

March 2017

MALAWI



2016/17

# Health Budget Brief

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## KEY MESSAGES

**The health sector received a budget of MK103 billion for the 2016-17 financial year, amounting to approximately 9% of the total budget. This constitutes a nominal increase of 27% and a real increase of 4%, from the previous year.**

- ✓ The upward change was driven by an increase in the budget for operational costs (Other Recurrent Transactions), amounting to MK22 billion.
- ✓ The Government's contribution to development spending decreased from MK6.5 billion to just over MK3 billion, which is approximately 3% of the health budget.

**It is essential that the health budget is protected from spending cuts in the future.**

**The Malawi health sector is probably one of the most donor supported in the world. Donor support provides 80% of development expenditure. Donor support to the Health sector has been steadily increasing over time but has become more fragmented and is increasingly focused on treating specific diseases. The Health Sector Wide Approach (SWAp) once directed a significant amount of resources to areas of greatest need in support of the Government's strategic plan.**

- ✓ External resources fund 73.8% of the health sector.<sup>1</sup>
- ✓ Disease specific donor funding sometimes neglect the basic primary health care systems required for child survival such as; treatment of diarrhoea as well as maternal health interventions. Currently an estimated 90% of total grants from the Global Fund to fight AIDS, Tuberculosis and Malaria are dedicated to HIV and AIDS health interventions.

**Donors should consider aligning their support to the revised Essential Health Package (EHP), which prioritises evidence based and cost effective health services.**

**Cash Management issues, especially delays in disbursements, have impacted negatively on the Ministry of Health's (MoH) ability to improve health outcomes. These issues stem from both the quality of line ministries' cash-flow submissions and co-ordination challenges between funding agencies.**

**The Ministry of Finance should fully implement its commitment to improving cash management expressed in the 2016-17 Budget Speech to resolve any identified budget implementation challenges.**

**The Ministry of Health should be congratulated for making the bold step to increase the percentage of public resources allocated to primary and preventative health care.**

- ✓ In 2016-17, 20% of MoH budget was dedicated to primary health care, 15% to secondary health care and 8% to tertiary health care.
- ✓ The decentralisation thrust of Government, including the new management structures at district levels will help promote primary and preventative health care.

**The Government should continue to mobilize sufficient resources, and ensure their equitable allocation, towards primary and preventative health care.**

<sup>1</sup> World Health Organization Global Health Expenditure database

The Health Resource Allocation Formula directs allocations to district councils in a simple and transparent manner, which avoids accusations of geographic favouritism. The formula is a critical step towards equitable health financing.

The Government should periodically assess the effectiveness of the formula to ensure public financing on health benefits all people.

Both the Health Sector Strategic Plan II (HSSP II) and the revised Essential Health Package (EHP) are in draft form and are yet to be adopted. These policy documents guide health sector funding. The EHP seeks to direct all resources towards the provision of relevant, basic, cost-effective services to poor Malawians.

The Government should finalize and ensure full implementation of the HSSP II and the revised Essential Health Package, being frameworks for achieving equitable and efficient health outcomes.

The Government of Malawi has put in place various proposals for expanding the fiscal space to improve investments in health, especially from domestic sources. These include earmarked taxation, innovative financing mechanisms and national health insurance.

- High unemployment, informality of the economy, high proportion of the rural population and slow economic growth make the introduction of a National Health Insurance Scheme difficult, at this point in time.
- Additional taxes, under the auspices of innovative financing mechanisms, for example, are likely to hit hardest on poor people.

Each proposed measure to increase revenues to finance health expenditures should be carefully assessed for progressivity, cost-efficiency, sustainability and overall potential, given the Malawi socio-economic context. This is important to avoid a situation whereby, for example, the burden of taxation and other financial contributions becomes too heavy on poor families.

## 1. Introduction

**Table 1** Key health indicators

Indicator	Current Status
Health Spending per capita	\$39.2 (lowest in SADC)
Total expenditure on health as a percentage of GDP	11.1% (highest in SADC) <sup>2</sup>
Physicians	1 per 52,632 people
Nurses and midwives	1 per 3,534 people
Specialist surgical workforce	1 per 212,382 people <sup>3</sup>
Neonatal Mortality	27/1000 births <sup>4</sup>
Infant mortality	42/1,000
Under five Mortality	64/1,000 births
Maternal Mortality	574/100,000 live births <sup>5</sup>

The Government of Malawi (GoM) has made significant strides to ensure all people, including vulnerable children are healthy, but a lot more resources are required to improve the quality of health services in the country. In particular, the GoM has made progress in reducing child and maternal mortality. Life expectancy has also increased. As expressed in the 2030 Agenda for Sustainable Development, ensuring healthy lives and promoting the well-being for all, at all ages, is essential to sustainable development. Working closely with a range of development partners, the Government is working hard to improve nutrition, strengthen health systems and reduce the incidence and impacts of killer diseases such as tuberculosis and HIV/AIDS. Huge challenges in the health sector however still exist, including acute shortages of health staff, equipment and drugs.

Insufficient and inequitable health financing has been identified as one of the main barriers for all people in Malawi to have access to affordable and quality health care. In nearly all of the 28 districts, especially those hardest to reach, there is insufficient health infrastructure to ensure quality health service delivery.

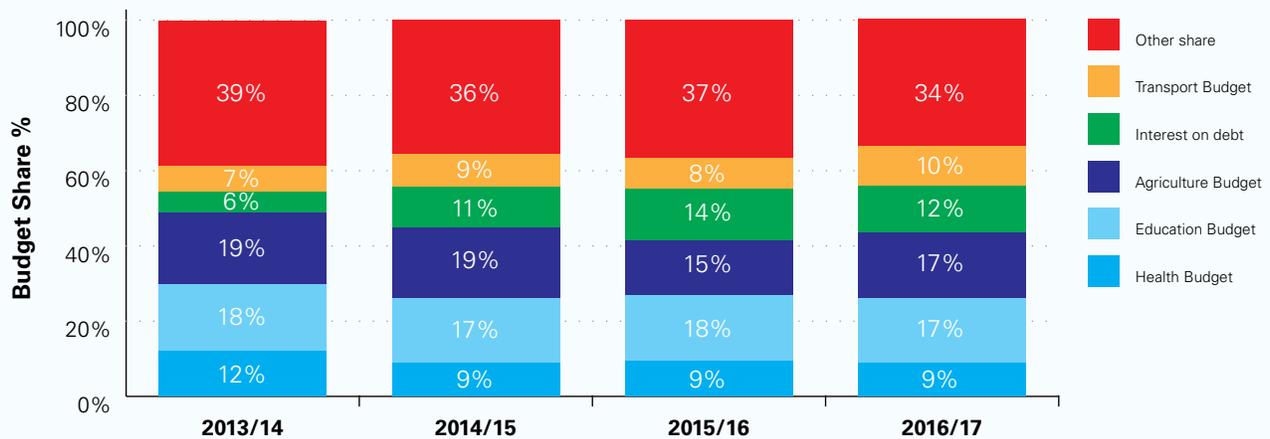


## 2. What Resources are available to the Health Sector?

The Government has shown a commitment to the Health sector, by increasing overall allocations in nominal terms by 27% and 4% in real terms from the 2015-16 approved estimate of MK81 billion, to MK103 billion in the 2016-17 approved budget. In financial year 2016-17, the government ring-fenced health spending from budget cuts that almost all budget lines have faced over the past few years. The budget share for the health sector has remained stable from 2014-15 as education and agriculture received smaller budget shares. Figure 1 shows the approved allocations to the health sector over the past four financial years in relation to other sectors. Through the International Monetary Fund (IMF) Extended Credit Facility, the Government was encouraged to control spending by keeping expenditures within expected revenues and grants. The national budget is under severe pressure in part because of rising domestic borrowing and subsequent interest repayments, which consumed an estimated 12% of the national budget.

2 WHO, Global Health Expenditure Database <http://apps.who.int/nha/database/ViewData/Indicators/en>  
 3 WHO, Global Health Observatory <http://apps.who.int/gho/data/node.main.A1444>  
 4 National Statistical Office, 2015-16 Malawi Demographic and Health Survey, p.20  
 5 Ministry of Health, 2016. Malawi National Health Accounts Report for fiscal years 2012/13, 2013/14 and 2014/15. Ministry of Health, Department of Planning and Policy Development, Lilongwe, Malawi

**Figure 1** Composition of Total National Budget (2013-14 – 2016-17)

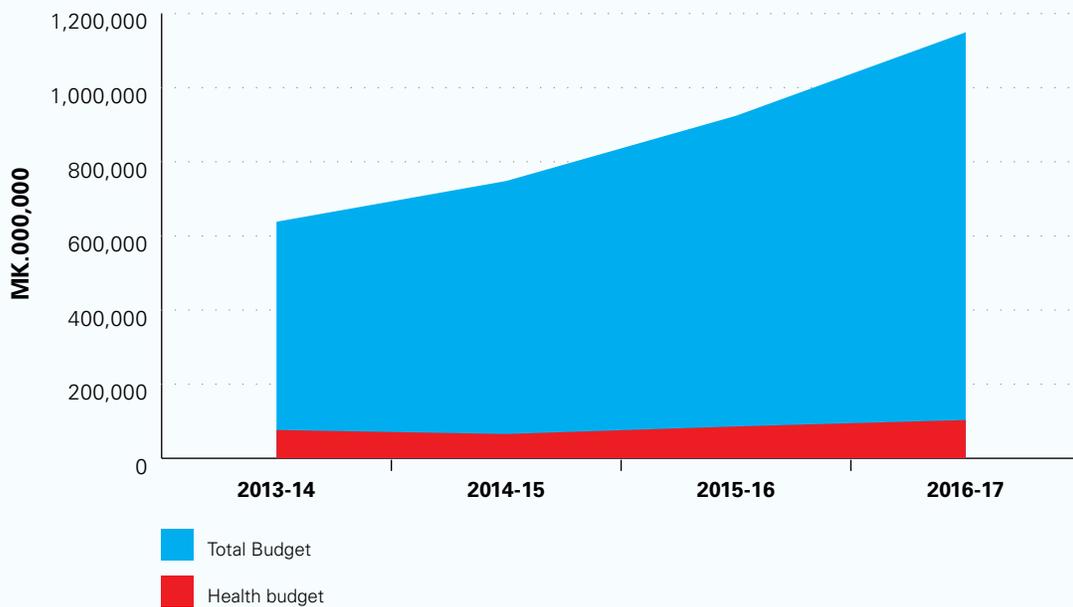


Source: Ministry of Finance, MGDS Data

While allocations to Ministry of Health increased in nominal terms, health spending as a percentage of the national budget has declined from 12% in 2013-14 to 9% in 2016-17 budget. The reduction of funding to the National AIDS Commission accounts for most of this reduction, which in 2013-14 was almost one third of the health sector budget. Malawi surpassed the Abuja target of 15% in

2007-8 (16.6%), 2009-10 (15.1%) and 2010-11 (15.8%). Since then the expenditure share to health has been decreasing; however, financial year 2015-16 shows a marginal increase from a low of 8.7% in 2014-15. Figure 2 shows that the growth in the health budget (red area) has not kept pace with the growth in the overall budget (blue area).

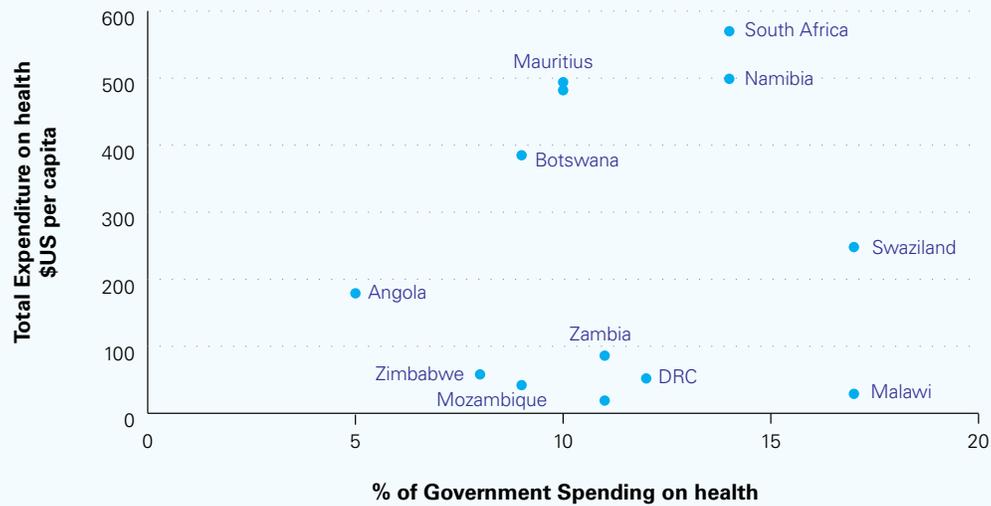
**Figure 2** Health Budget Comparison to National Budget 2013/14 - 2016/17



Although Malawi dedicates more resources to the health sector than most countries in the region as a percentage of government spending and as a percentage of GDP, its per-capita health spending is one of the lowest in the region. The per capita spending reflects the low GDP of the country, mainly dependent on agriculture, which has suffered from recurrent droughts.

Health spending as a percentage of the national budget has declined from 12% in 2013-14 to 9% in 2016-17 budget.

**Figure 3** Malawi Health Expenditure Comparison to SADC Countries

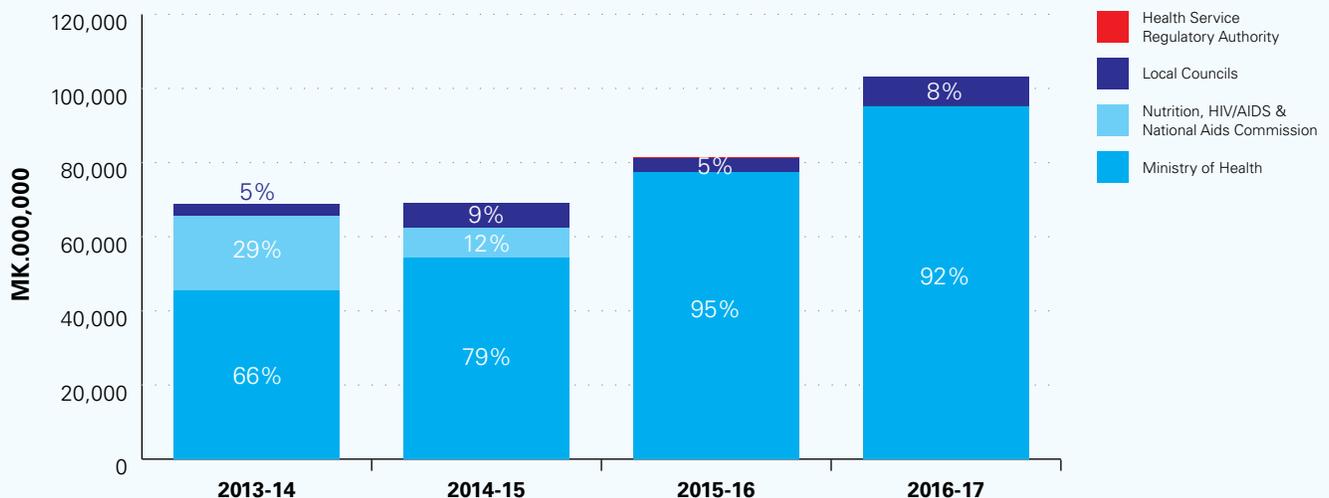


### 3. What is the composition of the health sector budget?

Government resources for the health sector are largely directed to the Ministry of Health (MoH). In 2016-17, allocations to the MoH accounted for 92% (MK95 billion) of the total health sector budget as shown in Figure 4. The Nutrition, HIV/AIDS and National Aids Commission was subsumed by the MoH in 2015-16. Local Councils

only received a small share of the budget, about 8% (MK8 billion) of the total health budget. The allocation to Local Councils is based on the Health Resource Allocation Formula used by the National Local Government Finance Committee. The vast majority (89%) of funding is earmarked for drug purchases. The Health Services Regulatory Authority has budgetary independence from the MoH, being a subvented organisation, to reinforce its policy independence.

**Figure 4** Health Sector Allocations 2013-14 - 2016-17



Source: Ministry of Finance, Financial Statement. Years 2013-14 – 2016-17

An estimated 20% of MoH's 2016-17 budget is dedicated to Primary Health Care, 15% to secondary health care and 8% to tertiary health care. To effectively deliver health services, there is need for an appropriate balance between primary, secondary and tertiary health care spending. The MoH acknowledges the need to prioritise primary and preventative health care in its budgets.

In 2016-17, allocations to the MoH accounted for 92% (MK95 billion) of the total health sector budget.

### Box 1: Levels of Health Care

**Community:** Preventative healthcare measures begin at the community level. Health Service Surveillance Assistants provide doorstep care and preventive services.

**Primary:** In this category, the Government provides the first point of institutional based care. It comprises of dispensaries, rural hospitals, health centers, health posts, outreach clinics, and maternity units. Primary health staff include; medical assistants, clinical officers and nurses that provide both preventive and basic curative care at the primary level.

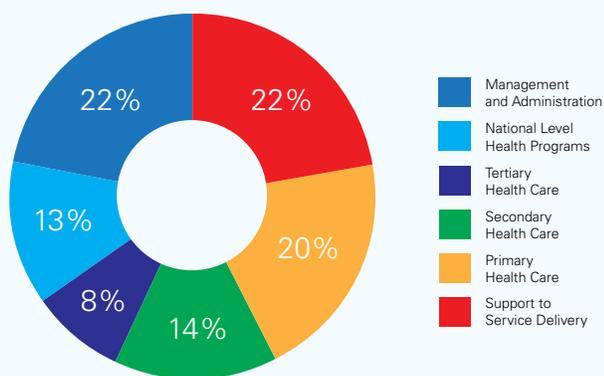
**Secondary:** In this category, the Government provides hospital based curative care. The service providers comprise of district hospitals and Christian Health Association of Malawi (CHAM) hospitals. These hospitals provide a referral point for primary level facilities and offer services ranging from surgical services, emergencies, general medical and pediatric, and patient care for common and acute conditions.

**Tertiary:** The services provided are similar to those provided at the secondary level with the addition of a small range of specialist surgical and medical interventions.<sup>6</sup>

With the advent of PBB, it also decided to restructure its budget from focusing on diseases and health interventions to focusing on levels of health care. The new program categories include Primary Health Care, Secondary Health Care and Tertiary Health Care. Within each of the categories, expenditures are divided into curative and preventative services. This will allow for tracking of the percentage of MoH and District Councils' budgets dedicated to each category.

Government development expenditure on health reached a historic low of 3% in 2016-17 as donor contributions steadily increased from 1% of the MoH budget in 2012-13 to 14% in 2016-17. This reflects a nation-wide reduction in development expenditure, mainly as a result of constrained fiscal space. It is however crucial that development spending by donors be aligned to national priorities, especially through the Public Sector Investment Program (PSIP). Donors should also consider directing development spending towards maintenance of existing Government infrastructure and projects, which have been stalled due to insufficient development spending from government. The drafting of a Capital Investment Plan (CIP), which aims to guide all health development spending is a step in the right direction.

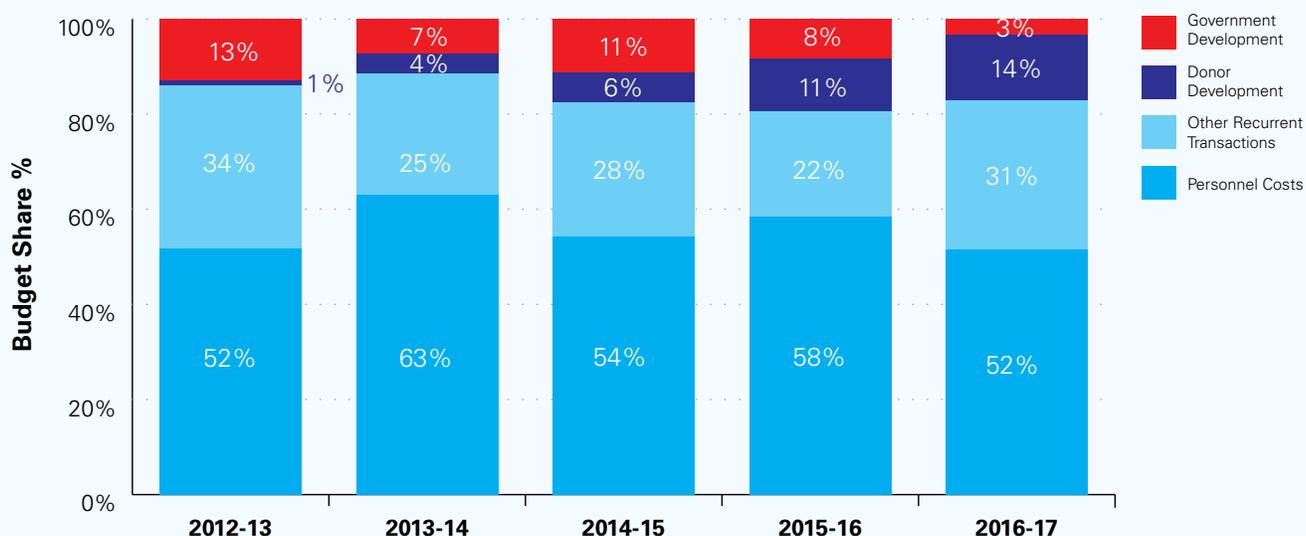
Figure 5 2016-17 Budget Estimates by Program



An estimated 20% of MoH's 2016-17 budget is dedicated to Primary Health Care, 15% to secondary health care and 8% to tertiary health care.

6 Ministry of Health, 2016. Malawi National Health Accounts Report for fiscal years 2012/13, 2013/14 and 2014/15. Ministry of Health, Department of Planning and Policy Development, Lilongwe, Malawi

**Figure 6** MoH Budget by Economic Classification (2012-13 to 2016-17)



**If the Ministry is to effectively deliver its mandate an appropriate mix of development expenditures, other recurrent transactions (ORT) and personnel emoluments (PE) is required.** Insufficient development expenditures can result in facilities that are not in good enough condition. Conversely, there may be well-equipped health facilities with few qualified doctors and nurses due to an imbalance between development and recurrent expenditures. At the same time, health workers may be sufficient in terms of numbers, but may lack the materials and drugs needed to deliver health services.

#### 4. How is the Health Budget Utilized?

**In recent years, the Ministry of Health has consistently reported late release of funding as a major hurdle in the implementation of its budget.<sup>7</sup> Several reasons account for this including cash flow problems, quality of cash-flow submissions and weak co-ordination between agencies.** These delays have, in some cases, resulted in drug stock outs, reduced staff morale and increased absenteeism due to late payment of salaries. Current cash management challenges can be traced to historical weaknesses in the cash system. In particular, the practice of disbursing funds which are unrelated to cash-flow submissions seem to have dis-incentivised MoH and other MDAs from improving the quality of their submissions. Thus, while overall budget credibility has improved since 2013-14, cash management issues may need to be tightened. This has been identified as a persistent Public Financial Management problem in Malawi.<sup>8</sup> The Minister of Finance acknowledged this in his 2016-17 budget speech and made a commitment to address the problem.<sup>9</sup>

7 Ministry of Finance, Economic Planning and Development, Draft Estimates of Expenditure on Recurrent and Capital Budget for the Financial Year 2016/17, Program Based Budget.  
 8 2015 Article IV Consultation—Press Release; Staff Report; and Statement by the Executive Director for Malawi  
 9 2016-17 Budget Speech. P.31.

#### 5. What is the level of donor funding to the health sector?

**Donor support to the health sector has been increasing steadily from about \$50 Million in 2003-4 to 350 Million in 2014-15.** Figure 7 below shows donor disbursements to the health sector as reported in the Aid Management Platform.



**Donor support to the health sector has been increasing steadily from about \$50 Million in 2003-4 to \$350 Million in 2014-15.**

**Figure 7 Donor Health Sector Funding (2003-2015) in US\$**



Source: Aid Management Platform

Until financial year 2015-16, a significant amount of donor support to the health sector was through a common financing mechanism called the Health SWAp. The Global Fund to fight AIDS, Tuberculosis and Malaria now disburses more funding than the Health Sector Joint Fund, which succeeded the Health SWAp. The Health SWAp helped to improve co-ordination between donors and the Government. The Health SWAp also had a strong focus on the Essential Health Package, in order to make low cost health interventions widely available, especially to vulnerable children and their families. Since the abandonment of the SWAp, several pooled funding mechanisms have emerged. The most significant of these being the Global Fund and the Health Sector Joint Fund.

The Global Fund is providing a significant amount of support to Malawi, approximately US\$616 million from 2014 to 2017, making it the largest single health fund in the country. The Global Fund is supported by the United States of America, the European Union, United Kingdom, Germany, Japan, Ireland and Norway. It receives technical support from UNAIDS and the World Health Organization. The Global Fund focuses on treating three diseases, as the name suggests: Malaria, Tuberculosis and HIV/AIDS. Although crucial, disease specific funding does not always target the most pressing and most cost effective health interventions. Table 3 shows that many of the least cost effective health interventions, according to Net DALYs<sup>10</sup> rankings, are being prioritized while some of the most cost effective interventions are not and are unavailable in much of the country.

<sup>10</sup> Disability Adjusted Life Year (DALY). One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population. The change in net DALYs measures the expected net health benefits of the full implementation of a health intervention. Source: WHO.

**Table 3 Top four and bottom four health interventions ranked by Net DALYs averted.**

Intervention	Incremental Cost Effectiveness Ratio	Population DALYs averted per 1000	Cases per annum	Total cost	Cumulative Cost	Total DALYs averted	Net DALYs averted (full implementation)
Zinc (diarrhoea treatment)	\$0	73000	7,455,177	\$1,787,880	\$1,787,880	17,817,873	17,813,805
Oral Rehydration Salts	\$0	113000	8,661,655	\$937,089	\$2,724,969	16,630,377	16,627,925
Male circumcision	\$20	51	855,420	\$30,813,206	\$33,538,176	8,323,237	5,589,315
Management of obstructed labour	\$11	90	91,844	\$1,099,805	\$34,637,980	2,497,118	2,036,400
Condoms	\$91	11	4,175,919	\$11,898,916	\$116,947,231	250,555	-130,149
ART for men	\$307	3	222,933	\$14,218,889	\$131,166,119	675,452	-2,782,217
ART for women	\$307	3	394,691	\$25,173,728	\$156,339,848	1,195,848	-4,925,756
Paediatric ART	\$799	1	53,765	\$3,859,284	\$160,199,132	784,438	-9,663,977

Source: Ochalek Jessica, 2016.<sup>11</sup>

<sup>11</sup> Ochalek Jessica Marie, et. al., (2016), Supporting the Development of an Essential Health Package: Principles and Initial Assessment for Malawi, Centre for Health Economics, University of York, Research Paper No. 136.

**Current contributors to the HSJF are DFID with an initial commitment of MK6.31 billion, Norway MK8.36 billion, Flanders MK695 million, and Germany, committing MK7.6 billion in the second year of the Fund's operation.** The Health Sector Joint Fund (HSJF) emerged as a way to reduce fiduciary risk while preventing aid fragmentation and maintaining alignment to the Government's HSSP. The Fund supports health services to the poor in Malawi, including water and electricity for health facilities, medical equipment, infrastructure for health centres and staff housing. The Fund also has Service Level Agreements with the Christian Health Association of Malawi. While the HSJF is much smaller in terms of overall funding, its alignment to the HSSP means it is likely to have a greater overall impact on health outcomes in Malawi.

## 6. How decentralised is the Malawi Health sector?

**MoH's budget remains highly centralised with only 39% of MoH funds reaching district health offices. District Councils only receive 8% of health sector funds.** Ministry of Health Headquarters and the National AIDS Commission consume a large portion of the Government's health budget. The centralised purchasing of pharmaceutical supplies is partially responsible for the concentration of resources at Headquarters. This was necessitated by concerns of drug theft at District Health Offices.<sup>12</sup> All District Assemblies have been mandated with establishment and strengthening of health management and accountability structures. To strengthen district level public financial management, MoH is creating the new position of Directorate of Health and Social Services. Previously, the District Health Officer was responsible while being housed in the District Hospital.

**Decentralization of health functions and funding to District Assemblies is likely to result in tailored and in more efficient mix of inputs as well as more accurate and up to date planning and reporting.** Payroll and performance information is better understood at the district level rather than national level. The decentralisation program is also likely to improve cost recovery efforts. District and Central Hospitals will once again be able to retain all user fees collected. Following instances of less satisfactory accounting and management of resources, budget guidelines were revised to stipulate that all revenues collected would be returned to the Ministry of Finance.<sup>13</sup> While this has improved accounting and the management of resources it has been at the expense of revenue raising efforts. Only a fraction of expected revenues are presently being collected. With further decentralization central and district hospitals will most likely be able to directly access revenues raised in their respective areas. This may serve as a stronger incentive to collect fees.<sup>14</sup>

**Allocations to Local Councils are made through the National Local Government Finance Committee using the Health Resource Allocation Formula, which has been in place since 2008.** The formula allocates funds according to a weighted population index.

Weighted Population = (population) \* (index for need) \* (index for difference in costs) \* (index for supply)

The weights used to determine allocations are as follows:

- 50% population weighted by stunting
- 15% population weighted by infant mortality rate
- 15% population weighted by outpatient utilization rates
- 5% geographical size
- 15% bed capacity

The formula is simple, transparent and fairly objective. It also minimises accusations of favouritism based on political, geographic and other considerations. Little research has however been conducted to assess the extent to which the formula is contributing to improved health outcomes and equitable access to health services. It may be important to review this formula.

**To be effective, the decentralisation of health services should be accompanied by capacity building of relevant structures in public finance management systems, including procurement, cash management, financial oversight, accounting and reporting in order to minimize bottlenecks, leakages and fiduciary risk.** Included in the package for decentralisation reforms is the plan to create health centre level cost centres. A separate budget category for health centres would give more budgetary independence to health centres. This reform would bring the Ministry of Health in line with the Ministry of Education Science and Research and the Ministry of Agriculture, Irrigation and Water Development.

## 7. How is the Health Sector Financed?

**For a number of years, the majority of health sector expenditures have been financed by donors.** Since the withdrawal of budget support by donors in 2013, the Government of Malawi has generated a number of proposals to increase domestic revenue to finance health expenditures. Table 4 below provides a list of some of the measures that have been proposed by the Government. It is not clear whether these options have been comprehensively analysed for feasibility and costeffectiveness.

12 Consolidated report for HSSP

13 Ministry of Health, Malawi Health Financing Situation Analysis, p.43

14 Ministry of Health, Report on the Review of Issues Related to decentralization of the Health Sector, May 2015

**Table 4 Proposed Revenue Raising Measures for Health**

1	Introduce reciprocal visa fee for incoming travellers to Malawi
2	Introduce sin taxes on alcohol & tobacco consumption
3	Introduce a fuel levy for health
4	Strengthen paying wings in district and central hospitals and gradually introduce optional paying services and move towards introduction/ expansion of user fees at district and central hospitals for non-EHP combined with appropriate health insurance schemes
5	Introduce corporate tax for health
6	Introduce telecommunication mobile phone tax for health
7	Increase private sector investments in health
8	Lobby Ministry of Finance to meet Abuja target of 15% allocation to the health sector as a share of total government expenditure

Source: Ministry of Health. *Health Financing Strategy, May 2014.*

**All proposals for revenue generation need to be carefully assessed for feasibility, cost-efficiency, relevance and sustainability given the socio-economic context of Malawi.** The proposals should also be in line with international practices on public resource mobilization, outlined in the Addis Ababa Action Agenda on Financing for Development. Tax policies, for example, should be progressive, simple, efficient, equitable and predictable. At the same time assumptions and revenue forecasts under each measure, on the basis for which the proposal was made, should be investigated to ensure that they are practical and realistic. Given that almost all proposals involve the creation of a separate fund, there is risk of weakening of central government's public finance management capacity, increasing fragmentation of funding and reducing the capacity of Government to respond to macroeconomic shocks.

**Although seemingly an excellent an idea, the socio-economic circumstances in Malawi may not favour, at least for now, introduction of a contributory National Health Insurance Scheme for all people.** The informality of the economy, weak data and statistical systems, high unemployment, and entrenched poverty levels make it difficult to implement this proposal, at the moment. The Malawi Revenue Authority (MRA) does not have a system in place to collect revenue from the informal sector. Existing evidence seems to suggest that collecting revenue from this sector is generally expensive, often inefficient and could worsen inequalities.

## 8. Conclusion

The health sector in Malawi is underfunded and should be prioritised in national budgeting. At the same time, efforts should be made to align funding to the most needed health interventions as specified by the EHP. Making basic health interventions such as diarrhoea treatments widely available has the potential to greatly improve health outcomes for Malawians.

Sustainable Development Goals and the Malawi Growth and Development Strategy III (being developed) are once in a lifetime opportunities for the GoM to consolidate gains made over the past decade in reducing mortality and promoting the well-being of all people. It is only through a sustained increase in public spending on health, especially on primary and secondary health care, combined with efficient management of resources, that all Malawians can live healthy lives.

## Glossary of terms

**Development expenditure** - is defined by the Public Sector Investment Program as significant (over MK 100 million) project expenditure with a completion date. Development spending provides returns in lowering operating costs or generating revenue. Development spending is divided into Part I (project support from external aid) and Part II (project support from domestic resources).<sup>15</sup>

**Economic Classifications** - presentation of the budget according to economic inputs such as wages, operations and capital. The production of goods and services requires a mix of inputs.

<sup>15</sup> Ministry of Finance, Budget Manual, 2009.

**Nominal Increase in budgets** - Changes in allocations which are not adjusted for inflation

**Other Recurrent Transactions (ORT)** - Refers to items such as office supplies, fuel, utilities, routine maintenance, meetings and other program costs as well as acquisition of fixed assets.

**Personnel Emoluments (PE)** - spending on wages and allowances.

**Real Increases in budgets** – Changes in allocations which are adjusted for inflation.