

© UNICEF/ Josh Estey

2017/18 Health Budget Brief

Towards Universal Health Coverage
Achieving SDG 4 & 5

unicef 
for every child

Key messages and recommendations

1 The total health sector budget barely increased in 2017/18 compared to the previous year.

Recommendation: Health sector ceilings should be reviewed upwards in line with overall changes in government budget, if the country is to progressively move towards Abuja Commitment to allocate 15% of total budget to health.

2 Fiscal space to increase public spending on health is limited.

Recommendation: The Government should review the health financing strategy, find ways of doing more with less resources by improving the efficiency of expenditures and also explore innovative financing mechanisms.

3 Budgets for community and primary health care allocated to District Councils have declined in real terms since 2014/15, despite launch of National Community Health Strategy and Essential Health Package.

Recommendation: The Government is called upon to at least maintain allocations to primary health care to District Councils in real terms to avoid regression in health outcomes and reorient budgets towards integrated community health services.

4 Budget execution challenges persist such as delayed transfers and payments, leakages of drugs and other health commodities and low asset utilization.

Recommendation: The Government should strengthen and standardise record keeping, inventory management and health expenditure accountability systems and encourage social accountability actions by citizens.

5 Results based financing has potential to increase efficiency in health expenditures, but it is only practised in a few districts.

Recommendation: The Government should work with development partners to take to national scale pilot projects on results based financing.

PART 1 INTRODUCTION

This budget brief explores the extent to which the 2017/18 national budget addresses health needs of all people in Malawi especially children and women. The brief analyzes the size and composition of allocations to the health sector in financial year 2017/18. It also offers recommendations to the Government on how future budgets can be more efficient, effective and equitable to improve access to quality of health services in Malawi.



© UNICEF

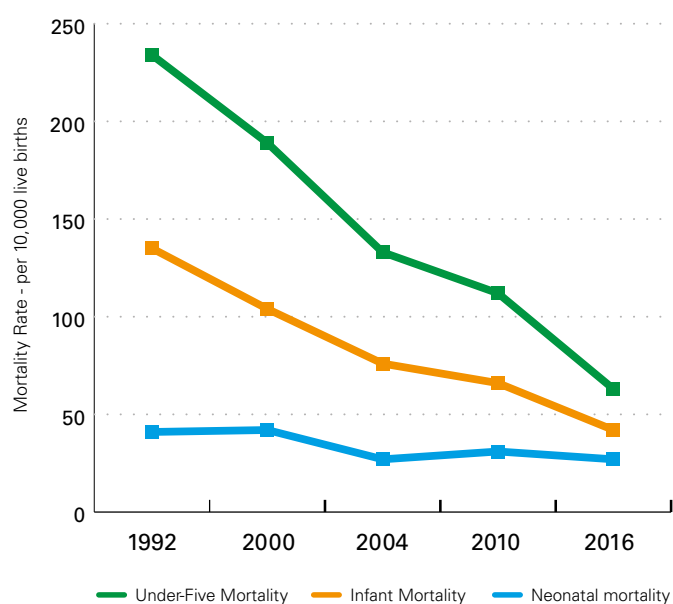
PART 2 HEALTH SECTOR OVERVIEW

Health and Population is one of the five priority areas of the Government for the next five years as outlined in the Third Malawi Growth and Development Strategy (MGDS III). Through the MGDS III, the Government has committed itself to improve access, equity and quality of primary, secondary and tertiary health services. In recent years, the Government developed robust health sector policies and plans to guide its interventions and to inform health sector resource mobilization and allocation. In 2017, the Government launched the second Health Sector Strategic Plan (HSSP II), Essential Health Package (2017-2022), Sexual and Reproductive Health Policy (2017-2022), National Community Health Strategy (2017-2022) and the Country Multi-Year Plan for the Expanded Program on Immunization (2017-2021). Box 1 below provides a list of key strategic frameworks on health developed by the Government. The development of health sector policies and strategies has, however, not been accompanied by adequate financing to ensure their full implementation.

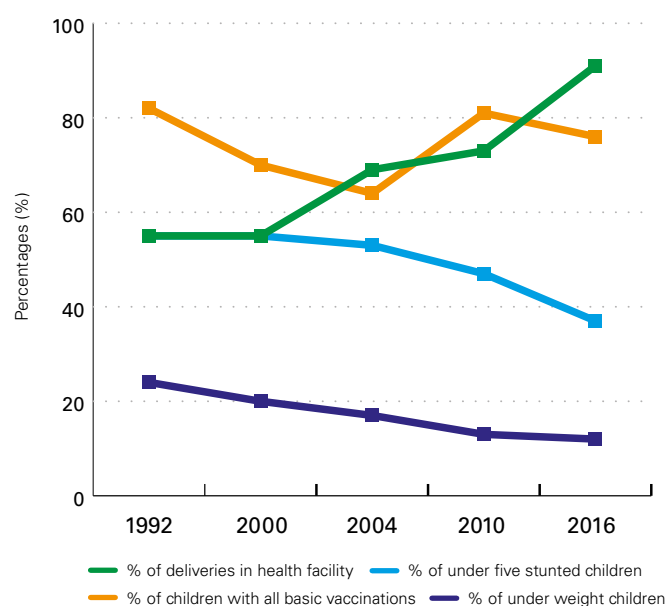
Box 1: Health Sector Policies and Plans

Health Sector Strategic Plan (HSSP II), (2017-2022)
Essential Health Package, (2017-2022)
Every Newborn Action Plan, (2016-2020)
Sexual and Reproductive Health Policy, (2017-2022)
Health Sector Quality Management Policy, (2017-2022)
National Health Information Policy, (2015-2020)
Child Health Strategy, (2015-2020)
Community Health Strategy, (2017-2022)
Health Sector Quality Management Strategy, (2017-2022)
Country Multiyear Plan-EPI, (2017-2021)

Through the MGDS III, the Government has committed itself to improve access, equity and quality of primary, secondary and tertiary health services.

Figure 1: Trends in Mortality Rates

Source: Malawi Demographic Health Survey (MDHS) (2015/16)

Figure 2: Trends in Child Health

Source: Malawi Demographic Health Survey (MDHS) (2015/16)

Over the past two decades, significant gains have been made in the health sector, especially in maternal and child health, although challenges remain. As shown in Figure 1, infant mortality went down from 189 deaths per 1000 live births in 2000 to 62 deaths in 2015. Infant mortality also decreased from 104 deaths per 1000 live births to 42 during the same period. It is however important to note that under-5 mortality is higher in rural areas than urban areas (77 deaths per 1,000 live births versus 61 deaths per 1,000 live births) and highest amongst poorest communities. The poorest are usually the least educated and commonly found in rural areas. By region, under 5 mortality is highest in the Central region (81 deaths per 1,000 live births) and lowest in the Northern region (57 deaths per 1,000 live births). The percentage of women who gave birth in a facility significantly increased from 55% in 2000 to 91% in 2016. Stunting went down from 55% to 37% during the same period. A few health indicators however worsened. For example, the percentage of children that received all full vaccinations went down by five percentage points from 81% in 2010 to 76% in 2016. Development partners have played a critical role in helping the Government to improve access to and quality of health services.

✓ Key Takeaways

- **The Government is encouraged to investigate underlying reasons for geographic disparities in under-five mortality and infant mortality.**
- **The Government should pay attention to neonatal mortality which is decreasing at a very slow pace.**
- **The Government is called upon to find ways of reversing the negative trend in the number of children that receive all basic vaccinations.**

PART 3 HEALTH SECTOR SPENDING TRENDS

The health sector received the fourth highest share of the 2017/18 total budget (9%) after education, agriculture and debt repayment. In total, the sector was allocated MK124 billion up from MK120 billion in financial year 2016/17. This amounts to a 2.84% increase in nominal terms and 13% decline in real terms. The education sector received 18% of the total budget followed by Agriculture at 15.5% and debt repayment at 15%. Compared to 2016/17, the total health sector budget increased at a lower rate (2.84%) in nominal terms than the general government budget which went up by 16.34%.

The decline in health sector budgets in real terms reflects tight fiscal space for health. Fiscal space challenges have been worsened by weak revenue performance and declining on-budget support from donors. The decline in budget support worsened with the discovery of huge theft of public resources in 2013. Heavy debt repayment, consuming an estimated 15% of the 2017/18 national budget, has also crowded out social sector spending.

Health sector budgets are far below what is required to implement all approved health sector policies and strategies. The 2017/18 total health sector allocation (US\$170 million) is almost 3 times less than the projected cost estimates in the HSSP II. The five-year cost of the HSSP II is estimated

to be US\$2.6 billion and costs are forecast to increase from US\$504 million in financial year 2017/18 to US\$540 million in 2021/22. The total cost per capita each year is expected to remain constant at about US\$30. In financial year 2017/18, the government allocated US\$9 per person to the health sector. The total cost of providing high-quality community health services to all people in Malawi from 2017-2022 is estimated at US\$407 million, or US\$81 million each year and about US\$3.9 in recurrent costs per Malawian each year by year 5.¹ Currently, per capita recurrent costs to District Councils average MK800, which is slightly over US\$1.

The total budget allocation to the health sector is nearly six percentage points below the Abuja commitment. Malawi, being one of the African Union member states, committed itself to allocate at least 15% of its total government budget to the health sector. Unfortunately, since 2012/13, the government has, on average, allocated 9% of its annual budget to health. The 2017/18 health budget is approximately 3% of the Gross Domestic Product (GDP) of Malawi. This figure has remained relatively constant since 2012/13 (Figure 3).

1 National Community Health Strategy, 2017-2022

Figure 3: Health Sector Spending Trends

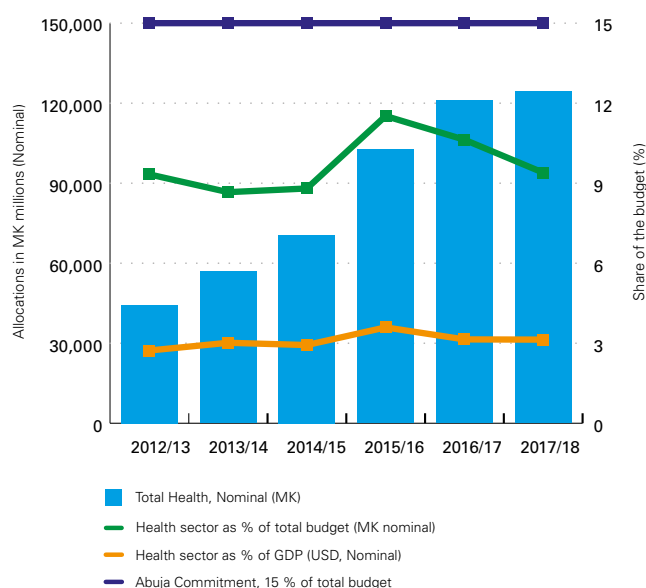


Figure 4: Trends in per Capita Allocations

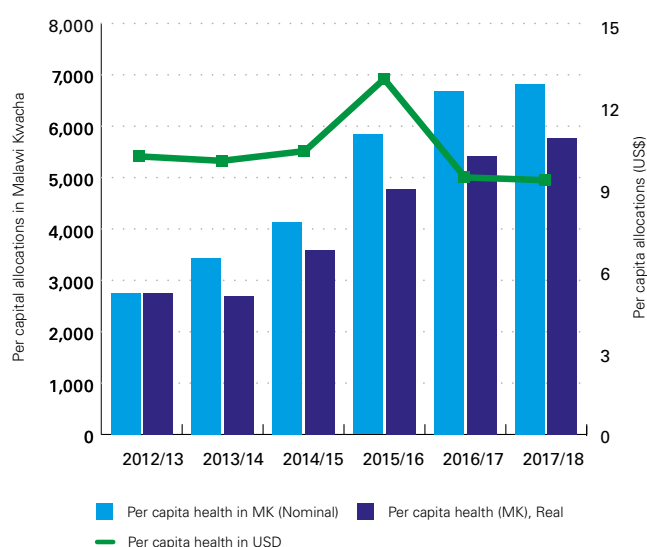
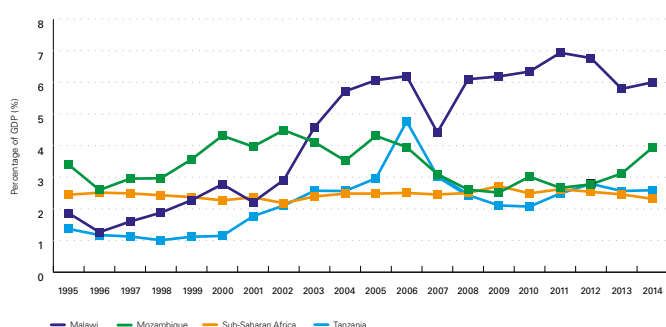
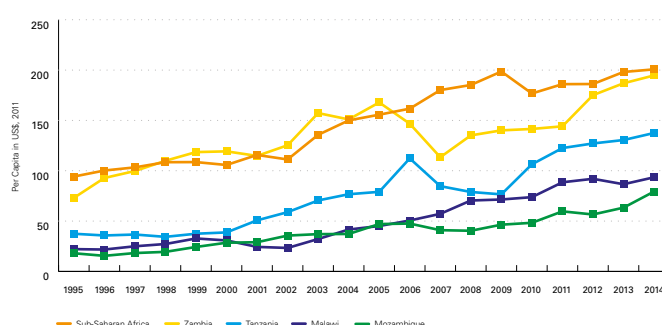


Figure 5: Trends in Health Spending as a % of GDP



Source: UNICEF, with data from <https://data.worldbank.org>

Figure 6: Per Capita Health Expenditures for Selected Countries



Source: UNICEF, based on data from <https://data.worldbank.org>

Per capita budget allocations to the health sector – spanning goods and services, wages, and capital spending—has declined in United States Dollar (US\$) values since 2015/16. Per capita allocations in Malawi Kwacha doubled between financial year 2012/13 and 2017/18 (Figure 4). However, in United States Dollars, per capita allocations to health slightly declined from \$13 per each person in 2015/16 to \$9 in 2017/18.

Malawi spends a higher proportion of its GDP on health than many countries in sub-Saharan Africa. Data from the World Bank shows that in 2014, for example, Malawi spent an equivalent of 6% of its GDP on health when the sub-Saharan average was 3.9%. Malawi's neighbours – Mozambique and Tanzania spent 2.3% and 2.6%, respectively.

Although Malawi dedicates a relatively higher percentage of its GDP on health, its total per-capita health expenditure is one of the lowest in the sub-Saharan region. In 2014, Malawi spent US\$93 per person when the sub-Saharan average was US\$201, with Zambia spending US\$195. The per capita spending reflects the low GDP of the country. Malawi is a relatively small economy, mainly dependent on agriculture.

✓ Key Takeaways

- **The Government is called upon to progressively revise ceilings to the health sector to meet the Abuja commitment to allocate at least 15% of its total government budget to health.**
- **Considering that most of the drugs and medical supplies are imported, it is crucial that the Government at least maintain per capita allocations in US\$ values, as expected in the HSSP II.**



© UNICEF/Asselin

PART 4 COMPOSITION OF HEALTH SECTOR BUDGETS

The Ministry of Health (MoH), is the main beneficiary of the health sector budget. The ministry was allocated MK74 billion, which is almost 60% of the 2017/18 health sector budget. District Councils got the second largest share (40%), of which 25% is for personal emoluments (PE). Kachere Rehabilitation Centre and the Health Services Regulatory Authority², the only two subvented organizations under the health sector, got less than 1% of the health budget. Altogether, these two organizations received MK647 million which is approximately 0.52% of the total health sector budget.

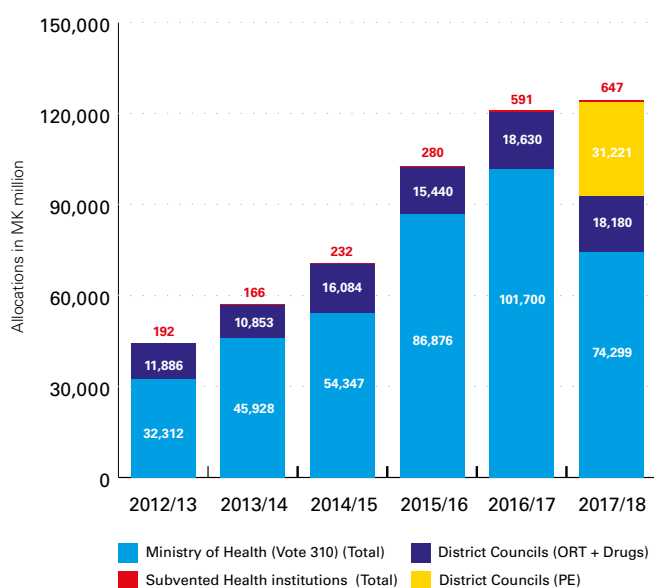
The allocation to the MoH declined from MK101 billion to MK74 billion because salaries and wages for district level staff will now be transferred directly to District Councils. In financial year 2017/18, MK31 billion will be transferred directly to District Councils as personal emoluments (PE) for primary and secondary health staff. If the allocation had remained with MoH, this means that the ministerial vote (310) would have increased by nearly 4% in nominal terms from MK101 billion to MK105 billion, but declined by approximately 12% in real terms.

² The Health Services Regulatory Authority has budgetary independence from the MoH to reinforce its policy independence. Kachere mainly provides rehabilitatory health services to people with disabilities.

Nearly half of the MK74 billion allocated to the Ministry is for supporting service delivery, with approximately 35% going to management and administration. Out of the entire ministerial allocation, 11% has been allocated to tertiary health. A small fraction of the ministry's budget was allocated to primary and secondary health (2% and 0.84% respectively). Budget allocations to national level health programs decreased by 94% from MK12 billion in 2016/17 to MK714 million in 2017/18. This is largely because a lot of contributions from development partners went off-budget.

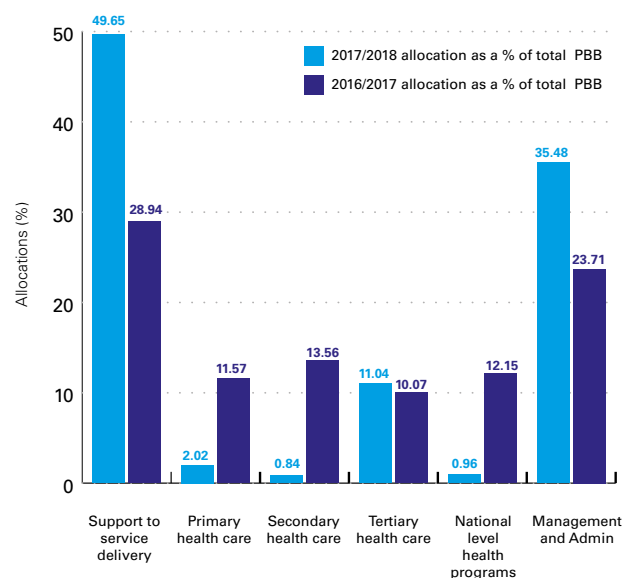
Approximately 63% of the health sector budget allocated to District Councils (MK31 billion) is for PE. Due to unavailability of data, it was difficult to split total PE budget between primary and secondary health. The remaining 47% is for other recurrent transactions (ORT). The combined ORT budget to District Councils is composed of MK10.2 billion for drugs (presented as primary health care under the National Local Government Finance Committee) and MK7.9 billion for other medical supplies and services. The combined ORT budget (MK18.1 billion) is slightly lower than the MK18.9 billion allocated in 2016/17 by 2.4% in nominal terms and 17% in real terms. In nominal terms, the primary health care budget to District Councils barely changed since 2014/15 despite high inflation between 2014 and 2017.

Figure 7: Composition of the Health Budget by Agency



Source: UNICEF calculations based on Estimates in the 2017/18 PBB

Figure 8: Share of the MoH Budget by Program (2016/17 & 2017/18)



Source: UNICEF calculations based on Estimates in the 2017/18 PBB



© UNICEF/Pirozzi

Primary and secondary health services account for the largest share of the total health budget, although insufficient to meet demand. In the current year, primary and health services got 42% of all health sector resources, with 7% going to tertiary education. National and other support services received 30% of the total health sector budget, with management and administration taking up 21% (Figure 10).

Budget allocations to national level health programs decreased by 94% from MK12 billion in 2016/17 to MK714 million in 2017/18.

Figure 9: Composition of allocations to District Councils

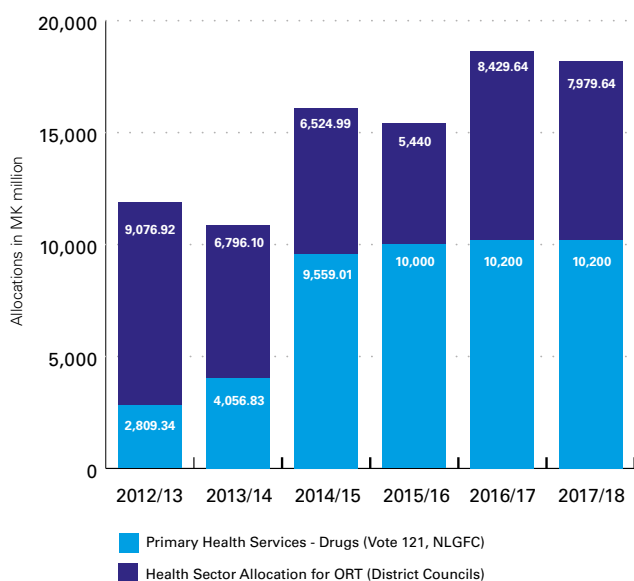
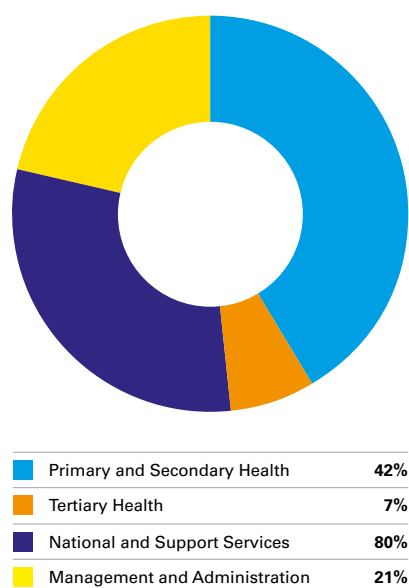


Figure 10: Composition of the 2017/18 Health Budget by Program



Source: UNICEF calculations based on Estimates in the 2017/18 PBB

Source: Unicef, based on Estimates in PBB

The primary and secondary health budget modestly increased by 16.5% but declined by 1.4% in real terms, compared to allocations in 2016/17. Allocations to tertiary health and national support services declined in both nominal and real terms as shown in Figure 11.

The majority of health sector resources are for recurrent expenditures, especially PE. In financial year 2017/18 approximately 79% of sector resources (MK98 billion) will go to recurrent expenditures compared to 86% in 2016/17. An estimated 55% (MK54 billion) of recurrent costs are for PE, with the remainder (45%) allocated for drugs, medical supplies and other health services. The drugs budget to all Districts (MK10.2 billion) takes up 8.2% of the health sector budget.

The Government's own contribution to the development budget (Part II) has significantly increased in the current year compared to 2016/17. In the current year, Development II budget increased by 100% in nominal terms and 76% in real terms from MK3 billion in 2016/17 to MK6 billion in 2017/18. This increase is in line with a general rebalancing of government budgets to increase the proportion of development expenditures, which over the past few years, had remained lower than the 25% threshold, which the Government set for itself.

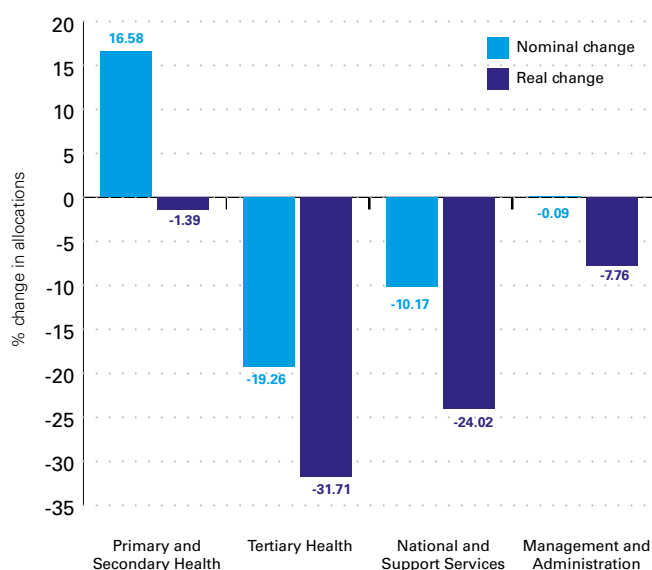
The majority of health sector resources are for curative services such as drugs, medical supplies and associated wages. It is however important to note that some resources for preventative programs are lumped up with curative programs.

For example, there is no separate budget line for sanitation services, yet every year a majority of communities suffer from preventable diseases like cholera. Some of the preventative programs are financed from the national level. Unfortunately, allocations to national programs suffered a 94% decline in nominal terms from the 2016/17 budget. Preventative services are a crucial component of the National Community Health Strategy.

Key Takeaways

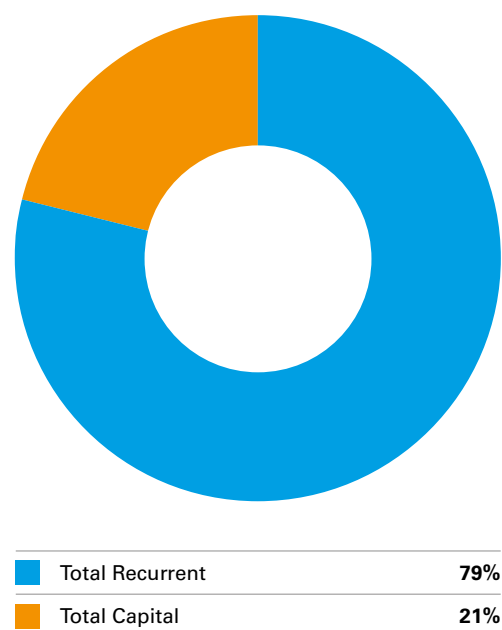
- **To avoid regression in health outcomes, the Government should safeguard the ORT budget to District Councils in real terms.**
- **Within the recurrent budget, the Government should ensure balance in allocations to PE and ORT.**
- **The government should ensure balance in allocations to different levels and types of health services (community, primary, secondary and tertiary) and also between curative and preventative health expenditures.**

Figure 11: Change in Allocation by Program Compared to 2016/17



Source: UNICEF calculations based on Estimates in the 2017/18 PBB

Figure 12: Composition of 2017/18 Total Health Budget by Economic Classification



Source: UNICEF, based on Estimates in PBB



© UNICEF/Pirozzi

PART 5 EQUITY OF HEALTH SECTOR BUDGETS

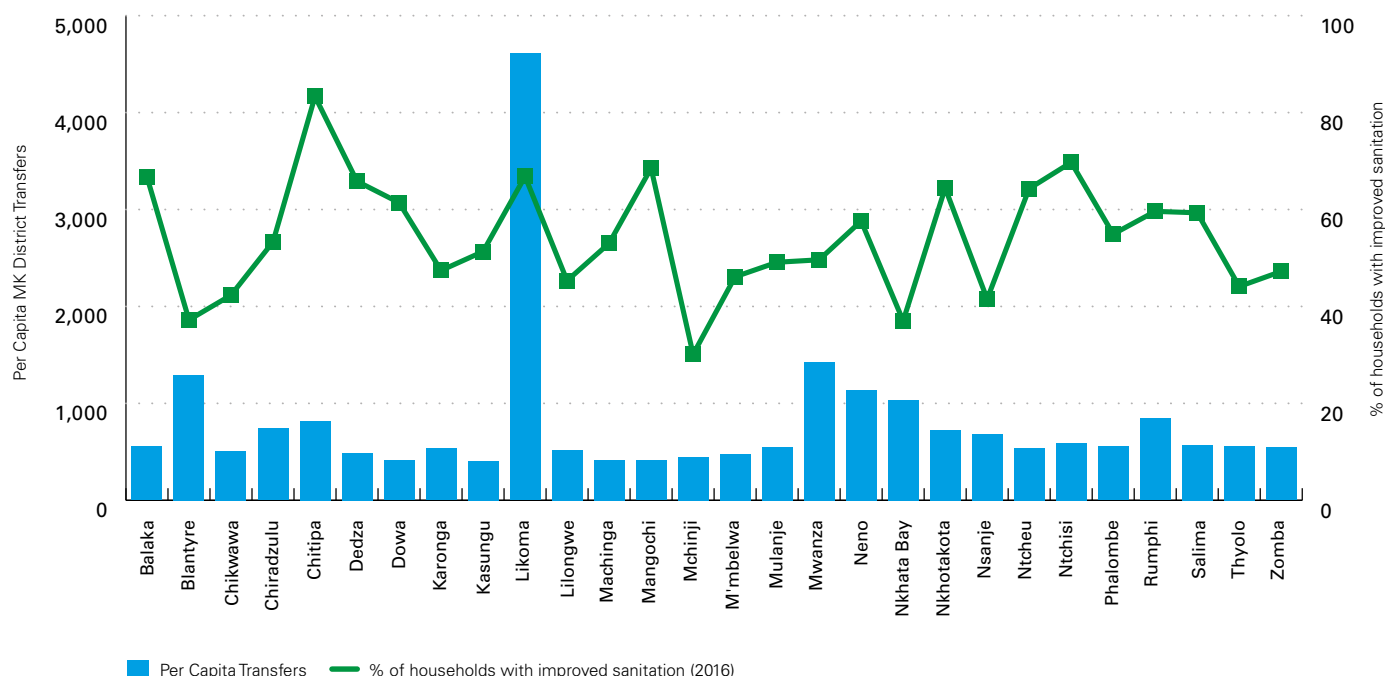
Per capita transfers to District Councils reflect some level of equity in allocations, although there are a few outliers like Likoma. In financial year 2017/18, the average per capita allocation to District Councils was MK800, in current prices. The lowest per capita allocation to District Councils for financial year 2017/18 is MK405 (Kasungu) with Likoma getting the highest allocation (MK4610), with a standard deviation of MK793. The high allocation to Likoma may be a result of transportation costs but also small population size which means that economies of scale cannot be achieved. Allocations to District Councils are made through the National Local Government Finance Committee (NLGFC) using the Health Resource Allocation Formula, which has been in place since 2008. Population is a key consideration in the formula. Given the wide range in per capita allocations, it may be necessary for the Government to revisit the allocation formula.

Allocations to District Councils do not show a strong relationship with health indicators, such as level of sanitation. Districts with poor sanitation (proxy indicator for community health) such as Zomba and Thyolo are receiving low per capita allocations despite showing poor sanitation outcomes (Figure 13).

There is hardly any information on whether off-budget health expenditures are equitable. This is partly because most development partners, including NGOs, have not been submitting health expenditure information to the Aid Management Platform. Reports from partners however seem to suggest that off-budget resources are mostly earmarked and sometimes not equitably distributed, as some Districts apparently receive more donor support than others. There are also parallel health financing mechanisms in Malawi, which are not effectively coordinated, thereby generating some inefficiencies.

The Global Fund, provided significant amount of support to Malawi (approximately US\$616 million) to fight AIDS, tuberculosis and malaria.

Figure 13: Per Capita Health Sector Allocations



Foreign funding to the health sector reflects programmatic inequities as earmarked resource flows seem to be skewed in favor of specific diseases rather than general health systems strengthening. For example, since 2014, the Global Fund, which is the main external health financier, provided significant amount of support to Malawi (approximately US\$616 million) to fight AIDS, tuberculosis and malaria. The Fund now disburses more funding to the Government than the Health Sector Joint Fund (HSJF), which succeeded the Health SWAp. During rainy seasons, significant resources have been channeled towards cholera treatment. The focus on specific health problems may come at the expense of low cost preventative health interventions such as improved sanitation.

Key Takeaways

- Alongside responding to specific health challenges and diseases such as cholera, TB, malaria, HIV and AIDS and cholera, it is crucial that donors also support the implementation of the National Community Health Strategy.
- Development partners, including NGOs, are encouraged to coordinate their support with MoH to ensure geographic and programmatic equity and efficiency in health financing.
- The Government should finalize review of the health budget allocation formula to District Councils in order to achieve geographical equity.

PART 6 HEALTH SECTOR BUDGETS AND DECENTRALIZATION

Health is amongst the few sectors that are relatively advanced in terms of fiscal decentralization. As indicated earlier, salaries for district level staff will now be paid directly to District Councils. The majority of sub-national level functions have been rolled out to District Councils since 2015. District Councils are now responsible for all community, primary and secondary health services.

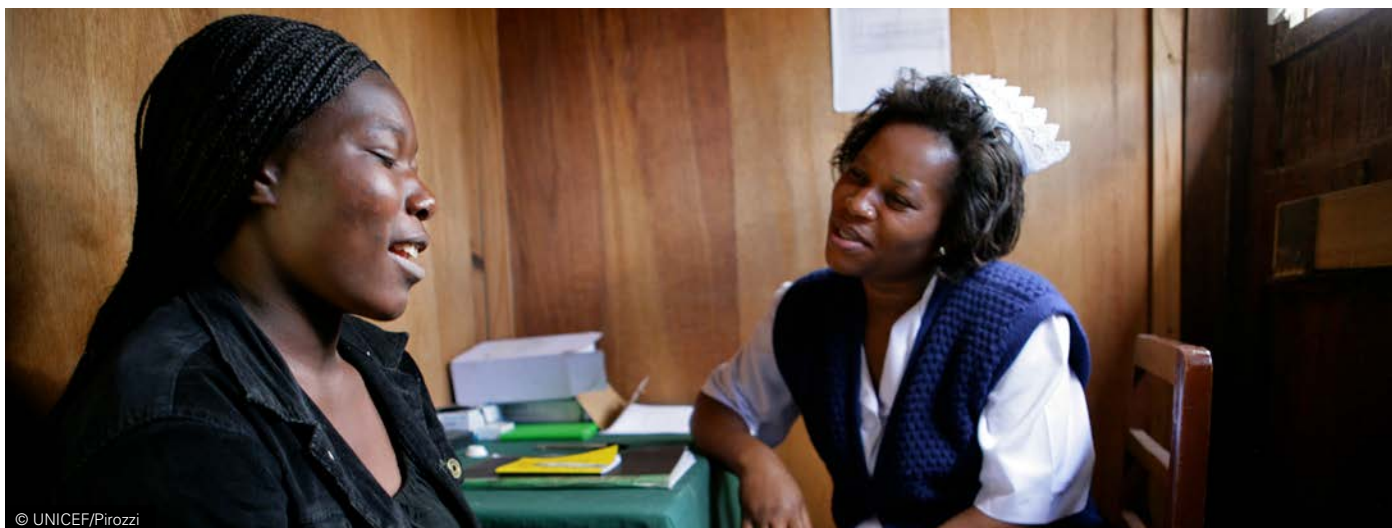
District Councils now independently purchase drugs through the Central Medical Stores (CMST), with funds disbursed through the National Local Government Finance Committee (NLGFC). Field reports from UNICEF partners have however showed an increase in emergence orders by District Councils. There have also been reports of leakages in the supply chain of CMST which the Government should address.

✓ Key Takeaways

- To ensure fiscal decentralization achieves its intended purposes, the Government is encouraged to strengthen local level health financing systems, including through increasing coverage of results based financing being piloted in a few District Councils.
- The Ministry of Finance should allocate human and technical resources to monitor progress with devolution of health payroll and fiscal decentralization in general.



© UNICEF/Pirozzi



© UNICEF/Pirozzi

PART 7 BUDGET CREDIBILITY AND EXECUTION ISSUES

Even though health outcomes have improved since 2010, several challenges persist with regards to the implementation of health sector budgets. One recurring challenge is that budgets are not always spent within set timelines. In financial year 2016/17, nearly all of the drugs budget for District Councils was spent in the first six months. Interestingly, in the following year (2017/18), only 35% of the planned expenditures on drugs for district hospitals and clinics, and 70% for national hospitals, were spent in the first half (July to December 2017). This points to two potential challenges which the Government should investigate: 1) credibility of health budgets, and 2) likely fiscal slippages in budget execution.

Delays in disbursement of funds to departments and health facilities have become common and frequent. District Health Offices have, on several occasions, reported late release of funding as a major hurdle in the implementation of their budgets. In the past few years, several Districts Councils reported between two to five months of delay in transfers of funds from the national to sub-national levels.³ In addition, funds received are often below what was requested, suggestive of cash flow problems. Cash flow problems may arise from under-performance of revenues and grants and subsequently how they are prioritized. Poor revenue performance has, in the past, resulted in 'cash rationing', whereby disbursements are dependent on available cash and therefore largely unrelated to budgets and cash flow requirements. Effective needs forecasting, prioritization and timely payment of purchases of goods and services is key to improving the efficiency of health expenditures.

3 UNICEF Malawi, Staff Field Reports.

Despite concerted efforts by the Government to curb such challenges, leakages persist. Even though initiatives such as the Drug Theft Investigation Unit, Health Centre Advisory Committees and several social accountability actions have helped to reduce pilferages, recent studies⁴ have shown that wastages and leakages are common in Malawi. For example, a study by the Global Fund found 33% of sampled private vendors stocking Malaria drugs procured by donors meant for Malawi's public health facilities.⁵ Leakages are caused by several factors including inadequate inventory control, poor record keeping, weak public supply management system and inaccurate reporting of receipts, stock levels and other supplies. Drugs and other items are sometimes issued to patients without being properly recorded. In several facilities, health records are not consolidated nor standardized across commodities and departments.⁶

Some health sector resources are also wasted through non-maintenance of assets. UNICEF supported social accountability initiatives in the health sector revealed several cases of assets not being used because of maintenance issues. Ambulances, medical equipment and some furniture have been cited as examples of assets that are found not in use because of minor problems which may require a small budget for maintenance.

4 See -Clinton Health Access Initiative (CHAI), 2013, Health Commodity Leakage in Malawi- A quantitative and qualitative study on the national leakage of medicines and health supplies, Royal Norwegian Embassy, Lilongwe and also Chirwa W.C., Mwalimbwire T., and Mwaungulu E.E, 2017, A Rapid Assessment Study of Formal and Informal Networks Facilitating Leakage of Health Commodities in Malawi, DFID, Lilongwe.

5 Global Fund, 2017, Proactive Investigation into Anti-Malarial Product Theft from Public Health Facilities in Malawi, Geneva, The Global Fund, Office of the Inspector General.

6 Ibid

A study by the Global Fund found 33% of sampled private vendors stocking Malaria drugs procured by donors meant for Malawi's public health facilities.⁵

✓ Key Takeaways

- The Government should enhance the capacity and role of the CMST, given parallel procurement systems and reports of leakages within the supply chain.
- There is a need to further strengthen coordination in health sector resource mobilization and spending to improve efficiency of expenditures.
- The Ministry of Health should consider decentralizing maintenance of assets used at District Level and ensure adequate budgets are allocated for this function within the ORT for District Councils.
- The Ministry of Health is encouraged to consider expanding coverage of results based financing to all Districts, as one way of improving efficiency of health financing.

Challenges have also been identified with regards to procurement. Firstly, there are parallel procurement systems by development partners, with the Government using the Central Medical Stores (CMST). Fragmentation makes it difficult for Malawi to enjoy economies of scale in procurement. Recent studies have also revealed leakages within the CMST supply chain. In the past few years, the number of emergency orders for drugs and other medical supplies have also increased, effectively increasing the risk of abuse and leakages in procurement.⁷ Some districts have also raised questions regarding transparency in procurement and supply chain management.⁸

Budget execution challenges are compounded by weak health expenditure monitoring and evaluation. Due to limited human and technical resources it is often difficult for the Government to effectively monitor performance of the health sector to identify inefficiencies and suggest remedial actions.⁹ For example, due to limited follow up and monitoring of expenditures, there is no reconciliation done between stock card issues from facility pharmacies and actual consumption recorded in clinic registers.¹⁰



© UNICEF/Asselin

⁷ Chirwa W.C., Mwalyambwire T., and Mwaungulu E.E., 2017, A Rapid Assessment Study of Formal and Informal Networks Facilitating Leakage of Health Commodities in Malawi, DFID, Lilongwe

⁸ UNICEF Field Reports.

⁹ Chirwa L., 2013, Knowledge synthesis on Malawi health system: Literature review, Connecting Health Research in Africa and Ireland Consortium (ChRAIC).

¹⁰ Chirwa W.C., Mwalyambwire T., and Mwaungulu E.E., 2017, A Rapid Assessment Study of Formal and Informal Networks Facilitating Leakage of Health Commodities in Malawi, DFID, Lilongwe

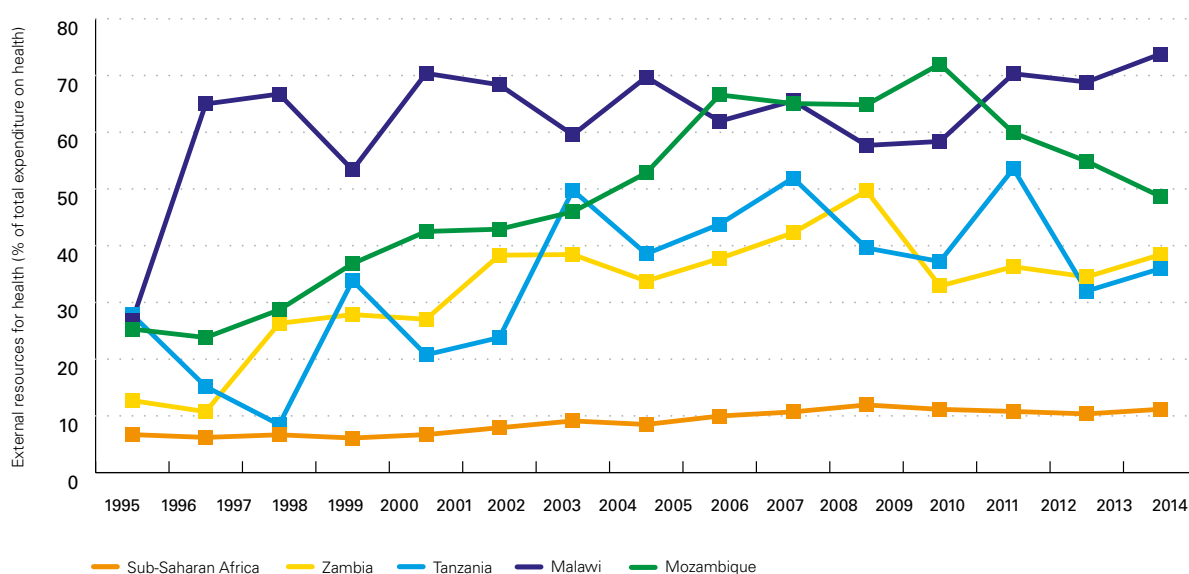
PART 8 HEALTH FINANCING

Malawi's health sector financing comprises general revenue, donor funding and household expenditures in the form of direct payments by patients and private health care insurers. However, fiscal space to ensure universal health coverage remains very limited. Since financial year 2013/14, donor financing has been declining and is increasingly off-budget. Since 2015, the Government has engaged various stakeholders to consider introduction of national health insurance, user fees and other innovative financing mechanisms to improve fiscal space for health. Unfortunately, some of the suggestions are not viable at this point in time. For instance, the report of the Health Insurance Expert Panel considered by Government in 2017 concluded that the costs of implementing a national health insurance would be unacceptably high compared to expected income. Although this proposal is not viable in the short term, there is potential for it in the long term. 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 present. Proposals for sin taxes on alcohol and tobacco were also found to have potential only in the medium to long term, because revenue projections were overly optimistic. Some of the proposed tax measures are likely to have economy-wide effects, including undermining the simplicity and efficiency of the tax system.

Malawi receives significantly more donor resources for health than most countries in sub-Saharan Africa. In 2014, for example, external resources accounted for 74% of total health expenditures, when the sub-Saharan average was 11%. Over-dependency on external sources however creates sustainability challenges in the delivery of health services.

Despite decline in total donor flows, the health sector is the most donor funded sector in Malawi. Data from the Malawi Aid Management Platform shows that between 2012 and 2015, the health sector received the largest share of all donor flows to Malawi (Figure 15). In 2017/18, donor contributions to the development budget were approximately 76%. Development I (donor resources) alone constitutes approximately 27% of the Ministry of Health Budget. This percentage does not consider most of the off-budget expenditures through non-governmental organizations.

Figure 14: Share of External Resources



Source: Unicef, based on data from World Development Indicators

Donors fund nearly 85% of nutrition related programs.

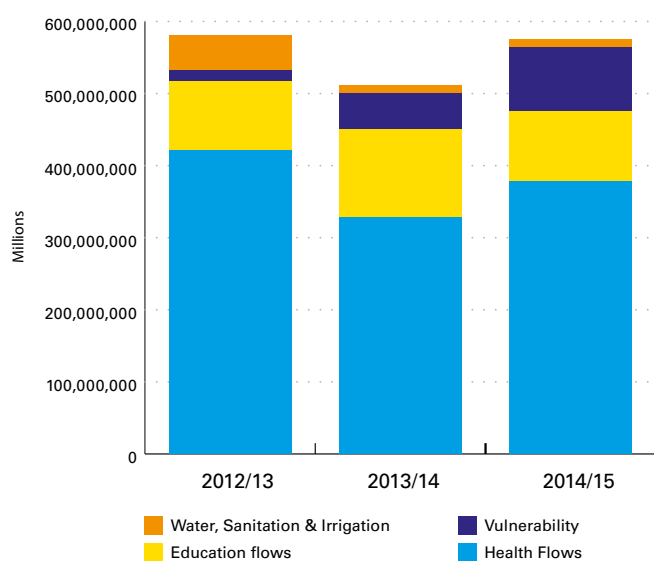
In financial year 2017/18 the government has allocated a total of MK425 million for nutrition related interventions, with on-budget contributions from donors exceeding MK2.5 billion.¹¹ These interventions include management of severe and acute malnutrition, school meals, deworming, nutrient supplementation and community based promotion activities. Nutrition related programs are budgeted for under Ministry of Health (MoH), Ministry of Gender, Children, Disability and Social welfare (MoGCDSW) and Ministry of Ministry of Civic Education, Culture and Community Development (MoCECCD). Although the Ministry of Agriculture, Irrigation and Water Development (MoAIWD) is expected to be one of the nutrition promotive ministries, it has no direct budgetary allocation to nutrition specific activities in financial year 2017/18.

¹¹ This does not include unreported expenditures by other development partners and civil society organizations.

The majority of families in Malawi cannot afford to pay for health services nor do they have health insurance.

Out of pocket payments for health services have averaged 10% since 2010. This is significantly lower than the Sub-Saharan average of 31%. In 2014, whilst out of pocket payments accounted for 11% of total health expenditures in Malawi, they were 23% in Tanzania and 33% in Zambia, as shown in Figure 16. The percentage of total health expenditure from direct out-of-pocket payments decreased from 22% in 2000 to 11% in 2014.

Figure 15: Health Sector Share of ODA Flows to Malawi

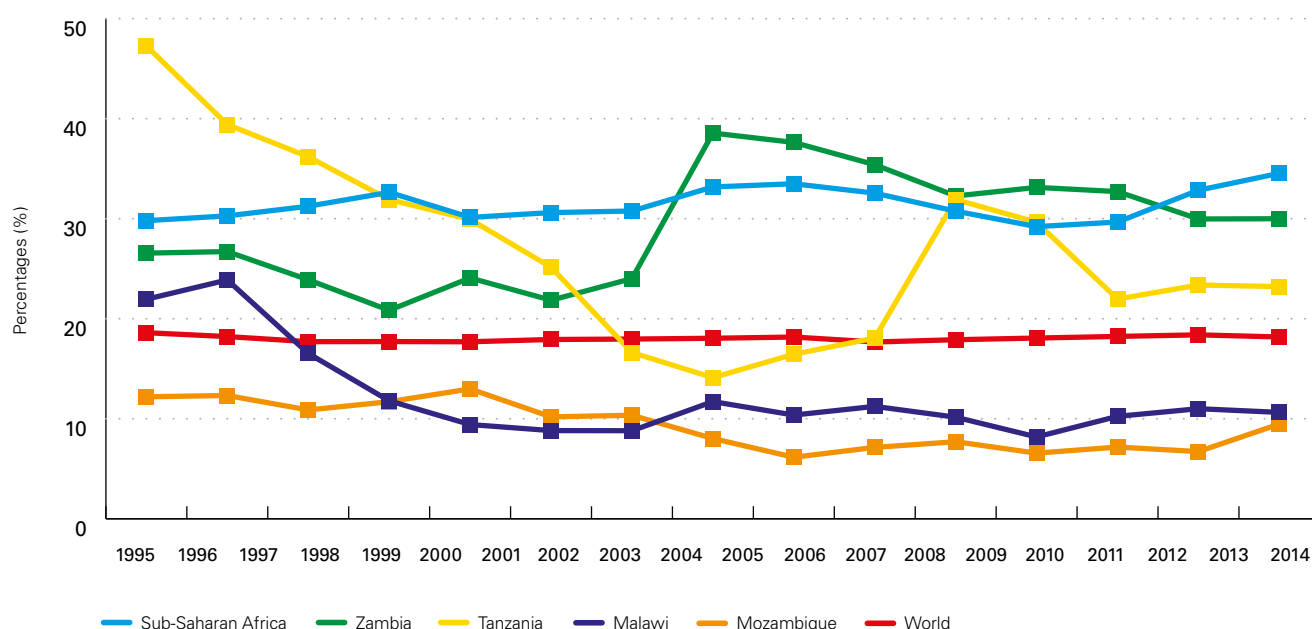


Source: UNICEF based on data from the Malawi Aid Management Platform



© UNICEF/Pirozzi

Figure 16: Trends in Out of Pocket Health Expenditures



Source: Unicef, based on data from World Development Indicators

The Government has established the Health Sector Joint Fund (HSJF) to reduce fiduciary risk in health financing while preventing aid fragmentation. More however still needs to be done to increase the effectiveness of this and other coordination mechanisms. The HSJF will be key in ensuring better alignment of health financing with the Health Sector Strategic Plan. While the HSJF is much smaller in terms of overall funding, its alignment to the HSSP means it holds the potential to have a substantial impact on health outcomes in Malawi.

Key Takeaways

- **Ministry of Health should carefully assess progressivity, cost-efficiency and sustainability of possible policy options to increase health sector resources.**
- **With donors taking the lead in development spending, it is essential that they align their spending with Government priorities.**
- **Given that the majority of families cannot afford to pay for health services, the Government has the obligation to increase its investments in health to ensure Universal Health Coverage.**

PART 9 POLICY ISSUES

Efficiency and effectiveness of health expenditures: Given restricted fiscal space, improving the efficiency of expenditures becomes crucial to generating additional resources from efficiency gains and to improve impact of health expenditures, especially on women and children. Improving efficiency requires a strategic and complementary mix of measures from the macro to the micro level. At the macro level, the MoH should review the allocation mix to different programs, strengthen national health accounts, enhance the purchase function and encourage timely reporting and accountability by District Councils. Results based financing also has the potential to improve efficiency in health expenditures. Unfortunately, this approach has not been taken to scale in all Districts of Malawi. At the micro level, several measures need be bolstered such as reconfiguration and integration of service delivery; appropriate use of information technology; a requirement to periodically publish performance information; strengthening monitoring, evaluation, audit and inspection; and scaling up behavioural communications. Increasing public spending alone, without robust behavioural communications, for example, is an insufficient measure to improve sanitation outcomes.

Integrated Community Health Service Delivery. The launch of the National Community Health Strategy (NCHS), Essential Health Package and ongoing fiscal decentralization are opportunities for the Government to improve the equity and quality of health services. Human, technical and financial resources should therefore be allocated to deliver the Essential Health Package. Unfortunately, as discussed earlier, the amount of resources being allocated to District Councils, especially for drugs and other primary health care services, do not seem commensurate with requirements of the NCHS.

Life-cycle approach to health service delivery. To be effective, health sector programs and budgets should respond to age, gender and geographic deprivations and vulnerabilities. One critical area that the Government and development partners should focus on is to prevent maternal, newborn and child deaths. This also includes promotion of the health and development of all children. Improving the nutrition of girls and women could minimise future maternal health problems. For example, low infant weight, and rapid childhood weight gain has been found to increase the risk of type 2 diabetes, whose effects can last for a life time.¹²

¹² Fall, C. (2009), 'Maternal nutrition: Effects on health in the next generation', Indian J Med Res Vol 130, pp.593-599.

✓ Key Takeaways

- **Government and development partners should focus on improving efficiency and effectiveness in health spending to consolidate gains made in the past decade.**
- **The Government should give special attention to maternal, newborn and child health, where returns on investment are very high.**
- **In financial year 2018/19, the government should set aside resources for recruiting additional community health workers and giving them high-quality and integrated pre-service and in-service training, and ensure their equitable distribution across all districts.**



© UNICEF/Pirozzi

Key Terms

Approved Budget Estimates	The budget as approved by Parliament.
Budget Outturn	Actual spending during a given period.
Development (Part I)	Share of the budget for long term public investments contributed by donors.
Development (Part II)	Share of the budget for long term public investments from domestic resources.
Economic Classifications	Budget classification based on economic inputs.
Gross Domestic Product	Total value of goods and services produced by a country in each year.
Nominal change	Changes in budget allocations which do not factor in inflation.
Other Recurrent Transactions (ORT)	Budget for day to day items such as drugs, office supplies, fuel, utilities, routine maintenance and other operations.
Personnel Emoluments (PE)	Salaries, wages, allowances and other staff entitlements.
Real change	Changes in budget allocation after adjusting for inflation.



© UNICEF/Pirozzi

For more information, contact:

Edward Archibald

Chief, Social Policy

earchibald@unicef.org

Bob Libert Muchabaiwa

Social Policy & Economic Specialist

bmuchabaiwa@unicef.org

UNICEF Malawi

UNICEF House, Airtel Complex

PO Box 30375

Lilongwe

Malawi

Tel: +265 (0)1 770 770

www.unicef.org/malawi