

HEALTH BUDGET BRIEF

2018/2019



This budget brief is one of four that explores the extent to which the national budget addresses the needs of children under 18 years in the Kingdom of Eswatini. This brief analyses the size and composition of budget allocations for the fiscal year 2018/19, and offers insights into the efficiency, equity and adequacy of past spending in the health sector. The main objectives of the brief are, firstly, to synthesize complex budget information so that it can be easily understood by all stakeholders and, secondly, to put forth key messages which can inform policy and budgeting decision-making processes.



KEY MESSAGES

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10.1% of total expenditure is spent on health in Eswatini, which falls far below the government commitment to scale up health spending and meet the Abuja Declaration of 15% of all resources generated to be allocated to health. In order to meet this target, the Government of Eswatini should investigate the potential for introducing innovative financing mechanisms including involving the private sector which will could raise up to an additional 0.5% of gross domestic product (GDP).

The government spends the majority of its resources on personnel and administration. To achieve greater outcomes such as reduced under five child mortality, higher rates of investment are needed in the health sector. In order to make fiscal space for investment, the government should focus on decreasing costs for travel and training and reducing its bloated wage bill.

HIV/AIDS rates in Eswatini are amongst the highest in the world. The government has achieved the PEPFAR goal of 90-90-90. Still, the cost of treating HIV/AIDS as well as the years of lost productivity from early HIV/AIDS-related deaths remains a huge recurrent cost for government. Notwithstanding progress, more must be done to prevent new cases altogether.

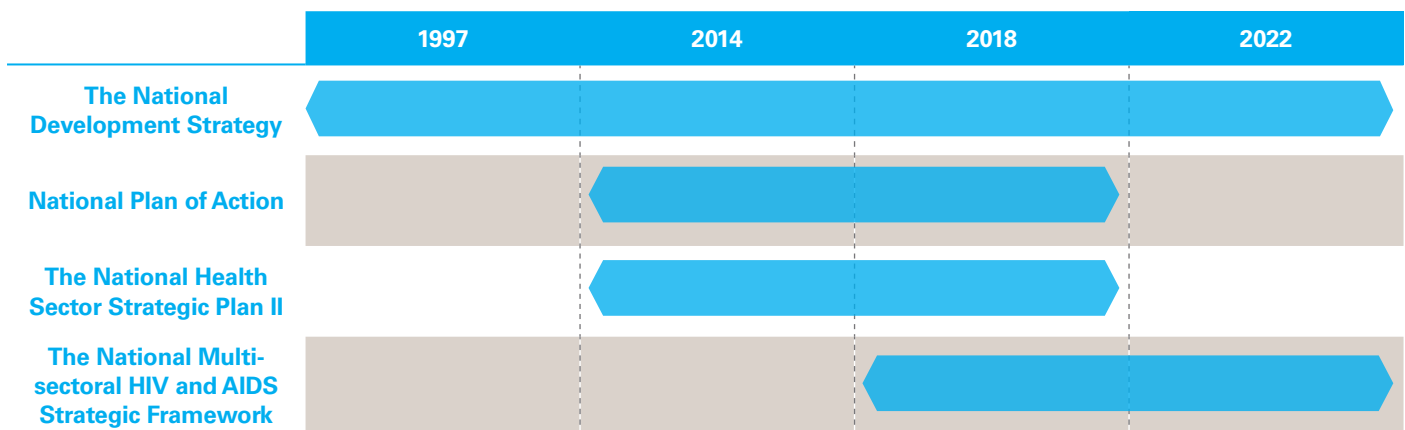
Budget credibility is erratic. It is recommended that a joint government, World Bank and UNICEF-sponsored Public Expenditure Review (PER) of the health sector is undertaken urgently to understand the underlying issues causing this disturbance. In addition to highlighting budget credibility issues, such a review will also be able to identify weaknesses in other areas of public expenditure management such as arrears build up, which, if rectified, could lead to improved efficiency of health-based public expenditure and thus greater impact of current spending on health outcomes.

The majority of donor health resources are spent off budget. In line with OECD-DAC best principles, donor funding should increasingly flow through governments' own systems. This is a joint agenda. Moving forward, the government must prioritize strengthening their public finance systems to ensure a reduction in fiduciary risk for on budget donor funds, whilst donors can respond to these initiatives by moving away from proliferating off budget project support modalities, reducing transaction costs for both sides.

INTRODUCTION

The health sector in Eswatini is delivered under the mandate of the national government and the Ministry of Health based on guidance contained in a number of different strategic plans. Namely, the National Strategic Plan, the National Plan of Action and the Second Health Strategic Plan. Health is the fourth focal area in the 2013-2018 Programme of Action (see Figure 1).

FIGURE 1: MAIN STRATEGIC DOCUMENTS FOR HEALTH



Source: Government of Eswatini

Key policy objectives related to the health sector under the National Plan of Action are as follows:¹

- Develop appropriate organizational structures at the national, regional and health facility level in order to improve management, coordination, planning, monitoring and evaluation of health services.
- Improve and expand comprehensive primary and reproductive health care programmes.
- Improve the health infrastructure and delivery system in the Kingdom.
- Improve cooperation with donor agencies as well as NGOs involved in the delivery of health care services.
- Strengthen the fight against the HIV/AIDS pandemic.
- Intensify the mobilization of “Health for All” through nation-wide health education campaigns.

The Ministry of Health (MoH) is responsible for the formulation of policies, regulations, norms, standards and guidelines for health services as well as for mobilizing financing through the National Health Sector Strategic Plan (NHSSP II). The MoH also works with a number of partners including the United Nations Population Fund, the World Bank, WHO and local and international NGOs. In Eswatini, health services are delivered across primary, secondary and tertiary levels.

NHSSP II commits to delivering a comprehensive set of health services in a holistic way. The plan is built around a functional rather than structural approach, with various interlocking elements that all work towards a common health agenda. NHSSP II draws on the Swaziland Development Index, the National Development Strategy (2018) and the National Health Policy (2007), which are informed by global and countrywide health aspirations. It constitutes the medium-term strategic focus for the health sector.

¹ National Development Strategy Plan.

NHSSP II has the following three specific objectives:

1. Increasing the number of health and related services and interventions provided across the country (introduction of interventions as and where needed).
2. Expanding population coverage by the various health and related services and interventions (scale-up of intervention use).
3. Reducing the household financial burden incurred at the point of access and in the use of health services.

Targets are set and monitored through the Swazi

Development Index 2022. Key indicators for health are for (i) Life expectancy at birth, (ii) Maternal mortality rate, (iii) Child mortality rate and (iv) Trained nurses and midwives

per 100,000 people. These targets are monitored annually through the Swazi Development Index 2022. It is expected that if these objectives are met that life expectancy can be increased from 49 years in 2006 to 60 years by 2022.

Significant investments in health over the last decade have improved life for many, however challenges remain.

Life expectancy for men dropped from 60 years in 1997 to 45.3 years in 2012, primarily as a result of the HIV/AIDS epidemic but has more recently increased to 55.1 years (2018). The current overall average for men and women is 57.7 years. The observed average for lower middle-income countries is 68 years. From a regional perspective, life expectancy is slightly below the average for sub-Saharan Africa which is 60 years² (Table 1).

TABLE 1: SELECT SOCIOECONOMIC AND SOCIAL PROTECTION INDICATORS

INDICATOR	VALUE	INDICATOR	VALUE
Total population (2018)	1,139,370	Under five mortality per 1,000 live births (2017)	67
Population growth rate (2018)	1.2%	Life expectancy at birth – males (years) (2018)	55.1
Children under 18 (2018)	568.656	Life expectancy at birth – females (years) (2018)	59.1
Children as % of population (2018)	49.9%	Maternal mortality rate per 100,000 births (2017)	589
National poverty rate (2017)	58.9%	Child mortality under one per 1,000 live births (2018)	50
Child poverty rate (2013)	70%	HIV/AIDS rate male 14 to 49-year-olds (2018)	34.3%
Extreme poverty (2017)	20.1%	HIV/AIDS rate female 14 to 49-year-olds (2018)	18.9%
Immunization rate children 1-2 years (2018)	88%	HIV prevalence 0-14 years (2017)	2.8%

Sources: UNICEF (2013) *Child and orphan poverty in Swaziland*; UNDP Human Development Report (2016); UNICEF (2016) *State of The World's Children*; Eswatini Household Income and Expenditure Survey 2016/17 (2018); SHIMS2 2016–2017 (2017); WHO and UNICEF (who.int/immunization/monitoring_surveillance/en) (2018); World Development Indicators (WDI) database (2018)

Overall, access to health workers is limited. Although recent data is not available, the number of nurses and midwives as measured for 1,000 people decreased from 3.15 in 2000 to only 1.39 in 2009. According to the same data, there were no doctors per 1,000 persons available whereas in 2009 there were 0.15 per 1,000 people (Table 2).

TABLE 2: ACCESS TO HEALTH WORKERS

	2000	2009
Physicians (per 1,000 people)	0.00	0.15
Nurses and midwives (per 1,000 people)	3.15	1.39
Physicians (total)	2.12	173.56
Nurses and midwives (total)	3,338.32	1,636.42

Source: World Health Organization's Global Health Workforce Statistics, OECD, supplemented by country data (Extracted August 2018)

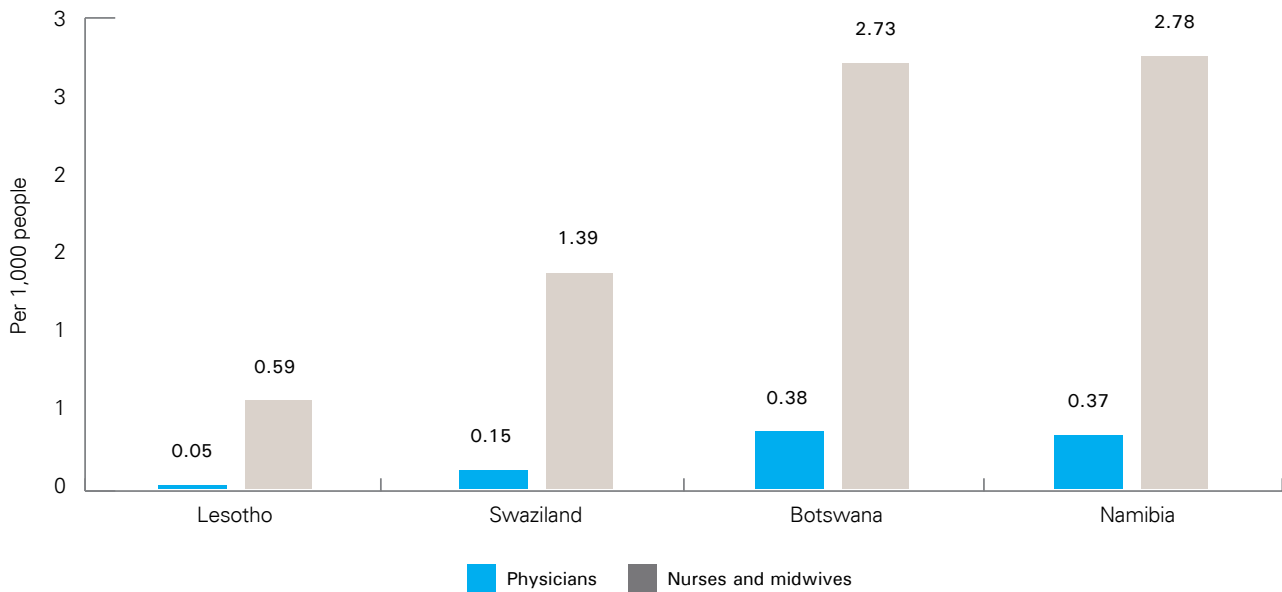
² World Bank (2017) Public Health Sector Expenditure Review 2017, Washington D.C.

Eswatini exhibits some of the lowest access rates to nurses and doctors in the region. Eswatini performs better for access to both physicians and nurses than Lesotho with 0.05 physicians and 0.59 nurses per 1,000 people (Figure 2).

The percentage of births attended by skilled health professionals is relatively high and compares well at a

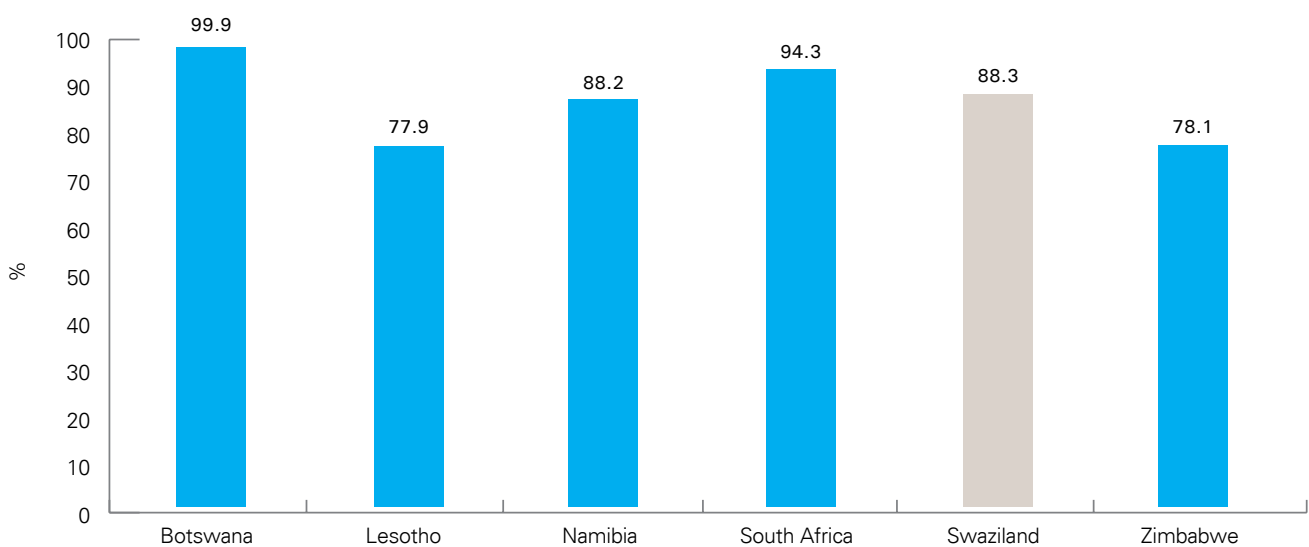
regional level. The percentage of births attended by skilled professionals is currently 88.3% of the population (Figure 3). Whilst this could be improved to levels as high as 99.9% in Botswana, Eswatini fares better than Lesotho (77.9%) and Zimbabwe (78.1%). In spite of this, the maternal mortality rate for 100,000 live births is still very high at 589.

FIGURE 2: ACCESS TO HEALTH WORKERS, SWAZILAND VERSUS ITS NEIGHBOURS



Source: World Health Organization's Global Health Workforce Statistics, OECD, supplemented by country data.

FIGURE 3: BIRTHS ATTENDED BY SKILLED HEALTH PROFESSIONALS



Source: UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys.



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Over 34% of the adult population is HIV positive and 2.8% of children under 14 are infected.³ In response to this epidemic, the National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018–2022 was developed. This five-year policy and planning document is focused on resource allocation, programming and implementation of the HIV response in the Kingdom of Eswatini. The vision for this NSF is to end AIDS as a public health threat by 2022 through epidemic control by focusing on drastically reducing new infections and AIDS-related deaths.

Antiretroviral therapy (ART) has been extended to cover the majority of the population by 2018. Among people living with HIV aged 15 and older who know their HIV status, 87.4 percent self-report current use of ART: 86.9 percent of HIV-positive females and 88.6 percent of HIV-positive males who know their HIV status self-report current use of ART.⁴ In addition, the MoH has introduced nurse-led ART initiation to facilitate rapid scale-up of services and the promotion of HIV care and treatment services. This has resulted in increased access to ART contributing to the reduction in HIV incidence by nearly half and a doubling of viral load suppression among people living with HIV.

Health outcomes remain a serious challenge for emaSwati children. The Swaziland Child Monitoring report (2017) noted that the under-five mortality rate remains at 80 children per 1,000 live births, while the infant mortality rate is currently 50 children per 1,000 live births (Table 1). In spite of

some progress, these numbers remain very high. The main reasons for under five deaths are non-infective gastroenteritis and colitis, calorie malnutrition and pneumonia.⁵

Stunting and wasting are serious challenges in Eswatini.

Approximately 25.5% of children under 5 are stunted, while 5.8 % are underweight (Figure 4). To tackle nutrition-related challenges for children, the government joined the Scaling Up Nutrition (SUN)⁶ movement in December 2013. At the time, Eswatini had launched national programmes including the integrated management of acute malnutrition and food by prescription. Eswatini had also begun improving political and policy coherence through the alignment and coordination between sectors and stakeholders with the development of a national nutrition strategy integrating key variables such as HIV/AIDS, poverty alleviation and food security.

Immunization rates amongst children 12-23 months is relatively high but could be improved. Currently 90% of children are immunized before they turn 23 months (Figure 5).

At present there are three health child-focused programmes tasked with addressing all childhood conditions. These programmes are the expanded programme on immunization (EPI), the integrated management of neonatal and childhood illnesses as well as the nutrition programme. These programmes work hand in hand with other programmes that also offer child-focused interventions.

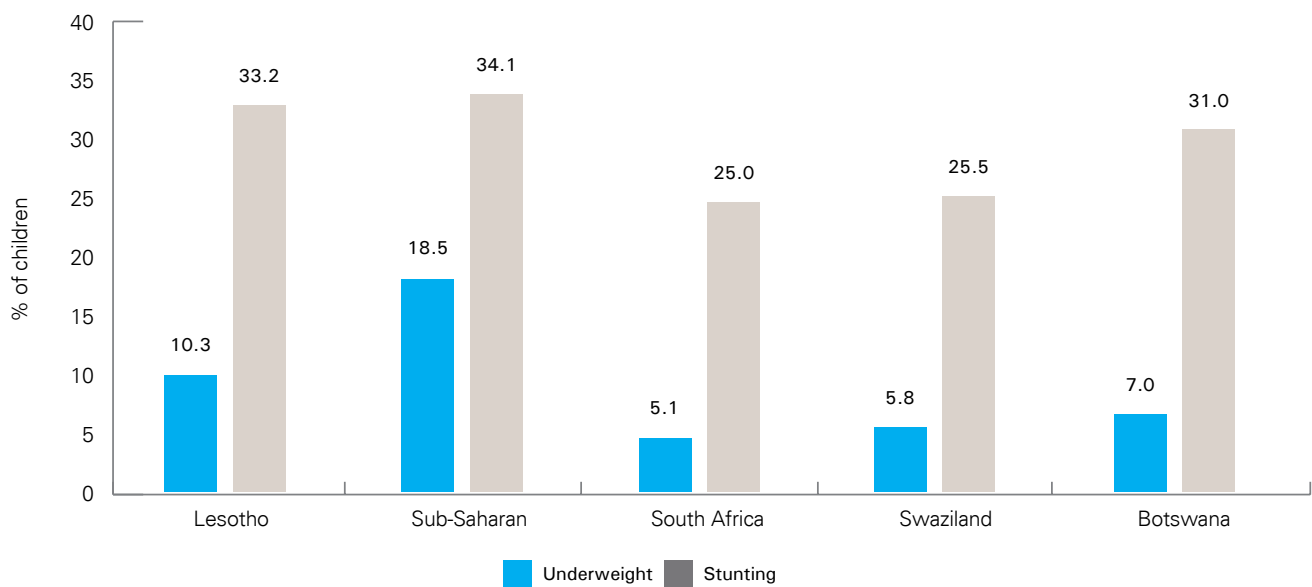
³ SHIMS2.

⁴ Ibid.

⁵ NATIONAL CHILD HEALTH Report (2017) Government of Lesotho.

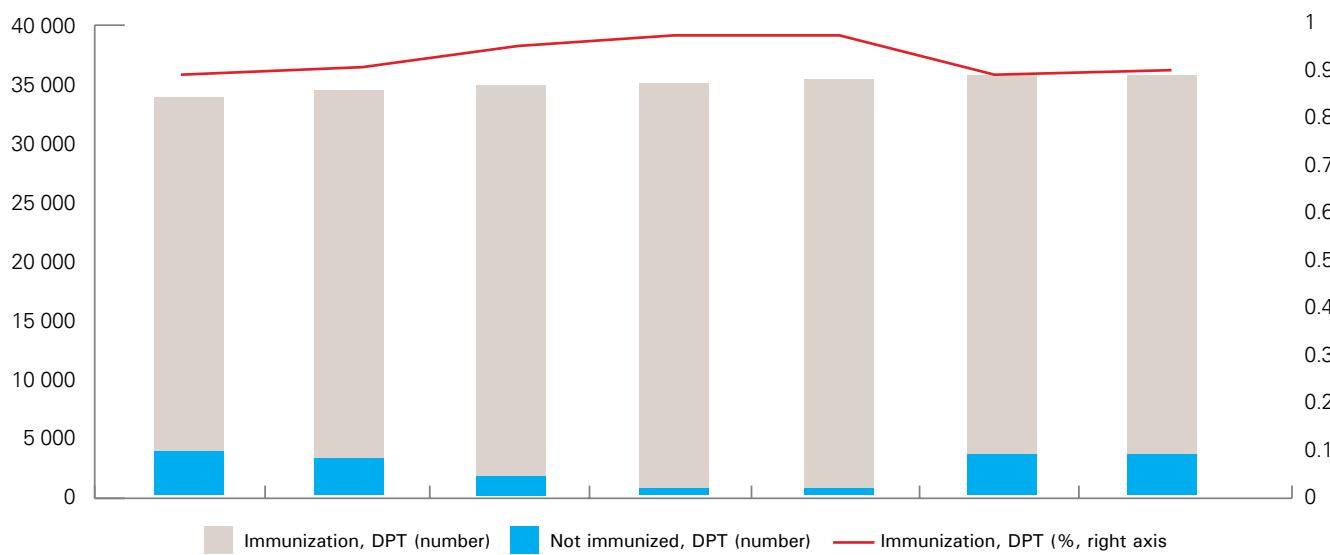
⁶ SUN is an organisation under the UN umbrella mandated with eradicating malnutrition.

FIGURE 4: RATES OF STUNTING AND WASTING AS % OF UNDER 5, ESWATINI AND ITS NEIGHBOURS 2017



Source: World Development Indicators (extracted 2018)

FIGURE 5: RATES OF IMMUNIZATION 12-23 MONTHS



Source: WHO and UNICEF (who.int/immunization/monitoring_surveillance/en)

TAKEAWAYS

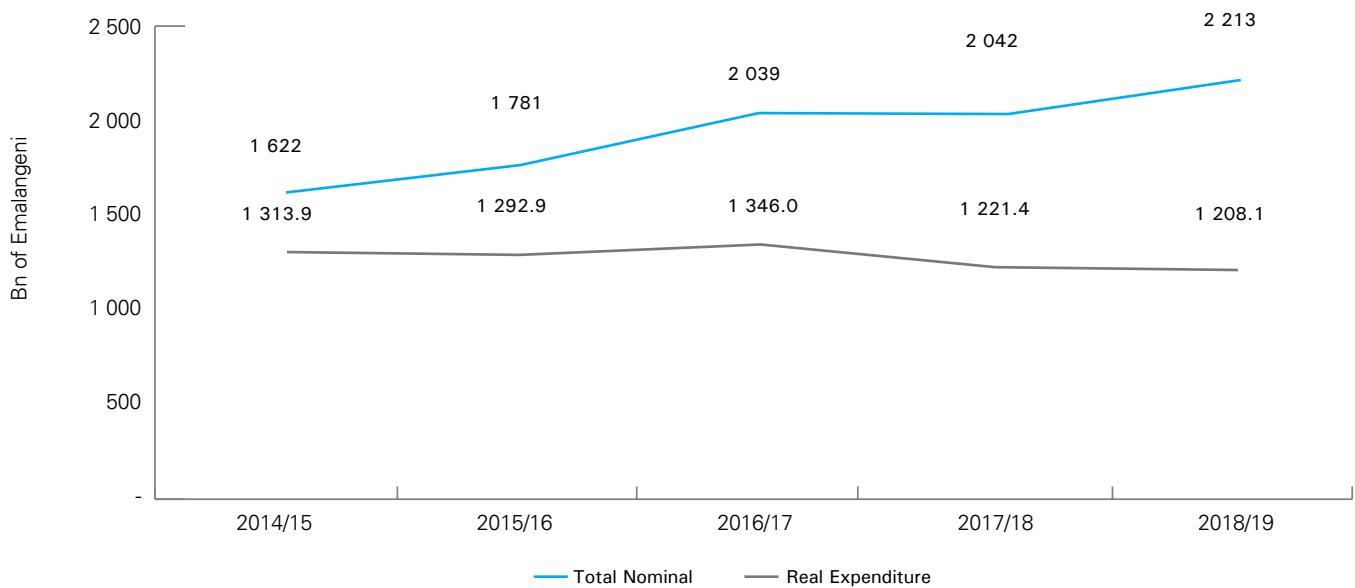
- EmaSwati’s life expectancy rates fell in the early 2010s as a result of HIV but now, with ART, lives are being extended.
- Neonatal, infant and child mortality and malnutrition are pervasive and widespread. Efforts to prevent and treat HIV/AIDS, improve access to emergency obstetric and neonatal care services, access to child health services and continued interventions to strengthen cross-sectoral approaches to address malnutrition must be scaled up.

HEALTH SPENDING TRENDS

The 2018/19 nominal budget for health is expected to reach 2,213 billion Emalangeni, which represents a nominal increase of 8.3% compared to last year. In real terms, however, actual spending will decline by close to 1% (Figure 6). When looking back over the past five years, nominal spending has increased by 36.4% between 2014/15 and 2018/19 although it has actually decreased by 8% once accounting for inflation.

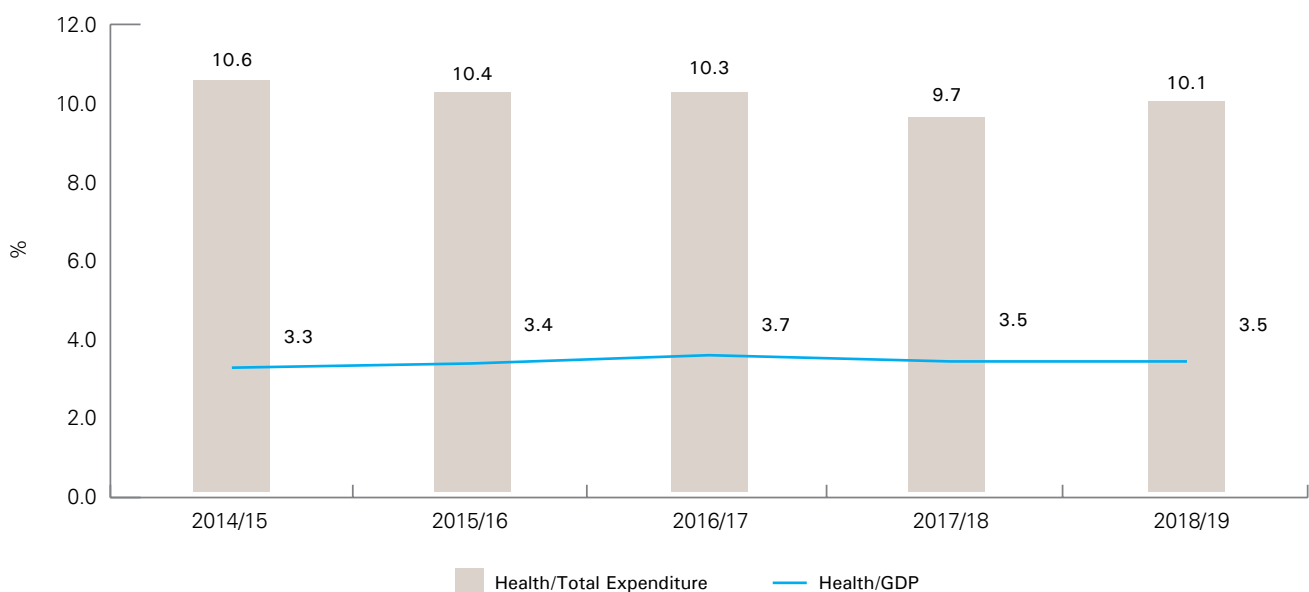
Expenditure in health as a percentage of GDP and as a share of the total budget has remained relatively stagnant over the period of 2014/15 to 2018/19. Health as a share of the total budget has declined from 10.6% to 10.1% since 2014/15. Health spending as a share of GDP has averaged 3.5% and is projected to maintain this level this fiscal year (Figure 7). Health per capita is roughly USD 248 per annum.

FIGURE 6: APPROVED BUDGET - REAL VERSUS NOMINAL EXPENDITURE FOR HEALTH, 2014/15-2018/19 IN BN OF EMALANGENI



Source: The Government of the Kingdom of Eswatini, annual budget book estimates (various) and estimates for the 1st of April 2018 to 31st of March 2021

FIGURE 7: APPROVED BUDGET FOR HEALTH SPENDING AS A SHARE OF GDP AND TOTAL EXPENDITURE, 2014/15-2018/19 (%)

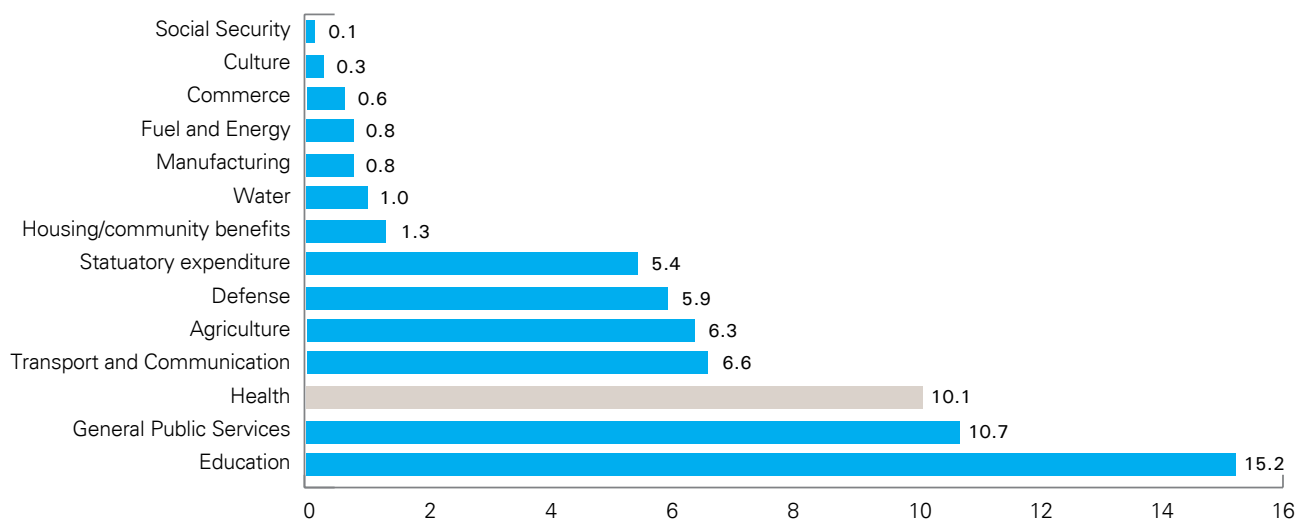


Source: The Government of the Kingdom of Eswatini, annual budget book estimates (various); estimates for the 1st of April 2018 to 31st of March 2021; and the MTFE (2018)



Health is the third largest sector in Eswatini at 10.1% of expenditure. Education is the biggest recipient of the budget share, followed by general public services. The allocations to the two most important sectors fall well below international targets. In 2018/19, education is budgeted to receive 15.2% (Figure 8), while health receives only 10.1%. It is important to recognize that the government's current financial commitment for health falls short of international targets of 15% of the budget for health (Abuja Declaration).

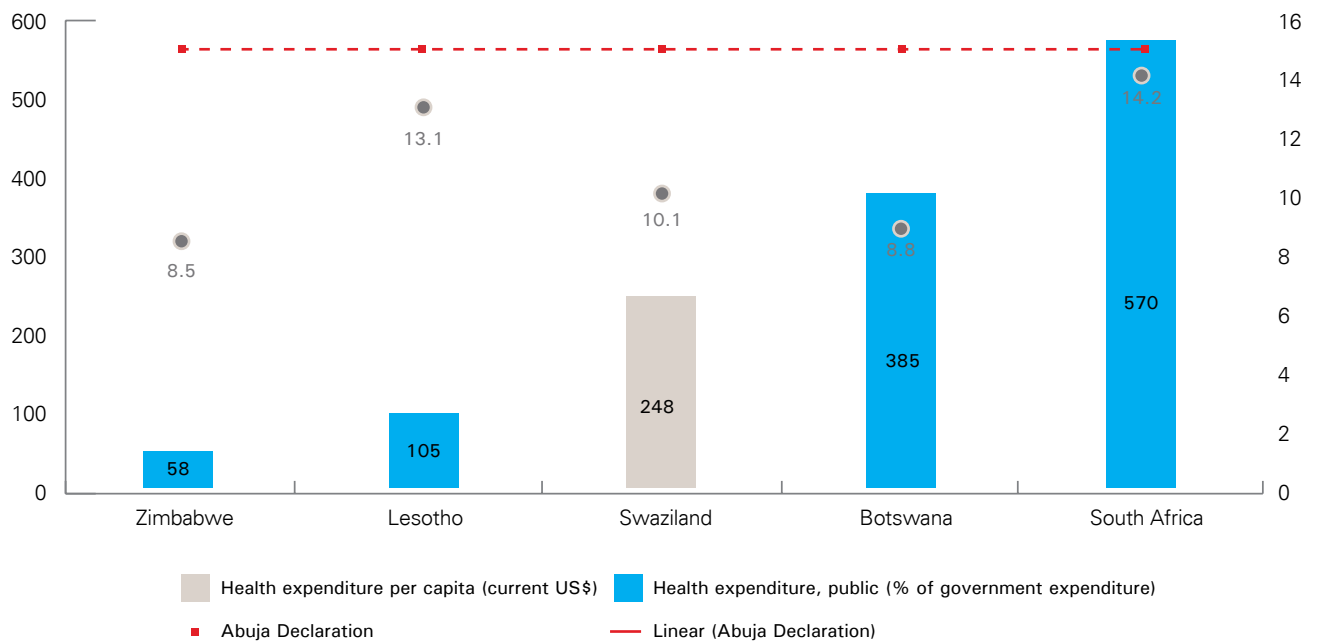
FIGURE 8: APPROVED BUDGET - SECTORAL EXPENDITURE AS A SHARE OF TOTAL EXPENDITURE, 2018/19 (%)



Source: The Government of the Kingdom of Eswatini (2018) estimates 1st of April 2018 to 31st of March 2021

Eswatini spends less than some of its neighbours on health at 10.1% of total expenditure and currently does not meet the Abuja target of 15%. All countries in the sample fall short of the Abuja Declaration. However, South Africa spends 14.2% of its total budget on health and Lesotho spends 13.1%. In contrast, Botswana only spends 8.8% and Zimbabwe 8.5% of their total spending on health (Figure 9).

FIGURE 9: HEALTH AS A SHARE OF TOTAL EXPENDITURE, ESWATINI AND ITS NEIGHBOURS, 2017



Source: World Development Indicators (2018)

TAKEAWAYS

- Health is the third largest sector at 10.1% of total spending. This falls below the Abuja Declaration of 15% of total expenditure to be allocated to health.
- In relationship to its neighbours, Eswatini spends less of its total budget on health than South Africa and Lesotho.
- In real terms, health spending has been declining since 2016/17.

COMPOSITION OF HEALTH SPENDING

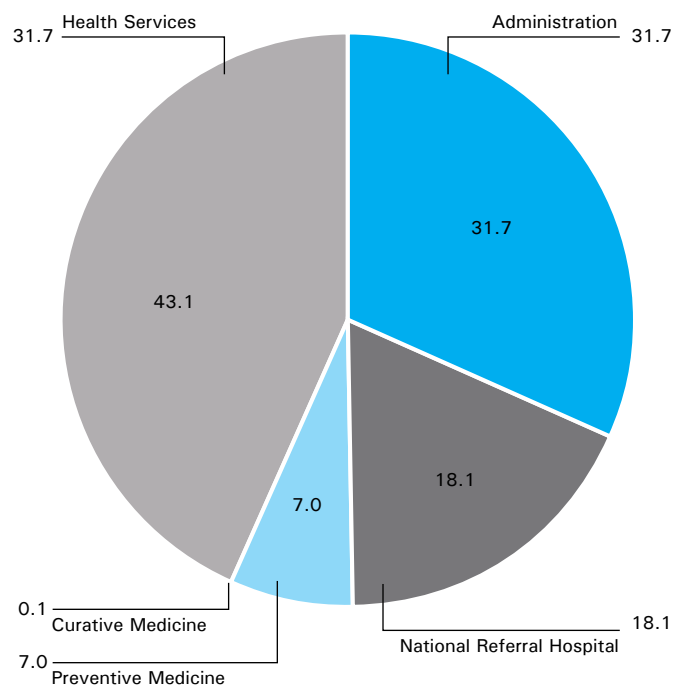
Eswatini's health service delivery system is structured around a four-tier system. Health services begin at the community level followed by clinics and public health units, health centres and regional referral hospitals, and national referral hospitals. Data is not available by this level of disaggregation for analysis.

Administration data suggest that the largest share of the health recurrent budget goes to Health Services (43.1%). This is followed by administration (37.1 %), national referral hospitals (18.1%), preventive medicine (7%) and curative medicine (0.1%) for 2018/19.

The vast majority of Eswatini's health budget is spent on recurrent items. The recurrent budget has increased from 87.0% to 90.4% of total expenditure between 2014/15 and 2018/19 (Figure 11).

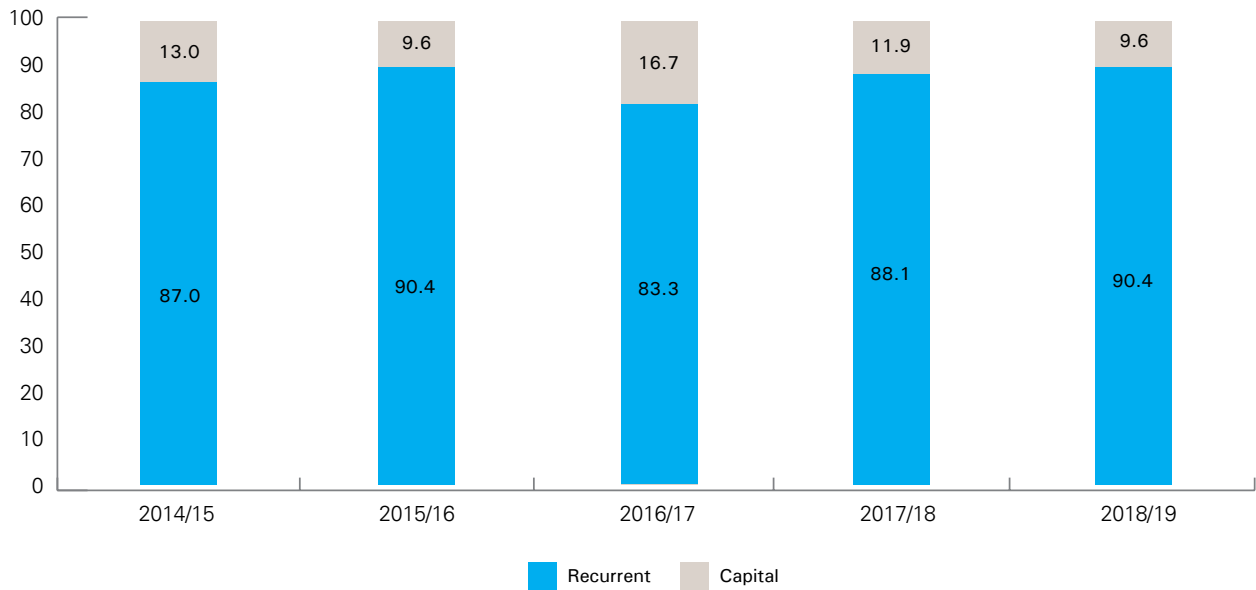
Breaking down the budget by economic classification shows that the largest expenditure item is personnel which has increased from 37.9% to 43.0% between 2014/15 and 2018/19. This is followed by drugs (26.5%), goods and services (15.9%) and transfers (14.6%) for this fiscal year (Figure 12). Notably, the share spent on goods and services has declined significantly from 25.2% in 2014/15 to 15.9% in 2018/19. Cuts in this area have likely been made to create fiscal space for salaries.

FIGURE 10: BREAKDOWN OF THE RECURRENT BUDGET FOR THE APPROVED BUDGET BY ADMINISTRATIVE CLASSIFICATION, 2018/19 SHARE OF TOTAL RECURRENT BUDGET (%)

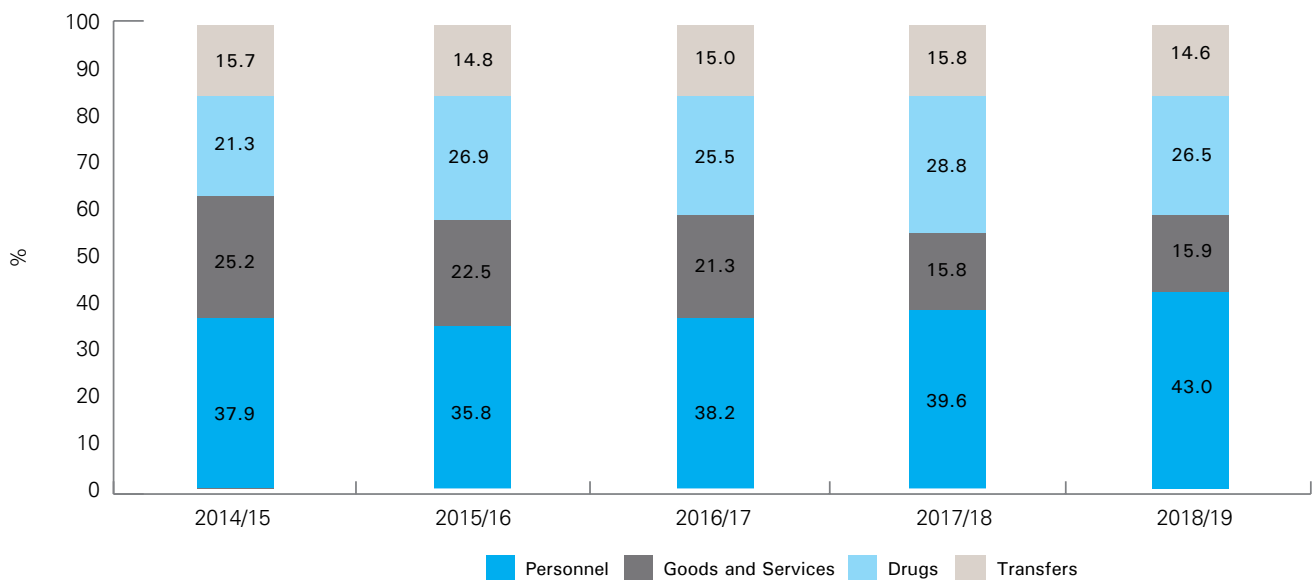


Source: The Government of the Kingdom of Eswatini (2018) estimates 1st of April 2018 to 31st of March 2021



FIGURE 11: APPROVED BUDGET COMMITMENTS FOR RECURRENT VERSUS CAPITAL EXPENDITURE FOR HEALTH, 2014/15-2018/19

Source: The Government of the Kingdom of Eswatini, annual budget book estimates (various) and estimates for the 1st of April 2018 to 31st of March 2021

FIGURE 12: BREAKDOWN OF RECURRENT SPENDING BY ECONOMIC CATEGORY, 2014/15-2018/19

Source: The Government of the Kingdom of Eswatini, annual budget book estimates (various) and estimates for the 1st of April 2018 to 31st of March 2021

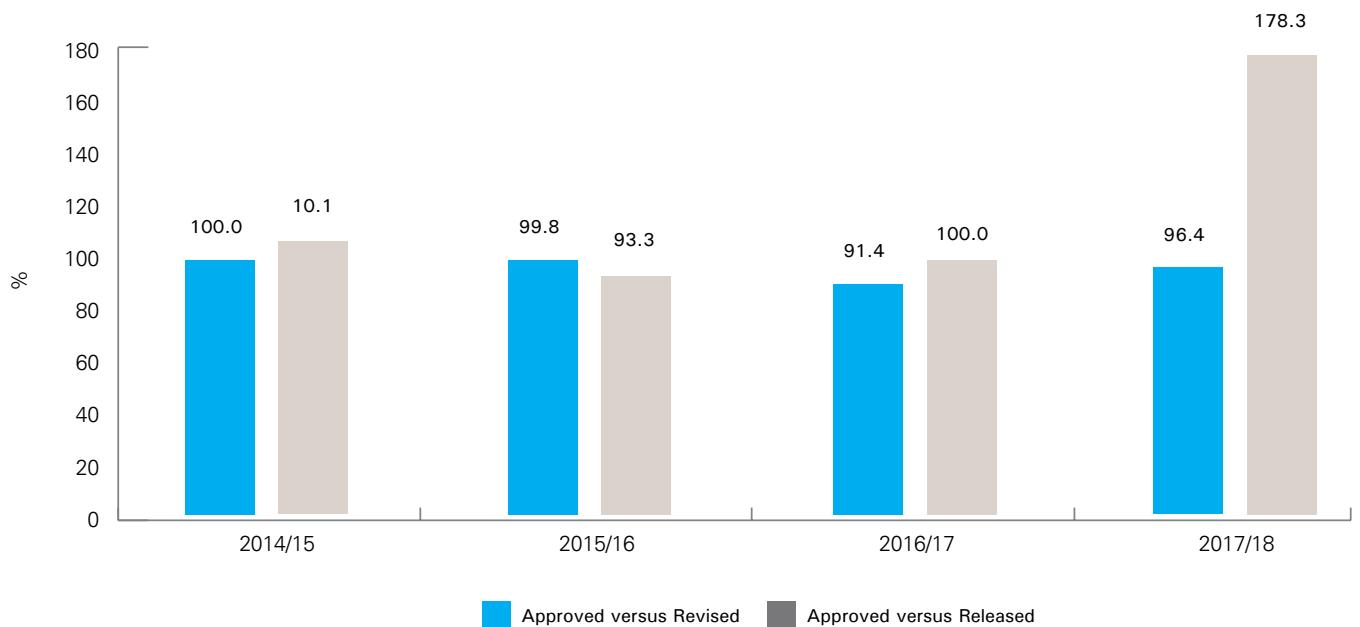
TAKEAWAYS

- At close to 90% in recent years, recurrent spending is consuming the majority of the health sector budget. It indicates potentially serious inefficiencies in the use of resources, such as salaries available to pay nurses but no funding for infrastructure.
- The donor and government development budget are not currently integrated.

BUDGET CREDIBILITY

The accuracy of budgeting and budget execution is highly erratic for the years between 2014/15 and 2017/18. The approved budget versus the revised budget changed in commitment level terms by between 8.6% in 2016/17 to 4.6% in 2017/18. Performance was much better in 2014/15 where there was 0% variation and only 0.2% variation in 2015/16. On the other hand, variations between the approved budget versus actual releases present worrisome trends, except for 2016/17 where there was a 0% variation between the approved budget and actual releases. In 2014/15, releases were 7.1% higher than what had been approved by Parliament, in 2015/16 they were 6.7% lower than the approved budget and, in 2017/18, releases were almost double at 78.3% overspending (Figure 13).

FIGURE 13: BUDGET CREDIBILITY - THE APPROVED RECURRENT BUDGET VERSUS ACTUAL RELEASES, 2014/15-2017/18 (% SHARE OF TOTAL)



Source: The Government of the Kingdom of Eswatini, annual budget book estimates (various) and estimates for the 1st of April 2018 to 31st of March 2021

TAKEAWAYS

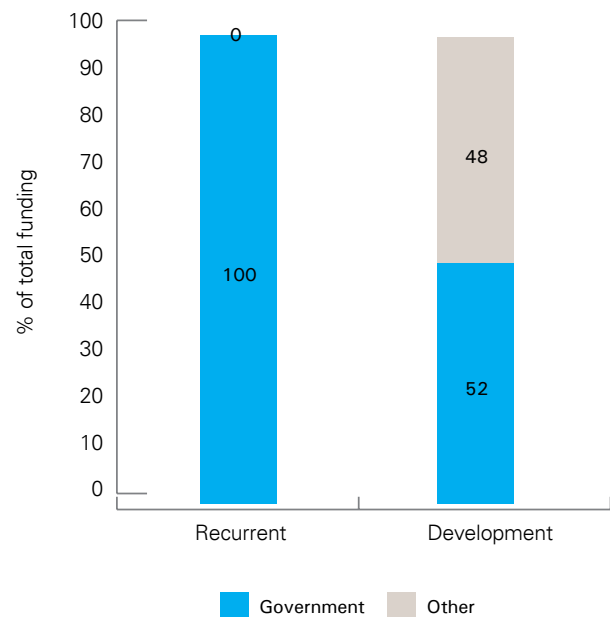
- The accuracy and performance of spending has been erratic in recent years, with large over and under execution for the recurrent budget.

FINANCING THE HEALTH SECTOR

In Eswatini, the majority of on budget health sector spending (90% of the budget) is recurrent and self-financed. The development budget at only 10% of total spending on health in 2018/19 was approximately 50% financed by government and 50% financed by donors (Figure 14). Of the total donor funding committed to the health sector over the last five years, 64% was in the form of loans (Table 3).

The majority of 309 million USD in resources committed over the period of 2014/15 to 2017/18, is off budget. Annualised data is not available but, for the whole period, the External Resource Report confirms that 20.5% of committed donor funding in the health sector is on budget. The main donors are the EU, Germany, UNICEF and WHO.

FIGURE 14: SHARE OF FUNDING FOR RECURRENT AND DEVELOPMENT FOR HEALTH (%), 2018/19



Source: The Government of the Kingdom of Eswatini, annual budget book estimates (various) and estimates for the 1st of April 2018 to 31st of March 2021

TABLE 3: LIST OF DONOR PROJECTS COMMITMENTS WITH FINANCING FROM 2014/15-2017/18 (IN MILLIONS OF US)

DP	PROJECT	VALUE IN MN OF USD	DP	PROJECT	VALUE IN MN OF USD
EU	Eswatini Health, HIV/AIDS and TB Project	22.2	WHO	Health Promotion	9.1
GF	Eswatini Malaria Elimination	4.0	WHO	Health Systems Strengthening	2.8
GF	Reduction of HIV in Eswatini	25.2	WHO	HIV/AIDS	7.5
GF	Tuberculosis: Expand Access to High Quality DOTS	25.9	WHO	Malaria	4.2
KF	National Referral Hospital Project	148.9	WHO	Maternal and Child Health	8.0
KF	National Referral Hospital Project	0.5	WHO	Non-Communicable Diseases	4.4
WB	Eswatini Health, HIV/AIDS and TB Project	20.0	WHO	Tuberculosis	2.4
WFP	Food by Prescription	9.1	WHO	Vaccine Preventable Diseases	5.3
UNICEF	Young Child Survival and Development	9.5			
Total = 309 million					

Source: External Assistance Report 2017/18



TAKEAWAYS

- Donor assistance contributed to 5% of the total health sector budget in 2017/18.
- The External Assistance Report provides information on commitments from donors and whether or not these funds are on or off budget. However, these projects are not included in the government disaggregated estimates for its own development budget.



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