

HEALTH BUDGET

SWAZILAND 2017/2018

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HEADLINE MESSAGES

- The Ministry of Health was allocated E1.85 billion in the 2017/18 Budget, representing 9.1% of the total Budget.
- Swaziland's 2017/18 total Health Budget is significantly skewed towards recurrent programmes, with 85% on recurrent costs, and only 15% for capital development programmes.
- Shiselweni receives the lowest allocation for health services, and has the highest recorded under-one and under-five deaths in health facilities in Swaziland in 2016
- Swaziland's per capita allocation of US\$123.62 is higher than average Sub-Saharan Average (US\$98.20) though outcomes remain weak and comparable to some developing countries, who spent much less per capita.
- There is therefore need to:
 - improve efficiency, effectiveness and equity of spending
 - adopt cost efficient procurement systems for vaccines and drugs
 - address staff shortages to meet the WHO thresholds of 25 medical personnel per 10,000
 - improve the vaccination spending on operational costs to reach the hard-to-reach children

INTRODUCTION

Health is one of the top priorities of the Government of Swaziland and is enshrined as a fundamental right in the country's constitution. Improved healthcare is one of the key goals that the government is prioritising under the Sustainable Development Goals (SDGs) – Goal 3 – of ensuring healthy lives and promoting well-being for all at all ages. The Ministry of Health (MoH) is the principal ministry, mandated to provide leadership in the production, delivery and utilisation of health services which will consistently increase longevity and quality of life for all Swazis. The National Budget is one of the key policy tools at the disposal of the government to achieve its desired goals in health and other sectors.

This brief, therefore, seeks to analyse the extent to which the 2017/18 Budget allocations to health contribute towards meeting the government's goal of improving health outcomes for all, especially children. It is one of the four Budget Briefs (Overall Budget, Education and Social and Child Protection) that have been produced by UNICEF, in collaboration with the government, to inform programming and advocacy efforts by stakeholders, for improved budgetary outcomes in health.

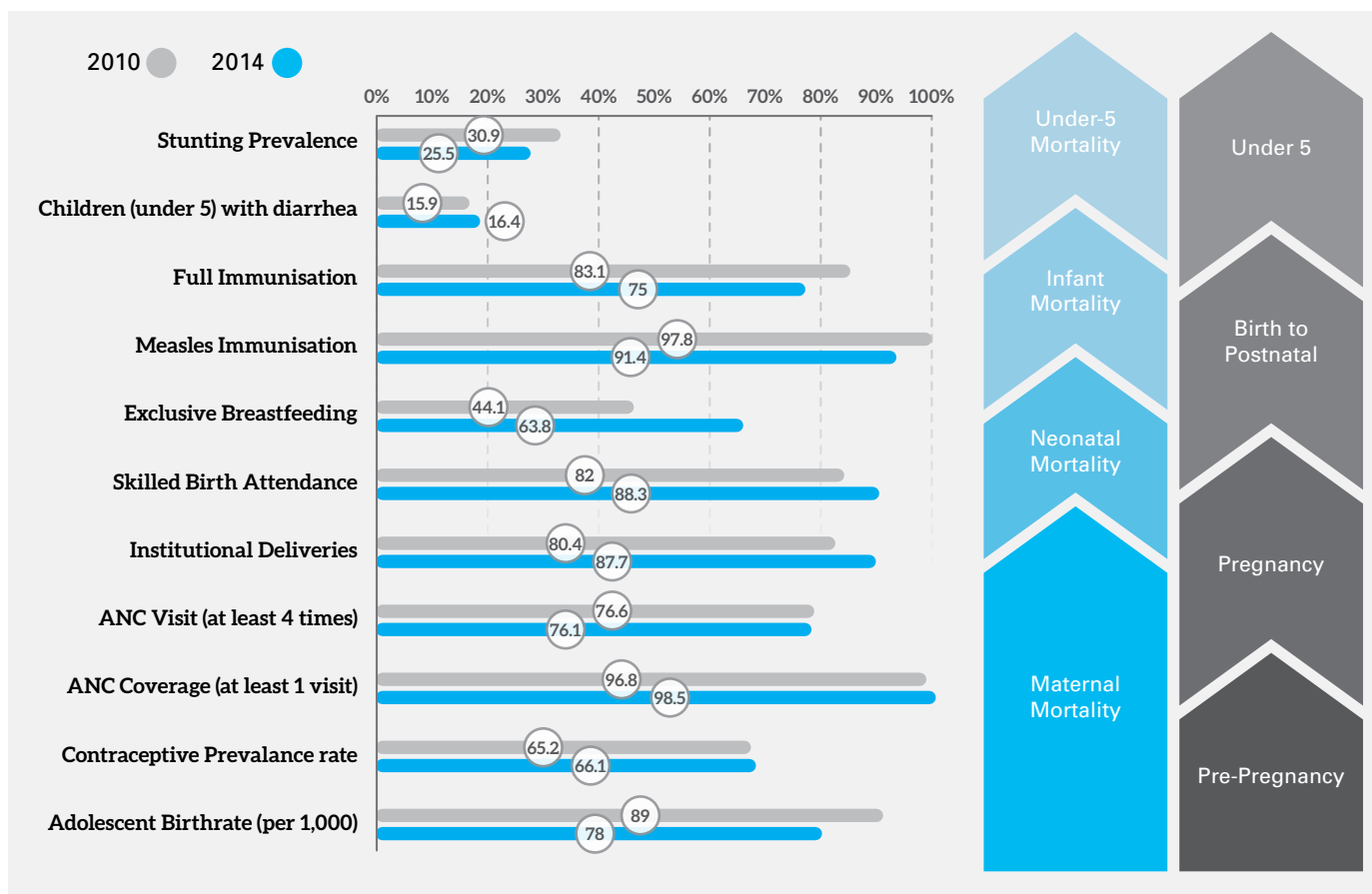


FIGURE 1: Key Health Care Indicators for Swaziland



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SECTOR OVERVIEW AND KEY INDICATORS

The Government of Swaziland has made significant progress in improving the health outcomes of its citizens, especially children. Both infant and under-five mortality rates have been on the decline, with the Under-five Mortality Rate (U5MR) recording the biggest drop from 104/1,000 in 2010 to 67/1,000 live births in 2014. Further significant improvements have been recorded in institutional deliveries (80.4 to 87.7%) and skilled birth attendance (82.0% to 88.3%) (Figure 1).

However, a lot more still needs to be done to improve the health outcomes of children, in pursuant to the Country's vision to become a first world country by 2022. For instance, one in every four Swazi children is stunted, whilst full immunisation has fallen from 83.1% in 2010 to 75% in 2014, showing a negative trend. The government's policy thrust should therefore focus on sustaining the gains recorded whilst making sure that real public investments are equitably and efficiently spent to achieve better health outcomes for all, including increasing the budget for outreach programmes for immunisation.

2017/18 HEALTH BUDGET ANALYSIS

Recent Achievements of the Health Budget

- Commitment to the procurement of HIV drugs by ring-fencing E261.00 million annually
- Renovation of the maternity wing at Mbabane Government Hospital, with the first neonatal unit
- Introduction of two new vaccines; IPV for prevention of poliomyelitis, and Measles Rubella Vaccine for prevention of measles and rubella in 2016, which contributed to achieving vaccination rates of 81.1% and 81%, respectively
- Completion of the Out-Patient Department at Mbabane Government Hospital which is now fully operational
- Construction of clinics in rural areas at Nhlangunjani, Mkhitsini, Bhudla, Nsalitje, Mkhwakhweni, Vusweni, Ekufikeni, Mambane and Ndzingeni
- Commissioned three clinics in Mkhuzweni, Mangweni and Ndzingeni in Hhohho region

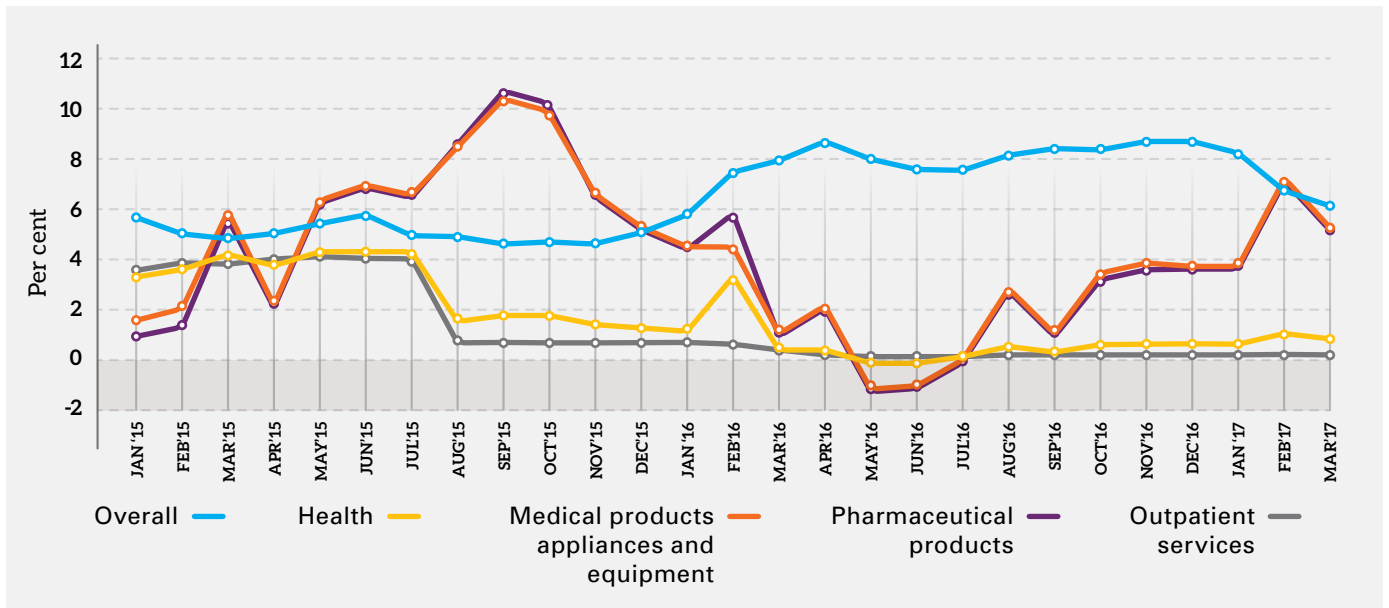


FIGURE 2: Trends in Health Care Inflation
Source: Swaziland Central Statistics Office

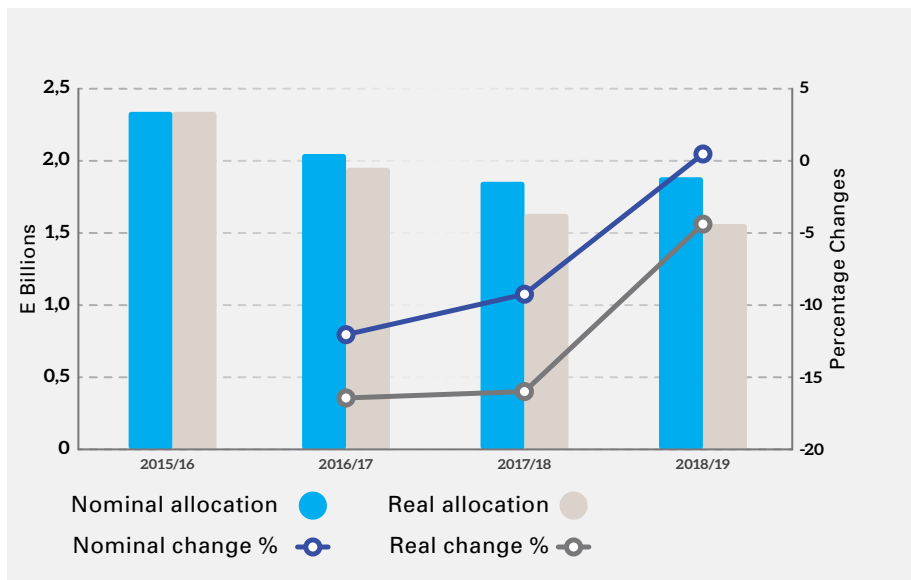
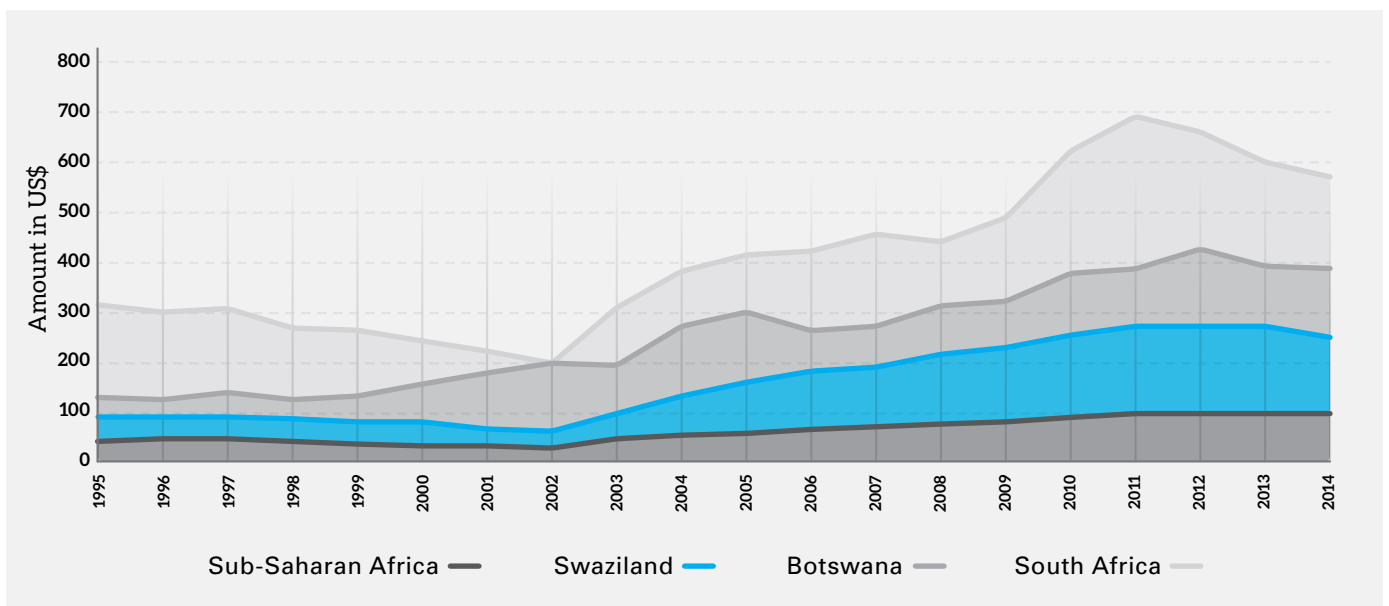


FIGURE 3: Trends in the Allocations to MoH
Source: 2017/18 Estimates of Expenditure Book

FIGURE 4: Health Expenditure per Capita (Current US\$)
Source: Global Health Expenditure Database 2014





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Trends in Health Inflation

Prices of healthcare products and services have generally been rising, although at a decreasing rate.

Annual health inflation averaged below 4% in 2015 closing 2016 at 0.4% (Figure 2). Health care inflation trended below overall inflation throughout the period 2015 to 2016. In general, healthcare inflation gives the trends in prices of healthcare products and services and is an important factor determining access to healthcare for the general public who include the poor and marginalised children, particularly when out-of-pocket payments (OPP) are a major source of healthcare expenditure. High OPP affects the health seeking behaviour of the poor, in this case the 63% of the population and 69% of children considered to be living in poverty. In Swaziland, OPPs account for 10.3% of total health care expenditures compared to South Africa (6.5%), Namibia (7.2%), Botswana (5.2%) and Lesotho (16.5%)¹.

The major contribution to the declining health inflation has been the important role played by the government in the procurement of drugs. Almost 100% of the major vaccines and antiretroviral drugs are procured by the government, and provided to hospitals free of charge. Thus, the government bears the full costs of price changes at sources to maintain affordability at

the point of seeking care. However, some shortages of medicines have been reported- in some cases due to delays encountered in the procurement process.

2017/18 Budget Allocation

The Ministry of Health was allocated E1.85 billion in the 2017/18 budget, representing 9.1% of the total budget and 3.2% of GDP. The allocation represents a 9.2% nominal decline from the E2.04 billion allocated in 2016/17 financial year. In real terms, the allocation to the MoH declined by 15.7% from E1.94 billion to E1.63 billion (Figure 3), mainly on account of constrained government revenues. This however, does not include the E340 million allocated for personnel from sub-vented organisations into government establishment².

Against the projected improvements in revenue collection, the government aims to progressively improve health care allocations to E1.87 billion in 2018 (Figure 3).

Without factoring external support, the 2017/18 allocation significantly falls short of the requirements in the sector. Preliminary costing of the Essential Health Care Package (EHCP) shows that a minimum of E2.5 billion³ (translates to E2,181.00 ~ US\$168.00

1. <http://data.worldbank.org/indicator/SH.XPD.OOPC.TO.ZS?view=chart>, accessed on 28 July 17

2. Also E15 million worth of durables, including medical equipment, are procured via central transfers and not reflected here.

3. Cost Analysis of Essential Health Care Package, November 2016

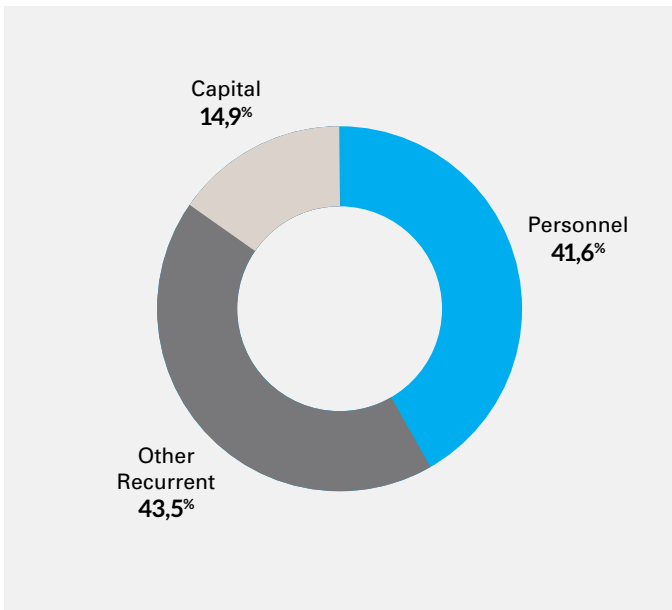


FIGURE 5A: Composition of the MoH Budget for 2017/18

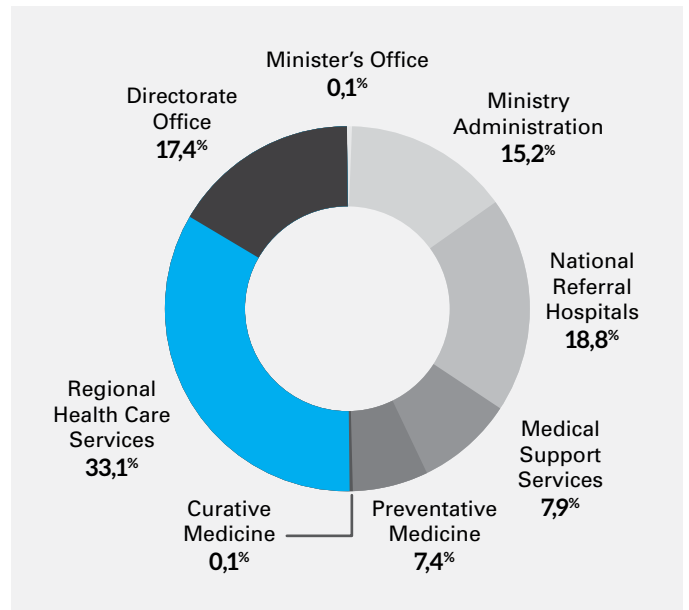


FIGURE 5B: Composition of MoH Recurrent Budget By Programmes 2017/18

Source: 2017/18 Estimates of Expenditure Book

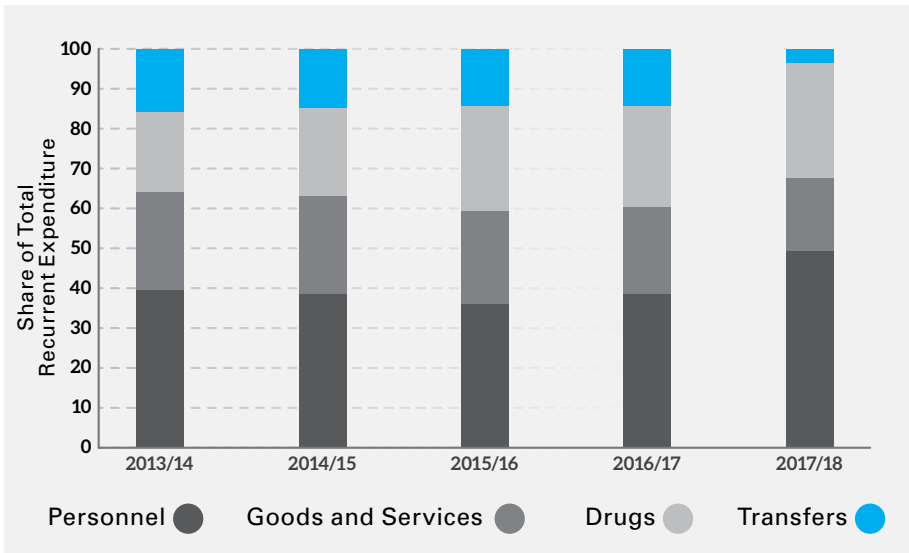


FIGURE 6: Recurrent Health Budget By Control Item (2014-2018)

Source: 2017/18 Estimates of Expenditure Book

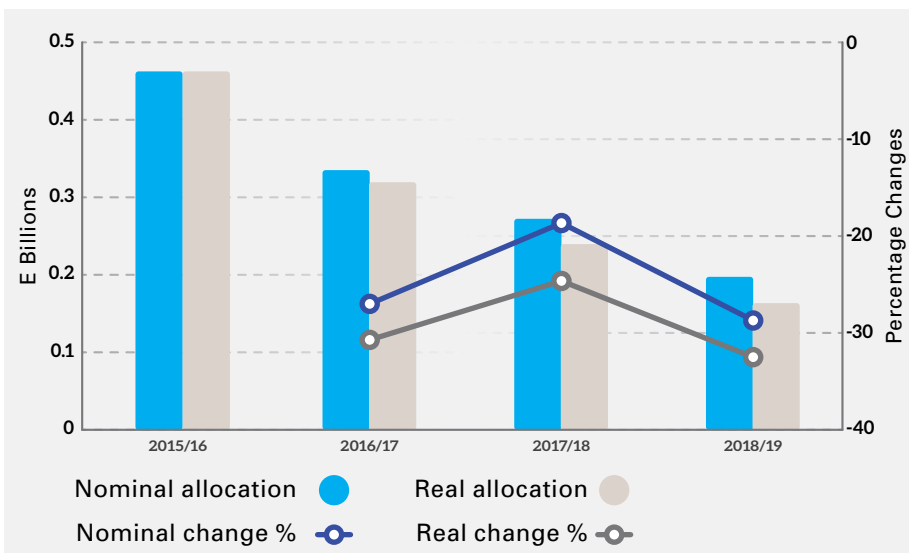


FIGURE 7: Trends in the Capital Expenditure for MoH

Source: 2017/18 Estimates of Expenditure Book

	Per Capita	U5M/1000	Maternal mortality/100,000	Immunisation %
Swaziland	132.62	67	592	75
Zimbabwe	20.54	69	651	69
Zambia	93	119	591	77
Malawi	39.2	64	574	87

TABLE 1: Per Capita Spending vs Health Outcomes (2014)

Source: Various Country MICS Reports and Budget Briefs

per capita) would be required in 2017/18 to ensure an equitable minimum package of healthcare services for all Swazis. In addition, the allocation of 9.1% in Swaziland is 5.9% lower than the 15% Abuja target, as a share of total expenditures.

However, Swaziland's per capita allocation, at US\$123.62 (which excludes external resources and out-of-pocket payments), exceeds the World Health Organisation (WHO) per capita target of US\$86.00, should the budget be fully spent. Although it is dwarfed by South Africa and Botswana, it is respectably higher than the Sub-Saharan Africa (SSA) 2014 average of US\$98.20 per capita (Figure 4).

Despite this, the country is yet to achieve the US\$168.00 Essential Health Package target and per capita expenditure in many developed countries, consistent with the 2022 vision of becoming a developed country. For instance, by 2014 developed countries were spending an average US\$5,265.99 per capita on health. Swaziland therefore needs to progressively increase its health care spending in order to be at par with other developed countries.

More so, despite spending more than its regional peers, Swaziland's health outcomes do not match the level of investment, due in part to the severe HIV/AIDS crisis, given the high HIV prevalence rate of 26%. Furthermore, Swaziland, as a low-middle income country, is experiencing an epidemiological transition with non-communicable diseases accounting for about a quarter of morbidity and mortality. The country's health outcomes have remained comparable to developing countries, which on average spent far less than Swaziland (Table 1). This points to the need to improve efficiency of spending.

Composition of the MoH Budget Allocation

Swaziland's 2017/18 total Health Budget is significantly skewed towards recurrent programmes. Eighty-five per cent of the 2017/18 allocation will be spent on recurrent costs, with employment costs accounting for 45%, with only 15% for capital development programmes (Figure 5a). Despite the large share of employment expenditures, Swaziland still faces challenges related

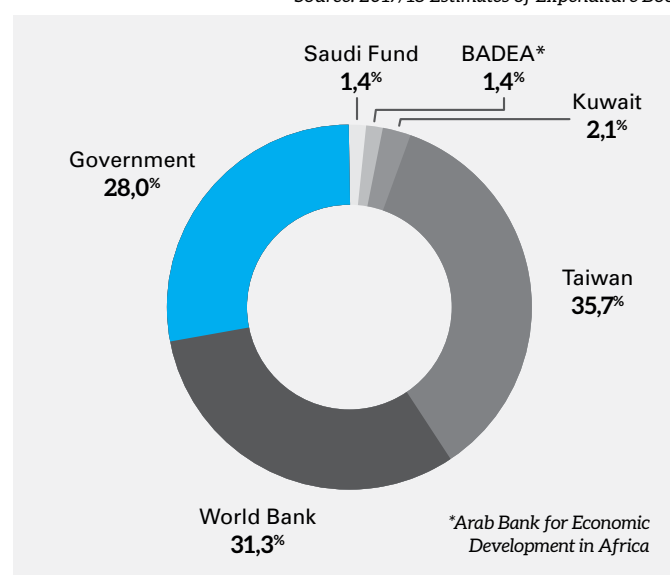
to the adequacy of skills and numbers of healthcare workers. The Second National Health Sector Strategic Plan (2014-2018) target ratio for 2017 in terms of trained nurses and midwives per 10,000 people, is 2.4, and the targeted ratio of medical staff (doctors, nurses and midwives) to 10,000 population for 2017, is 2.3, compared to the WHO threshold of 25 medical staff per 10,000 people. For a middle-income country, this could be considered as a human resource crisis affecting the health delivery system's capacity to deliver better health outcomes. Hence the need for improved budgetary investments in developing human resources for health.

Whilst there is inadequate capital related investment in general, there are significant equity issues which need to be addressed in the health sector, to achieve healthcare infrastructure development. For instance, the average facility per 1,000 people is 2.6 and is lowest in Shiselweni at 1.7, compared to 3.4 in Manzini⁴. Distance to the nearest facility is a common factor that affects health-seeking behaviour and therefore, access, particularly for vulnerable women and children.

Regional health care services were allocated 33.1% of the Budget (Figure 5b). This budget is used for providing

FIGURE 8: Sources of Health Capital Financing for 2017/18

Source: 2017/18 Estimates of Expenditure Book





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healthcare services through regional clinics, hospitals and public health units across the four regions of the country. The national referral Hospitals (Mbabane Government Hospital, the Tuberculosis Hospital and the Mental Hospital in Manzini) were allocated the second largest share of the budget, accounting for 18.8%, whilst the Directorate Office, responsible for ring-fencing the budget for antiretroviral (ARV) drugs got 17.4% of the total recurrent budget. Medical Support and Preventive Care Services were allocated a combined share of 15.3%. Disease Control and Prevention is one of the key strategies under Health in Vision 2022, and efforts are being made to scale up the preventive strategies to reach universal coverage⁵. There is however a challenge of unpacking the details of the composition of the Health budget, and this may require renaming sub-line items in the Budget Estimates Book to reflect current MoH implementation programmes and services.

The Immunisation Unit, which focuses on immunising children received a budget of E38.11 million in the 2017/18 budget. This represents a 33.4% decline from the E57.22 million estimated expenditure in 2016/17, which could not achieve full immunisation coverage. As such, the current allocation will not be sufficient for prevention, and against falling immunisation coverage from 83.1% in 2010 to 75% in 2014. With one in every four Swazi children not receiving full immunisation, more resources are needed to ensure full immunisation coverage, including operational and transportation costs, to reach the hardest-to-reach areas.

Trends in the Composition of Recurrent Expenditures

Personnel costs are expected to increase by 10.7 percentage points to 48.9% of the recurrent budget in 2017/18. The jump in employment costs can be attributed to salary

adjustments and increase in staff levels aimed at addressing the existing human resources gaps.

However, the government remains committed to the procurement of major healthcare drugs. As such, the share of expenditure on drugs is projected to increase to 28.9% (Figure 6). This is commendable as it has helped contain healthcare inflation and at the same time ensured the availability of major drugs, to the benefit of all citizens, including children.

Whilst the increased share of allocation towards drugs can be attributed to rising costs at source, improved efficiencies in the government procurement systems can help reduce the total cost of drugs and vaccines. More could be achieved through cost efficient alternative options for the procurement of vaccines and other drugs, thereby freeing resources for that programme. For instance, estimates in other countries show

5. The Second National Health Sector Strategic Plan, 2014-2018



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that savings of up to 60% can be made with a more efficient procurement system for vaccines. With such savings, the government can easily double its expenditure on other high impact interventions such as maternal and newborn health, to levels comparable to Swaziland's income status. Lessons can be drawn from regional experiences such as those of Namibia and Lesotho, where procuring vaccines through UNICEF Supply Division at affordable costs, makes substantial savings for the government.

Trends in the Capital Budget

The share of the budget spent on capital expenditures is very low. In 2017/18, the allocation to capital investments for health is projected to decline both nominally (18.3%) and in real terms (24.2%) to E274.75 million and E242.73 million, respectively (Figure 7). Therefore, such a declining trend in the

capital budget affects healthcare infrastructure improvements.

Some key capital projects that were on-going, with commitment and expenditure of a combined sum of E482.83 million by the end of the 2016/17 financial year, are reported to have been suspended due to poor quality of work - among them, the TB hospital in Manzini, and the Lubombo Regional Hospital Phase 2. Other micro-projects have also not been completed due to cash flow issues. This highlights the need for efficient planning at the sector ministry (MoH), and expenditure prioritisation at the Ministry of Finance, to achieve value for money for the investments, and for achieving the intended goals.

Sources of Health Care Financing

The Government's recurrent health budget is wholly (100%) financed from domestic revenues. However, this only relates to direct budgetary

support. For instance, the E274.75 million Capital Budget for 2017/18 is externally financed, with 72% coming from external sources, while 28% comes from the Government of Swaziland. Of the external funding sources, a combined 67% will come from the Taiwan Government and the World Bank (Figure 8).

In fact Swaziland's Health sector continues to receive the highest share of external aid for both recurrent and capital funding. Total external aid to the health sector has increased steadily from 29% in 2014 to 39% in 2016 (Figure 9). Most of the aid received has been directed towards HIV and TB programmes. The combined effect of donor support and the ring fencing of HIV funding under the Directorate from 2015, has resulted in an increase in the number of people on ART (Antiretroviral therapy) from 147,274 in 2015 to 171,765, in 2016, of which children under 14 on ART increased from 8,063 to 9,501 in 2016.

Although donor contribution is crucial for Swaziland, future unpredictability of donor-funding, especially for middle-income countries, raises funding sustainability concerns for the sector. Hence, the need for increased domestic resource-mobilisation efforts particularly towards funding capital projects in the health sector.

In addition, health indicators are aggregated at the regional level and show minimum variations - for instance immunisation is 70.4% in Hloho and highest in Manzini at 78.7% according to MICS 2014. Better equity analysis would benefit from disaggregated expenditure and healthcare indicators at the lowest administrative unit of government, the Tinkundla.

Equity in Health Spending

Achieving equity in spending should be at the core of the government's budget spending. However, the Swaziland Budget is centralised making it difficult to make conclusive analysis of the equity in resource budget expenditure. Only 33.1% of the budget goes to regional health facilities.

Budget Execution

The rate of Budget implementation has remained significantly high in Swaziland. In some instances actual expenditure exceeded the original budget estimates. For instance, in 2016/17, there was a 7% overrun on the total recurrent budget, owing to revisions in original allocations, in drugs, transfers, consumables, and Central Transport Authority Charges (CTA), among others (Figure 10).

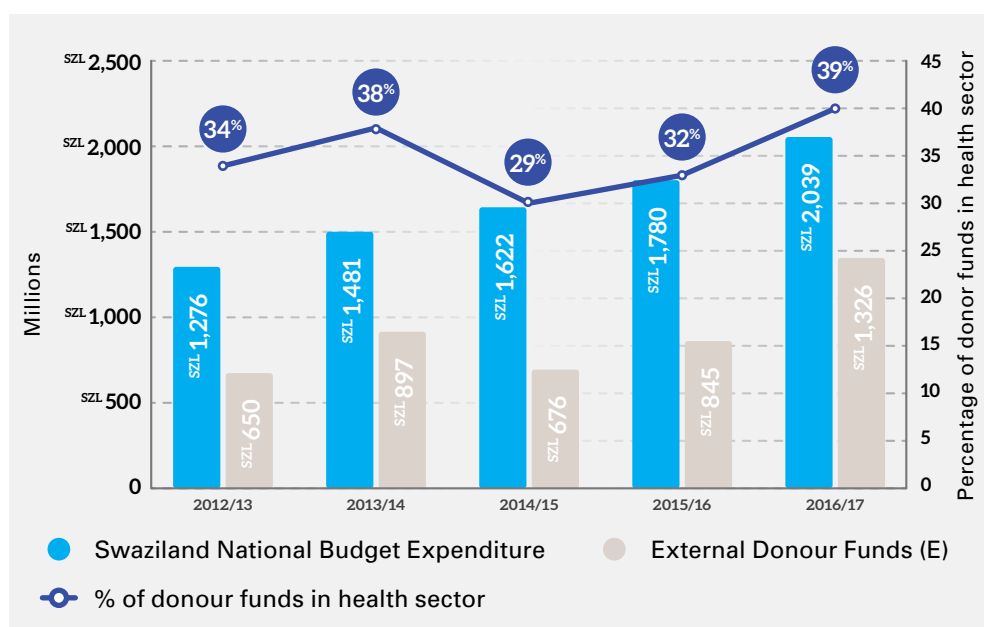


FIGURE 9: Health Sector Budget and External Funding 2012-2016
Source: External Assistance in Swaziland Reports - Ministry of Economic Planning and Development

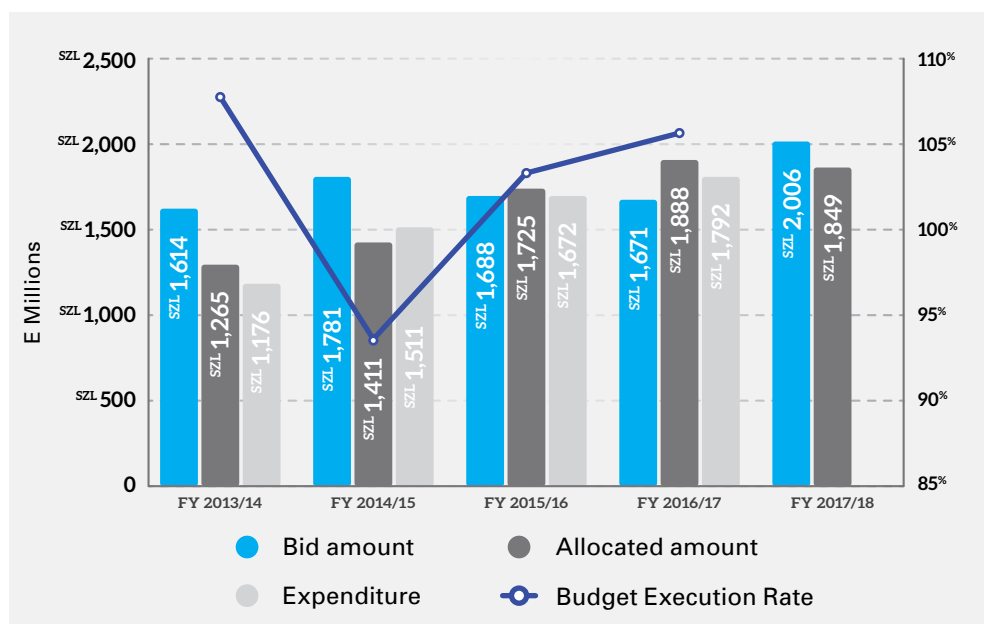


FIGURE 10: MoH Budget Request vs Expenditure 2013 - 2017
Source: Data provided by CHAI - upon request



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RECOMMENDATIONS:

- Adopt alternative and efficient procurement systems for vaccines and drugs. Estimated savings of at least 20% can be made through more cost effective procurement systems through international partners. The savings could be channelled towards high impact interventions in immunisation, maternal and under-five mortality.
- Improve the immunisation budget to include operational costs, including vehicles to take the service to the hard-to-reach children, given that 25% of children were not fully immunised by the end of 2014.
- Address the existing gaps in human resources for health, to meet the WHO standards of 25 medical personnel per 10,000 people. This should also target midwives to improve skilled birth attendance. For instance, revisions of on-call allowances vis-à-vis salaries, will free resources which can be used to recruit more health personnel.
- Spend capital on health infrastructure, especially in rural areas, with requisite maternity infrastructure, to meet the 5km radius to the nearest facility, as recommended by the WHO. This will help improve institutional deliveries as well as maternal and newborn health.
- Aim for the Overall Budget allocation to reach the Essential Health Care Package (EHCP) estimated at US\$168.00 from the current US\$123.62 in the 2017/18 financial year; and scale up preventative strategies to reach universal coverage.
- Spend resources for health more efficiently and equitably to correspond with outcomes, particularly targeting the children and populations in the hard-to-reach parts of the country.
- Enhance domestic resource-mobilisation efforts to reduce the donor reliance for capital spending. This is against the background of unpredictability of donor-funding, especially for middle-income countries.
- Rename sub-line items in the finance system to reflect current MoH implementation programmes and services. This is to support transparency and clear understanding of Ministry of Health budget allocation and utilisation.

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