2019/20 Health Budget Brief

Towards Full Implementation of the Essential Health Package: Achieving SDG 3 in Malawi

MALAWI

Key messages and recommendations

1 **Excluding public debt charges, health remains the third spending priority for the Government of Malawi (9.4% of the national budget), but allocations continue to fall short of national and international targets.**

→ **Recommendation:** Given limited fiscal space, the Government is encouraged to finalize and implement the Health Financing Strategy to consolidate gains achieved in the health sector. In doing so, it is critical to sustain investments in the Essential Health Package (EHP) and to focus on enhancing value for money in health spending.

2 **The Government is commended for allocating a total of MK558 million to the Expanded Program on Immunization (EPI) in fiscal year (FY) 2019/20, up from MK264 million in 2018/19. However, the increase has not benefited the vaccine procurement allocation that remained at MK200 million as in FY2018/19.**

→ **Recommendation:** The Government is recommended to explore sustainable ways to finance the procurement of vaccines for immunization and to meet the programs' financial needs, estimated at MK1.3 billion in 2020/21, in constant prices.

3 **The Ministry of Health and Population (MoHP) is commended for initiating a process to review the Health Sector Resource Allocation Formula (HRAF) to ensure that transfers to Local Authorities are equitable.**

→ **Recommendation:** The MoHP together with the National Local Government Finance Committee (NLGFC) and the Ministry of Local Government and Rural Development are encouraged to finalize the development of the HRAF and facilitate its approval by relevant authorities.

4 **Efficiency of health spending is hampered by shortages of critical health staff, energy challenges and a malfunctioning Health Information Management System (HIMS), especially in rural areas.**

→ **Recommendation:** The Government should prioritize recruitment of key district health personnel, including Community Health Workers, establishment of sustainable energy systems, especially for the cold chain and strengthen information management systems.

5 **There are notable budget credibility challenges in the health sector, especially for development projects, including those funded by donors.**

→ **Recommendation:** The MoHP should assess underlying factors leading to low budget absorption of donor funds. A budget absorption study is recommended.

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1. INTRODUCTION

This budget brief explores the extent to which the FY2019/20 National Budget addresses health financing needs of citizens in Malawi, especially children. Specifically, it analyzes the size, composition and equity of allocations to the health sector in FY2019/20. The brief concludes with a set of recommendations on how the Government of Malawi (GoM) can increase and improve the quality of public spending on health, including by enhancing efficiency, effectiveness and equity in the allocation and utilization of health sector resources to benefit all children in Malawi.

The analysis is based on an in-depth review of available budget documents. For FY2019/20, the analysis considers the approved budget allocations as presented in the Detailed Estimates of Expenditures and Program Based Budget (PBB), whereas revised budget estimates are used for previous years. The trend analysis covers eight years, spanning from FY2012/13 to FY2019/20 and FY2012/13 is used as the base year in adjusting allocations for inflation. The analysis is complemented by a review of health financing related reports, produced by the Government, Development Partners and NGOs.

The health sector budget comprises allocations to various ministries, departments and agencies (MDAs). These include the Ministry of Health and Population (MoHP) (Vote 310), health sector transfers for other recurrent transactions (ORT), personal emoluments (PE) and drugs to District Councils through the National Local Government Finance Committee (NLGFC) and, lastly, Sub-vented Health Organizations (SHOs) (Vote 275)[1].

1 These are Medical Council of Malawi, Nurses and Midwifery Council of Malawi, Pharmacy, Medicines and Poisons Board (these three replaced the Health Services Regulatory Authority – 2012/13 to 2018/19), Kachere Rehabilitation Centre, National Aids Commission (NAC) and Malawi Red Cross Society.

2. OVERVIEW OF HEALTH SECTOR IN MALAWI

Health and Population is one of the five priority areas of the Government of Malawi. Through the Third Malawi Growth and Development Strategy (MGDS III) (2017-2022) the Government committed itself to improve access, equity and quality of primary, secondary and tertiary healthcare services. The Government has also developed robust health sector policies and plans covering the MGDS III period. In 2017, the Government launched the Second Health Sector Strategic Plan (HSSP II), the Essential Health Package (EHP) (2017-2022), the Sexual and Reproductive Health Policy (2017-2022), the National Malaria Strategic Plan (2017–2022), the first ever National Community Health Strategy (2017-2022), the National Quality Policy and Strategy and the Multi-Year Plan for the Expanded Program on Immunization (2017-2021). Furthermore, the approval of the Health Policy in 2018 expanded the mandate of the Ministry of Health to include population.

Malawi has made considerable gains in the health sector over the period concerned by this analysis. Data from the UN Inter-Agency Group for Child Mortality Estimation show that under five (U5) mortality declined from 75.4 deaths per 1,000 livebirths in 2012, to 59.2 in 2015 and 49.7 in 2018. This is lower than most peer countries in the SADC region, as shown in Table 1.

TABLE 1 Under five mortality, per thousand livebirths in SADC countries (2012-2018)

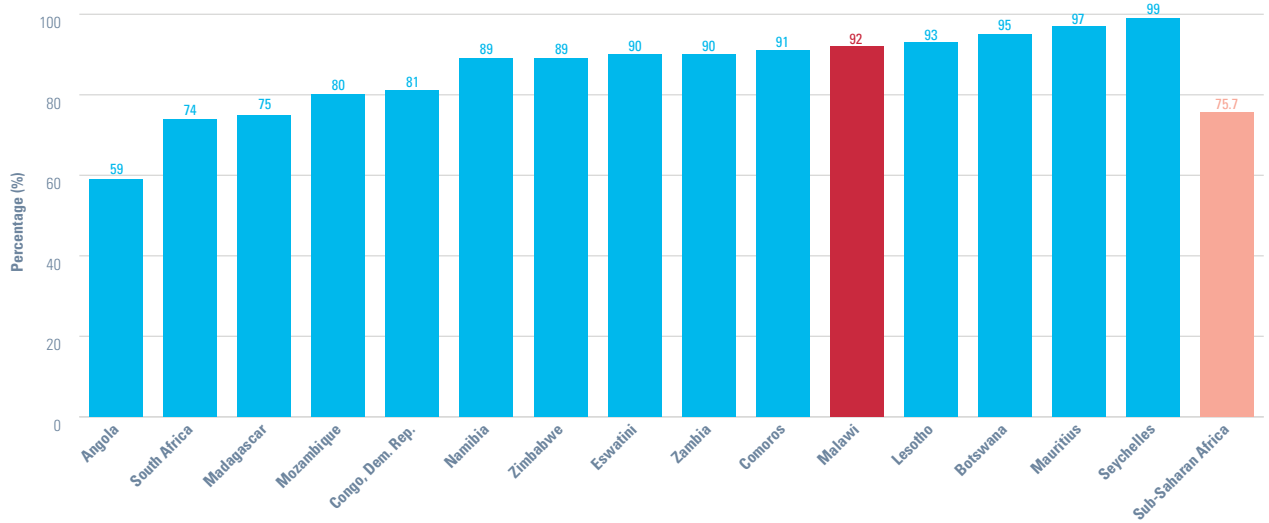
Country	2012	2013	2014	2015	2016	2017	2018
Mozambique	94.7	89.9	86.1	81.8	78.1	75.5	73.2
Zambia	74.3	70.7	66.9	64.6	62	59.4	57.8
Malawi	**75.4**	**68.6**	**63**	**59.2**	**55.7**	**52.7**	**49.7**
Zimbabwe	69.8	62.3	57.5	54.3	50.4	49.3	46.2
Sub-Saharan Africa	93.7	90.4	87.5	84.8	82.2	79.9	77.5

Source: UN Inter-Agency Group for Child Mortality Estimation

For many years, Malawi has sustained a high coverage of immunization, well above 80%, when for instance, the Sub-Saharan Africa average for DPT is 75.7% (Figure 1). Malawi has also managed to reduce the prevalence of malaria from 33% in 2014 to 24% in 2017. Stunting also declined by ten percentage points from 47% in 2010 to 37% in 2016.

Malawi has sustained a high coverage of immunization, well above 80%.

FIGURE 1 Immunization, DPT (% of children ages 12-23 months) (2018)



Source: World Development Indicators (WHO and UNICEF,2018)

However, significant work is required to sustain the gains realized to date and to achieve relevant SDG and national targets. At 49.7 deaths per 1,000 livebirths, U5 mortality is twice the target of 25 deaths per 1,000 livebirths of SDG 3.2 and slightly above the national target of 48 deaths per 1,000 livebirths. Maternal mortality, currently at 439 deaths per 100,000 livebirths, is 25% over the HSSP II target of 350 and thrice the SDG 3.1 target of 140 deaths per 100,000 live births. Malawi's HIV prevalence remains high, with 9.1% of the adult population living with HIV, while tuberculosis (TB) continues to be a major public health problem. Figure 2 summarizes the current status of health indicators in comparison to HSSP II targets.

Several health system challenges are limiting the delivery of quality health services as shown in Figure 3. The World Health Organisation ranks Malawi as one of the countries with acute shortage of health workers. Currently, there is a shortage of at least 7,000 Health Surveillance Assistants (HSAs). The sector also suffers limited in-service training and poor staff retention. With regards to the health information system (HIS), Malawi faces challenges linked to the presence of parallel information systems and the poor performance of the routine HIS. Quality of health care has also been compromised by drug stockouts, weak supply chains, inadequate basic equipment and infrastructure as well as electricity problems for the cold chain.

FIGURE 2 Summary of Health Indicators Against HSSP II (2022) Targets

	Maternal mortality ratio	Neonatal mortality rate	Infant mortality rate	Under-five mortality rate	Malaria parasite prevalence among children (6-59 months)	Adolescent fertility rate (15-19 years)	Total fertility rate
Current (2017/18)	439 per 100,000 live births	22.7 per 1,000 live births	38.5 per 1,000 live births	50 per 1,000 live births	24%	144 per 1,000 adolescent girls	4.44 children per woman
HSSP II target (2022)	350 per 100,000 live births	22 per 1,000 live births	34 per 1,000 live births	48 per 1,000 live births	20%	100 per 1,000 adolescent girls	3 children per woman
SDG 3 target (2022)	140 per 100,000 live births	12 per 1,000 live births		25 per 1,000 live births			

Source: MDHS 2015/16, MMIS (2017) and World Development Indicators (2019)

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FIGURE 3 Health System Challenges in Malawi

Source: UNICEF (2019)

KEY TAKEAWAY

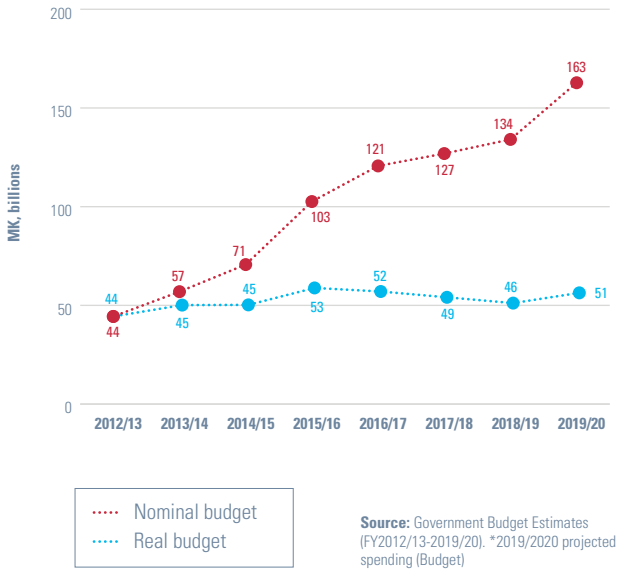
⊕ Progress made so far in improving health outcomes, can only be sustained by continued public investments in strengthening the national health system.

The World Health Organisation ranks Malawi as one of the countries with acute shortage of health workers.

3. HEALTH SECTOR SPENDING TRENDS

A total of MK163 billion was allocated to the health sector in FY2019/20, up from the revised estimate of MK134 billion in FY2018/19 (Figure 4). This implies a 21.4% increase in nominal terms and 10% in real terms. In FY 2019/20, the health sector remains the third largest sector in terms of budget allocations, with 9.4% of the total budget, after education with 25% and agriculture with 10.4%. This only holds, if public debt charges, making up 14% of the total budget, are excluded. It is also important to note that the health sector enjoys significant off-budget expenditures that are not considered in this analysis.

FIGURE 4 Trends in Health Sector Spending, 2012/13 as base fiscal year

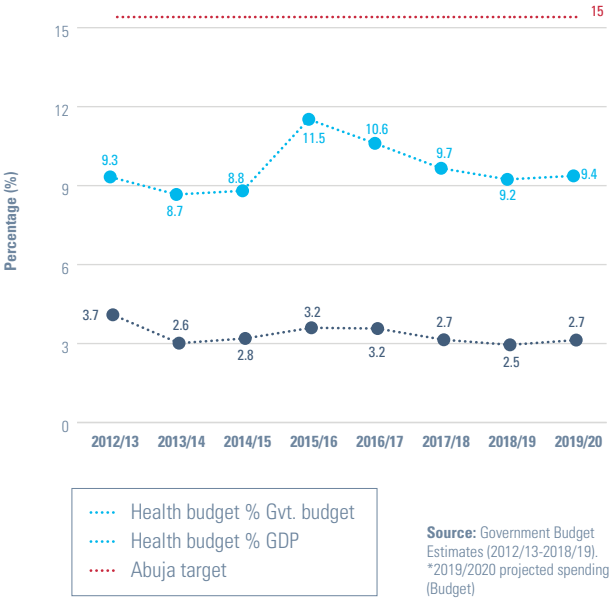


Source: Government Budget Estimates (FY2012/13-2019/20). *2019/2020 projected spending (Budget)

Since FY2012/13 Malawi's spending on health has been below the Abuja Declaration target for African States to allocate at least 15% of their total budget to the health sector. The share of the total government budget allocated to the health sector has averaged 9.6% between FY2012/13 and FY2019/20. As a percentage of GDP, health sector budgets stagnated at around 3% over the same period.

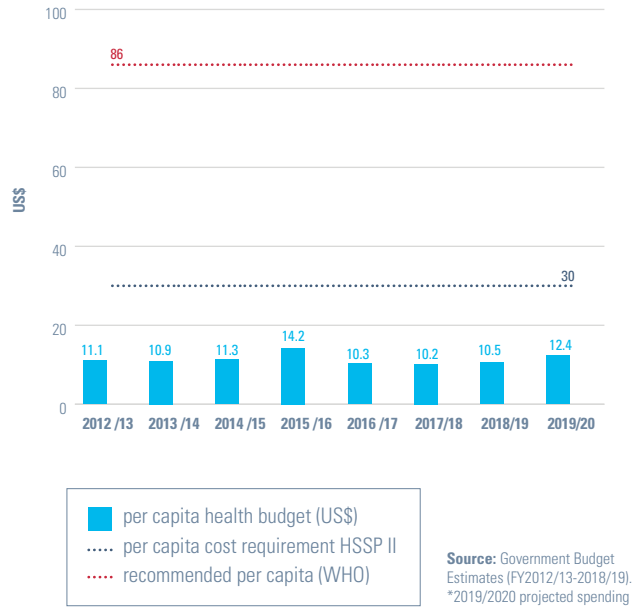
Government spending on health continues to fall short of cost estimates in sector plans. At MK9,268 (US$12.4, current prices), the health budget allocation for FY2019/20 is roughly 40% of cost estimates in the HSSP II. In per capita terms, the total health sector budget (US$12.40) is almost half of cost estimates (US$30) in the HSSPII, and a mere 14% of the US$86 minimum per capita investment recommended by World Health Organisation (WHO) to provide basic health services.

FIGURE 5 Trends in Health Sector Spending as a Share of Govt. Budget and relative to GDP



Source: Government Budget Estimates (2012/13-2018/19). *2019/2020 projected spending (Budget)

FIGURE 6 Trends in per capita public health allocations



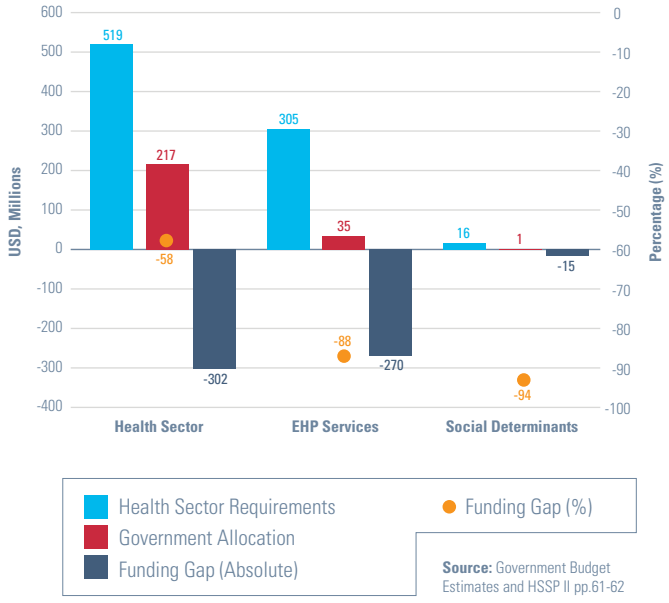
Source: Government Budget Estimates (FY2012/13-2018/19). *2019/2020 projected spending

Malawi spends relatively less public resources on health in per capita terms than its neighbours.

Total health sector budget allocations have consistently fallen short of the HSSP II estimates by an average of 60%, between FY2017/18 and FY2019/20. The 2019/20 health sector allocation is approximately 40% of the required US$519 million per year. As shown in Figure 7, the financial gap is wider for the Essential Health Package (88%) and the Social Determinants of Health (94%) than other areas. The figures, however, exclude significant resources that are channelled to communities through off-budget means.

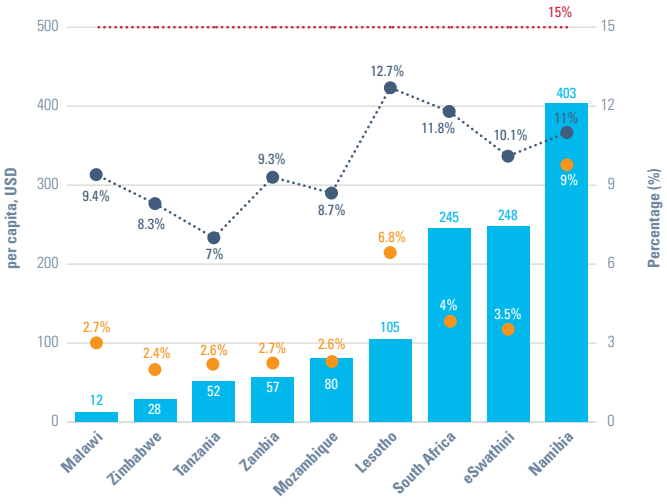
Malawi spends relatively less public resources on health in per capita terms than its neighbours. Latest data from UNICEF budget briefs shows that per capita public health spending is around US$52 in Tanzania and US$80 in Mozambique, compared to US$39 in Malawi as shown in Figure 8. However, when viewed in relation to national budget and GDP, Malawi's budget allocations to health compares relatively well with other SADC countries. For instance, Malawi allocated 9% of its national budget to health in 2018/19 compared to 7% in Tanzania and 8.7% in Mozambique.

FIGURE 7 FY2019/20 health sector allocations compared to HSSP II cost estimates



Source: Government Budget Estimates and HSSP II pp.61-62

FIGURE 8 Health Spending in Selected SADC Countries



Source: UNICEF Country Health Budget Briefs

KEY TAKEAWAYS

- The health sector is a key spending priority for the Government, but allocations are insufficient to meet financing needs. This issue should be addressed during medium term expenditure planning.
- The Government is encouraged to finalise the health sector financing strategy, which will serve as a framework to resources additional resources to improve health spending.

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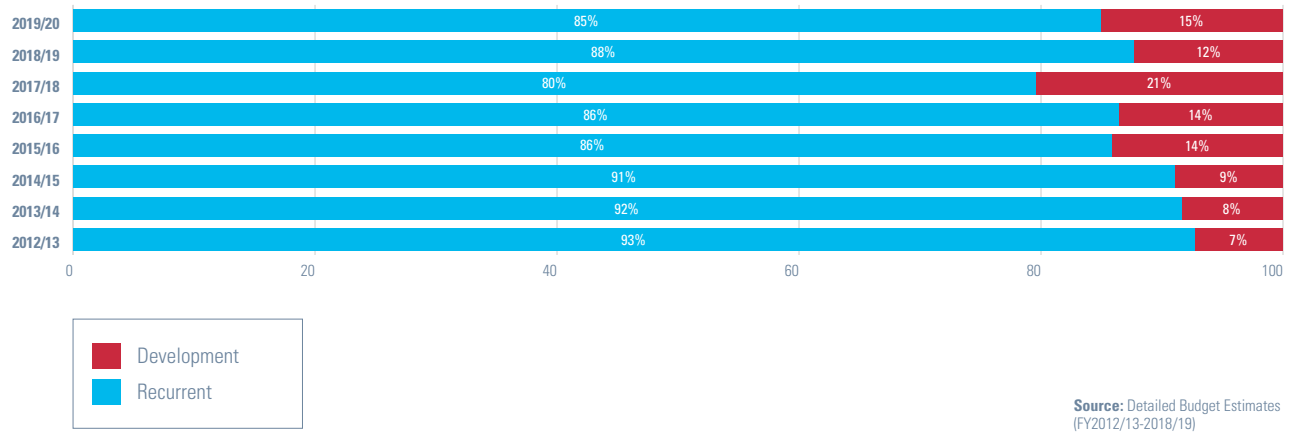
4. COMPOSITION OF HEALTH SECTOR BUDGETS

Recurrent costs continue to absorb most of health sector budgets. In FY2019/20, a total of MK138.1 billion, or 85% of the health sector budget, has been allocated to recurrent costs compared to MK24.6 billion, or 15% of the health sector budget, for development projects (Figure 9). About 58% (MK80 billion) of the recurrent budget for FY 2019/20 will be spent on personal emoluments (PE). The remainder (42%) will go to other recurrent transactions (ORT) namely drugs, medical supplies and operations. Notwithstanding the size of the PE budget, the health sector faces significant staff shortage, especially at district level. The development share of the health sector budget for FY2019/20 has nominally doubled from the 2012/13 share of 7% up to 15%, as shown in Figure 9. In nominal terms, the development budget increased by 49% from a revised estimate of MK16.5 billion in FY2018/19 to MK24.6 billion in FY2019/20.

Most health sector allocations (53%) are channeled through MoHP, with another 44% through District Councils, mainly for personnel emoluments (PE). The remainder (3%) is allocated to sub-vented health organizations (SHOs). The distribution of health resources has generally remained the same over the past two financial years as shown in Figure 10. In nominal terms, budget allocations to MoHP have increased by 28%, which is twice the increase in allocations to District Councils and SHOs of 14%.

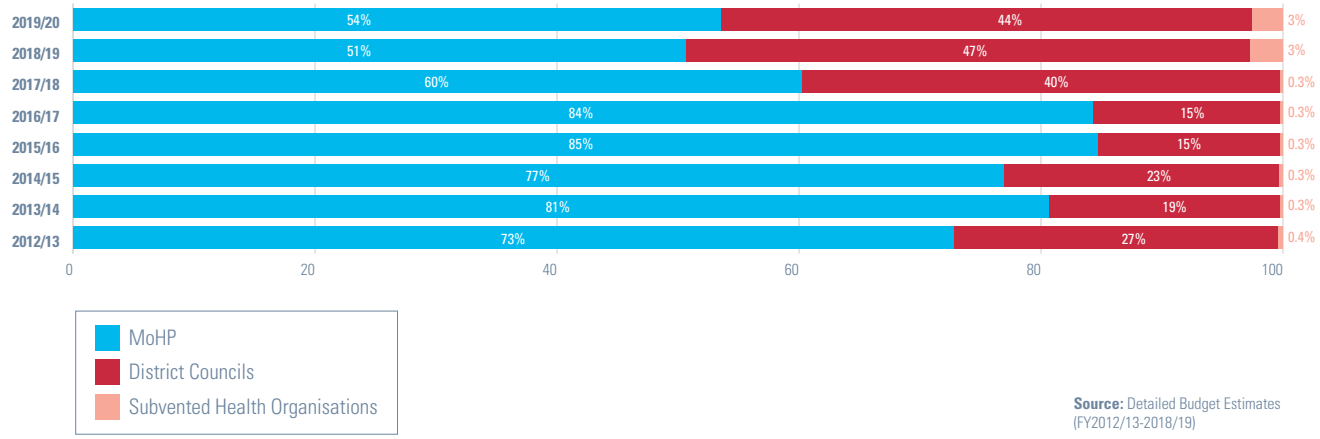
The share of the budget allocated towards the provision of EHP services has declined in the current financial year compared to the previous one. Figure 11 shows that the EHP budget as a share of the MoHP budget declined from 52% in FY2018/19 to 30% in FY2019/20. In FY2019/20, EHP services were allocated a total of MK26.4 billion, compared to MK34.9 billion in FY2018/19. The decline in the EHP budget is linked to a slight change in the budgeting approach by the MoHP between 2018/19 and 2019/20. In 2019/20, the MoHP requested Central Hospitals to further disaggregate their budgeted activities, resulting in a decline in the health service

FIGURE 9 Trends in the Composition of the Health Budget by Economic Classification



Source: Detailed Budget Estimates (FY2012/13-2018/19)

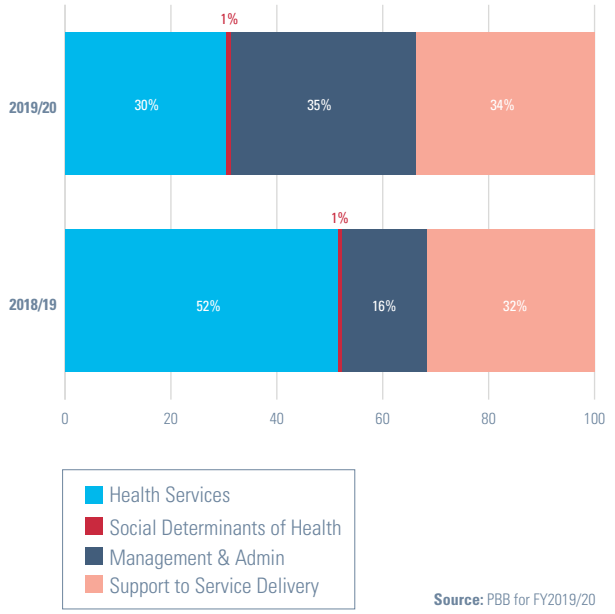
FIGURE 10 Composition of Health Sector Budgets by Agency



Source: Detailed Budget Estimates (FY2012/13-2018/19)

provision-related aspects as a proportion of total activity costs. Therefore, the absolute decline in the EHP budget does not necessarily reflect a decline in the provision of health services in the country.

FIGURE 11 Program Composition of MoHP Budget



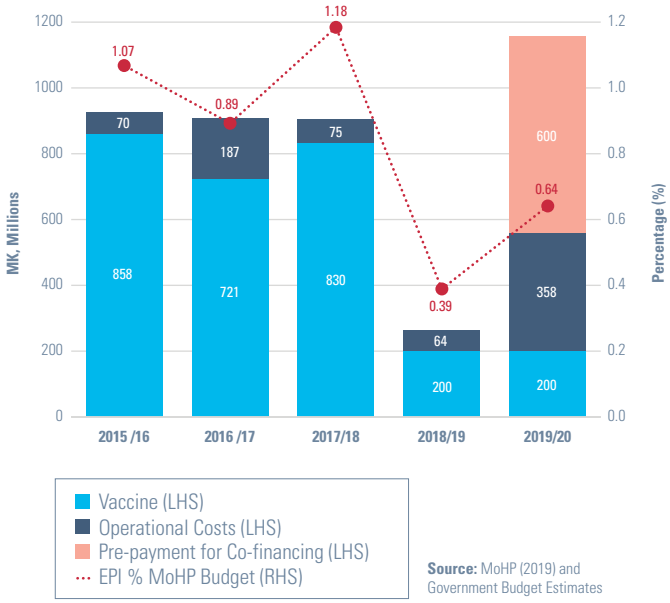
Source: PBB for FY2019/20

Allocations to Management and Administration (Program 20) significantly increased as a share of MoHP budget from 16% to 35% between 2018/19 and 2019/20 (see figure 11). In nominal terms, the allocation to Management and Administration has increased by 181%, from MK10.8 billion in 2018/19 to MK30.4 billion in 2019/20, which is linked to the change in the budgeting approach explained above. The budget for support to service delivery increased by 37% in nominal terms and marginally as a share of the MoHP budget, from 32% to 34%. Although increasing by 26% in nominal terms, allocations to Social Determinants of Health continue to constitute a very small share (0.82%) of the MoHP budget. This program is aimed at reducing environmental and social risk factors that have a direct impact on health.

The allocation to environmental health has considerably decreased in 2019/20. A total of MK256 million was allocated to environmental health in 2019/20, which is 41% nominally lower than the MK415 million allocated in 2018/19. The decline has widened the financial gap for 'Services for environmental and social determinants of health' as costed in the HSSP II. In total, the Government allocated MK713 million to "Environmental and social determinants of health' (program 22) in 2019/20, which translates to US$951,250. This is only 6% when compared to required costs under HSSP II of US$16.3 million.

The Treasury allocated a total of MK558 million for EPI in 2019/20, up from MK264 million in 2018/19 as shown in Figure 12. On top of the allocation for the fiscal year, the MoHP used underutilized funds from the Zomba Mental Hospital's Drug budget for 2018/19 to the tune of MK600 million to frontload the payment for the procurement of vaccines in 2019/20. This brings the total available amount for EPI in 2019/20 to MK1.158 billion. This allowed Malawi to come closer to the co-financing obligations for the fiscal year 2019/2020 (MK1.2 billion). To date, Malawi has only been able to meet its co-financing obligations through financial support provided by the Health Sector Joint Fund (HSJF). For 2020/21, UNICEF estimates that the Government will require about MK1.3 billion (US$1.74 million) for vaccines and injection materials, as shown in Table 2.

FIGURE 12 Trends in EPI Spending



Source: MoHP (2019) and Government Budget Estimates

TABLE 2 EPI Budgetary Needs for 2020/21, Including Service Costs

Item	Amount (USD)	Amount (MK)
Traditional Vaccines (excl. injection materials)	589,329	441,996,510
Co-financing (excl. injection materials)	743,493	557,619,750
Injection Materials (for both Td and New Vaccines)	409,467	307,100,040
Total EPI Budgetary Need	**1,742,288**	**1,306,716,300**

Source: UNICEF Malawi (2020)

The decrease in allocations to EPI, especially in FY2018/19 is mainly because of the reduction of the discretionary ORT budget allocated to the MoHP. The reduction in the discretionary ORT budget for the MoHP, from which the EPI resources are drawn, is linked to the ring-fencing of major items, such as the procurement of ambulances. The Treasury ring-fenced the item "Vaccines and Blood Products" for the Central Hospitals in 2019/20. However, the Central Hospital's budget is mostly used to procure blood products only, given that immunization activities and the related procurement are handled by the MoHP directly.

The Government is commended for allocating funds to Community Health to the tune of MK31 million in 2019/20. In Malawi, "Community Health" refers to the provision of basic health services in rural and urban communities with the participation of people who live there. Community Health is essential in improving health and livelihoods, especially for rural communities, where 84% of the population lives, 24% of whom do not live within five kilometres of a health facility. The allocation to Community Health is worth 0.02% of the MoHP budget. Although significantly lower than the financial requirements, the allocation demonstrates Government's commitment to implement the National Community Health Strategy (NCHS) launched in 2017.

KEY TAKEAWAYS

- The MoHP, with support from donors, should continuously engage the Treasury to increase EPI budgetary allocations in line with financing needs and the co-financing requirements.
- The MoHP is requested to make publicly available expenditure information, including through the publishing of National Health Accounts which allow for the identification of expenditures on key health interventions such as the EPI.

The Government is commended for allocating funds to Community Health to the tune of MK31 million in 2019/20.

5. EQUITY OF HEALTH SECTOR BUDGETS

Disparities exist in child health outcomes amongst District Councils, between rural and urban populations, and wealth quintiles. These could be addressed through a strengthened equitable resource sharing formulae. For example, U5 mortality is higher in rural than urban areas (77 deaths per 1,000 live births compared to 61 deaths per 1,000 live births, respectively). By region, U5 mortality is highest in the Central Region (81 deaths per 1,000 live births) and lowest in the Northern (57 deaths per 1,000 live births). Stunting in under five children is 46% among children in the lowest wealth quintile, 37% among those in the middle wealth quintile and 24% for children in the highest wealth quintile. Vaccination coverage ranges from 32% in Mangochi to 81% in Mwanza.

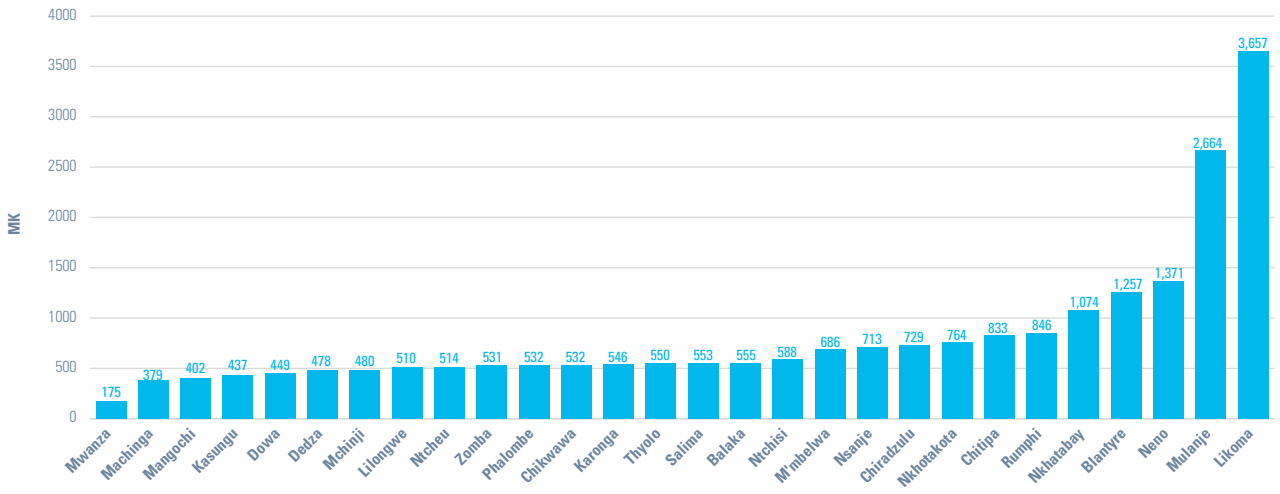
Given the foregoing, the MoHP is commended for embarking on a review of the health resource allocation formula (HRAF). The formula is a key tool for achieving equity in health financing and is expected to respond to morbidity as well as geographic, age and gender related disparities. The revision of the formula is currently at an advanced stage and is scheduled to be finalized in 2020. Figure 13 shows that per capita health sector ORT transfers to District Councils range from as low as MK175 in Mwanza to MK3,657 in Likoma, the least populated Island district with 14,527 people. Per-capita allocations to District Councils average around MK500 per year.

Off-budget resources are mostly earmarked and not equitably distributed, as some districts receive more donor support than others. Districts' dependency on donor support is very high, ranging from 70% to 88% of the total health funding. The fifth round of the health sector resource mapping revealed that a total of US$338 million (including donor funds) available from the overall resource envelop in 2017/18 was spent at district level. The funding, however, significantly varied across districts – ranging from US$5 million in Likoma to US$44 million in Lilongwe, with a median of US$12 million. The resource mapping also reported district variations in level of donor dependency. For instance, Phalombe registered the greatest percentage of health funding from external sources (88%), while Dowa was the lowest (70%). Variations in donor funding across districts are partly due to district-specific projects, which are typically not integrated into the District Development Plans (DDPs). Increased transparency and coordination has potential to lead to equitable distribution of health sector resources.

KEY TAKEAWAYS

- Inequitable distribution of donor funding is likely to exacerbate disparities in distribution of health services.
- The review of the health resource allocation formula by the MoHP is a step in the right direction to address disparities in child health outcomes and equity in health financing.

FIGURE 13 Per Capita ORT Transfers by District Council



Source: NLGFC (2019)

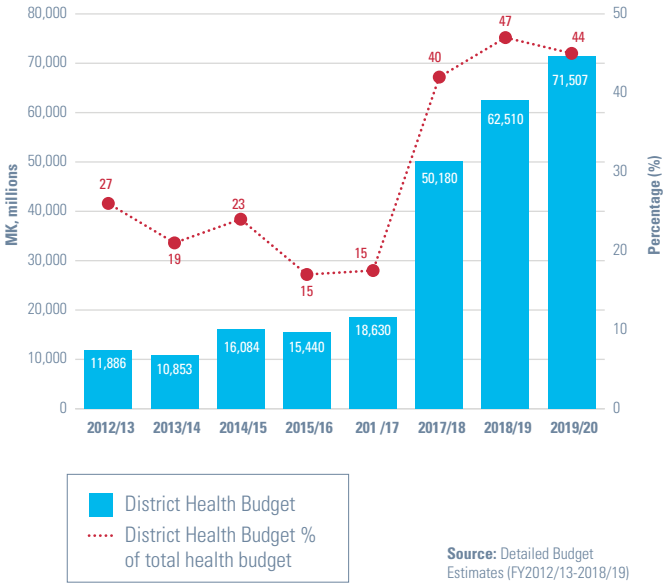
6. HEALTH SECTOR BUDGETS AND FISCAL DECENTRALIZATION

Health is the second largest fiscally decentralized sector. In FY2019/20, the health sector was allocated 27% (MK8.7 billion) of total ORT transfers to Local Authorities, the second highest after education (30.4%). Agriculture ranks third, receiving 5% of total ORT transfers. In terms of PE, the health sector received a total of MK47.4 billion, which is 22% of total district PE and second to education which received MK150 billion (70%).

District Councils also receive significant resources for drugs, through the NLGFC. The procurement of drugs is done through the Central Medical Stores (CMST). A total of MK15.6 billion was allocated for the purchase of drugs at district level in 2019/20. Overall, the FY2019/20 budget shows that 44% of the health sector budget will be managed at district level. Strengthening procurement and financial reporting and accountability systems at the local level is therefore key to ensuring that decentralization achieves intended health outcomes.

The district health budget for ORT has steadily increased since FY2016/17 in nominal terms (Figure 14). A total of MK71 billion was allocated to District Councils in FY2019/20. Compared to 2018/19, this allocation represents a 15% increase in nominal terms and 4% increase after accounting for inflation. The increase in allocation to District Councils was mainly driven by salaries, which grew by 19% in nominal terms and 8% in real terms. Overall, there was a salary adjustment in the FY2019/20 national budget of 10-15%. As has been the case over the past three financial years, the ORT budget increased by only 5% in nominal terms. In real terms, the ORT budget went down by 5%. The total drugs budget increased by 7% in nominal terms but decreased by 3% after adjusting for inflation compared to the previous year.

FIGURE 14 Trends in Transfers to District Councils



Source: Detailed Budget Estimates (FY2012/13-2018/19)

KEY TAKEAWAY

⊕ Considering that a significant portion of health sector resources are expended at District level, it is important for the government to further strengthen health financing and expenditure systems at sub-national levels to improve value for money.

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7. BUDGET CREDIBILITY AND EXECUTION ISSUES

There are notable budget credibility challenges in the health sector, especially for development projects, including those funded by donors. In FY2018/19, for instance, the total development budget was revised downwards by 35% from the approved amount of MK25.4 billion to MK16.5 billion. Resources from the Joint Health Fund reflected in the PBB were underspent by 42%, with only MK5.2 billion spent out of an approved amount of MK9.1 billion as shown in Table 3. The allocated budget is also not fully disbursed. In 2017/18, for example, only 53.1% (MK3.8 billion) of the revised infrastructure and medical equipment budget (MK7.3 billion) was disbursed[2]. In addition, disbursed funds are usually not fully spent. For example, while a total of MK133 million was disbursed to the programme on Social determinants of health in 2017/18, only MK127 million (95%) was spent.

TABLE 3 Selected Variances in Approved and Revised Budgets for MoHP in 2018/19

	Approved	Revised	% Revision
Ministry of Health and Population	75,134	67,838	(10)
Total development budget under MoHP	25,446	16,518	(35)
o/w Joint Health Fund	9,153	5,278	(42)
Strengthening PPP for Reproductive Health and Rights (PSI)	1,578	0	(100)
Construction of Cancer Centre	2,800	1780	(36)
Construction of Mponela Hospital	200	0	(100)

Source: Government Budget Estimates

Off-budget donor funds face absorption challenges. For instance, over the period 2015-17, Malawi absorbed 68% of the total allocation ($33 million) for malaria. Recently, the absorption of Government funds has considerably improved owing to the improved functionality of the Project Implementation Unit (PIU) at MoHP[3]. Going forward, the Government is encouraged to systematically assess and address underlying challenges affecting absorption of grants.

Several reasons contribute to budget credibility challenges. First, there are procurement challenges, including limited capacity, especially at the central level; lack of clear guidance for MoHP departments on procurement processes, including central-level procurements for districts; unclear role of the central government in procurements undertaken at the district level, and excessive emergency procurements.[4] Moreover, although the MoHP prepares procurement plans every year, they are rarely followed resulting in ad hoc procurements and accumulation of arrears[5]. Second, concerns have been raised with regards to delays in the approval of projects. Third, delays and failure to disburse committed funds by some donors has also contributed to budget credibility challenges.

Persistent budget execution challenges are adversely impacting on value for money in health spending. Challenges such as late disbursement of funds, poor record keeping and financial reporting by District Councils and health facilities, wastages and leakages are commonly reported despite concerted efforts by the Government to curb them. A report by the Office of the Inspector General (OIG) (2019)[6] revealed that there is limited visibility and accountability of medicines at district and health facility levels. District Health Offices (DHOs) do not maintain proper records of medicine. For example, 24 of the 25 (96%) health facilities visited during the audit period (January 2017 to June 2019) had significant variances between stock issued from the main store, quantities dispensed, and remaining stocks at the dispensing units. Some health sector resources are also wasted through non-maintenance of assets. For example, an Inventory Assessment by Physical Assets Management (PAM) carried out by the Ministry of Health in 2016 showed that 20-25% of medical equipment is out of service.

KEY TAKEAWAYS

- ⊕ Huge variances between approved and actual expenditures, especially for development projects, point to the need for the Government to investigate both supply and demand-side constraints in budget execution.
- ⊕ Dialogue with key donors is critical to better understand reasons for low absorption rates for externally financed health sector projects.

2 2019 Annual Economic Report, page 123.
3 OIG Report (2019)
4 See MoHP, http://www.health.gov.mw/index.php/directorates/administration/procurement
5 This challenge is also acknowledged by the Ministry of Health in the HSSP II report (See HSSP II final document, pp. 31)
6 https://www.theglobalfund.org/en/oig/updates/2019-12-09-global-fund-grants-in-malawi/

Over the period 2015-17, Malawi absorbed 68% of the total allocation ($33 million) for malaria.

8. FINANCING OF THE HEALTH SECTOR IN MALAWI

Health sector financing in Malawi is heavily dependent on donor funding, especially for development projects. In 2019/20, for example, 85% of the total health development budget is expected to be financed by donors. Donor funding is channeled in two ways – as direct budget support and largely as off-budget support via NGOs. Although the Government will contribute 87.2%[7] to the total public health sector, if off-budget resources are included, the Government contribution will go down to about 25% according to information in the fifth round of the Health Sector Resource Mapping (2017/18-2019/20). When combined together, in 2017/18, for instance, three-quarters (US$477 million) of the Total Health Expenditures (THE) channelled through on and off-budget means were donor funded with the Government contributing US$162 million. The proportion of financial contributions by main sources are shown in Table 4.

TABLE 4 Top Four Financiers of the Health Sector in Malawi

Name of Financier	Financial contribution (%)
The Global Fund	28
The Government	25
The United States	16
Health Sector Joint Fund	6

Source: Fifth Round of the Health Sector Resource Mapping

Health sector resources from donors are categorised into pooled[8] and non-pooled funds. The pooled funds are largely programmatic and managed under central, local government and voluntary health insurance schemes. The Global Fund and the Health Services Joint Fund (HSJF), set up in 2015, are the two largest pooled schemes. The non-pooled funds are managed by Not for Profit Institutions Serving Households (NPISH/NGOs) or come in the form of out of pocket expenditures (OOPs) with no risk pooling or with private pools.

Donor support is heavily skewed towards specific health interventions. At programmatic level, most donor resources are earmarked for three diseases – HIV/AIDS, TB and malaria. In the HIV/AIDS subsector, for instance, the Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR) contribute about 95% of total financing. The Government funds health systems strengthening (HSS), in the areas of human resources, health infrastructure and equipment at 12% of the total HIV-related HSS expenditure in 2017[9]. Although to a smaller extent, the Government also fund voluntary medical male circumcision (VMMC), prevention of mother-to-child transmission (PMTCT) (2%) and prevention for priority populations (1%) as shown in Table 5.

TABLE 5 Annual Investment (%) Profile by Program Area in 2017

Program Area	GoM (%)	Global Fund (%)	PEPFAR (%)	Other (%)
Clinical Care, treatment and support	0	75	21	4
Community-based care, treatment and support	0	0	83	17
PMTCT	2	23	75	0
HIV testing and counselling	0	0	100	0
VMMC	4	0	89	7
Priority population prevention	1	12	42	45
AGYW prevention	0	100	0	0
Key Population prevention	0	28	59	14
OVC	0	0	100	0
Laboratory	0	0	100	0
Strategic information, surveys and surveillance	0	0	58	42
Health System Strengthening	12	16	32	40

Source: Malawi Country Operational Plan (COP) 2018 (Strategic Direction Summary)

Despite modest increases in health sector allocations, there is limited fiscal space to expand health spending from Government's resources. A 2018 fiscal space analysis for Malawi revealed that the country's resource envelope is constrained, yet there are large financing needs across all sectors, including health. Cognizant of the fiscal space challenges, the Government has resorted to loan financing. For instance, the Government borrowed $10.5 million from the World Bank to help meet its co-financing commitment of $33 million for HIV, TB and malaria for 2017-2019[10]. However, borrowing has the potential to heighten the country's risk of debt distress. In 2019/20 alone, public debt charges of MK243.9 billion are forecast to consume 15.5% of the nation's annual revenue. In addition to loans, Malawi has been receiving significant grants from development partners.

Recognizing that there is limited fiscal space to increase health financing, the Government of Malawi has been considering several policy options including earmarked taxation, innovative financing mechanisms and national health insurance.[11] Recent studies have, shown that high

7 Note that the 87.2% refers to the share of Government's contribution to the 2019/20 health budget for both recurrent and development budget.

8 Pooling is the health system function whereby collected health revenues are transferred to purchasing organizations. Pooling ensures that the risk related to financing health interventions is borne by all the members of the pool and not by each contributor individually. Its main purpose is to share the financial risk associated with health interventions for which there is uncertain need.

9 Malawi Country Operational Plan (COP) 2018

10 Global Fund Observer (GFO), March 2019 (http://www.aidspan.org/gfo_article/malawi-faces-wide-ranging-challenges-global-fund-grant-implementation)

11 Ministry of Health. Health Financing Strategy, May 2014.

unemployment, informality of the economy, high proportion of the rural population and slow economic growth make the introduction of a National Health Insurance (NHI) Scheme difficult. At the same time, additional taxes, under the auspices of innovative financing mechanisms are likely to hit hardest on poor people. The Health Financing Strategy (HFS) also includes introduction of a 'Health Fund' and Performance Based Financing (PBF). Moving forward, 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 the burden of financing health services becomes too heavy on poor families.

KEY TAKEAWAYS

- Given size of the economy and fiscal space challenges, donor resources will continue to be required for the Government to improve health sector spending. The Government is therefore encouraged to develop strategies to tap into a wide range of international public and private resources.
- Finalization and implementation of the health sector financing strategy will be key in addressing funds gaps in the sector.

ACKNOWLEDGEMENTS

This budget brief was produced by Tapiwa Kelvin Mutambirwa, under the guidance of Alessandro Ramella Pezza and Nkandu Chilombo. Valuable inputs were provided by Steve Macheso, Samuel Chirwa, Tedla Damte and Bejoy Nambir from the Health Section and Mathew Cummins, Bob Muchabaiwa, Deborah Camaione and Tobias Baehr from the Regional Office. Special thanks goes to Pakwanja Twea and Nikhil Mandalia from the Ministry of Health and Population for providing valuable technical inputs.

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