 2009.

Resolução 73/2007. Carta de Direitos e Deveres do Doente. I Série. No. 38. 18 de dezembro de 2007.

Diploma Ministerial 40/2003. Regulamento de Parceria entre o Serviço Nacional de Saúde e o Sector Privado Com Fins Não Lucrativos. I Série. No. 14. 2 de Abril de 2003.

Diploma Ministerial 39/2003. Regulamento do Regime de Abertura de Farmácias. I Série. No. 14. 2 de Abril de 2003.

Diploma Ministerial 98/94. Taxas e Emolumentos. I Série. No. 30. 27 de Julho de 1994.

Lei 25/91. Cria o Serviço Nacional de Saúde. I Série. No. 52. 31 de Dezembro de 1991.

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