

## Obstacles to the Provision of Healthcare Services

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It always seems impossible until it's done

Nelson Mandela

### I OVERVIEW

#### A Introduction

Mozambique is a country with a surface area of around 800,000 km<sup>2</sup>, located in Southeast Africa. It became independent in 1975 after around five centuries of Portuguese colonisation. At the time of independence, Mozambique was one of the poorest countries in the world. Between 1976 (less than a year after the proclamation of independence) and 1992, the country was ravaged by a war that caused large-scale destruction of its economic and social infrastructure and affected over 5 million Mozambicans, of whom around 1 million lost their lives and 4 million were forcibly displaced from their homes (Pim and Kristensen 2007).

Thus, in 1992, when the war ended, Mozambique was the poorest country in the world, with a per capita GDP of only US\$354 (2011 PPP) (Gradín and Tarp 2019). The economic growth seen in Mozambique from 1995 onwards led to a reduction in poverty levels, with the per capita GDP trebling in only twenty-five years (Gradín and Tarp 2019). Despite this economic growth, Mozambique remains one of the poorest and least developed countries in the world.

In Mozambique today, over half the population (estimated at around 29,000,000, 66 per cent of whom live in rural areas) lives below the poverty line (less than US\$2 per person per day) (Gradín and Tarp 2019). According to data from 2017, Mozambique has a per capita GDP of US\$1,136 and a Human Development Index of 0.442, putting it in 180th place out of 189 countries

(UNDP n.d.). According to data from 2019, Mozambique has a Sustainable Development index of 53 points out of 100, putting it in 136th place out of 162 countries (Sachs et al. 2019: 21).

The process of economic growth that is leading to a reduction in poverty has occurred and occurs at the same time as an increase in economic and social inequalities. These take place in a country with previous inequalities between urban and rural areas and between regions (North, Centre, and South).

## **B Concept of Health and Social Determinants of Health**

To study the topic of health in Mozambique, it is first necessary to understand the concepts of health and social determinants of health. According to the World Health Organization (WHO), ‘Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’ (WHO 2006). This means that a person might not be sick in the normal opinion of people (i.e. not suffering from fever, diarrhoea, cough, or headaches and going to work every day) and even so not enjoy good health.

There is a consensus that the living and working conditions of individuals and groups in the population influence their health situation. In other words, most illnesses and health inequalities – which exist in every country – are derived from the conditions under which people are born, live, work, and grow old. This is where the concept of social determinants of health comes from. For the WHO, social determinants of health are the social conditions under which people live and work (WHO n.d.).

Some examples of social determinants of health are – apart from the quality and accessibility to healthcare and services – the quantity and quality of food a person ingests regularly and the quality of the water and sanitation to which they have access. The same goes for housing and transport conditions, the education level, the working environment, the consumption or not of tobacco, alcohol and other drugs, and the state of mental health of individuals and community.<sup>1</sup>

One of the most important social determinants of health are the institutions in a country or a community. Institutions are the rules of the game (formal or informal) that the political, economic, and social players in the country or community are expected to follow. Each society operates with a set of political, economic, and social rules created by the state and the citizens together. In this chapter, we focus on the role institutions have in the state of health of Mozambicans.

<sup>1</sup> The 1991 Dahlgren-Whitehead ‘rainbow model’ maps the relationship between the individual, their environment, and health. Individuals are placed at the centre, and surrounding them are the various layers of influences on health – such as individual lifestyle factors, community influences, living and working conditions, and more general social conditions (see ESRC 2021).

## C A Brief History of the Health Services in Mozambique before and after 1975

The history of the health services in Mozambique encompasses four different periods:

- a) the period prior to the independence of Mozambique (1975);
- b) the period immediately after independence (1975–80);
- c) the period from 1980 to 1993;
- d) the period from 1993 to the present day.

### 1 *Period before Independence*<sup>2</sup>

Although the Portuguese arrived in Mozambique in the late fifteenth century, the organisation of health services by the colonial power in the then districts (now provinces) dates only from the nineteenth century, with the building of the first health infrastructures and the creation of rules for their operation. Around 1898, the colonial health system was organised in eleven health districts, with each district having a civil hospital and a military hospital.

The health system created by the Portuguese colonial government, which lasted until 1975, was concentrated in the cities and towns where the majority of the colonists lived. It was a fragmented system, based on hospitals and prioritising curative medicine (to the detriment of health promotion and disease prevention). Finally, it had a racist structure.

In rural areas, where 85 per cent of Mozambicans lived before 1975, the majority of the people lived more than 20 km away from the closest health facility. In the event of illness, this led to the vast majority of Mozambicans resorting almost exclusively to traditional medicine practitioners.

### 2 *Period Immediately after Independence (1975–1980)*

Immediately after the formation of the Transitional Government, the Committee for the Restructuring and Reorganization of the Health Sector was set up. After 1975 – based on the findings and recommendations of the Committee for the Restructuring and Reorganization of the Health Sector – the first government of independent Mozambique defined and began implementing a health policy whose essential principles are enshrined in Decree-Law No. 1/75, of 29 July.

Article 37 of that decree-law states:

The essential aim of the Ministry of Health is to put the provisions of Article 16 of the Constitution into practice. It is up to the state to organize a health system that will benefit all Mozambican people.

This campaign will be guided by FRELIMO's policy to place health at the service of the people.

<sup>2</sup> Gulube (1996).

A unified National Health Service will be created to serve all sectors of the population, irrespective of their ethnic group, economic or social level or religion.

Because rural areas were completely neglected in colonial times, efforts must be immediately focused on these areas.

Health is a right of the citizen and a duty of the state [author's underlining].

In the National Health Service, preventive action and curative action must be totally integrated at the base, but it must always be remembered that prevention should take priority over cure. Health education and environmental sanitation will play a major role in the actions of the Ministry.

On 24 July 1975, the government of Mozambique announced the abolition of private medicine practices. The five years after independence were characterised by substantial changes in the health sector. Along with the abolition of all types of private medicine, the process of creating and structuring the public health service, called the National Health Service, was begun. Significant steps were taken towards eliminating the fragmented and racist nature of the health services. Hundreds of new health units were built, the vast majority in rural areas. Implementation of a health policy began. This would essentially be enshrined by the WHO three years later under the name of Primary Health Care.

It should be noted that in these early days of independence, debate arose around health as a right versus the financial capacity of the state to assure this right. It was in the context of this debate that, in 1977 – when the Free Medicine Act was approved<sup>3</sup> – the government restricted free healthcare to disease prevention campaigns, while curative activities had to be paid for, albeit at very low prices.

During this process – and notwithstanding the immense enthusiasm of both the people and the healthcare workers – the greatest difficulty lay in the extreme lack of (a) human resources of all types and at all levels and (b) financial resources.

Apart from the National Health Service, the Military Health Service and the Paramilitary Health Service were also set up, under, respectively, the Ministry of National Defence and the Ministry of the Interior. In prisons, health units were and still are managed by the Ministry of Justice.

### *3 From 1980 to 1993*

After 1980, the efforts to build a public health service to serve the entire population were seriously affected by the war. In all the provinces, over one hundred healthcare workers were killed, hundreds of health units and ambulances were totally or partially destroyed, and tonnes of medicine and medical supplies were destroyed or stolen. Over half of the health network in rural areas collapsed, with dramatic consequences for the health of millions of Mozambicans, especially children, women, and the elderly.

<sup>3</sup> Law No. 2/77, of 27 September 1977.

The political and military instability and subsequent economic crisis worsened when, in 1987, the so-called Bretton Woods institutions (the World Bank and the International Monetary Fund) imposed economic policies on the government of Mozambique that led to a drastic reduction in public spending, including the provision of free healthcare to the majority of the citizens.

At the same time – and due to the joint pressure of the Mozambican political and economic elite (on the one hand) and the imperatives of the policies imposed by the Bretton Woods institutions (on the other) – in 1992, the government of Mozambique reintroduced private for-profit medicine, which had been abolished in 1975 (Law No. 26/91, of 31 December<sup>4</sup>).

#### *4 Period from 1993 to the Present Day*

The war ended with the signing of the Rome Peace Accords in October 1992. In 1993, the process of building the health system began again, particularly the National Health Service. Over the last twenty-five years, hundreds of the health units that had been destroyed were rebuilt and hundreds of new health units were built.

The majority of these health units are health centres and facilities and are mainly located in rural areas. However, the construction of the National Health Institute, a central hospital (in Zambezia Province), a provincial hospital (in Maputo Province), and more than ten district hospitals and infrastructures aimed at providing training to human resources working in health and the logistics of medical supplies must be highlighted.

The National Council for the Fight against HIV/AIDS (CNCS), which is presided over by the Prime Minister, was also set up.

At the same time – and along with a small, but increasing, number of clinics, medical practices, laboratories, and private imaging services – dozens of non-governmental organisations (NGOs) appeared, almost all dedicated to vertical programmes in the health area.

However, it must be pointed out that due to the widespread poverty, the private medicine sector, including the NGOs, covers only 5 per cent of the population.

## **D Description of the Health Sector**

In Mozambique, the health sector is called the National Health System and is structured in the following subsystems:

1. a public subsystem run by the state and called the National Health Service;
2. a private subsystem;

<sup>4</sup> Law authorising the provision of healthcare by natural or legal persons under private law, for profit or not.

3. a military and paramilitary health subsystem;
4. socio-professional organisations such as the Medical Council, the Nursing Council, and the Medical Association of Mozambique, considered part of the National Health System.

The National Health Service is directly dependent on the Ministry of Health and is by far the largest provider of healthcare to the around 29 million Mozambicans. It includes four central hospitals (each one with over 600 beds), seven provincial hospitals (between 250 and 350 beds), two psychiatric hospitals, a little less than fifty district hospitals, and 1,585 health centres and facilities spread throughout the districts and communities in the country. It employs over 90 per cent of health workers in Mozambique.

The private subsystem is divided into (a) private for-profit; and (b) private not-for-profit medicine. The private for-profit sector is concentrated in the cities (mainly in the capital, Maputo) and includes two hospitals (both in Maputo City), a few dozen clinics, medical practices, pharmacies, laboratories, and imaging services. The for-profit private sector is devoted almost exclusively to curative activities.

The private not-for-profit subsystem includes religious organisations and non-governmental organisations (NGOs), mostly foreign and directly funded by the so-called cooperation partners (donors). It also includes health facilities in some large public and private companies and in educational establishments, such as the Eduardo Mondlane University.

The military and paramilitary health subsystem is in an early stage. Mozambique has no hospital to care specifically for paramilitary forces.

The National Health Institute (aimed at research) and the Traditional Medicine Institute are under the auspices of the Ministry of Health.

## **E Traditional Medicine**

Traditional medicine exists alongside the National Health System. According to the WHO, 'traditional medicine is the sum total of knowledge, skills and practices, used in the diagnosis, prevention or elimination of physical, mental and social illnesses, based exclusively on past experiences and observations handed down from generation to generation, orally or in writing' (Ministry of Health 2015).

According to the Ministry of Health, around 70 per cent of the people in Mozambique use traditional medicine to treat physical, as well as mental and social, illnesses. The activity engaged in by traditional medicine practitioners, estimated at a ratio of 1 practitioner per 200 inhabitants, has more coverage of primary health services than the National Health Service.<sup>5</sup> This explains why there are still people in Mozambique who are born, grow up, and die

<sup>5</sup> The ratios for doctor/inhabitant and nurse/inhabitant are, respectively, 1/15,000 and 1/2,000.

TABLE 6.1 *What is known about the practice of traditional medicine*

Type	Coverage	Payment	Registration	Representativeness
Herbal medicine practitioners: those practitioners that treat patients with chemicals prepared from plants. Traditional midwives Healers who practice divination.	There are practitioners of traditional medicine all over the country, both in rural and in urban areas.	The provision of services by practitioners of traditional medicine is not free.	Patients often have recourse both to traditional medicine and so-called conventional medicine.	The Association of Traditional Healers of Mozambique (AMETRAMO) and the other associations of practitioners of traditional medicine do not represent all the practitioners.

*Source:* Author's elaboration.

using only traditional medicine for their healthcare. This fact is due, on the one hand, to the still poor geographic coverage of the National Health Service and, on the other hand, the intrinsic connection existing between traditional medicine and the defining traits of its users.

During colonial times, traditional medicine was perceived as associated with a lack of knowledge or superficial knowledge, superstitious, and based on folklore. Immediately after the proclamation of independence, the government of Mozambique recognised the importance of traditional medicine. In fact, Article 38(7) of the first decree-law of the government (Decree-Law No. 1/75, of 29 July), states: 'Boost medical and pharmacological research and, particularly, studies on traditional medicine'. Since then, traditional medicine has been gaining ground and consideration in government policies. In 1977, the Office of Traditional Medicine Studies was set up under the Ministry of Health. In 2010, the Office of Traditional Medicine Studies was closed and gave way to the Traditional Medicine Institute, also set up under the Ministry of Health.<sup>6</sup>

Despite these advances, the reality is that little is yet known about Mozambican traditional medicine (Tables 6.1 and 6.2).

## F The State of Health of Mozambican People

The state of health of the majority of Mozambicans is precarious. The burden of disease is high. Endemic infectious diseases predominate, such as malaria,

<sup>6</sup> Ministerial Order No. 52/2010, of the Ministry of Health, of 23 March 2010.

TABLE 6.2 *What is not known about the practice of traditional medicine*

Statistics	Training	Relationships	Type of activities	Integration
The exact number of practitioners of traditional medicine per province, district, and place (total number and by type of practitioner).	The type, content, and duration of training for each one of the three types of practitioners of traditional medicine.	The relationship between practitioners of traditional medicine and their patients (and their families), including the means of payment for the work done. The relationship between practitioners of traditional medicine and the other traditional authorities.	If practitioners of traditional medicine limit themselves to curative activities or if they engage in other activities, whether in the health area or in other areas.	The best strategy for integrating traditional medicine into the Mozambican Health System. Specifically, should traditional medicine be considered as a subsystem or should it be integrated into the National Health Service?

Source: Author's elaboration.

tuberculosis, AIDS, respiratory infections, diarrhoeal diseases (including cholera), and intestinal and bladder parasitosis, with the last three being very closely linked to access to drinking water and environmental sanitation.

Mozambique is one of the five countries in the world with the highest prevalence of tuberculosis (551 cases/100,000 inhabitants, compared to a world average of 140 cases/100,000 inhabitants) and among the 10 countries in the world with the highest prevalence of AIDS. Data for 2015 indicate that the overall prevalence of AIDS in people aged 15 to 49 was 13.2 per cent. Among women, it was 15.4 per cent versus 10.1 per cent for men, and AIDS is more prevalent in urban areas (16.8 per cent) than in rural areas (11.0 per cent) (Ministry of Health et al. 2013; Ministry of Health et al. 2018). Cholera is endemic, with outbreaks practically every year, varying only in the part of the country it appears. A study carried out between 2005 and 2007 and encompassing over 80,000 school-age children revealed a generalised occurrence of bladder infection caused by *Schistosoma haematobium* (national prevalence of 47 per cent) and intestinal helminths (national prevalence of 53.5 per cent) (Augusto et al. 2009). These diseases, related to lack of access to drinking water and basic environmental sanitation, are responsible for a higher number of deaths than malaria and AIDS combined. Mozambique is one of the few countries in the world where leprosy still exists.



At the same time – and as is the case in other African countries – an epidemiological transition is underway. Thus, the incidence and prevalence of non-communicable diseases, particularly high blood pressure and other cardiovascular diseases, diabetes, chronic respiratory diseases, cancer, and trauma (especially road traffic accidents) is increasing inexorably. A study on cardiovascular risk factors carried out in 2005 shows a high prevalence of high blood pressure (34.9 per cent).

Data from the UNICEF Annual Report 2019 entitled *The State of the World's Children 2019: Children, food and nutrition* (UNICEF 2019) indicate that Mozambique has one of the highest rates of child malnutrition in the world (43 per cent of children under five suffer from chronic malnutrition and 8 per cent from acute malnutrition). Chronic malnutrition increases the morbidity and mortality rate in children aged under five and reduces their cognitive abilities. The same report reveals that, for the first time in many years, Mozambique reported cases of pellagra, a disease linked to niacin (vitamin B<sub>3</sub>) deficiency.

Other indicators reflecting the deficient nutritional situation of Mozambicans are the following (Ministry of Health et al. 2013; Ministry of Health et al. 2018):

- Fourteen per cent of newborns (whose birth weight was registered) weighed less than 2.5 kg at birth (underweight);
- Sixty-four per cent of children under five, and 54 per cent of pregnant women, were suffering from anaemia;
- in 2011, only 45 per cent of the families questioned used iodised salt;
- in 2015, the exclusive breastfeeding rate was only 55 per cent.

Mozambique is among the countries in the world with the highest birth rates (five children per woman) and gross mortality (11.8/1000 inhabitants) and a low life expectancy (53.7 years). Maternal mortality (452/100,000 live births) and infant mortality (68/1,000 live births) are also very high (INE 2019).

## II INSTITUTIONAL FACTORS WITH AN IMPACT ON THE HEALTH SECTOR

The institutional factors that weaken the performance of the health sector can be structured according to five conventional areas.

### A Rule of Law and Judicial Independence

Despite it being enshrined in the constitution, Mozambique is still far from being a state under the rule of law.

With regard to the health sector, there are several factors – mainly related to non-compliance with the laws in force – which contribute to this:

- The process of contracting companies to carry out public works (such as building health centres, hospitals, human resource training centres and

institutes, warehouses, housing for healthcare staff, etc.), as well as the acquisition of medicine, medical supplies, hospital equipment, and the like (such as ambulances), is very often done on the fringes of the law. There is frequent, abusive, and illegal recourse to what is called *private treaties* to the detriment of public tenders. This all leads to the construction of poor-quality buildings, the acquisition of medical supplies and equipment of inferior quality, and the unlawful siphoning of money to dishonest business people.

- In clear breach of the law, the processes of selecting people for jobs are frequently carried out without being offered for public tender. This gives rise to this selection being based on party political affiliation, nepotism, friendships, ethnic identity, and even the provision of sexual favours.
- With regard to promotions and career progression, it is common for the time periods provided for by law not to be complied with, allegedly due to budgetary restrictions.
- These practices are also contributed to by the fact that both trade union organisations (such as the Medical Association of Mozambique) and socio-professional organisations (such as the Medical Council and the Nursing Council) are weak and not very proactive.

The fact that these irregular situations persist – despite being frequently reported in the media and the repeated criticism in the annual report from the Administrative Court (Court of Auditors) to the National Assembly – gives citizens the feeling that the culprits can get away with anything because of the state's lack of political will, calling the legitimacy of that very state into question in the eyes of its citizens.

## B Voice, Participation, and Accountability

- Although it is provided for and heralded in the Constitution of the Republic<sup>7</sup> (Articles 89 and 116) and in the Charter of Patient Rights and Responsibilities,<sup>8</sup> the right of citizens to healthcare is not clarified or sufficiently protected.

In the National Health Service – and in clear breach of Article 116(4) of the Constitution – citizens are discriminated against by the state on a socio-economic basis. All but one of the central and provincial hospitals have special clinics, special consultations, and private rooms that are off limits to anybody who cannot pay the prices stipulated. It should be noted that there is no legal basis for the existence and operation of these special clinics, special consultations, and private rooms. All attempts made to close these

<sup>7</sup> Constitution of the Republic of Mozambique, 2018.

<sup>8</sup> Approved by Resolution No. 73/2007, of the Council of Ministers, of 18 December 2007.

special clinics, special consultations, and other special services have been thwarted due to resistance linked to the combined interests of the doctors, on the one hand, and the political and economic elite on the other.

Even in the services considered to be free by law, citizens are frequently subject to unlawful charges.

- The involvement of citizens and communities in the management and monitoring of health sector activities is very poor. Despite there being regulatory documents on the connection between the health sector and the communities, it is the norm for there to be no accountability to citizens regarding health activities. The citizens know little or nothing about the annual budget for the health sector, from its preparation to resource allocation priorities and how these resources are spent. This is one of the reasons explaining why the Ministry of Health budget favours allocations to:
  - a) central and provincial bodies to the detriment of district bodies, where primary healthcare takes place;
  - b) spending mainly on curative actions to the detriment of health promotion and disease prevention actions; and
  - c) money spent on needless bureaucracy (travelling abroad with the corresponding travelling expenses, expensive meetings at hotels and tourist resorts, acquisition of cars for leaders) to the detriment of the acquisition of medicine and medical supplies and equipment and ambulances that would improve the quality of healthcare.
- Particularly in rural areas – and because of fear of reprisal – citizens are afraid to report any abuses by health workers, such as absenteeism, non-compliance with schedules, ill-treatment, and unlawful charges.

### C Political Instability, Violence, and the Legitimacy of the State

Over forty years after the proclamation of independence, the National Health Service still does not cover the entire country or respond to the basic needs of all citizens, both in cities and towns and in rural areas. As previously mentioned, there are three causes:

- a) the colonial legacy;
- b) the destruction of hundreds of health units during the war that ravaged the country between 1976 and 1992; and
- c) the difficulty in moving forward more quickly, both in the replacement of the infrastructures destroyed and in the building of new infrastructures, due to the lack of human resources and financial constraints.

After a twenty-year period of calm, political and military instability re-emerged in the centre of the country in 2013. To further aggravate the situation, in October 2017, a military conflict broke out in Cabo Delgado Province, the cause of which is still not clear, and which is tending to spread.

The political and military instability:

- has negative repercussions on the lives of the people in towns and rural areas (where physical safety has been threatened and economic activities paralysed);
- negatively affects activities in the health sector and leads to stagnation or to setbacks in many health indicators. Two concrete examples of this negative impact are the temporary cessation of health promotion and disease prevention activities;
- ultimately calls the legitimacy of the state into question, either because the state cannot protect its citizens or because it does not assure the provision of basic health services, drinking water, basic sanitation, education, etc. in adequate quantity and quality.

## D State Capacity and Independence from Private Interests

Since 1975, the government of Mozambique has generally outlined appropriate policies for the health sector. The main problem lies in the weak capacity of the state to assure the implementation of these policies. There are many examples of this deficient implementation and the following are of particular importance:

### 1 *Lack of Human Resources and Low Motivation of the Majority of Human Resources*

The lack of human resources of all types – from doctors to orderlies, as well as nurses, pharmacists, laboratory and imaging professionals, management specialists, maintenance specialists, hospital administrators, etc., – is, alongside chronic underfinancing, the greatest weakness of the National Health Service.

No health facility (from the most modest health centre to the largest central hospital) has enough human resources. The doctor/inhabitant (1/15,000) and nurse/inhabitant (1/2,000) ratios do not allow for healthcare with even a minimum of quality.

The majority of the scarce human resources existing, particularly those working in the National Health Service, are unmotivated and demoralised, as they earn low salaries, lack basic working conditions (equipment, medicine, food, uniforms, etc.), and have to deal with a large (and always increasing) number of patients.

### 2 *Chronic Underfinancing and Poor Financial Management*

Since 1975, the health sector has faced the problem of not having enough funds to meet either operational expenses (salaries, fuel for transport, acquisition of medicine and other consumables, etc.) or investment expenses (building new health units, acquisition of equipment, etc.). In 2001, the WHO published the document *Macroeconomics and Health: Investing in Health for Economic Development*, in which it showed that the minimum required in any country

for the health sector to be able to ensure the provision of basic services stood at between US\$30 and 40 per person per year. More recently, the WHO has set a recommendation of US\$60, including both public and private spending (Jowett et al. 2016). This means that Mozambique should spend around 1.8 billion US dollars in order to ensure that the health sector could operate with a minimum of quality.<sup>9</sup> The reality is that, since 1975, the amount allocated to the National Health Service (which is responsible for healthcare for at least 90 per cent of Mozambicans) has never even reached a sum of US\$25 per inhabitant per year. Thus, it is clear that Mozambique is facing a problem of chronic underfinancing of the health sector.

This chronic underfinancing calls into question the right of Mozambicans to health, as provided for in the constitution and has caused the government – under pressure from the World Bank – to opt for solutions relying on user fees and other forms of immediate co-payment that penalise the vast majority of Mozambicans. This is clearly described in the WHO document (2010) entitled *Health Systems Financing: The Path to Universal Coverage*, which emphasises that universal health coverage will only become a reality when, and where, the citizens have access to quality health services (promotion, prevention, treatment, rehabilitation, and palliative care) without the fear of being irretrievably drawn into poverty.

Even more tragic is the fact that the management of the scarce financial resources is deficient. It is very common for the financial resources allocated to a certain period not to be fully used, whether through incompetence or negligence of the managers. The most obvious example is the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

### 3 *Insufficient Geographical Coverage*

One of the weaknesses of the Mozambican health system, and of its most important subsystem (the National Health Service) in particular, is insufficient geographical coverage, mainly in rural areas, where around 2/3 of Mozambicans live. Although the government has built over 1,000 health centres since 1975, mainly in rural areas, these remain insufficient for the demand. This explains why, to this day, there are Mozambicans who have to travel ten or more kilometres on foot to get to the nearest health facility.

In over 70 per cent 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 per cent of the districts do not have a pharmacy, either public or private.

This insufficient coverage explains, for example, the difficulty in (a) reducing the mother and child mortality rate and (b) increasing the vaccination coverage rates.

<sup>9</sup> This is based on a population of 30 million, and corresponds to around 12 per cent of GDP.

#### **4 Deficient Implementation of the Primary Healthcare Policy**

The primary healthcare policy prioritises health promotion and disease prevention over curative medicine. However, in Mozambique, healthcare is still predominantly curative and consists of medical interventions in hospitals and health centres.

Other aspects neglected by the primary healthcare policy are community involvement and inter-sector cooperation. It is well known that the greater the involvement of citizens and communities in the planning and monitoring of activities in the health sector, as well as current management of the activities of health units, the greater the satisfaction of these communities and the more careful and responsible the health workers. In Mozambique, the examples of community involvement are few and far between and consist essentially of sporadic meetings to listen to the views of patients at a minority of health units.

On the other hand – and as already mentioned – the state of health of a community depends on factors such as the quantity and quality of food available, a supply of drinking water, environmental sanitation, quality housing, access to quality education, and reliable transport at accessible prices, factors that are the responsibility of sectors other than the health sector. This is why improving the state of health of a community depends largely on cooperation between different government sectors at all levels and between the central government and local governance authorities. This is what is called inter-sector cooperation. In Mozambique – and despite regular meetings of the Council of Ministers – the ministries work in isolation from each other, like silos. The same situation is seen at provincial, district, and municipal levels. In addition, it is this practically non-existent inter-sector coordination that explains the fledgling state of initiatives such as school health, employee health, and the water and food hygiene area.

#### **5 Health Inequities**

Health inequities are health inequalities among population groups, which, apart from being systematic and relevant, are also unjust and avoidable. One of the main obstacles to improving the quality of healthcare in Mozambique has to do with the existence of health inequities.

Here are some examples of these inequities (Equity Observatory [Ministry of Health 2010]):

- the rates of infant mortality, maternal mortality, and malnutrition in children aged under five are higher in rural areas than in urban areas (urban–rural ratio of 1.6);
- children in the lowest wealth quintile are 1.8 times more likely to die before the age of five than children in the highest wealth quintile;
- a child in Cabo Delgado Province is around three times more likely to die before the age of five than a child in Maputo City;

- the rate of institutional births is slightly more than 40 per cent in Zambezia Province compared to over 90 per cent in Maputo City and Province;
- around 55 per cent of children in rural areas are vaccinated compared to 74 per cent in urban areas;
- Maputo City (with a population of around 1.1 million) has twice the number of doctors as Zambezia Province (with a population of over 5.5 million).

### ***6 Inefficient Planning and Management***

One of the weaknesses of the health system in Mozambique and particularly the National Health Service lies in the inefficient planning and management methods at all levels and in all sectors. Planning is carried out using rudimentary methodologies and the plans are rarely complied with in full. The quality of management of human resources, financial resources, medicine and medical supplies, transport, etc. is low, which generates a large number of inefficiencies. The same happens with maintenance of infrastructures and equipment.

Hospitals and other health units have very inefficient management and administration methods. Hospital administration practices are essentially the same as those that were in force at the time of independence. Although computers have been introduced in hospitals, they are mainly for the use of the executives and some employees. Not one single hospital has been completely computerised with the different sectors networked. The management of the clinical files of patients, outpatient consultations, the pharmacy, laboratories, kitchen, laundry, transport, etc. is all paper-based. The same happens with the maintenance of any hospital equipment. This archaic form of management and administration not only contributes to the poor quality of healthcare, but also to the corrupt practices engaged in by health workers.

### ***7 Poor Regulation Capacity in the Other Service Providers***

The Mozambican State has poor capacity to regulate the activities of the other providers of health services. Here are some examples:

- there are private clinics and practices that are set up and operate without authorisation from the competent authorities;
- several mandatory regulations issued by the Ministry of Health are not complied with by some service providers;
- control over the sale of medicine whether by state-licensed pharmacies or operators in the informal market is very deficient. It is common to see medicine acquired by the Ministry of Health on sale at markets and even on the streets. Mozambique is one of the few African countries and the only country in the Southern African Development Community (SADC) that does not have an operational regulatory authority for medicine;
- particularly at provincial level, priorities are frequently defined by the NGOs because they are the ones that fund the majority of health activities.

## 8 Corruption

Corruption is the misuse of the power entrusted to someone for private gain (Transparency International, n.d.[b]). Mozambique is among the countries considered the most corrupt in the world. According to the *Corruption Perceptions Index*<sup>10</sup> (which assesses the people's perception of corruption in the public sector), published by Transparency International, in 2019, Mozambique was in 146th place out of 180 countries, with an index of 26 (with 100 = *very clean* and 0 = *highly corrupt*). It should be noted that in 2013, Mozambique had an index of 30, which means the perceptions of corruption are increasing (Transparency International n.d.[a]). In Mozambique today, corruption is no longer seen as deviant behaviour, but rather has become something 'normal'.

The health sector is among those considered most corrupt, along with public works, education, the police, justice bodies, and others. In health, corruption is seen at all levels – from the central bodies of the Ministry of Health to health centres and maternity hospitals – and all over the country.

Corruption in the health sector takes a variety of forms, such as:

- unlawful charges both at the health units and in the Ministry of Health's management bodies;
- salary payments to 'ghost' employees;
- theft of medicine and medical supplies at all levels (from large warehouses to hospital pharmacies and wards);
- fraud in the tenders for the construction or renovation of infrastructures (such as hospitals, health centres, warehouses, etc.) and for the acquisition of equipment, medicine, and medical supplies;
- bribery to gain admission to the Ministry of Health's training centres;
- leaving work in the public sector to engage in private activities elsewhere;
- deliberate creation of difficulties in what is called normal service (free or almost free) to oblige patients to resort to what is called special service (much more expensive).

Corruption in the health sector has a particularly negative impact on poor patients and their families and contributes substantially to the increase in the dissatisfaction of the people with the health services. Unless corruption in the health sector is effectively, efficiently, and continuously combated, the goal of humanised and equal healthcare for all Mozambicans will never be achieved.

In conclusion, it should be noted that the failure in the fight against corruption is largely because in Mozambique, the judicial power is completely dependent on and subject to the executive power. This comes because of the constitution, according to which the members of the Supreme Court, the Constitutional Council, the Administrative Court, and the Office of the Attorney General are all appointed by the President of the Republic, and can

<sup>10</sup> Transparency International (2020).



be removed by the president at any time and without prior consultation with any state body.

### E Sovereignty and Independence

Now more than ever, it is clear that Mozambique needs help from the international community to improve the provision of quality healthcare to its citizens, especially the poorer ones. However, it is equally clear that this help must be given correctly to ensure that it does not have the opposite effect to what is intended.

Unfortunately, facts show that in the last thirty years, the government of Mozambique has not defined the public health policy independently. This applies both to the definition of priorities and particularly to the preparation of the budget for the health sector. The health policy is defined more by the international community (the cooperation partners or donors) than by the government of Mozambique.

This is the case because the international community (a) makes the largest financial contribution to the health budget and (b) orders and funds the 'consultations' where the diagnosis of the health sector is made and where health policy proposals are presented. It is based on these 'consultations' ordered and paid for by the international community that the government of Mozambique is pressured into prioritising selected strategies, programmes, and activities 'proposed' by the donors, not always coinciding with the strategies, programmes, and activities that are really a priority for improving the state of health of Mozambicans. We will cite examples of the negative role the cooperation partners play in the health sector in Mozambique.

First, human resources. Sufficient well-trained human resources are of vital importance for the correct operation of any health system. The shortage of human resources undermines the capacity of the health system to meet the health needs of the population. In Mozambique, the shortage of human resources is the biggest weakness of the National Health Service. Unfortunately, this shortage is aggravated by health workers (especially those more qualified and/or more experienced) leaving the National Health Service for work at embassies, NGOs, cooperation partner agents based in Maputo, and the private for-profit sector.

The main reason for this, but not the only one, is that these organisations pay higher salaries than the government. This is an internal brain drain, as opposed to the brain drain out of Mozambique. In Mozambique, the internal brain drain is at least three times higher than the brain drain out of the country. In other words, recruitment practices by the donor community in Mozambique undermine and weaken the National Health Service that this community claims it wants to strengthen.

At the same time, the macroeconomic policies imposed on Mozambique by the World Bank and by the International Monetary Fund mean there are tight limits to the contracting of human resources for the health and education

sectors by the government. This is why, over the last fifteen years, the government has been unable even to hire and employ all of the doctors, nurses, and other health workers trained in Mozambique.

Secondly, almost all of the cooperation partners decided to channel the largest slice of their financial resources not into the National Health Service (which provides healthcare to over 90 per cent of the population), but rather to NGOs and other partners dedicated to the so-called vertical programmes for fighting diseases. While this is motivated in part by corruption, already discussed above, it leads to overlapping competencies adding another source of inefficiency.

These vertical programmes, dedicated at the most to three diseases or a specific segment of the population (such as mother and child health), and with bottom-up dynamics, contribute to the weakening of the public health sector due to the duplication of efforts, the distortion of national health plans, the 'theft' of scarce human resources, and the chronic underfinancing of the National Health Service.

In addition to the above – and because the ultimate causes of diseases are not properly taken into account – these vertical programmes for combating diseases have a limited impact on improving the health conditions of poorer citizens and communities, despite the hundreds of millions of US dollars invested each year by the international community in health in Mozambique.

Thirdly, it is important to mention another nefarious aspect of the World Bank's policy. From the 1980s, the World Bank began demanding that all developing countries should introduce user fees as an option for funding health services. It is now agreed that user fees punish the poor and constitute an obstacle to access to healthcare by citizens. According to the WHO, user fees are 'the most unequal way of funding health services' (OXFAM 2013: 11). Worldwide, around 150 million people incur financial catastrophe due to direct payments for healthcare, while 100 million are being pushed into poverty, the equivalent of 3 people per second (OXFAM 2013). Although the WHO has already taken a clear stance against user fees and the World Bank has issued a *mea culpa* (see the speech of the then president of the World Bank, Jim Yong Kim, at the World Health Assembly in 2013), the reality is that user fees persist in Mozambique.

Finally, it should be pointed out that the majority of the reforms and strategies proposed for the health sector by the so-called cooperation partners are unrealistic given the poor economic capacity of the country and because the cooperation partners are not willing to provide the necessary funds for the policies they themselves advocate as the most correct for Mozambique. There are many examples, the most important of which is the much-acclaimed **universal health coverage**, which is a constant in speeches by the World Bank, the WHO, UNICEF, and others in the United Nations and in other international forums. This is how a situation is created where a poor country like Mozambique is eternally 'plagued' by serious problems in terms of the credibility of the health sector arising from the poor quality of the healthcare provided.

The question that naturally arises is: what causes this state of affairs?

The starting point is that it is the political process, which determines the type of institutions existing, and that it is the institutions (mainly political), which influence how this process operates. It is the political institutions of a nation, which define the capacity of its citizens to control the politicians and influence their behaviour. In turn, this determines whether the politicians are representatives and defenders of the rights of the citizens who elected them or if they have the ability to abuse the power entrusted to them to achieve their own ends, even if this is to the detriment of the majority of the citizens.

Mozambican society is a profoundly unequal society, divided between a privileged minority that holds the reins of political and economic power and 'the others', that is a vast majority of poor, disadvantaged, and marginalised citizens, who have little capacity of controlling the actions of the political leaders and very little influence on the determination of the fate of the country.

The final cause explaining the weakness of the institutional factors with an impact on the health sector and, very particularly, on the poor capacity of the Mozambican state to prioritise the public health sector (which as we have seen is responsible for the healthcare provided to over 90 per cent of Mozambicans) lies in the lack of political will of the political leaders to put the satisfaction of healthcare needs in the poorer segments in first place. These leaders are part of, or have close connections with, the privileged minority groups in society, who relegated the public health sector to second place, largely because their own healthcare needs are met by going to organisations (such as hospitals, clinics, rehabilitation centres, etc.) abroad or, when this is not possible, the national private sector.

Another no less important aspect lies in the fact that in Mozambique there is limited and deficient understanding of the problems in the health sectors among political leaders, citizens, and the so-called civil society. There is confusion between the narrow concept of curative medicine and the broader concept of health and public health at all levels of Mozambican society. This results in the healthcare being predominantly curative and revolving around procedures in health centres and hospitals, with the consequent subordination of the promotion of health, the prevention of illness, community participation, and inter-sector cooperation. This is called medicalisation of healthcare. At meetings between the people and politicians, requests from the citizens revolve around the construction of more hospitals and maternity hospitals or at least requests for ambulances. This lack of knowledge results in there not being more interest or political merit in the promotion of public health on the part of political leaders.<sup>11</sup>

At the same time, both the opposition leaders and the majority of civil society organisations (including the media) do not give due priority to or show any

<sup>11</sup> It is also correct that in Mozambique the political leaders do not give priority to the prevention of diseases.

ability to present concrete solutions for the most pressing health problems for the majority of Mozambicans.

To give an example, a Mozambican opposition force has never presented a duly prepared document on (i) the deficient implementation of the primary healthcare policy, (ii) the chronic underfinancing of the health sector, (iii) the inequities in health, (iv) the discrimination that poorer Mozambicans are subject to, even in the public health sector, the problem of leprosy (whose elimination in Mozambique was proven by the WHO in 2009, only to resurge due to the negligence of the government), or, (v) finally, on a coherent policy for the relationship of the government with the foreign donor community for the health sector.

The disputes and 'contradictions' between the party in power, on the one hand, and the opposition forces, on the other, revolve mainly around the sharing of resources by the different factions of the privileged elite.

It is interesting to note that these 'contradictions' always disappear when, for example, parliament is discussing increases in salaries and the allocation of more privileges to different party representatives. On these occasions, unanimity is the rule that has never been broken.

Finally, in Mozambique, the executive power controls and dominates both the legislative power and the judicial power. Under these conditions, there are no checks and balances, which would perhaps make the elite in power take interests other than their own into account.

These are the institutional factors that ultimately explain the poor performance of the health sector, particularly in the quality of the healthcare provided to the majority of poor, disadvantaged, and marginalised citizens.

### III THE FUTURE: ACTION PROPOSALS

In the short and medium term, the main challenges for the health sector can be looked at from two points of view:

#### **A The Nosological Point of View**

Over at least the next two decades, the burden of disease will continue to be very high in Mozambique. Although there is a trend towards a reduction in their incidence and prevalence, the infectious diseases referred to above (diarrhoeal diseases, respiratory illnesses, intestinal diarrhoeal diseases, schistosomiasis, tuberculosis, malaria, and HIV-AIDS) and child malnutrition will continue to predominate, all linked to the poverty that affects the majority of Mozambicans. At the same time, with the growth of the so-called middle class and the adoption of new and harmful lifestyles by an increasing number of Mozambicans (such as sedentarism, smoking, exaggerated and uncontrolled consumption of food high in fat, of alcohol, of soft drinks and sugary drinks, etc.) will continue to increase the incidence of non-communicable diseases.

If there is political will and better organisation, it will be possible to eliminate and then eradicate leprosy and then substantially reduce the prevalence of other diseases that are now neglected, such as trachoma, lymphatic filariasis, scabies, and rabies.

## B The Institutional Point of View

As previously mentioned, the Mozambican state is characterised by the weakness of its institutions, particularly political ones, which:

- on the one hand, make them vulnerable to the private interests of the privileged minority and the pressure from foreign organisations, whether international (the World Bank, the International Monetary Fund, etc.) or governmental, which, as we have seen, are commonly called cooperation partners; and
- on the other hand, they limit their capacity to respond adequately to the material and spiritual needs and desires of the majority of Mozambicans.

Ultimately, the aim is for there to be strong institutions in Mozambique, capable of outlining a health policy that puts the needs of the majority of its citizens in first place, provided with effective regulatory capacity, capacity to suppress all forms of crime, capacity to negotiate with the cooperation partners and make the interests of Mozambicans prevail, and that contribute towards balanced political, economic, and social development in the country.

With regard to the health sector, the ultimate aim is the provision of quality, free healthcare to all Mozambicans, without any economic, social, racial, ethnic, sexual, religious, or geographic discrimination.

Even in a country as poor as Mozambique, it is possible to advance progressively towards quality, free healthcare at all levels, and not just basic healthcare. Obviously, this is a long-term process, but it all depends on political will, **a clear definition of what the priorities are and what can be achieved in health sector at each stage** and the sustained implementation of an economic and social policy that will reduce poverty levels, as well as economic and social inequalities.

The crucial question is: how can this goal, which is as noble as it is ambitious, be achieved?

Our proposal focuses on six priorities:<sup>12</sup>

1 – Enshrining clearly in the constitution that: a) all Mozambicans have the right to quality, free public healthcare at all levels of care, without any economic, social, racial, sexual, religious, or geographic discrimination; and b) it is the responsibility of the government to progressively assure universal health coverage in Mozambique.

<sup>12</sup> These priorities should be thought of as first steps to be taken along initiatives in other areas such as the judicial sector and the rule of law.

2 – Based on the experience of other countries that made advances in political and administrative decentralisation, introducing changes to the structure and operation of the public health sector. One example that is a good source of inspiration is the Unified Health System (SUS) in Brazil, a country with social and anthropological characteristics similar to Mozambique.

Here, it is important at least to:

- Legislate the separation between the Ministry of Health (regulatory body) and the National Health Service (implementing body) with different budgets.
- Legislate the links between the National Health Service and the health services in municipalities and other local authorities.

All the aspects mentioned above should be contained in a law that defines a National Health Policy suitable for the next five decades, to be approved by the National Assembly (Parliament).

3 – Clearly defining how to progressively increase funding for the public health sector so that – as recommended by the WHO – the goal of at least US\$60 per inhabitant per year for health sector expenses is achieved by 2050. To do this, the government must:

- Implement the Abuja Commitment (Nigeria) of allocating 15 per cent of the state budget to health instead of the present 8 per cent.
- Institute a *specific health tax* (for example, through an increase in current taxes on tobacco, alcoholic drinks, soft drinks, luxury products like jewellery, cosmetic, perfume and cars, and charge a percentage fee on each airline ticket sold in the country).
- Change the priorities in the health budget so that at least 50 per cent of the government's health expenditure is allocated to districts and 25 per cent to primary healthcare.
- Eliminate user fees and other forms of direct payment for the healthcare provided by the public sector.
- Harmonise the different mechanisms for funding health under a universal coverage framework.
- Be guided by austerity and strenuously fight against needless expenditure.
- Significantly improve budget management at all levels.

It is important to clarify here that a national health insurance system set up and run either by the state or by private entities is not presently a viable option for Mozambique. And the reason is simple: Mozambique is one of the poorest countries in the world and with over half the population living on less than US\$2 per person per day, who would pay that insurance?<sup>13</sup>

<sup>13</sup> A proper national insurance system would require it (a) covers all the citizens; (b) covers all the diseases and treatments (including haemodialysis, organ transplants etc.); and (c) is funded domestically, with poor people being exempted from insurance fees.

On the other hand, we see no reason why private health insurance should not exist for the citizens who wish to have their healthcare provided by private health organisations.

4 – Implementing the primary healthcare policy nationwide, comprehensively and at all levels of healthcare. To do this, the government must:

- Progressively strengthen the National Health Service, which is the main sub-system of the National Health System.
- Give due priority to health promotion and disease prevention activities, rehabilitation, and palliative care, as well as curative activities.
- Implement effective coordination between the Ministry of Health and other sectors (Ministries, local authorities such as municipalities, NGOs, religious persuasions, unions, etc.) whose activities have an impact on the state of health of Mozambicans. As explained above, the health sector alone cannot assure an improvement in the state of health of Mozambicans. Many other sectors of governance and society play a crucial role in the improvement of living conditions – and, through this, the improvement of health conditions – of the people, through the provision of diversified food in quantity, drinking water, environmental sanitation, housing, transport, quality education, etc. The implementation of this inter-sector coordination should be inspired by the experiences in other countries.
- For inter-sector coordination to be effective and efficient, it must be institutionalised. It is under this framework that an Inter-Sector Health Coordination Council (CCIS) should be set up, a body whose mission will be to ensure inter-sector coordination, with the aim of taking concerted action on the social determinants of health at the different levels. It is important to specify the mission, the tasks, and the composition of the CCIS.
- Give priority to community participation. Community participation has two main aspects: (a) the right and duty of each citizen to participate individually and collectively in the planning and implementation of the healthcare aimed at them; and (b) the need for the entities responsible for the provision of healthcare to be accountable to the citizens (or their representatives) for their actions.

In this framework – and based on the experience of other countries, such as Brazil (Cornwall and Shankland 2008) and Thailand (Rasanathan et al. 2011) – community participation must be institutionalised through the set-up of bodies at all levels responsible for ensuring increasing involvement by the citizens and communities in health sector activities.

5 – Boosting the activities of the Traditional Medicine Institute.

Given the importance and the potential of traditional medicine in the provision of healthcare to Mozambicans, the government must further bolster the activities of the Traditional Medicine Institute, providing it with financial resources and qualified human resources at all levels. The Traditional Medicine Institute, working closely with the National Health Institute, must base itself

on the experience of other African countries, as well as the experience in Asian countries (like China, Vietnam, North and South Korea, etc.) to define the best ways to stimulate research into traditional Mozambican medicine, seeking ultimately to make the most of its enormous potential.

6 – Engaging the international community in the efforts with the aim of improving the quality of healthcare in Mozambique.

Such engagement implies, first, progressively reducing interference from cooperation partners in the formulation of health policies and the implementation of sovereign decisions made by Mozambicans.

On the other hand, if the international community does in fact want to help improve the quality of healthcare in Mozambique – so that the much-heralded universal health coverage that enshrines the values of universality, equity, and solidarity can be achieved – it should undertake the following actions:

- Allocate a larger proportion of closely monitored aid in the form of direct support for the National Health Service budget. Government-to-government aid through direct support for the state budget or the Ministry of Health budget is the best way of helping the government of Mozambique to achieve the aim of universal health coverage.
- Cease the promotion of inappropriate approaches in the name of universal health coverage, especially vertical programmes.<sup>14</sup>
- Help the government of Mozambique to make equity and universality explicit priorities from the outset. It is fundamental that poor people (i.e. the majority of Mozambicans) benefit at least in the same way as better-off citizens, at all stages.
- Help the government of Mozambique to measure and assess the progress and results of the actions aimed at universal health coverage, especially equity.<sup>15</sup>
- Take steps to combat the tax evasion that prevents Mozambique from having access to the financial resources that are so necessary in order to ensure quality healthcare for all Mozambicans.
- Honour their commitment to allocate at least 0.7 per cent of their gross domestic product (GDP) to official aid for the development and improvement of the effectiveness of aid to the health sector.

#### IV FINAL CONSIDERATIONS

Mozambique remains one of the poorest and least developed countries in the world. Here are some of the facets of poverty that directly influence the health of Mozambicans (INE 2019):

<sup>14</sup> An example is the Global Fund in Mozambique. Warren et al. (2017) conclude that the Fund should adapt grant implementation and monitoring procedures to the specific local realities.

<sup>15</sup> There is a clear need for evaluation with full publicity of the results involving independent reputed experts.



- Over 2/3 of Mozambicans do not have two balanced daily meals from the point of view of protein and calorie intake;
- Over half of Mozambicans do not have access to drinking water (only 5 per cent have running water in their homes and almost 60 per cent use water from wells, rivers, or lakes);
- Over 2/3 of Mozambicans do not have access to adequate basic sanitation (24 per cent do not have latrines and defecate outdoors and only 10 per cent have a toilet connected to a septic tank);
- Over 2/3 of Mozambicans do not live in decent housing (over 47 per cent live in grass-covered huts);
- Less than 25 per cent of Mozambicans have access to electricity in their homes;
- In 2017, the illiteracy rate (percentage of people aged fifteen or over that cannot read or write) was 39.0 per cent and the number of years of schooling for the people was 3.5 years. These figures conceal important gender inequities (the illiteracy rate is 27.2 per cent for men and 49.4 per cent for women and the number of years of schooling is 2.5 for women and 4.6 for men) and geographic inequities (the illiteracy rate in Cabo Delgado is almost twice that of Maputo City);
- The unemployment rate is high (24.9 per cent) (Sachs et al. 2019: 317).

Poverty blocks access to the benefits arising from economic growth. The differences between social groups, based on the place of residence, education level, and other social differentials, make the advantages arising from economic opportunities more accessible to certain groups.

Finally, economic inequality is frequently associated with worse results in the health area, not only for poor people, but also for the population in general (Wilkinson and Marmot 2003; Wilkinson and Pickett 2009). This is why the fight against poverty and economic and social inequality must be made a priority, so that economic growth in Mozambique can be seen through the achievement of the improvements recommended in the Sustainable Development Goals (SDGs).

## V CONCLUSION

All of the above makes it possible to conclude that the institutions – understood as the rules of the game (formal or informal) created jointly by the state and by citizens and that are expected to be followed by the political, economic, and social players – play an important role in the performance of the health sector and, through this, the economic and social development of Mozambique.

Of the institutional factors, the (in)capacity of the state and its (lack of) independence from private interests stand out negatively.

This (in)capacity and (lack of) independence of the state from private interests comes largely as a result of the state being under the control of a privileged

minority who do not give due priority to the basic health needs of the vast majority of the population.

If there is really a desire to improve the provision of healthcare to *all* Mozambicans, changes absolutely must be made in the institutions with influence on the health sector.

The most important institutional measures are the revision of the Constitution of the Republic, the strengthening of the National Health System (particularly the National Health Service), and the reduction of poverty and economic and social inequality.