Policy **Note** 05

Towards Mapping the Fiscal Space

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HEALTH SECTOR FINANCING STRATEGY IN MOZAMBIQUE

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Abbreviations

AFDB	African Development Bank	
ASEM	Assistência Médica e Medicamentosa	Medical and Medication Assistance
ATM	Autoridade Tributária de Moçambique	Tax Authority of Mozambique
CBHI	Community-based health insurance	
CFMP	Cenário Fiscal de Medio Prazo	Medium Term Fiscal Scenario
CGE	Conta Geral do Estado	General State Accounts
CIT	Corporate Income Tax	
CNS	Contas Nacionais de Saúde	
CSS	Contas Satélite de Saúde	
DNGERHE	Direcção Nacional de Gestão Estratégica dos Recursos Humanos do Estado	National Directorate for Strategic Management of the State's Human Resources
DNTCEF	Direcção Nacional do Tesouro e Cooperação Económica e Financeira	Directorate of Treasury and International Economic and Financial Cooperation
DPS	Direcção Provincial de Saude	Provincial health Directorate
DTS	Despesa Total com Saúde	
EITI	Extractive Industry Transparency Initiative	
FATF	Financial Action Task Force	
FS	Fiscal Space	
GDP	Gross Domestic Product	
GFF	Global Financing Facility	
HSF	Health Sector Financing	
HSFS	Health Sector Financing Strategy	
ICE	Imposto sobre Consumo Especial	Special Consumption Tax
IMF	International Monetary Fund	
INAS	Instituto Nacional de Acção Social	National Institute for Social Actin
INPS	Instituto Nacional de Previdência Social	National Institute for Social Security (public Servants)
INSS	Instituto Nacional de Segurança Social (	National Institute for Social Security
IPM	Imposto sobre a Produção Mineira	Mining Production Tax
IPP	Imposto sobre a Produção de Petróleo	Petroleum Production Tax
IRPC	Imposto sobre o Rendimento de Pessoas Colectivas	See: CIT
IRPS	Imposto sobre o Rendimento de Pessoas Singulares	See: PIT
IRRM	Impostos sobre a Renda de Recurso Mineiro	Mining Resource Income Tax
IS	Imposto de Selo	Stamp tax
ISD	Imposto sobre Sucessões e Doações	Inheritance Tax
ISPC	Imposto Simplificado para Pequenos Contribuintes	Simplified Tax for Small Tax payers
ISS	Imposto sobre Superfície	Surface Tax
LESSOFE	Lei sobre Sistema de Segurança Social Obrigatório de Funcionários do Estado	Law on Mandatory Social Security of Civil Servants
LGA	Local Government Authority	
MAEFP	Ministério de Administração Estatal e Função Publica	Ministry of State Administration and Public Service
MCH	Mother and Child Health	
MEF	Ministério de Economia e Finanças	Ministry of Economics and Finance
MGCAS	Ministério de Género, Criança e Acção Social	Ministry of Gender, Childres and Social Welfare

MISAU	Ministério de Saúde	
MOH	Ministry of Health	
NGO	Non Governmental Organization	
NHIL	National Health Insurance Levy	
OCS	Observatório do Cidadão para Saúde	Citizen Health Observatory
OGDP	Órgãos de Governação Descentralizados na Provincia	
OOP	Out of Pocket payment	
OSR	Own Source Revenue	
PAE	Programa de Medidas de Aceleração Económica	Programme of Measures to Accelerate the Economy
PBF	Performance Based Financing	
PECS	Pacote Essencial de Cuidados Sanitários	Essential Health Care Package
PESOE	Plano Económico Social e Orçamento do Estado	Annual Economic and Social plan and Budget
PESS	Plano Estratégico do Sector da Saúde	Strategic Health Sector Plan
PFM	Public finance management	
PG	Provincial Governor	
PHC	Primary Health Care	
PIT	Personal Income Tax	
PNS	Política Nacional de Saúde	National Health Policy
PO-RALG	President's Office for Regional Administration and Local Govt	
PPP	Public-Private Partnerships	
RBV	Resource -Based View	
RDT	Resource Dependence Theory	
REP	Representative of the State in the Province	
RSSB	Rwanda Social Security Board	
SAP	Serviço de Atendimento Personalizado	Personalized customer service
SDG	Sustainable Development Goals	
SDSMAS	Serviços Distritais de Saúde, Mulher e Acção Social	
SISRECORE	Sistema de Registo e Controlo de Receitas	Revenue Registry and Control System
SLFF	Sustainability-Linked Finance Framework	
SNS	Sistema Nacional de Saude	National Health System
SPS	Serviço Provincial de Saude	Provincial Health Service
SSB	sugar-sweetened beverages	
SWF	Sovereign Wealth Fund	
SWOT	Strength, Weakness, Opportunity, Threat	
TOC	Theory of change	
TOR	Terms of Reference	
TSU	Tabela Salarial Unica	Unified Salary Schedule
UHC	Universal Health Coverage	
UPF	Ultra-processed foods	
VAT	Value Added Tax	
WB	World Bank	
WHO	World Health Organization	

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1. INTRODUCTION AND OBJECTIVES

This paper was commissioned by N´weti and Wemos as part of the project "Equitable health financing for a strong health system in Mozambique". Its purpose is to contribute to the debate of the Mozambican Ministry of Health's draft Health Sector Financing Strategy (HSFS) 2025 – 2034[1]. This paper complements an initial report that analysed and suggested improvements to the HSFS document using a SWOT analysis[2].

With this report, N'weti aims to deepen the readers' understanding of the complex issue of health financing and the need to assess the existing fiscal space (FS) to optimize its use. It is hoped that this exercise will help the Ministry of Health[3] (MoH) develop a coherent approach to increase its capacity to generate, allocate, target and control domestic financial resources in alignment with the priorities outlined in its Health Sector Strategic Plan (PESS)[4] 2014-2019 (extended to 2024). The ultimate goal of both PESS and the HSFS is to contribute to Universal Health Care (UHC) in Mozambique and identify and commit the necessary domestic resources towards this end. Given that the HSFS is still in draft form, and a new PESS (2025-2034) is being developed, this analysis may provide valuable inputs for both ongoing works.

The main objective of the study is to map the Fiscal Space (FS) and analyse the most appropriate ways to increase health sector financing (HSF) in Mozambique through a national effort of resource mobilization. This includes:

a) determining the best strategy to utilize the existing fiscal space, considering fiscal and macroeconomic variables and constraints;

b) diversifying fiscal and non-fiscal revenue sources for health sector financing, and specifically;

c) ensuring that taxes on the consumption of substances such as alcohol and tobacco are channelled to the health sector.

This report has five main sections: i) Introduction and objectives; ii) Approach and methodology, iii) Context analysis, iv) Analysis of fiscal space and its components, and v) Conclusions.

The author would like to thank everyone who contributed, directly and indirectly, to this study. A particular Thank You goes to Dra Denise Namburete, Executive Director, Dr Andes Chivangue, Advocacy Coordinator and their colleagues at N'weti, as well as several Mozambicans, with whom the author exchanged views on the important subject matter of this report.

The findings, interpretations and conclusions expressed in this report are those of the authors and do not necessarily reflect the policies or views of N'weti or Wemos.

1. Governo de Moçambique, (2024) Estratégia de Financiamento do Sector Saúde (EFSS), 2025-2034. Ministério de Saúde, Abril, 2024. A previous version of the HSFS was tabled in 2021 but not approved. Some of the reasons are address by N'weti (2021).
2. N´weti, 2024.
3. Ministério de Saúde (MISAU)
4. Plano Estratégico do Sector da Saúde (PESS).

2. APPROACH AND METHODOLOGY

With the main focus of this study on fiscal space, it starts by defining the term fiscal space. In line with the WHO, fiscal space is understood as 'the budgetary room allowing a government to provide resources for public purposes without impacting fiscal sustainability[5]. In other word, the term circumscribes the domestic resource potential that needs to be mapped, assessed and mobilized to finance health sector reforms, particularly improving primary healthcare (PHC) towards achieving Universal Health Coverage (UHC) without compromising overall macroeconomic and fiscal stability[6]. For this study, we focus the assessment on seven constitutive components of domestic fiscal space (Heller, 2005a). These are:

1) Macroeconomic growth.
2) Domestic fiscal revenue from both direct and indirect taxes.
3) Specific earmarked taxes conditioned for health sector expenditure (e.g., 'sin' taxes);
4) Medical and medication deductions from public sector salaries.
5) Financial contributions by health insurance.
6) Own-source non-fiscal revenue of the health sector (user fees).
7) Improvement of allocation and efficiency in resource use.

Other possibilities to enhance fiscal space, such as tax policy measures, substituting expensive spending priorities with less expensive ones, and improving the business environment are not considered in this study. Similarly, external financial support, though occasionally considered part of any fiscal space analyses, is excluded in our FS analysis since not covered by the TOR. Interested readers are referred to a study on this matter produced by N'weti (2021). For the same reason we also avoid using the term 'purchasing of health services', which involves domestic and external, i.e. pooled resources[7].

Our analysis focuses on the seven aspects enumerated above using a methodology that includes, firstly, desk research and selected literature, which provides us with relevant analytical literature and theoretical background and with case studies of health sector financing (HSF)[8]. Secondly, the object and focus of the analysis is the HSFS document itself, which is 50 pages long, including nine figures and eight tables, and an annex. It is structured in seven main sections, according to the table of contents, reproduced here in Annex 6.1. Sections 4 (Financiamento da Saúde) and 5 (Intervenções por objectivos estratégicos de financiamento em Saúde) are of specific interest for this study. Generally, these parts of the document are of high quality and rich in data, some of which we use and quote. In reviewing the documents, its assessment and assertions, we offer complementary ideas and comments, where deemed useful.

Finally, the authors used fiscal data from 2019 to 2022, extracted from the PDF files of the annual Conta Geral do Estado (CGE) covering those years.

5. https://www.who.int/teams/health-systems-governance-and-financing/health-financing/policy/fiscal-space-for-health
6. From a perspective of public finance theory, economic stabilization is one of the three functions of a budget, together with allocation and (re)distribution of fiscal resources
7. 'Health purchasing is defined most generally as the allocation of pooled funds on behalf of the population to the providers of health services. For purchasing to be considered strategic, it must include an active process of allocating funds based on available information about health provider performance and population health needs, with the ultimate aim of increasing efficiency, equitable distribution of resources, and cost containment. Strategic purchasing decisions include: 1) what services and medicines to buy with available funds, 2) from which providers to buy, 3) how and how much to pay those providers' (Ekirapa-Kiracho, 2022: e2084215-2)
8. Chosen by a literature review methodology of random research articles and literature on the websites regarding HSF, fiscal space etc. covers publications by academic institutions, international organizations, consultancy companies, national institutions of health services and NGOs (see bibliography in annex 2).

3. CONTEXT ANALYSIS – SELECTED ASPECTS

3.1 The health sector– institutional and financial challenges

The National Health System (Sistema Nacional de Saúde – SNS) is defined, by the National Health Policy (PNS[9]) of 2021[10]. It consists of three sub-sectors (public, private and community subsystem) operating at four levels. The public subsector is referred to as the National Health Services (NHS). The private subsector includes both private profit-making and non-profit organizations,[11] while the communal or community subsystem encompasses community health services. According to the former Minister of Health, the SNS also includes the military and paramilitary health services, as well as socio-professional organizations such as the Doctors Association, the Nurses Association and the Medical Association of Mozambique (Garrido, 2020).

The following table gives an overview of private and public health facilities for the year 2019. It is reasonably assumed that since that year the number and share of private providers has increased.

Table 1: Health Facilities Ownership by Level

Facility Level	Public	Private	Subtotal	% Private
Primary	1,563	194	1,757	11.0
Secondary	51	30	81	37.0
Tertiary	7	0	7	
Quaternary	7	0	7	
Total	1,628	224	1,852	12.1

Source: Potenciar, 2021

The public part of SNS, and particularly the community health sector used by the vast majority of Mozambican households (91,6%), finds itself in a profound crisis. Two primary reasons are the lack of necessary, overdue reforms and the lack of (domestic) finance. The table 2 below shows significant reduction of government expenditure for health in 2019 and 2020, while donor support, which covers more than 50% of total health expenditure and often via vertical programmes, doubled, mostly due to extraordinary support during the Covid-19 pandemic.

9. Política Nacional de Saúde.
10. Resolution Nr. 4/95 of the Council of Ministers.
11. The reintroduction of profitable private medical care abolished in 1975, was legislated in 1991 (Law 26/91 of 31 December), regulated by Decree 9/92, of 26 May.

Table 2: Mozambique Health Sector Expenditure, by source (2019 and 2020), in 10^6 MTS and %

health Expenditure, by source	2019	(%)	2020	(%)
Goverment	18.995	46,7%	17.877	28,3%
Donors	10.422	25,6%	32.398	51,3%
Families e	3.435	8,4%	3.435	5,4%
Health Insurance	4.429	10,9%	5.492	8,7%
Social Security Systems	464	1,1%	531	0,8%
NGOs	327	0,8%	431	0,7%
Private Sector	2.600	6,4%	2.935	4,7%
Total (Despesa Total com Saúde -DTS)	40.672	100	63.098	100

Source: adapted from GoM, 2024: Tabela 2, on the basis of Contas Satélite de Saúde (CSS)

Gauging the fiscal gap and proposing remedies for its reduction are part of the development of a HSFS and, consequently, of strategic planning for the entire sector. The fiscal gap analysis needs to be assessed in relation to the strategic goals of HSF, such as achieving UHC, as outlined in the UN Sustainable Development Goal 3.8. To achieve this goal, several issues need to be addressed: financial risk protection, access to essential health-care services of quality, access to safe, effective, quality and affordable essential medicines and vaccines for all. Additionally, there must be a substantial increase in health financing and the recruitment, development, training and retention of the health workforce'[12].

While these goals are ambitious, they are critical for improving health outcomes. It is important to consider various perspectives and potential challenges in this context. For instance, the reliance on donor support raises questions about sustainability and self-sufficiency in the long term. Moreover, implementing overdue reforms and increasing domestic financing are complex tasks that require strong political will and effective governance.

Reflecting on these diverse viewpoints can promote a more comprehensive understanding of the issues at hand and encourage the development of robust strategies to address the fiscal gap and advance towards UHC.

12 https://www.globalgoals.org/goals/3-good-health-and-well-being/

Mozambique is one of those African countries which in the early 2000s took steps to reform their health care systems towards meeting the UHC goals, with varied success. The target set in 2001 by the African Heads of State to commit 15% of their annual expenditure to the health sector (Abuja Declaration) was only met in exceptional cases. Mozambique achieved 11.8% allocation on average during the period 2016- 2023 (GoM, 2024, table 4b). If one adds the additional resources mobilized by the government's response to Covid-19 and the salary adjustments in the health sector as result of the introduction of the Single Salary Schedule (Tabela de Salarial Única -TSU), the Abuja Target was met.

Besides the Abuja target, the HSFS considers two more strategic goals. The first goal is related to domestic public expenditure on health in relation to GDP. The WHO target suggests that 5-6% of GDP should be allocated to health to achieve satisfactory results in UHC. However, as the HSFS shows in Table 5, in the case of Mozambique this ratio reached only 2,25% on average during the period 2016 – 2023 (GoM, 2024, Figure 5).

Secondly, in relation to domestic public expenditure on health per capita, the HSFS states that international standards recommend allocating approximately US$ 86[13] per capita to the health sector to achieve satisfactory results in UHC (Jowett, 2016). Mozambique spent only a fraction of this amount, namely US$ 12,1 (internal financing) on average for the years 2016 to 2023, an amount increased to US$ 18,4 if we add external funding.

While one can argue that Mozambique is making reasonable progress towards achieving the Abuja commitment, the data on the other strategic goals reveal an enormous fiscal gap on the way to realizing UHC. Conducting a financial gap analysis, which compares expected health spending with potential health spending and spending needs, is recommended to guide financing decisions with regards to international health targets (Haakenstad et al. 2018).

3.2. Macroeconomic and fiscal constraints

The table below gives an overview on the macroeconomic and fiscal perspectives.

Table 3: Macro economic and fiscal projections 2016 -2030, in 10^6 MTS and %

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
GDP(Nominal)	761	843	906	970	989	1058	1175	1364	1464	1635	1798	2163	2572	2953	3392
Tax Revenue / GDP	22%	25%	24%	29%	24%	25%	24%	24%	27%	27%	27%	27%	26%	26%	25%
Total Revenue	166	213	213	277	235	266	286	326	391	442	493	574	671	762	865
Total Expenditure -	221	247	290	314	354	362	428	460	440	462	491	542	590	646	708
Total Expenditure / GDP	29%	29%	32%	32%	36%	34%	36%	34%	30%	28%	27%	25%	23%	22%	21%
Aid and Credits	27	31	34	27	35	34	37	37							
Total Expenditure domestic component	194	216	256	286	320	328	391	423							

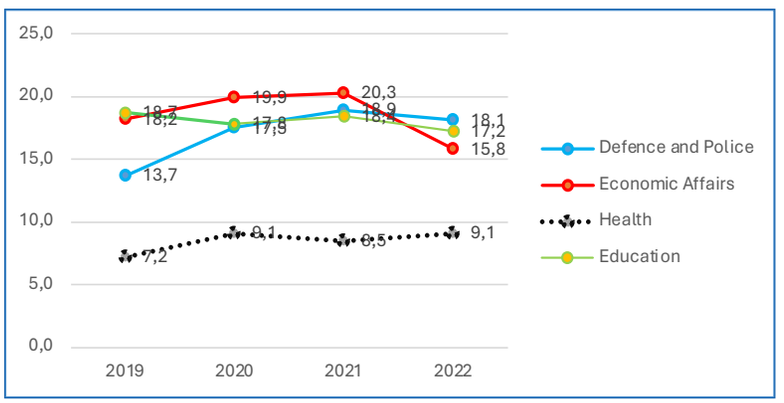
Source: GoM (2024: table 1)

From a HSF perspective, it is worthwhile to note two assumptions reflected in the table. Firstly, the revenue collected as a percentage of GDP is projected to remain constant at around 25,5% on average for the ten-year period 2020 – 2030. Secondly, the ratio between public expenditure and GDP is decreasing. In other words, there is a somewhat pessimistic perspective on the dynamics of fiscal space for expenditure financing in general.

13. The most recent target is USD 112 per capita.

What does this mean for health sector in relation to other functions for which the state is responsible? The Figure below shows the health expenditure (both recurrent and capital) as a percentage of total recurrent expenditure, compared to selected other key areas of state intervention.

Figure 1: Expenditure (executed), by selected functions as % of Total, 2019 – 2022, in %



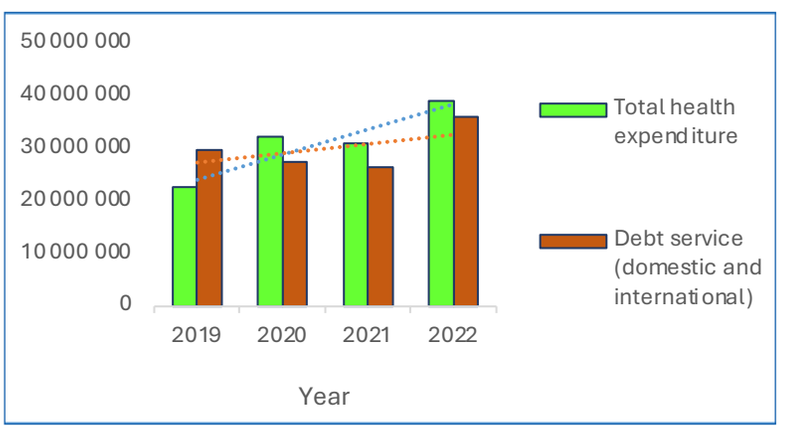
Source: author, based on CGE data. NB: data for health include own source and non-fiscal revenue.

This comparison shows how the health sector fares against other critical areas in terms of state budget allocation, providing a clearer picture of the prioritization of health within the overall fiscal policy framework.

A look at selected aspects related to economic, fiscal and poverty dynamics and constraints to growth may provide some clues for justifying this perspective:

- A marked decrease of GDP growth rate occurred between 2016 -2019, dropping from an average of 8 % (1993 -2015) to 3%. This was followed by a slow increase to 4 % up to 2023. This decline, combined with the simultaneous strong (urban) population growth rate of over 3% per annum led to a decrease in per capita GDP.
- A projected stagnation of economic growth for the rest of the present decade at about 4% per annum under the assumption that revenue production from liquified natural gas (LNG) continues to be further delayed.
- The increase of monetary and multidimensional poverty after 2015 by around 7%, resulting in a poverty rate of 55% (as compared to the 48% before that period). The Centre and North of the country are more affected than the South, with stark inequalities between urban and semiurban areas.
- Fragilization of the contracting economy between 2016 and 2021 by the effects of the hidden debt crisis, and it's devastating economic and fiscal knock-on effects (Cortez et al. 2021), as well as the decrease in foreign assistance. Additionally, the country faced the Covid-19 pandemic and several cyclones that devastated coastal parts of Mozambique.
- The intensification of the war against insurgence in Cabo Delgado province associated with rising spending on defence, security and law and order (see also Figure 1 above).
- Increasing external and domestic indebtedness for financing the budget deficit: between 2014 and 2021 the Debt-to-GDP ratio increased from around 65% to more than 100%. However, as the figure 2 shows, expenditure for health showed a certain degree of fiscal protection with a tendency to grow more than expenditure for debt service;

Figure 2: Expenditure for health vs debt service, in 10^3 MT



Source: author, based on CGE data

- Increasing indebtedness, however, not only meant increasing the fiscal and budgetary stress but also crowding out the private sector from access to credit. This has a negative knock-on effects for private sector driven economic activity, employment and growth, suffering already from reduced turnover and a high tax burden;
- The impact on revenue potential and health finance of the continuing downward trend in business turnover, business confidence, employment and earned incomes. This is observed by INE's monthly bulletins in 2021 (INE, 2021, 2021a), and it is likely to intensify the informalization of the economy and tax evasion.
- Associated with this, the general perception by industry and various business organizations is that the taxation levels and the cumulative tax burden for business of 36,1% of profit is extremely high for a developing country and, in comparison with the region, it negatively affects competitiveness, investment and production (CTA, 2022).
- Approved in August 2022, the Package of Measures to Accelerate Economic Development (PAE) provides fiscal incentives to promote growth, introduces measures for reducing bureaucracy and simplifying procedures, and seeks to increase efficiency and effectiveness of national and subnational authorities. At least in the short run, this has led to lower tax returns.
- Although Mozambique's investment potential is high, an unfavourable business climate together with a lack of transparency in government procurement, elite capture and slowness in government decision-making can delay or even abort projects of sustainable private and public investment for economic growth in the non-extractive sectors. In addition, according to the Basle Institute of Governance, Mozambique has one of the world's highest money laundering and terrorist financing risk. The Financial Action Task Force (FATF) has 'grey listed' the country. The government, the Central Bank and other institutions are undertaking efforts to meet FATF standards to curtail low rankings of creditworthiness and increase attraction for investment (outside the extractive sector).
- The IMF is particularly concerned about the unsustainability of the salary bill in the public sector which corresponds to approx. 73% of domestic tax revenue. This starkly limits the fiscal means available for diversifying the economy, for social investment, including in health, as well as urban infrastructure investment. in May 2024, an IMF mission stressed the need for fiscal consolidation 'necessary to secure fiscal and debt sustainability and preserve macroeconomic stability'

A more 'optimistic' perspective 'is related to assumptions on growth driven by the extractive industries and investment in associated forward and backward linkages, notably infrastructure. The African Development Bank (AFDB) projects the GDP growth rate to increase from 4.8% in 2023 to 8.3% in 2024, pushed by extractives and agriculture, leading the GDP per capita growth to jump from 2.0% in 2023 to 5.5% in 2024. However, for different reasons, in the early 2020s, major investments in natural resource extraction (heavy sands, precious stones, natural gas, etc., have only been marginally able to mitigate the economic and fiscal pressures, with less than expected revenue flows coming from the export of gas from the offshore floating liquification plant Coral South of the Cabo Delgado coast, which only kicked in in the first half of 2023. The US$ 20 billion investment in the onshore natural gas project in Palma / Cabo Delgado, led by TotalEnergies, was interrupted in April 2021 due to force majeure. Some first steps have been taken to recommence construction of the LNG plant in Palma, while waiting for a further improvement of the social and security situation which requires an increased budget allocation.

On the horizon of the macroeconomic and fiscal landscape, there is also a pressing need for massive resource mobilization to mitigate the effects of climate change. Mozambique is recognized as one of the ten most affected countries worldwide by climate change impacts. The government's ambitious National Climate Change Adaptation and Mitigation Strategy 2013–2025 is the main instrument to address climate change. The required financial resources for the period 2020 - 2030 is equivalent to more than US$ 50 bn, which is three times the GDP of the country. The AFDB concludes that 'given the financial gap, it is critical for the government to emphasize private investment, particularly on the green growth front, with low-carbon energy, agriculture, and climate resilient infrastructure and insurance schemes to meet its goals' (AFDB, 2023).

3.3. Distribution issues

Health sector financing intersects politically sensitive distributional issues related to income and fiscal burden. The question is: Which social classes benefit most from and are most interested in health financing, and which are overlooked? Or, in terms of fiscal sociology: which social classes and strata carry the major tax burden for sustaining a health sector for all citizens, and which are the net beneficiaries? Are pro-poor health policies and tariffs supported by higher income groups?

In terms of fiscal sociology, the distribution of the tax burden and the benefits derived from health sector services vary among different social classes and strata. Typically, higher income groups contribute a larger share of taxes and other financial contributions that sustain the health sector for the entire population. They often bear a significant portion of the fiscal burden through income taxes, corporate taxes, and other levies. Conversely, lower income groups may contribute less in direct taxes but tend to benefit more from public health services due to their higher utilization rates. This group relies heavily on subsidized or free health services provided by the government.

Pro-poor health policies and tariffs aim to ensure that health services are accessible and affordable for disadvantaged groups. However, the support for such policies among higher income groups can vary. Some higher income groups may support pro-poor health policies as part of broader social responsibility and solidarity. Others may oppose such policies if they perceive them as disproportionately benefiting lower income groups at their expense, or if they prefer a more privatized health system where they can access higher quality services through private providers.

Health sector financing involves complex dynamics of taxation, benefit distribution, and societal perceptions of fairness and equity. Understanding these dynamics is crucial for designing effective health financing policies that balance the needs of different social classes while promoting equitable access to healthcare services.

The former Minister of Health, a medical practitioner, does not mince his words when he insinuates that access to good health services in Mozambique is a matter of class and money. He argues that 'the deficiencies and inefficiencies of the health sector in Mozambique are largely due to the fact that the institutions that influence the health sector are controlled by a minority of privileged individuals who do not give the appropriate priority to the basic health needs of the majority of the population' (Garrido, 2020: abstract). His assertion highlights systemic inequalities where those with greater socio-economic status have disproportionate influence over health sector policies and resource allocation, potentially neglecting the healthcare needs of the broader population.

Income and wealth distribution, as measured by the Gini index, has become more skewed in favour of a smaller, wealthier segment of households, rising from 0,47 in 2009 to 0,52 in 2019. The Mozambican fiscal system is partly causing these dynamics of impoverishment. Although it is progressive and may contribute to reducing inequality, e.g. via in-kind transfers in primary education, it clearly increases monetary poverty via indirect taxes (VAT) and customs duties (World Bank, 2023). This does not mean that direct taxes, notably the Personal Income Tax IRPS and the Simplified Tax for Small taxpayers (ISPC), do not contribute to increased poverty. However, the effect is less palpable, since these taxes are progressive, and many poor people escape taxation by becoming part of the informal sector. According to this World Bank's Fiscal Incidence study, 'fiscal impoverishment indicators' show that 96% of poor individuals (at consumable income) became poor due to the combination of taxes and [cashable] transfers '(ibid: 98).

There are two main issues highlighted by the recent household income survey (INE, 2021). First, there is a discrepancy between, the substantial increase in household expenditure on health services and, the low and declining levels of available household income, particularly among the poor in many parts of the country. Secondly, there is a need to review and improve the fiscal system to mitigate the impoverishing effects on the population's disposable income and their capacity to pay for health services.

This situation raises, among others, the question of the feasibility of raising user fees for financing health service, as proposed in the HSFS document. We tend to agree with the considerations of the authors of the World Bank poverty

assessment study, who suggest that '[...] to offset the impoverishing effects of the tax system, the Mozambican social protection system should be strengthened in terms of coverage and generosity of the main social protection programs' (WB, 2023: 99).

Finally, the health sector has evolved into what one may call a 'stage of class struggles'. On one side, the government contends with medical and paramedical staff over the distribution of scarce public resources for and within the sector, often at the expense of Mozambicans who seek medical care. The primary focus of contention lies in issues of remuneration and investment, both necessary for improving productivity, efficiency and quality of public health services. Unionised health professionals justified the recent series of strikes by claiming that agreements negotiated with the government in June and August 2023 on salaries, overtime remuneration, equipment shortages, and other issues have not been honoured. The Ministry of Health (MISAU) insists that these issues may be resolved through further negotiations. By the end of May 2024, the strike was suspended because government agreed to open a door for negotiations, and not because the demands were met. In other words, as long as negotiations continue, the strike is suspended. The eventual outcome of the negotiations will certainly affect the redistribution of scare public resources within the sector amidst a clearly constrained fiscal space for HSF.

Consequently, MISAU and government may face here a policy dilemma, known as the 'Korpi and Palme paradox of redistribution' (Korpi and Palme, 1998). This paradox suggests that as efforts focus more on redistributing health benefits to poorer segments of society, wealthier income groups become less willing to contribute through taxes and social insurance, thus jeopardizing redistributive justice.

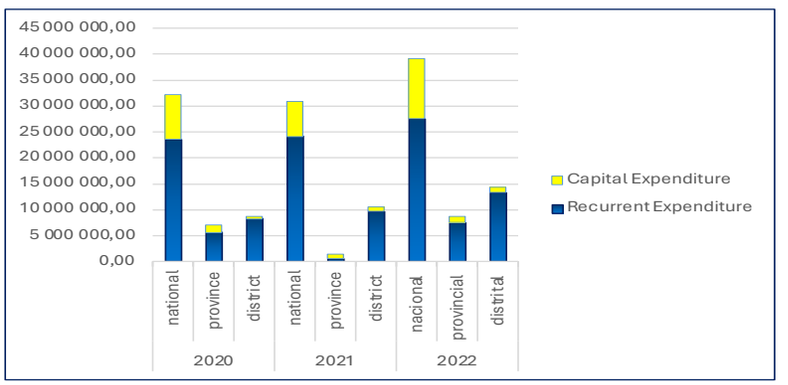
The delicate 'class coalition' of interests that has sustained the SNS may be at risk of disintegrating. On the one hand, wealthier strata of society who have the option of out-of-pocket payments in private clinics in Mozambique and abroad may reject increased taxation for public health services. On the other hand, the much larger, poorer strata of society may avoid utilizing health facilities due to their inability to afford current fees, despite the availability of reasonable quality services (OCS, 2022).

3.4. Health Sector decentralization

In the context of fiscal space analysis, the HSFS document stresses the need to monitor the macro-fiscal framework. It highlights the need for governance and management aligned with administrative and financial decentralization laws, aiming to reduce territorial inequities in resource allocation and to identify opportunities for financing the health sector.

The distribution of health expenditure by tiers of government is given in the Figure below.

Figure 3: Health expenditure (executed), by tier of government, 2020 -2022 (in 10^3 MT)



Source: author, based on CGE data; Please note provincial data for 2021- only for OGDP available

The figure shows the predominance of recurrent expenditure (including salaries) at national level with an increasing tendency. At national level is also where the share of capital expenditure is highest in relation to total expenditure.

About half of the annual budget is spent on the major hospitals and CMAM (the Central Warehouse for Medicine and Medical Products), all based in Maputo. Of course, CMAM provides services for the whole country, as does, to a large extent, the Maputo Central Hospital (HCM), e.g. in the case of oncology. Weimer and Carrilho (2017: 156) demonstrated that the Maputo-based institutions receive more than the sum of all the budgets allocated at both province and district level i.e. for general, district and rural hospitals. These central institutions account for two-thirds of the investment in the National Health Service. Moreover, approximately 90% of provincial and district spending is allocated to recurrent expenditure, with hardly any (domestic) capital investment.

Taking decentralization of the health sector as a serious step toward UHC (Garrido, 2022), would require radical restructuring of the health budget in favour of the public component of the Primary Health Care, Maternal and Child Health and preventive medicine at subnational level. According to Garrido (2022), at least 50% of the government's health expenditure would need to be allocated to districts and 25% to PHC. Additional funding would also have to be mobilized for capital expenditure (investment) in construction and rehabilitation of health units including water supplies and in equipment. In over 70% of the 154 districts, there is no hospital with an x-ray machine and/or a laboratory and/or an operating theatre. At the same time, over 40% of the districts do not have a pharmacy, either public or private (Garrido 2022: 18).

Although decentralization is one of the two strategic pillars of the PESS, little has been done in practice to operationalize this goal. In fact, the legislation governing municipalities foresees that PHC and primary education should be entirely a responsibility of the municipalities. This includes transferring those functions, along with the necessary human and fiscal resources to them, in line with Decree 22/2006. However, despite requests by several municipal councils, in line with Decree 33/ 2006, no meaningful decentralization in the sense of devolution of authority, powers and resources has taken place. It has been argued the central government wants to retain control of fiscal resources and the prerogative of holding tenders for the construction of health units at the central level. This centralization also extends to human resources, for reasons beyond the technical aspects, but related to the political economy of rent-seeking and maintaining a clientelist system. This approach is at the cost of a healthier and more effective SNS that could better serve the population (Weimer, 2021, Potenciar, 2021).

Even worse, the implementation of the new Decentralization Paradigm (Impissa, 2000) following the 2028 constitution review has fragmented the SNS even more. Not only is the responsibility for PHC now also attributed to the OGDP (for non-municipal areas), but it also has triggered a practical split of responsibilities, resources and technical competence between the Serviços Províncias de Saúde (SPS) under the deconcentrated Representação do Estado (REP) and the Direcção Provincial de Saúde, (DPS) under the devolved OGDP. Since both entities need staff, offices, vehicles and equipment, the politically driven budget priorities are predominantly focused on recurrent expenditure (funcionamento) with hardly anything allocated for capital expenditure. This has further weakened and underfunded an already fragmented sector and has limited its capacity to boost the primary health care services (CPS) at sub-provincial level and in the periphery, where they are most critically needed.

A HSFS within the framework of the PESS cannot ignore the crucial issue of decentralization, as it currently does. To visualize change and improve the existing HSFS draft document, we suggest two key measures:

The first is about enhanced integration of decentralization strategies. It follows Garrido's advice to look at on the experience of other countries that made advances in political and administrative decentralization, introducing changes to the structure and operation of the public health sector. Uganda comes to mind first, where the government has begun implementing reforms of the minimum health care package, emphasizing improved resource flows to health facilities at sub-national tiers of service, including through performance-based financing (PBF) projects linked to service quality, in which health units receive direct funding from both the government budget and development partners (Ekirapa-Kiracho et al, 2022). Another illustrative example is Tanzania, where health policy and financing are tailored to support the country's highly decentralized health system. They are anchored by the President's Office for Regional Administration and Local Government (PO-RALG), which is responsible for coordinating, facilitating and managing the implementation of the strategic plan through local government authorities at council, ward, village and community levels. The Local Government Authorities (LGAs) are responsible for managing and providing PHC services. The resources for HSF come from government fiscal revenue, donor contributions and to some extent from an emerging health insurance scheme. Additionally, Tanzania employs a performance-based financing model, often referred to as 'pay-for-performance', which incentivizes healthcare providers based on their performance in achieving predetermined health targets.

The second measure is to rediscover the value of transforming health units, particularly at sub-provincial level, into key actors with administrative and financial autonomy and reinforced administrative and management capacity. As Garrido has diagnosed, local health administrations (i.e. SDMAS) and health units use 'archaistic', outdated, pre-independence methods of management and administration, with the units utterly disassociated from planning, budgeting and administration of fiscal and human resources. Hence, a bold step toward decentralization of the sector would be to

bestow administrative and financial autonomy to the units themselves, as suggested by N´weti as well (Weimer, 2021a). This initiative could enforce their administrative capacity and give them access to resources via systems like e-sistafe and out-of-pocket payments of patients. Such a reform would strengthen the health units' capacity to provide basic services and improve performance under the leadership of a chief medical officer, seconded by competent staff transferred from entities like the SDMAS, or recruited from the labour market. This model, once well-tested, introduced and monitored, could also help simplifying and improving the generation, administration and accountability of own sources of revenue, a topic revisited in section 4.3.6.

3.5. Conclusion

In conclusion, and drawing on the HSFS paper, the major challenges facing the SNS and particularly PHC can be summarized as follows (Garrido, 2020, GoM, 2024, GoM, 2024a):

- chronic malnutrition continues to persists affecting 37% of children under 5 years old;
- High infant (39%) and neonatal (24%) mortality rates;
- Reduction of communicable childhood diseases is notable, but major challenges are still observed concerning HIV/ AIDS, Malaria and Tuberculosis and the increasing prevalence of non-communicable diseases (high blood pressure, diabetes, different kind of cancers), and consequences of excessive consumption of alcohol, tobacco and drugs;
- limited access to and quality of health services
- insufficient coverage of PHC services.
- widespread users' dissatisfaction with health services due to long waiting times, lack of essential medicines, corruption in access to health services and generally perceived low quality of services;
- Chronic underfunding of the health sector;
- Limited availability of health staff
- Underequipped health units;
- Continued high dependence on external funding, especially on vertical programmes;
- inefficiencies in the allocation and transparent use of the scarce available resources;
- lack of affordable access to quality health services for the poorer part of the population;
- limited coverage of SNS, especially in rural areas and in the northern provinces, together with lack of progress in health sector decentralization;
- marginal role of the private health sector, concentrated on the secondary level of health service.

Taken together these factors show the precariousness of the sector (Garrido) and cause structural limits of the allocation efficiency and distribution of financial resources and an outright fragmentation of the SNS, which in turn jeopardize the sustainability of the health sector (PESS, 2021: p. 44). Unless the budget for health is considerably increased, it may not be able to address these challenges and make progress towards UHC. There is clearly a need for major capital investments in the construction and equipment of health units (particularly in peripheral areas and at secondary, tertiary and quartery level), more recruitment and retention of staff, and improvement of their working conditions.

The HSFS is instrumental in stimulating the Government's 'commitment to a significant annual increase in internal resources'. This commitment - aims to address the sector's needs in the coming years, considering the demographic and epidemiological transition, emerging health needs, and the global context of the country's economic growth (GDP) together alongside its tax policy (PESS, 2021: p. 23, emphasis by author). Exploring and utilizing the fiscal space is an integral part of this effort.

4. MAPPING MOZAMBIQUE'S FISCAL SPACE

4.1. The Mozambican fiscal system

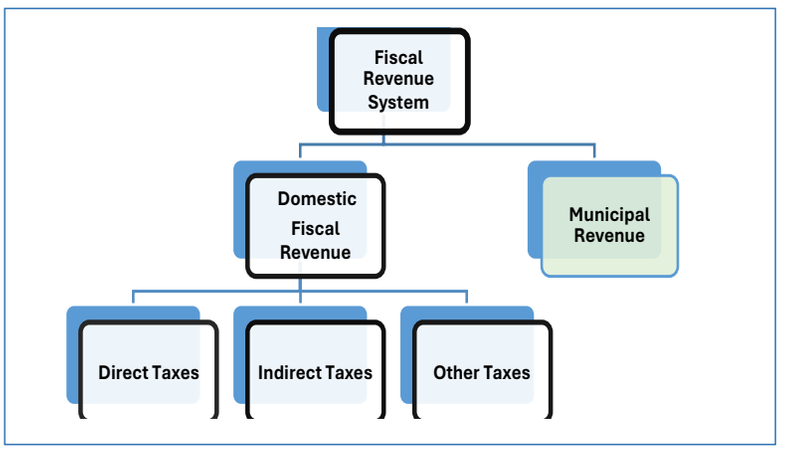
Before we analyze the selected components of Mozambique's fiscal space, we provide the reader with a brief overview of the Mozambican fiscal system. This system is illustrated in a simplified way in the figure 4 below. We assume that the full utilization of the potential revenue sources, minus tax exceptions, defines the fiscal space of the country.

According to Heller (2005), other factors which limit or enhance the fiscal space are, the tax base and tax potential of the country. A comparative study of Southern African countries on this matter, indicates that "financial deepening, economic development and trade openness influence tax capacity, while corruption and inflation influence tax effort" (Chigome & Robinson, 2021). In the case of Mozambique, the tax ratio (i.e. the total tax revenue as a percentage of GDP) was approximately 25% of GDP in 2022. This ratio varies with the effort of collection and changes of macroeconomic data (growth, trade, prices for imports and exports of commodities, etc.). It is considered a robust ratio in comparison to other countries. In Mozambique fiscal revenue collection and management are largely in the hands of the Autoridade Tributária de Moçambique (ATM), which channels the proceeds to the National Directorate of Treasury and International Economic and Financial Cooperation (DNTCEF) in the Ministry of Economics and Finance (MEF).

It is important to distinguish between fiscal and non-fiscal sources of revenue. Fiscal revenues are taxes, which every citizen and business must pay, irrespective of what they expect and need in terms of public services provided by the state at various tiers of government. These revenues are not earmarked for use for predefined specific expenditures (principle of non-affectation); all revenue collected flows into a pool, from where resources are used to plan and budget government expenditure. An exception to this rule is conditioned revenues, such in the case of ICE (see section 4.2.3). This is different from non-fiscal revenue sources. Non-fiscal revenue sources consist of payments to a government entity by the user, in exchange for a service bought or used by the citizen. These payments, in the form as levies and fees (user fees), are charged in direct correlation to a service, document or licence acquired by the citizen or a company. This is also the case in the health sector for the purchase of certain services.

The following Figure and listings illustrate the tax system in a simplified form.

Figure 4: Mozambique's Fiscal System – an overview



Source: author

The Direct Taxes are:

a) Personal Income Tax (IRPS).

b) Business / corporate Income Tax (IRPC[14]).

c) Simplified Tax for Small Taxpayers (ISPC);

d) Gambling Tax (partially reverting to municipalities hosting casinos)

e) Head or Poll tax, termed Imposto de Reconstrução Nacional (IRN), which is shared with districts and provinces)

f) Inheritance Tax (ISD[15])

g) Stamp tax (IS[16])

14. Imposto sobre o Rendimento das Pessoas Colectivas
15. Imposto sobre Sucessões e Doações
16. Imposto de Selo

The Indirect Taxes are:

a) Value-added tax VAT (IVA)

b) Customs and excise duties

c) Special consumption Tax (ICE[17])

The other taxes are linked to the extractive industries and include

a) Mining Resource Income Tax (IRRM[18])

b) Mining Production Tax (IPM[19])

c) Petroleum Production Tax (IPP[20])

d) Surface Tax (ISS[21])

In this study we focus on fiscal revenue only, both direct and indirect taxes, leaving aside the municipal tax system. We also do not consider non-fiscal sources of revenue, except for user fees generated in the health sector.

4.2. Fiscal Space Analysis, by component

As stated in the previews paragraphs, Heller (2005) defines 'fiscal space' as the "availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position" (cited by Cheng & Pitterle, 2018: 3). Always related to a mid-term perspective, this space is circumscribed by country-specific macroeconomic determinants such as domestic macroeconomic conditions, the fiscal situation, revenue and expenditure structure, debt structure and external economic environment. A more dynamic understanding of the term would look at a country's potential to expand its own financing capacity. From this perspective, fiscal space would mean "financing that is available to a government because of concrete policy actions for enhancing resource mobilization, and the reforms necessary to secure the enabling governance, institutional and economic environment for these policy actions to be effective, for a specified set of development objectives" such as UHC (Roy, 2009, cited by Cheng & Pitterle, 2018: 3).

17. Imposto sobre Consumo Especial
18. Impostos sobre a Renda de Recurso Mineiro
19. Imposto sobre a Produção Mineira
20. Imposto sobre a Produção de Petróleo
21. Imposto sobre Superfície

4.2.1. Macroeconomic growth

A World Bank study concludes that the major determinant of fiscal space is the growth rate of a country's GDP (Tandon et al., 2018). As noted in the SWOT study associated with this report, the HSFS proposal does not address this issue in terms of fiscal scenarios of growth and their impact on health sector financing. However, this does not mean that the HSFS proposal ignores assumptions on growth in its arguments and data analysis. These assumptions are made implicitly rather than explicitly. An example of this is Table 1 in the HSFS document on macroeconomic projections. The authors of this table assume growth rates for the 5-year period 2025 – 2030 varying between 6,1 % for 2026 and 10,0% for 2030. For the purpose of updating HSFS document, it would be helpful to compare this scenario with alternative ones, moderate and more optimistic, in an exercise which focuses primarily on the economic sectors driving growth, notably agriculture, the tertiary sector and, above all, extractive industries.

Regarding macroeconomic and fiscal growth scenarios, it would be helpful and of added value to the document to consult the scenarios presented in the recently published National Development Strategy (ENDE) 2024 – 2044, particularly section 7.2 of Chapter VII (GoM 2024a). Regarding methodology, making the distinction between base scenario and alterative scenarios could enhance the analysis. A good example thereof is UNICEF's study on fiscal space in Mozambique (Karkare et al, 2019). By outlining various scenarios, the HSFS document can better assess the potential impact of different economic conditions on health sector financing, thereby offering more robust policy recommendations.

Scenario data can also be drawn from the Mid-Term Fiscal Scenario (CFMP) 2025 to 2027, approved by the government in June 2024. According to press reports, it foresees an inflow of tax revenue from the production and export of natural gas at the offshore Coral Sul LNG plant of 4,268 million meticais (€67.5 million), rising to 5,016 million meticais (€73.2 million) in 2025 and to 4,795 million Meticais (€ 79.5 million) in 2027, corresponding to 0,27% of the country's GDP[22].

On the basis of and aligned with the CFMP, MISAU could develop a Medium-Term Health Action and Finance Plan (MTHAFP), as suggested by N'weti (2023) and others. A more collaborative action between MEF's - Direcção Nacional de

22. https://clubofmozambique.com/news/mozambique-tax-revenue-from-gas-estimated-at-e75-2m-per-year-up-until-2027-260123/

Políticas Económicas e Desenvolvimento (DNPED) and MISAU could be mutually beneficial, since this MEF directorate is not only responsible for elaboration of the CFMD, but also for fiscal analysis, forecasting and programming financial resources for the sectors, taking into account macroeconomic and demographic trends. Together with comprehensive and regularly updated data bases, this is a precondition for strategic planning and financing also in the health sector (Alebachew et al. 2023).

According to the World Bank (2021:15), strengthening the medium-term fiscal framework in Mozambique is vital also for another reason: the upcoming resource revenue windfall, which is the anticipated influx of revenue from natural resource exploitation. In this context, the Sovereign Wealth Fund (SWF), as a potential source of HSF, needs to be considered in growth scenarios of the fiscal space. Its underlying legislation was enacted in December 2023[23]. In line with the CFMP 2025 to 2027, the government plans to transfer, on average, 2.103 billion meticais (32.9 million dollars) annually to the SWF, until 2027[24].

The SWF's aims to channel resources from the production and export of fossil energy, notably Liquified Natural Gas (LNG), into the state budget through a phased process. This approach is forward-looking and strategically designed to ensure sustainable economic benefits. The SWF has two primary objectives:

a) accumulation of savings by maximizing the value of the fund with a view to ensure that revenues from non-renewable natural resources are invested and shared between several generations, and

b) to contribute to fiscal stabilization, with a view to isolating the budget and the economy from the harmful impacts resulting from fluctuations in commodity prices on international markets.

By achieving these objectives, the SWF can play a crucial role in enhancing Mozambique's fiscal stability and economic resilience, ultimately contributing to sustainable development and improved public services.

The management and application of SWF money is via the PESOE, i.e. through the State Budget, to finance domestic investments in priority areas, which will maximize long-term returns to the economy and society. One might argue that investing in UHC and substantially improving the PHC services and facilities, particularly in the periphery, represents a critical economic and social investment priority for all Mozambicans including future generations.

4.2.2. Domestic Revenue

Tax revenue is a major determinant of progress towards UHC. Reeves et al. (2015) found that in countries with low tax revenues, an additional US$ 100 tax revenue per year substantially increases the proportion of births attended by a skilled health professional. This effect is more pronounced when direct taxes on capital gains, profits and income are preferred over indirect taxes such as value added tax (VAT), with their regressive effects. These authors conclude that increasing domestic tax revenues within a pro-poor framework is instrumental in achieving UHC.

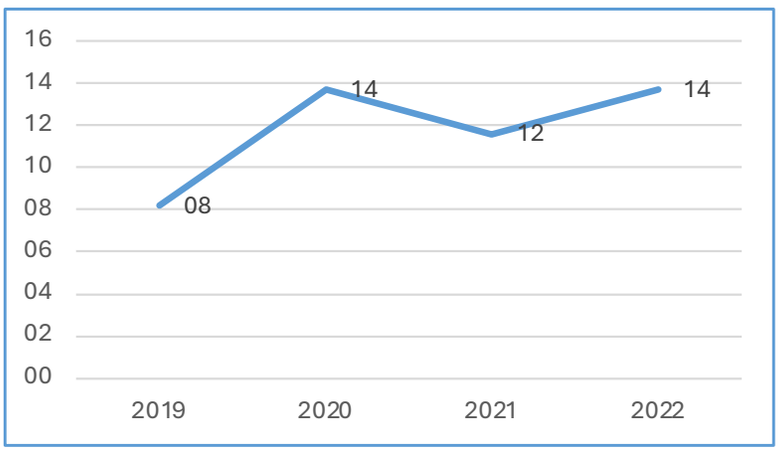
In Mozambique, the main domestic sources of fiscal revenue available for financing the Annual Economic and Social Plan and Budget (PESOE[25]), including health and other public services, are those collected nationally via the ATM. This is on the basis of the existing tax system, which was described above, whose main sources are the Personal Income Tax (IRPS), the Corporate Tax (IRPC) and the Value Added Tax (IVA), as well as revenue from customs and excise taxes.

The figure below shows the share of total government expenditure as a percentage of the total domestic revenue. It confirms the trend shown for health expenditure in Figure 1 above.

23. Lei n.º 1/2024, de 9 de janeiro
24. https://clubofmozambique.com/news/mozambique-allocates-32-9-million-a-year-to-sovereign-fund-in-2025-27-scenario-260230/ te

25. Plano Económico e Social e Orçamento do Estado

Figure 5: Health expenditure as % of Total Domestic Revenue, 2019 - 2022



Source: Author, based on CGE data

Increasing the fiscal space provided by domestic fiscal revenue for HSF towards achieving UHC implies, among other measures, to increase the share of health expenditure in relation to the total revenue. With reference to Garrido (2022) and other authors we suggest setting, by legislation, an annually increasing funding target, in the form of a percentage of one or the other fiscal revenue sources, earmarked for the public health sector. This measure should be also informed by the population growth rate so that per capita spending of fiscal resources increases substantially in order to meet the US$ 86 per capita international goal. This a priori condition for HSF planning and budgeting may also be associated with a change of priorities in the health budget so that at least 50% of the government's health expenditure is allocated to districts and 25% to PHC, thus supporting the strategic goal of sectoral decentralization. (Garrido, 2020: 28f).

Examples from other African countries are encouraging. Earmarking of a certain percentage of domestic fiscal resources may be combined with additional measurers, as suggested above. For example, Ghana's HSFS is operationalized by a specific Health Financing Dynamic Framework (Government of Ghana, 2015) and is intrinsically linked to the government's Sustainable Finance Framework, with its specific Sustainability-Linked Finance Framework (SLFF) (Government of Ghana, 2021). It translates the SDGs into national planning and budgeting priorities, including for the health sector. Ghana also provides national health insurance coverage for the labour force, including both formal- and informal-sector workers. This is partly financed through annual earmarked allocations to the health sector through a portion of the Value Added Tax (VAT), known as National Health Insurance Levy (NHIL) (SPARC, 2021, Scheiber et al, 2012). Maybe a closer look at the case of earmarking, from either VAT or the income taxes (IRPS and IRPC) for HSF could be part of the way forward for putting HSF on a more solid footing. Earmarking a percentage of VAT for HSF would certainly mitigate the negative impact on poverty caused by this tax, as identified earlier. This policy measure would reflect an effort to increase equity. This option would also be more advantageous, in comparison to raising health sector fees, which have distributional and regressive effects. It would also mitigate the challenge associated with collecting, administrating and accounting for user fees (see Section 4.2.6).

4.2.3. Specific earmarked revenue – 'Sin' Taxes

The HSFS document distinguishes between two types of specific revenue generated by government and allocated to the health sector as consigned part of its resources. The first type is the so called 'sin taxes'.

The Specific Consumption Tax (IEC) is applied, as the name suggests, on the consumption of certain goods at time of purchase. Items subject to this tax are perceived to be either morally suspect, harmful, or costly to society and the health of the population. Examples of 'sin taxes' include those on tobacco, alcohol, gambling, and sugary drinks or sugar-sweetened beverages (SSBs) (White & Wilson 2024). The rapidly spreading consumption of ultra-processed foods (UPF) is of major health concern; they are suspected to cause deficiencies of the immune system[26] and therefore, could be taxed. One could also consider taxing private sound systems to curb sound pollution as a public health hazard[27], as well as taxes to curb the negative effects on health posed by exaggerated use of plastic packaging[28] (WHO, 2022). Garrido (2020) also suggests considering taxes on luxury products like jewellery, cosmetics, perfume and locally bought airline tickets.

26. https://www.theguardian.com/society/2024/feb/28/ultra-processed-food-32-harmful-effects-health-review
27. According to WHO, noise can cause a number of short- and long-term health problems, such as for example sleep disturbance, cardiovascular effects, poorer work and school performance, hearing impairment, etc., affecting particularly children: https://www.who.int/europe/news-room/fact-sheets/item/noise
28. The increasing presence of micro plastic in the air, earth and water may cause serious health issues such as endocrine disruption, weight gain, insulin resistance, decreased reproductive health, and cancer.

The HSFS (GoM, 2024) recognizes, in principle, the health hazards posed by the sale and consumption of alcohol, tobacco, SSB and possibly the spread of micro plastic, and the need for taxing the respective products. It argues that the reduction of consumption via taxation would not only generate revenue earmarked for the health system, but, above all, lower the prevalence of health issues and diseases caused by these products, and, by extension, lower the cost of medical attendance and treatment. The net gains could be redirected to health financing.

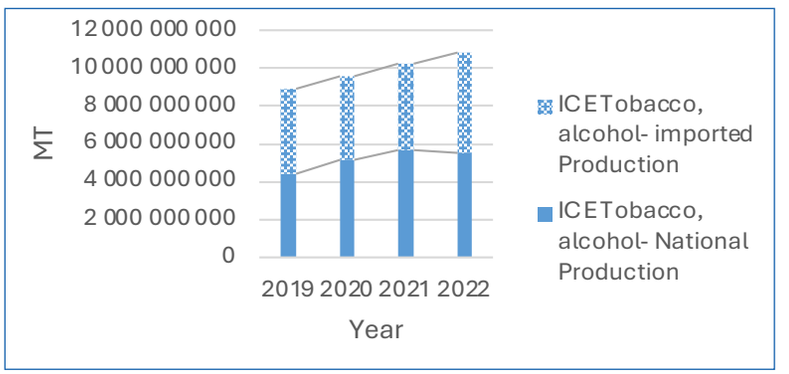
The document also states that 'MISAU will work with the MEF and the Tax Authority and other competent authorities to periodically modify the Specific Consumption Tax (ICE) and assign taxes to the health sector, along the following lines:

- Increase existing taxation on tobacco, alcohol and sugary drinks.
- Tax new products within ICE: Canned food products, processed meat.
- Introduce the allocation to health of health taxation and taxation of car insurance and other transport.
- Study the feasibility of taxing other products, such as ultra-processed food products, plastic packaging and contaminating economic sectors[29] (GoM, 2024, section 5.4.2).

From a legal point of view, the consumption of imported tobacco and alcoholic beverages and the importation and possession of luxury cars is taxed under a special regime, based on the law nº 17/2017 of 28 December (Código do Imposto sobre Consumo Especifico- ICE), and the Decree Nº 75 / 2019, of 16 Set. up to 2023. The revenue generated from the importation of tobacco and alcoholic beverage was part of general tax income, observing the general budget principle of no-affectation. This means that this type of revenue is part of the general revenue pool and not earmarked to financing a determined type of expenditure, in this case health. This rule was altered in May 2023, when the Executive decided to use these taxes to finance the general budget, the health sector, and the State Secretariat for Sports to the tune of 50 %, 35 % and 15 % of the yield, respectively[30].

The following figure gives the evolution of the ICE tax yield for the period 2019 -2020.

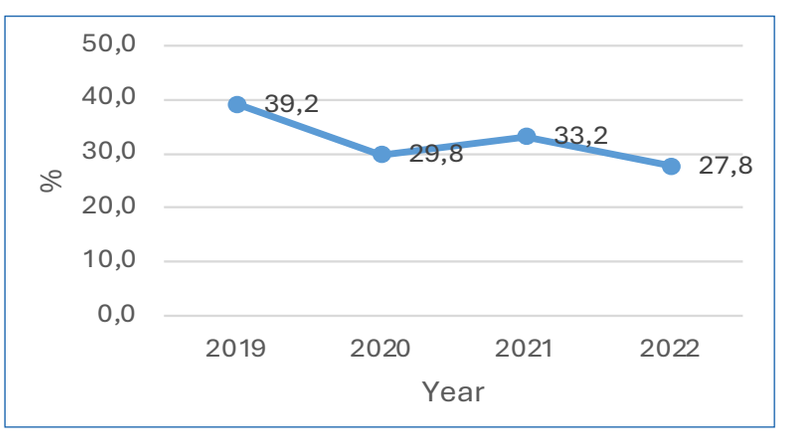
Figure 6: Revenue from ICE (tobacco and alcohol), 2019-2022, in MT



Source: author, based on CGE

As illustrated in the following figure, the ICE contribution to the health expenditure (both the import and the local production components), as registered in the CGE for the years under consideration, suggests that if the yield of collection is fully assigned to the health sector, it would still represent a staggering 33% of total health expenditure on average, despite its declining trend.

Figure 7: Total ICE revenue contribution to Health expenditure, 2019 – 2022, in %



Source: author, based on CGE

29. Emphasis by author. The meaning of this term is not clearly defined.
30. Decree N° 36/2023 of 27 June., which revokes the decree N° 75/2019.

To emphasise the significant potential of this type of consigned tax for public health in general and for HSF in particular, it seems consequent to consider widening its scope and including more of the aforementioned 'sin taxes' on substances and goods which increase health risks, notably UPF and SSB. The historic resolution of 2 March 2022, by heads of state, ministers of environment and other representatives of UN member states to forge a legally binding global agreement to ban the use of plastic by the end of 2024[31], represents a golden opportunity to extend taxation on plastic as an additional resource for HSF. Concerning the effectiveness of tax collection, this tax, which in essence is an indirect tax, could be part of the solution of a share of VAT, earmarked for health (see previous section).

However, fiscal arguments for the increased utilization of this fiscal space potential must be carefully weighed against political considerations, particularly regarding the regressive distributive nature of indirect taxes mentioned above. As the recent example of Kenya shows, the general public, and particularly the youth, are resistant to tax increases and their knock-on effects on prices for consumer goods and services amidst widespread poverty and unemployment. Urban groups' manifestations against such measures may lead to violence (Klaus, 2024). Given the distribution issues addressed in section 3.3 similar reactions cannot be ruled in the case of Mozambique.

More details on the mechanisms of how this tax is collected, accounted for and channelled to the Treasury department could not be retrieved within the framework of this study and its methodological and time constraints. It is up to the Working Group of representatives of MISAU, MEF and ATM proposed by the HSFS document to establish in detail the potential of this conditioned revenue, the mechanisms of its generation and administration, and the way the revenue reaches the sector which it is supposed to finance.

4.2.4. Medical and Medication Assistance (Assistência Médica e Medicamentosa – ASEM)

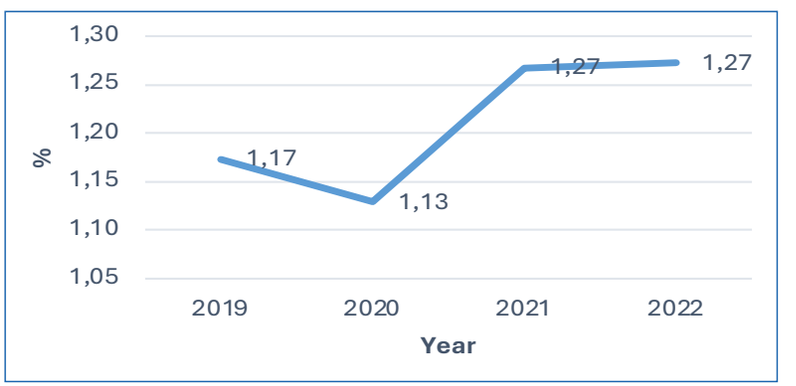
The medical and medication assistance[32] (ASEM) represents a consigned source of revenue for HSF, generated by levying the income of public servants and pensioners. The Decree N° 21/96 defines a mandatory contribution of 1.5% of the salary of approximately 368,000 'Public Servants and Agents of the State' [33] to contribute to medical expenses in the public sector, including family members. According to the HSFS document, the amounts collected are channelled directly to MISAU. In the period 2016-2023 this amount represented an average of 4.1% of internal fiscal resources and was mainly used to purchase medicines for the SNS. However, the analysis of the CGE data give the following picture of ASEM's evolution.

Figure 8: ASEM Total contributions, 2019 – 2022, in MT

Source: author based on CGE.

The table shows that the collection of ASEM has considerably increased during the years under observation, mostly as a result of salaries increase and the number of civil servants. The figure below gives the percentage of ASEM contributions in relation to total health expenditure.

Figure 9: ASEM as percentage of total health expenditures, 2019 - 2022



Source: author, based in CGE data

31. https://www.unep.org/news-and-stories/press-release/historic-day-campaign-beat-plastic-pollution-nations-commit-develop
32. Assistência Médica e Medicamentosa.
33. Other sources speak of an estimated at 500.000 active and 200.000 retired public servants (personal information.

Assuming the data is accurate, this table shows the contribution of ASEM to total health expenditure of an annual average of 1,2 %, which is quite modest. Reasonable doubts can be raised as to whether ASEM contributes to domestic revenue with 4,1% as stated by the HSFS document. It seems more likely that ASEM's contribution is significantly below 1%. There is clearly an issue of metrics to be clarified.

Further aspects merit consideration. The first is that covering the use of health services by civil servants and their family members via ASEM represents only a fraction of what is essentially a much wider mandatory social security system. ASEM is part of the Instituto Nacional de Previdência Social (INPS) for civil servants, whereas the Instituto Nacional de Segurança Social (INSS) caters for salaried workers and voluntary contributors and the Segurança Social Básica, administered by the Instituto Nacional de Acção Social (INAS), for vulnerable and handicapped persons without regular cash income.

Secondly, in the case of the INPS, only public servants and pensioners are covered by ASEM epitomized by the Cartão de Ajuda Médica e Medicamentosa issued to all eligible users. The respective legislation's main focus, however, is on pensions and not so much on health care [34]. The experience with the mandatory health care scheme for civil servants has not been encouraging. Recent reports[35] suggest that the financing capacity of INPS for the retired civil servants has, for various reasons, reached its limits, potentially jeopardising the monthly payments of pensions.

Thirdly, institutionally speaking, the health insurance part of the social security scheme does not seem to be well managed and transparent, from the point of view of the health care needs of the beneficiaries[36]. Finally, health care insurance in the public sector appears not to be institutionally firmly anchored, neither in INPS under the tutelage of MEF nor in National Directorate for Strategic Management of the State's Human Resources (DNGERHE[37]) in the Ministry of State Administration and Public Service (MAEFP).

A number of questions arise from our assessment regarding ASEM's contribution and modality to HSF:

a) Which are the actual numbers of contributors to and beneficiaries of the ASEM scheme?

b) Which is the exact scope and purpose of ASEM? Does it really and exclusively focus on health as the term suggests, or does it go beyond that and encompasses social security as a whole? Which is the ratio of distribution of collected revenue between health and other social security purposes?

c) Taking into account the statement in the HSFS draft 'this contribution does not represent a difference in the taxpayer's individual benefits[38]': Is ASEM's fiscal nature that of an additional tax (for public servants only) or a kind of scheme to levy fee payment of the civil servant (for an unspecified service)? Or is it a type of hybridization between a tax on a selected group of taxpayers (i.e. a source of fiscal revenue) and fee (non-fiscal revenue)?

d) How are ASEM's accounts managed and published by INPS and to which institution is INPS accountable? What is the institution of oversight?

e) How is the revenue collected transferred to the health sector? Directly, via the treasury department or any other institution?

f) How are those revenues considered in planning and budgeting for the health sector, what is being financed?

These questions remain to be addressed.

4.2.5. Financial contributions by private health insurance

The HSFS draft document gives some indication of the contribution of private voluntary health insurances to the total health expenditure, as per the percentages shown in the table below. According to the data, this contribution peaked in 2019. Unfortunately, there is no data available to show the evolution of that contribution and analyse the causes of the fluctuation.

34. Law 8/2021, of 30 December concerning the Sistema de Segurança Social Obrigatório de Funcionários do Estado (LESSOFE)
35. https://www.cipmoz.org/wp-content/uploads/2024/04/Insustentabilidade-do-fundo-de-pensoes.pdf
36. Personal information by a senior public servant
37. Direcção Nacional de Gestão Estratégica dos Recursos Humanos do Estado
38. Original: Esta contribuição não representa um diferencial nos benefícios individuais do contribuinte

Table 4: Contribution of private health insurance to health expenditure, in %

Year	Percentage
2015	7.0
2019	11.0
2020	9.0

Source: author based on GoM, 2024, Figure 2

It remains unclear whether those percentages relate to the whole SNS, encompassing both public and private health service providers, or if they apply to either one exclusively. In our assessment we assume that these figures reflect mostly the small segment of private health care providers whose clients are covered by health insurance. Car insurers also cover health costs in case of accidents and treatment of injuries, but hardly any data exists to permit an assessment in this regard.

As we have seen in Table 1, in the section 3.1., above, private health care providers most frequently operate in the secondary level of the SNS, and to a lesser extent at primary level, the latter predominantly the case in Maputo. The rise in both the number and coverage of health insurance companies is associated with the increasing numbers of private sector health units, particularly in the capital city, and in regions where there are extractive industries, major infrastructure investment and globally relevant tourism[39]. In other words, one may assume a positive correlation between economic development, growth and income generation on the one hand, and the spread of private clinics and health insurance on the other. Therefore, a careful assessment of the economic growth potential and scenarios is necessary to understand these dynamics more comprehensively, as proposed in section 4.2.1.

Private health insurers usually operate on a global and regional level. They usually cater for the needs of a minority of individuals, such as senior civil servants, senior staff of State-owned enterprises[40], employees of multinational companies, corporations and small and medium scale enterprises registered and operating in Mozambique, i.e. for a restricted number of beneficiaries with relative high income. With their exclusive focus on profitable private health care providers, one may doubt whether they are inclined to contribute to the financing of the public and communal health sector. Their focus tends to be on providing services to paying clients rather than investing in broader public health initiatives. This situation underscores the potential disparity in access to healthcare between those covered by private health insurance and the broader population relying on public and communal health services.

There is no systematic information on the – unregulated - private health care subsector and private health insurance companies, the institutional framework under which they operate, the dynamics of their evolution, the relationship between quality and price of services rendered, etc. It is, therefore, suggested to explore these matters further in the context of a separate study which would provide data and inputs to the process of finalizing the Mozambican HSFS document. Such a study also could include the cases of illegally operating health care providers such as the Instituto de Coração (ICOR), allegedly operating as an NGO to avoid paying taxes[41].

Looking beyond Mozambique, the introduction of a mandatory health insurance for all Mozambicans irrespective of their income continues to be on the policy agenda, especially under the premise of UHC. We do not know whether the team which elaborated the draft of the HSFS considered African countries with successful health insurance schemes. The case of Rwanda comes to mind, where any Rwandese must provide proof of being insured once approaching a health unit for medical examination or treatment. If the patient has no individual insurance, they must demonstrate to be part of a community-based health insurance scheme that will cover the payment of their user fee. Indeed, Rwanda stands out with having achieved high levels of population coverage through social protection systems, including via a mandatory health insurance that guarantees access to healthcare services for all citizens. Its HSFS (Republic of Rwanda,2019) is underpinned by a specific Health Financing Sustainability Policy which introduces performance-based planning and budgeting at the level of health facilities for achieving specific targets (Republic of Rwanda, 2015). This financing instrument complements annual government budget allocations, financing via a community-based health insurance (CBHI), and payments via the Rwanda Social Security Board (RSSB) scheme for public- and private-sector workers and for pensioners (SPARC ,2021a).

39. Vilanculos, a global tourism destination and a central place for social and commercial Infrastructure for the extractive fossil energy industries in the adjacent Inhassoro district, may serve as an anecdotal example: within the last seven years, at least three private clinics sprang up.
40. i.e. and members of the national economic and political elite

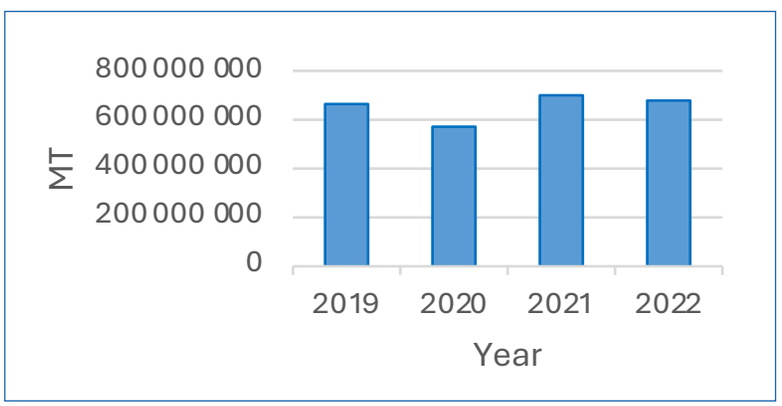
41.. https://cddmoz.org/wp-content/uploads/2020/07/Instituto-do-Coracao-nao-paga-impostos-ao-Estado-alegadamente-porque-cuida-da-saude-de-criancas-provenientes-das-camadas-mais-carenciadas-da-populacao-mocambicana-.pdf

4.2.6. Non–Fiscal Own source revenue (OSR) – user fees

As we have seen in Section 4.1., user fees for patients are part of the earmarked non-fiscal revenue of the health sector. This service acquired may be a special examination, treatment, admission to a ward, prescription of medicine, issuing of a medical certificate or provision of a 'specialized' service sometimes referred as Serviço de Atendimento Personalizado (SAP)[42], for which often a 'moderating fee' (taxa moderadora) is charged when the service meets certain quality standards.

It is difficult to ascertain the total annual yield of this non-fiscal own-source revenue (OSR) in the health sector, both in absolute terms and in relation to the total expenditure of the sector. The Conta Geral do Estado (CGE) where this revenue should be registered, provides incoherent information, if any at all. The only exception is the Hospital Central de Maputo (HCM), whose received user fees are shown in the Figure 10 below. This lack of comprehensive data across the sector makes it difficult to assess the overall financial impact of non-fiscal OSR on healthcare financing in Mozambique.

Figure 10: HCM Fees Revenue, 2019 - 2022, in MT



Source: author, on the basis of CGE data

Regarding overall contribution of non-fiscal revenue to health financing from domestic sources, the HSFS document estimates, based on e-sistafe data, that this contribution averages 0.6% annually for the period 2016 – 2023 (GoM, 2024: Figure 7). This suggests that non-fiscal revenue sources play a modest role in financing healthcare services in Mozambique, at least during this period.

We would argue that this is a gross underestimation, for two main reasons.

The first reason is the mechanism by which the user fees are defined, communicated, collected, administrated, accounted for and transferred to the health sector. This mechanism is complex, highly bureaucratic, involves many steps and actors and lacks transparency. Formally this process has not less than 14 phases, summarized below[43]:

- The line ministry, i.e. MISAU, annually defines the fee rates – not in a very transparent way- and decides the way that the generated resources are distributed within the sector, i.e. between provincial and district level. These instructions are annually communicated by the MEF to all tiers on subnational government via a circular letter.
- Theoretically, the health sector user fees (together with the consigned OSR of other sectors and, in case of non-payment, the associated fines) must be recorded in the province's or district's Codigo de Postura e Foral[44], a type of local charter (or statutes) which should be publicly available for the users, e.g. at the level of health units. This is rarely the case.
- At the health unit, e.g. at a district hospital, the user fees are collected by the district administration or the SDSMAS, and deposited in a specific bank account. The 'saldo' (or remainder) of the amount is transferred to the delegation of the ATM´s Fiscal Area to which the district belongs no later than the 10th day of each month. Completing a Form 51 (by the ATM, Fiscal Area Office) and a Model B (by the district Administration) are necessary bureaucratic procedures. A PFM management system for district non-fiscal OSR developed in 2004, the Sistema de Registo e Controlo de Receitas (SISRECORE), is not used any more besides in few provinces such as Nampula; but still in a highly inconsistent way (Vasquez, 2023).
- The ATM's role is essentially limited to receiving the collected amounts of OSR and channel them to the national treasury[45], transmitted to the National Directorate of Treasury (DNT) at MEF in Maputo.

42. A common example is to deliver childbirth a SNS maternity ward under a special regime, in which the obstetrician, gynaecologist or midwife charge a pregnant woman a fee for all inclusive services, including transport of to and from hospital, delivery of the baby, (often via CS) and even registration of the birth with the authorities. This is usually not in line with rules and regulations and the principle of equal treatment for all. it is doubtful whether this fee accrues to the health unit.

43. See EITI, 2023, p. 150.
44. Code of Postures and Charters
45. The procedures to be followed are also defined in the Circular n° 01/GAB-MF/2010, de 06 de Maio

- The MEF, in the annual planning and budgeting process, is allocating the non-fiscal OSR to the health sector, benefitting both the institutions at provincial level (Direcção Provincial de Saúde - DPS) and at district level (SDMAS).

Given these procedures, it becomes obvious that the collection, administration and reinvestment of health OSR pose is challenging. Not only does ATM not play an active role in the collection of this revenue, but there is a justified suspicion that part of the revenue derived from user fees is 'retained at source', at the health units. This retention often occurs to mitigate the insufficiency fiscal allocations and / or expenditure cuts, which impedes the necessary purchasement for the operation of the health units. Corrupt practises in collecting and utilization of fees have also been singled out as a major challenge (Garrido, 2012, GoM, 2024).

The second reason to support the underestimation argument has to do with the utter lack of institutional and human capacity and competence of health units to administer user fees, i.e.: set and disseminate the rates, issue receipts upon delivery of the service rendered and payment received, keep records of and account for revenue collected, classify the receipts in e-sistafe and inform MEF on the user fees income and its utilization. Administratively speaking, what can one expect from a health unit which, for the time being, does not even have the right to use an official stamp when issuing a vaccination certificate[46]? As observed above, the 'archaic' management of health units, and their lack of autonomy and capacity prevents them to play a significant role in managing OSR in the form of user fees. For them to play this role, one must consider their structural reform along the lines suggested in Section 3.4.

Thus, a HSFS and a policy aiming at tapping into the on-fiscal OSR (user fees) potential of public health units as a source for HSF requires considering at least three issues:

- The need for a profound, if not radical, reform of the health units. Health units must be bestowed with administrative and financial autonomy and reinforcing their administrative staff through capacity building. The authors of the HSFS draft document are aware of the need of reforming the direct payment system for user fees and outline specific measures to be taken (in section 5.1.2 of the HSFS). However, we believe, that these proposals are not far-reaching enough. They do not address the need to decentralize the sector and to streamline the cumbersome procedures of the collection, administration and redistributing the sectors non-fiscal OSR.
- The relationship between the quality of services rendered and the fees charged. A recent study on Mozambique's SNS by the Observatório do Cidadão para Saúde (OCS) concludes that user fees have not contributed to improved services. On the contrary, they have a tendency to deteriorate them, because those receiving the fees seem to be more interested in maximizing the income generated from the fee than in improving the services[47]. The Household Income survey 2019 – 2020 suggests that 40.5% of users of SNS are not satisfied with the quality of services rendered. The main reasons are long waiting times and lack of medicines (INE, 2022).
- The regressive effects of user fees on household income, which determines access to health services financed by OOP. There is high risk that charging, and eventually increasing, user fees may lead to second-class treatment or even exclusion of those who cannot afford to pay. The above mentioned study by OCS suggests that raising user fees could result in catastrophic expenditure for households. This means that a household is barred from access to health services and subject to impoverishment because the cost of healthcare exceeds a certain threshold relative to the monthly household income or value of consumption. The authors of the HSFS draft document believe, on the basis of the recent Household Survey 2019-2020, that this risk is remote, except in the case of access to specialized clinics and payment of unregulated extra charges (GoM, 2024: Section 4.3.2).

4.2.7. Improvement of allocation efficiency in the health sector

The HSFS document subscribes to the premise that achieving efficiency gains and reducing wasteful management practices, pilfering, and other forms of financial mismanagement can create significant reserves that could be utilized to increase fiscal space (FS).

It suggests three areas of priority intervention:

46. Personal information by a senior staff member of a district hospital.

47. https://www.observatoriodesaude.org/pagamento-de-taxas-privatiza-os-hospitais-publicos-e-prejudica-as-populacoes-mais-desfavorecidas-no-acesso-aos-servicos-de-saude/

a. the management of medicines and medical and laboratory products and the supply and distribution chains;

b. the allocation and management of human resources, and

c. the integration of all health programmes at local level health units.

We would add two more suggestions to the list: Firstly, exploring the possibility to achieving efficiency gains through decentralization of functions and resources, including down to health unit level within municipalities (see previous section). Secondly, we advocate for seeking efficiency gains through performance-based budgeting, drawing on the good experience in countries such as Rwanda and Ghana. This approach is already been piloted in Mozambique's health sector by initiatives such as the Global Financing Facility (GFF).

In making these suggestions, we are aware that health units, with more autonomy, would need to play a pivotal role in performance-based financing (PBF) management and thus become an agent for reinforcing decentralization within the health sector reforms. We also need to adjust the input-based allocation logic of e-sistafe to make it more compatible with the ex-post, output-based approach inherent to PBF. As long as the PBF operates in a parallel PFM system, it fragments the payment system and governments are likely to revert to the input-based system once the project closes, even if the PBF approach has shown results[48]. This alignment is crucial for sustainable improvements in efficiency and effectiveness within the health sector financing framework.

4.3. Conclusions

In this section, we present our conclusions and recommendations in a summary form:

a) Exploring more growth scenarios systematically, particularly regarding revenue from extractive economic sectors, would add value to the HSFS draft document;

b) Each of the fiscal space components discussed has its specificities, advantages and disadvantages, and their net effects on fiscal space need to be carefully analysed and considered for inclusion, or not, in the finalization of the HSFS document;

c) Part of such assessment should also include evaluating the cost-effectiveness of generating additional financial resources or increasing the yield of the existing ones, in relation to the expected benefits;

d) There is a critical need for verifying and updating data as part of an ongoing process. The importance of a consistent and regularly updated database on fiscal matters, including non- fiscal data in the health sector cannot be overstated for effective planning, budgeting and forecasting;

e) It is important to enhance the understanding and analysis of at least two components of the fiscal space discussed above: the private sector health services together with private health insurance, and the way ASEM works, or not, as a promising avenue for HSF. We recommend commissioning separate studies on these subjects.

f) There can be no doubt, that 'dormant' fiscal reserves may be utilized through measures that increase allocative efficiency, improve administration, especially at health unit level, and decrease corruption and misappropriation of funds.

48. https://www.rbfhealth.org/blog/what-it-takes-mainstream-performance-based-financing-government-budget

5. FINAL CONSIDERATIONS

This analysis sought to contribute to the drafting process of the Mozambican HSFS. It is hoped that the data produced and analyses offered serve this purpose.

From the distance of an external observer, five issues merit further consideration, which go beyond the technical matters addressed in this study, but are related to political choices and decision-making, when considering policies and strategies to increase fiscal space for health:

The first issue is related to a choice in favour of implementing user fees, which has distributional dimensions flagged in the context analysis. This matter is controversially discussed in the health circles and academia. One opinion argues in favour of such fees to increase income to the health sector, thereby improving the quality of services. Conversely, others argue that such informal fees foster corruption and exclusion. The World Bank has expressed a favourable opinion on introducing what is referred to as 'moderating fees 'under the condition that the revenue is retained in the sector and serves for improved quality of health care. This view is totally opposed by, among others, the former Mozambique's Minister of Health, Ivo Garrido who argues against fees for health services citing their regressive nature, which not only violates the Constitution, but also excludes citizens from access to health services.

The second issue is associated with this topic but has much far-reaching implications. Looking at an increase in the sector's OSR to widen the fiscal space needs to be carefully analysed. This matter is extremely complex from an institutional and fiscal perspective and may not yield the expected results. In our opinion, this issue reveals the need to profoundly rethink the way OSR is generated, administrated and used in the health sector, together with a restructuring of the local health units in line with principles of devolution of authority, functions and resources. This does not necessarily mean transferring power to local governments, but to health units in general and to local hospital in particular. It should be clear that this matter can only be addressed by a profound reform.

Thirdly, there is a choice to be made regarding the proposal of earmarking a certain percentage of fiscal revenue generated by a specific type of tax for allocation to the health sector. Among the different direct and indirect taxes (excluding the conditioned tax ICE) some authors clearly prefer VAT. Although, as we have demonstrated, this tax has regressive effects and may exacerbate poverty, it nevertheless could be considered the primary choice as a source for HSF. VAT represents one of the most buoyant[49] fiscal sources of revenue, especially with improved VAT administration, and thus has a significant positive impact on domestic resource availability when the economy picks up. This is why UNICEF argues that Mozambique could most effectively reduce the fiscal gap in the health sector by improving VAT administration efficiency. Mitigating the VAT´s regressive effects would require linking the VAT component in HSF to improvements in health sector performance and quality of services. This could be reinforced by the PBF approach.

Fourthly, in our opinion there is a viable option in using a part of the expected revenue windfall from extractive industries for HSF, via the SWF and annual PESOE. This option undoubtedly has the advantage to turn the hitherto frustrated, expected and promised gains from extractive industries into something tangible for all Mozambicans. Moreover, it represents a major investment in healthy human resources for the present and future generations.

Finally, we conclude that the political choices to be made between favouring one fiscal component over another within Mozambique's fiscal space, are not the most obvious solution to the problem. A more effective approach would involve an intelligent mix of components and reform measures, including the introduction of health insurance for all Mozambicans and sectoral decentralization. Together, these strategies can bring substantial improvements of access to quality health services for all Mozambican children, women and men, together with an increase of financial means. These are lessons learned from good examples such as Rwanda and Ghana.

It is hoped that this study is contributing to such a reflection.

49. This term means that a tax revenue increases more than proportionately in response to a rise in GDP

6. ANNEXES

6.1. Estratégia de Financiamento do Sector Saúde (EFSS), 2025–2034

Table of contentes

6.2. Bibliography

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