Republic of Malawi

Ministry of Health

THE NATIONAL HEALTH FINANCING STRATEGY 2023–2030

January 2023

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ABBREVIATIONS

BoD	burden of disease
CHAM	Christian Health Association of Malawi
CMST	Central Medical Stores Trust
CoC	Code of Conduct
CSO	civil society organization
EHP	Essential Health Package
FP	family planning
GDP	gross domestic product
GoM	Government of Malawi
HBP	health benefits package
HCMC	health centre management committee
HDG	Health Donor Group
HEPU	Health Economics Policy Unit
HFD	Health Financing Division
HFS	Health Financing Strategy
HF TWG	Health Financing Technical Working Group
HHFA	Harmonized Health Facility Assessment
HSJF	Health Services Joint Fund
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Group
IMF	International Monetary Fund
MDA	ministries, departments, and agencies
MoF	Ministry of Finance
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoU	Memorandum of Understanding
NHA	National Health Accounts
NPISH	non-profit institutions serving households
OOP	out-of-pocket
PFM	public financial management
PIU	project implementation unit
PPP	public-private partnership
THE	total health expenditure
UHC	universal health coverage

US$	U.S. dollars
VHI	voluntary health insurance
WHO	World Health Organization

PREFACE

Universal health coverage (UHC) is a critical part of the agenda of the Government of Malawi (GoM). As a signatory to the Sustainable Development Goals, the GoM has committed itself to, among other goals, improving access to healthcare services for all Malawians without imposing undue financial hardships on the citizenry. This international policy commitment has been integrated into the national policy architecture through the Malawi Vision 2063, the National Health Policy (2018–2030), and the Health Sector Strategic Plan III (HSSP III).

Malawi's 2023–2030 National Health Financing Strategy (HFS) sets out clear pathways through which the GoM will finance universal health coverage (UHC) policy activities. The key principle underpinning the strategy and the UHC policy objective is that all resources available for healthcare services in Malawi must be aligned towards HSSP III activities, and all stakeholders should mutually account for the results. To achieve the UHC policy objective, the HFS brings in bold initiatives for mobilising resources, pooling the resources towards a common UHC goal, creating more efficient ways of purchasing services, and providing for strong stewardship and data for the health financing decision-making mechanism.

Through this strategy, stakeholders in the health sector have committed to find ways to increase the amount of resources available per capita per annum from US$40 to US$86 by 2030. Stakeholders have also committed to at least double the amount of resources managed by the GoM to at least 80 percent of total health expenditure (THE). In addition, stakeholders have agreed to institute more and better ways of purchasing healthcare services and enact specific health financing laws that will enable implementation of key reforms. Let me assure all stakeholders that the GoM will ensure that all necessary legislation will be enacted for a better health financing system.

The health sector we want is possible and will happen, but all of us should invest in better health financing systems, as outlined in the strategy.

Honourable Khumbize Kandodo Chiponda, M.P.
MINISTER OF HEALTH

ACKNOWLEDGEMENTS

The National Health Financing Strategy (HFS) has been developed through a rigorous and consultative process involving many stakeholders. The Ministry of Health (MoH) is grateful to all stakeholders who contributed to this process. The ministry is grateful to the Department of Planning and Policy Development staff for providing technical leadership in all processes leading to developing, finalising, and approving the strategy.

The Ministry would like to thank the partners that funded or provided technical expertise to the process: The U.S. Agency for International Development (USAID), through the Health Policy Plus (HP+) project, for providing technical and financial assistance towards all stages of the Strategy; the Clinton Health Access Initiative (CHAI), for providing technical assistance in costing and financial assistance towards the cost validation workshop; UNICEF, for funding stakeholder consultation workshops; and the World Health Organization (WHO), for providing funding towards the workshop on development of health financing activities.

Special thanks should also go to members of the Core Health Financing Strategy Development team. The members were drawn from the Ministry of Health, National Local Government Finance Committee, HP+, CHAI, Kamuzu University of Health Sciences, University of Malawi, Christian Health Association of Malawi, Network of Journalists Living with HIV, Medical Aid Society of Malawi, and COMPASS network of civil society organisations.

Dr Charles Mwansambo
SECRETARY FOR HEALTH

EXECUTIVE SUMMARY

(a) Introduction

The 2023–2030 National Health Financing Strategy for Malawi (HFS) provides detailed mechanisms through which the National Health Policy (2018–2030) and the Health Sector Strategic Plan (HSSP) III (2023–2030) will be financed. It sets out the key health financing strategies that will enable the country to improve on its universal health coverage (UHC) indicators.

The key principle for the HFS is "one plan, one budget, one monitoring and evaluation framework." To this end, the HFS acts as the health financing operational framework for the National Health Policy (2018–2030) and the HSSP III (2023–2030). The concepts, objectives, strategies, and activities outlined herein are directly linked with those in the National Health Policy and HSSP III. However, they are elaborated further in the HFS. Other specific health financing principles used in this strategy are the following:

i. Fairness in resource mobilisation, resource distribution, access to care, and healthcare outcomes
ii. Allocative, cost, and technical efficiency across the health system
iii. Inter-sectoral collaboration, including and especially in matters related to public finance management (PFM)
iv. Financial risk protection for users of healthcare services
v. Evidence-based decision making
vi. Health security[1]
vii. Transparency and accountability

(b) Situation Analysis

Macroeconomic Performance

Macroeconomic performance for Malawi is generally poor. From 2016 to 2020, economic growth averaged 3.2 percent per year, far below the required 6 percent rate for sustainable poverty reduction.[2] This trend implies that Malawi will likely remain a low-income country for the foreseeable future and require continued donor support to provide adequate and good-quality healthcare services.

Universal Health Coverage Performance

Table ES 1 provides a summary of UHC performance for Malawi. Malawi is performing relatively well on the UHC score index, largely because of its very high financial risk protection score. It is therefore important to maintain the principle of solidarity whilst ensuring increases

[1] Health security refers to how governments respond to public health threats and emergencies, including preparedness. Global public health security is defined as the activities required, both proactive and reactive, to minimise the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries.

[2] International Monetary Fund. 2017. "Malawi Economic Development Document." *IMF Country Report No. 17/184*.

in domestic financing. Solidarity is realised through tax contributions and donor financing, which ensure that individuals unable to pay for services can access the same for free at the point of care.

Table ES 1: Summary of UHC General Performance in Malawi

Domain	Unadjusted score for equity (%)	Adjusted score for equity (%)
Service coverage	53.99	51.74
Financial risk protection	97.45	94.1
UHC score	75.28	69.77

Source: Ministry of Health (2021).

Health Financing System Performance

Table ES 2 presents key health financing data for Malawi.

Table ES 2: Selected Health Financing Indicators for Malawi

Variable	Current Value
Per capita total expenditure on health (US$)	39.9
Total health expenditure (THE) as % of gross domestic product	8.8%
Government expenditure on health as % of THE	24.1%
Donor expenditure on health as % of THE	54.5%
Government per capita THE (US$)	9.6
Government THE as % of total government expenditure	8.4%
Total private health insurance spending as % of THE	9.1%
Out-of-pocket expenditure on health as % of THE	11.9%
Total expenditure on primary healthcare as % of THE	39.7%
Percentage of THE pooled under government financing scheme	40.3%
Percentage of THE managed by government agents	39.4%
Percentage of THE spent on HIV/AIDS	40%

Source: The Malawi National Health Accounts (2022).

The Malawi health system is heavily under-resourced, with per capita total health expenditure (THE) at an estimated US$39.9, compared to the recommended public sources expenditure of US$86 for low-income countries such as Malawi.[3] The system's financing is highly donor dependent, with 54.5 percent of all resources coming from donors. Of all resources, 40.3 percent are pooled under the government scheme. However, the percentage of resources managed by the government is slightly less, at 39.4 percent of THE, indicating that the government has less control than donors in making direct expenditure decisions.

[3] Jowett M, Brunal MP, Flores G, Cylus J. Spending targets for health: no magic number. Geneva: World Health Organization; 2016 (WHO/HIS/HGF/HFWorkingPaper/16.1; Health Financing Working Paper No. 1); http://apps.who.int/iris/bitstream/10665/250048/1/WHO-HIS-HGFHFWorkingPaper-16.1-eng.pdf

Allocative inefficiency is demonstrated by low expenditures on primary healthcare entities or preventive healthcare, which stands at 39.7 percent. However, this situation likely occurs because secondary- and tertiary-level healthcare providers also predominantly provide primary healthcare services, thus compounding efficiency challenges.

Public Financial Management (PFM) and Healthcare Service Delivery

Table ES 3: PFM Performance, by Budget Phase with Respect to Health Service Delivery Goals in Government Health Facilities

Budget Phase	Health Service Delivery Goals[4]			
	Efficiency	Equity	Quality	Accountability
Formulation	D+	C	C	D+
Execution	B	B	C+	B
Evaluation	C	D	B	C

Source: Adapted from World Bank. 2021. *Public Financial Management in the Health Sector: An Assessment at Local Government Level in Malawi.* Washington, DC: The World Bank. Available at: World Bank Document.

The performance of PFM for achieving public health service delivery goals in Malawi is very weak, especially at the budget formulation stage, where efficiency and accountability are weakest, as shown in Table ES 3.

(c) Strategic Directions

The vision of the HFS is to have a fully functional healthcare financing system that supports achievement of the UHC aspirations espoused in the Constitution, National Health Policy, and health sector strategic plans. The goal is to create a well-governed health financing architecture able to mobilise adequate resources, distribute the resources in an efficient and equitable way, and strategically purchase services based on a well-defined benefit package in pursuit of UHC goals.

The HFS has four objectives, as follows:

i. ***Mobilise adequate, sustainable, and predictable funds for the health sector to optimally deliver essential health services.*** The key strategies under this objective are as follows:
    - Improve efficiency across all health system functions at all levels of the healthcare delivery system
    - Enhance participation of communities in financing public health services
    - Improve and scale up optional paying services in public facilities
    - Increase external funding to the health sector
    - Improve financing of healthcare services, including family planning (FP), using domestic resources
    - Introduce innovative health financing mechanisms

[4] The scores range from A+, representing the best performance, to D-, representing the worst performance.

ii. ***Improve efficiency and equity in pooling and managing resources for the health sector.*** The key strategies under this objective are as follows:

- Reduce fragmentation of health sector funding
- Strengthen leadership, governance, and accountability mechanisms to ensure harmonisation of health financing decision making across all levels of the health system
- Improve management and accountability of government and donor funds

iii. ***Develop and implement strategic purchasing measures across the healthcare service delivery continuum.*** The key strategies under this objective are as follows:

- Define and implement benefit packages for all levels of care
- Develop and implement effective strategic resource allocation and use measures across the healthcare delivery system
- Develop and implement effective provider payment mechanisms

iv. ***Establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system.*** The key strategies under this objective are as follows:

- Strengthen institutional capacity in health financing and PFM to effectively implement the HFS
- Strengthen generation and use of evidence in health financing decision making at all levels
- Strengthen the advocacy capacity for the HFS
- Strengthen the legal, regulatory, and policy frameworks for health financing

(d) Monitoring and Evaluation

The following are the key selected indicators for the strategy.

Variable	Current Value	2030 Target
Equity-adjusted UHC index score	69.68%	85%
Equity-adjusted Reproductive Maternal Neonatal Child Health Coverage Index score	57.6%	81.4%
Percentage of households making catastrophic payments for healthcare, using 10% of total consumption basket spent on healthcare	4.2%	2.1%
Equity-adjusted financial risk protection score	94.1%	97.05%
Proportion of households with catastrophic out-of-pocket expenditure exceeding 40% of non-food expenditure	1.34%	0.67%
Medical impoverishment rate	3.75%	1.88%
Percentage of facilities able to deliver the full Health Benefits Package (HBP) based on facility level	73%	90%
Per capita health expenditure (US$)	US$39.4	US$86

Variable	Current Value	2030 Target
General government domestic THE as % of total government expenditure (GGHE-D/GGE)	8.8%	15%
Total expenditure on primary healthcare providers and preventive services as % of THE	39.7%	60%
Percentage of resources managed by government agents	39.4%	78.8%
Percentage of key health financing stakeholders whose financial resource tracking data are routinely available in the DHIS2 (For simplicity, key stakeholders are defined as all district health offices [DHOs], all central hospitals, key donors [10], National AIDS Commission, and the MoH)	0%	100%
Number of health financing laws enacted (Voluntary Insurance Law, Health Trust Funds Law, National Health Financing Law	0	3

1. INTRODUCTION

1.1. The Health Financing Strategy

The 2023–2030 Malawi Health Financing Strategy (HFS) provides detailed mechanisms through which the National Health Policy (2018–2030) and the Health Sector Strategic Plan (HSSP) III (2023–2030) will be financed. It sets out the key health financing strategies that will enable the country to improve on its universal health coverage (UHC) indicators.

1.2. The Process of Developing the Health Financing Strategy

The HFS has been developed with inputs from various public and private stakeholders, and from a review of national and international literature on health financing. The extensive consultations and literature review were done to ensure that the Strategy has both a local and global outlook. It also builds on the previous attempts (2012–2015) to develop an HFS.

The methodological guidance for developing the HFS is adapted from the World Health Organization's (WHO) "Developing a National Health Financing Strategy: A Reference Guide" (2017).[5] The key documents reviewed as part of the development of the HFS include the following:

Table 1: List of Key Documents Consulted in Development of the Strategy

- Malawi Vision 2063
- Malawi Implementation Plan 1 (2021–2030)
- National Health Policy (2018–2030)
- HSSP Ⅱ
- The HSSP Ⅱ Mid-term review
- HSSP Ⅲ
- PFM Rapid Assessment Results (2020)
- The Study on Health Sector Efficiency in Malawi (2015)
- Resource mapping results for Rounds 5 (2018) and 6 (2020)
- COVID-19 Resource Mapping
- COVID-19 National Health Accounts (NHA)
- 2022 NHA
- Assessment of the Mixed Provider Payment System in Malawi (2019)
- Developing the Universal Health Coverage (UHC) Index for Malawi (2020)
- National Health Insurance Feasibility Study (2017)
- Health Fund Feasibility Analysis Results (2017)
- Malawi Health Financing Assessment (2018)
- Maintaining Essential Health Services During the COVID-19 Pandemic in Malawi: Assessing Changes in Government and Donor Resource Allocation[6]
- Strengthening Expenditure for Human Capital (2020)

[5] Kutzin J., S. Witter, M. Jowett, and D. Bayarsaikhan. 2017. *Developing a National Health Financing Strategy: A Reference Guide*. (Health Financing Guidance No 3). Licence: CC BY- NC-SA 3.0 IGO. Geneva: World Health Organization.

[6] The World Bank Group. 2021. Maintaining Essential Health Services during the COVID-19 Pandemic in Malawi: Assessing Changes in Government and Donor Resource Allocation. Washington, DC: The World Bank.

1.3. Guiding Principles of the Strategy

The key principle for the HFS is "one plan, one budget, one monitoring and evaluation framework." To this end, the HFS acts as a health financing operational framework for the National Health Policy (2018–2030) and the HSSP III (2023–2030). The concepts, objectives, strategies, and activities outlined herein are directly linked with those in the National Health Policy and HSSP III. However, they are elaborated further here. Other health financing-specific principles used in this strategy are as follows:

a) Fairness in resource mobilisation, resource distribution, access to care, and healthcare outcomes

b) Allocative, cost, and technical efficiency across the health system

c) Inter-sectoral collaboration, including and especially in matters related to public financial management (PFM)

d) Financial risk protection for users of healthcare services

e) Evidence-based decision making

f) Health security[7]

g) Transparency and accountability

[7] Health security refers to how governments respond to public health threats and emergencies, including preparedness. Global public health security is defined as the activities required, both proactive and reactive, to minimise the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries.

2. CONTEXTUAL FACTORS

2.1. Development Perspective and the Health Financing System

The development perspectives of Malawi have been shaped by both international and local contexts. From the global perspective, the Sustainable Development Goals (2015–2030) are the dominant influence shaping the Malawi development landscape. Regionally, the African Union's Agenda 2063, a 50-year strategic development framework, is an important blueprint for Malawi's development agenda. Locally, the Malawi Vision 2063 and Malawi Implementation Plan (2021–2030) are critical documents that shape the current development discourse in Malawi.

The health financing policy context is shaped by several legal, policy, and regulatory promulgations at international, regional, and local levels. Globally, the following policies have been critical in shaping the health financing landscape in Malawi:

- Sustainable Development Goal on health and well-being, especially Target 3.8 "Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all."
- Paris Declaration on Aid Effectiveness. This declaration focuses on making aid more responsive to the needs of recipient countries.
- World Health Assembly resolution (WHA64.9) on sustainable health financing structures and universal coverage (2011). The resolution called for health financing to be based on principles of equity and solidarity, and focus on prepayments for healthcare to avoid catastrophic payments.
- The Astana Declaration on Primary Health Care.[8] This declaration urges countries to focus on primary healthcare financing and aligning stakeholder support towards national programmes.

Regionally, the Abuja Declaration, which calls for countries to allocate a minimum of 15 percent of the national budget to health, has influenced the design of the Strategy. Domestically, the Constitution of the Republic of Malawi mandates that healthcare must be provided to all, commensurate with the health needs of Malawian society and international standards of healthcare. The Constitution also mandates that the government ensure adequate nutrition for all to promote good health and self-sufficiency. These constitutional mandates have shaped the health financing policy landscape in Malawi. In particular, the provision of free healthcare services at the point of service delivery in all public health facilities is usually justified based on these constitutional mandates. Other important policy documents shaping the Malawi healthcare financing system landscape are the National Health Policy and the HSSP III.

[8] This declaration replaced the Almaty Declaration on Primary Health Care (1978).

The Malawi healthcare system uses the service delivery model formerly known as the Essential Health Package (EHP) to provide both primary and secondary healthcare services. The first EHP was defined in 2000 as a core list of cost-effective interventions to guide allocation of scarce resources. The nomenclature for the EHP has also changed; it is now called the Health Benefits Package (HBP). This strategy is based on the HBP principles as revised in 2022.

2.2. Socio-economic Context and Health Financing Implications

2.2.1. Population

The 2018 Population and Housing Census showed that the population of Malawi was 17.6 million people in 2018, with an average annual growth rate of 2.9 percent. The uptake of modern contraceptive prevalence rate is at 58 percent. At the current population growth rate,[9] the estimated population of Malawi will be 21.5 million in 2025 and 24.8 million in 2030. The health financing implications are as follows:

i. High population growth rate will exert significant pressure on public healthcare resources in absolute terms.

ii. To increase nominal per capita health spending, the government and its partners will need to increase their spending on health by more than 2.9 percent annually.

2.2.2. Poverty and Unemployment

Poverty in Malawi is high, at an estimated 51.5 percent.[10] Using the World Bank definition of poverty,[11] the poverty incidence rate for Malawi was 70.3 percent[12] in 2016, making it the fourth poorest country in the Southern Africa Development Cooperation region and on the African continent. Income inequality as measured by the Gini coefficient is high, at 0.45 in 2016. The Gini coefficient has also worsened from 0.39 in 2005.[13] The percentage share of income for the poorest 20 percent of the population is estimated at 6.4 percent.[14]

In addition, 89 percent of those employed are in the informal sector. Of the 11 percent in the formal sector, the average wage is US$113 per month and the median is US$37 per month.[15] The health financing implications of the high poverty rate and low formal sector participation are as follows:

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[9] Assuming a constant annual population growth rate of 2.9 percent.

[10] World Bank. 2020. Available at: https://www.worldbank.org/en/country/malawi/overview.

[11] Poverty is defined as earning less than US$1.90 a day at purchasing power parity (PPP). In this case, the PPP used was for Southern and East African countries.

[12] International Food Policy Research Institute. 2019. "IFPRI Key Facts Series: Poverty." Available at: http://massp.ifpri.info/files/2019/05/IFPRI_KeyFacts_Poverty_Final.pdf.

[13] Government of Malawi. 2017. "Malawi Growth and Development Strategy III."

[14] The World Bank. n.d. "Country Profile | World Development Indicators." Available at: https://malawi.un.org/en/42159-malawi-growth-and-development-strategy-mgds-iii-2017-2022; https://databank.worldbank.org/views/reports/reportwidget.aspx?Report_Name=CountryProfile&Id=b450fd57&tbar=y&dd=y&inf=n&zm=n&country=MWI

[15] Oxford Policy Management Limited. 2016. *National Health Insurance Feasibility Assessment for Malawi*.

i. It is difficult to implement a contributory national health insurance scheme because of the anticipated low revenue base from formal sector employees and the challenges of collecting contributions from the informal non-poor.

ii. The voluntary private health insurance (VHI) market will remain small in the short to medium term because most clients of the VHI are engaged in formal employment.

2.2.3. Corruption

Corruption and misuse of public resources are significant components of the socioeconomic fabric of Malawi and have been cited as a key development challenge in Malawi Vision 2063. In the health sector, misuse of public resources manifests itself in leakages of medicines and commodities, especially at the health facility level.[16] Corruption also manifests itself through the existence of informal[17] payments in public health facilities. The implications of these issues on health financing are as follows:

i. More resources are spent on implementing an activity, including treating patients, than in a leakage-free system.

ii. There are concerns regarding financial risk protection for the poor, who must make informal payments to access basic, timely healthcare.

2.3. Key Macro-Fiscal Contextual Factors

2.3.1. Macroeconomic Context-National Accounts and Prices, and their Effect on Health Financing

Table 2: Selected Macroeconomic Indicators for Malawi (2012–2020)

Variable	2012	2013	2014	2015	2016	2017	2018	2019	2020
GDP in billions of constant 2015 US$	5.58	5.87	6.2	6.37	6.53	6.79	7.09	7.48	7.54
GDP in billions of current US$	6.03	5.52	6.05	6.37	5.43	8.94	9.88	11	12.2
GDP per capita, (current US$)	392	348	371	381	316	506	545	592	637
Annual GDP growth rate (%)	1.9	5.2	5.7	2.8	2.5	4.0	4.4.	5.4	0.8
Inflation (annual %)	17.7	27.3	20.9	20.5	19.5	13.5	6.1	7.7	10.2

Source: World Development Indicators (2022).

Table 2 presents data on key macroeconomic indicators. Malawi's real gross domestic product (GDP) has averaged 3.54 percent between 2012 to 2020. The implications for health financing are as follows:

[16] Carlson, C., W. Chijere Chirwa, and N. Hall. 2015 (unpublished). "Study of Health Sector inefficiency In Malawi."
[17] Ibid.

- Malawi is off track for achieving sustainable poverty reduction, which requires a minimum 6 percent annual real economic growth rate,[18] implying that at its current average economic growth rate, Malawi may not be able to raise sufficient domestic resources for health. Conversely, it implies that donor financing for health will remain critical in the foreseeable future.
- Substantial increases in public resources for health could also be realised from reconfiguring the public budget in favour of health. This approach requires economic evaluation evidence demonstrating better value derived in investing in health compared to other sectors.

Inflation has also been a major macro-economic challenge in Malawi, averaging an annual rate of 15.9 percent between 2012 and 2020. The implication for health financing is that inflation reduces the amounts of health goods and services that can be purchased per available Malawi Kwacha (MK).

2.3.2. Fiscal Performance

Table 3: Fiscal Indicators for Malawi (2012–2020)

	2012	2013	2014	2015	2016	2017	2018	2019	2020
General government gross debt (% of GDP)**	35.3	33.5	35.5	37.1	41.5	43.9	45.3	54.7	59.3
Current account balance (% of GDP)**	-6.5	-5.9	-5.8	-12.2	-13.1	-17.8	-14.4	-11.9	-14.2
Total government revenue (% of GDP) ^^	17.3	17	15.2	15.4	14.8	15.8	15	14.8	14.7
Tax revenue (% of GDP)^^	13.6	14.1	15.9	15.2	15.5	12.2	12.2	12	11.7
Total government spending (% of GDP) ^^	18.8	20.7	18.3	19.5	19.7	21	19.4	19.3	22.8

Sources: ^^ World Bank. "World Development Indicators 2022." Available at: Malawi | Data (worldbank.org).** International Monetary Fund. "World Economic Outlook 2022." Available at: Malawi and the IMF.

Table 3 presents key fiscal indicators for Malawi. The fiscal performance analysis results are as follows:

i. **Fiscal envelope:** In Malawi, general government expenditure was estimated at 22.8 percent of GDP in 2020. A rule of thumb suggested in WHO guidance would place this percentage as a low to medium level of fiscal capacity,[19] implying limited ability to increase healthcare funding from public budget, holding all things constant.

ii. **Taxation capacity:** The tax-to-GDP ratio was estimated at 11.7 percent of GDP in 2018. A rule of thumb suggested in WHO guidance would place this percentage in the very low fiscal capacity category.[20] The implication for health financing is that if the public budget

[18] International Monetary Fund. 2017. "Malawi Economic Development Document. IMF Country Report No. 17/184." Available at: file:///C:/Users/mjedi/Downloads/cr17184.pdf.

[19] McIntyre D., and J. Kutzin. 2016. *Health Financing Country Diagnostic: A Foundation for National Strategy Development*. Health Financing Guidance No. 1. Geneva: World Health Organization.

[20] Ibid.

sectoral shares are not reconfigured in favour of health, there is limited scope for substantial increases in the health budget, holding all other things constant.

iii. **Revenue versus long-term spending capacity:** Overall assessment of the International Monetary Fund (IMF) on debt sustainability for Malawi is that the country is at moderate risk of external debt distress and high overall risk of debt distress.[21] In addition, the IMF also concluded that Malawi has a weak debt carrying capacity. According to the IMF, debt-to-GDP ratio remained at 59.3 percent in 2019.[22] This ratio is above average compared to other African countries[23] and poses a significant limitation to the government's ability to increase spending on health and other sectors. It is also significantly higher than the maximum recommended debt-to-GDP ratio of 40 percent for low-income countries.[24]

From the preceding subsections on fiscal performance, it is clear that Malawi does not have a lot of room for increasing expenditures in health; this conclusion is in line with the World Bank findings of 2017,[25] which found that Malawi does not have much room in the macro-fiscal space to increase spending on healthcare, holding all other things constant.

2.4. Public Financial Management (PFM) and Healthcare Services Delivery

2.4.1. PFM and Healthcare Services Delivery in Malawi

Table 4: PFM Performance, by Budget Phase, with Respect to Health Service Delivery Goals in Government Health Facilities

Budget Phase	Health Service Delivery Goals			
	Efficiency	Equity	Quality	Accountability
Formulation	D+	C	C	D+
Execution	B	B	C+	B
Evaluation	C	D	B	C

Source: Adapted from World Bank. 2021. *Public Financial Management in the Health Sector: An Assessment at the Local Government Level in Malawi.* Washington, DC: The World Bank. Available at: https://openknowledge.worldbank.org/bitstream/handle/10986/35925/Public-Financial-Management-in-the-Health-Sector-An-Assessment-at-the-Local-Government-Level-in-Malawi.pdf?sequence=1&isAllowed=y

[21] International Monetary Fund Report. Second and third reviews under the three-year extended credit facility arrangement and requests for waivers of non-observance of performance criteria and augmentation of access—press release; staff report; and statement by the executive director for Malawi. IMF Country Report No. 19/361. Available at Malawi: Second and Third Reviews Under the Three-Year Extended Credit Facility Arrangement and Requests for Waivers of Nonobservance of Performance Criteria and Augmentation of Access-Press Release; Staff Report; and Statement by the Executive Director for Malawi (imf.org).

[22] International Monetary Fund. 2022. "World Economic Outlook for Malawi." Available at: https://www.imf.org/en/Countries/MWI#countrydata.

[23] IMF World Economic Outlook, as analysed by the Brookings Institution. Brookings Institution. 2018. "Sounding the Alarm on Africa's Debt." Available at: https://www.brookings.edu/blog/future-development/2018/04/06/sounding-the-alarm-on-africas-debt/.

[24] McIntyre D., and J. Kutzin. 2016. *Health Financing Country Diagnostic: A Foundation for National Strategy Development*. Health Financing Guidance No. 1. Geneva: World Health Organization.

[25] World Bank. 2017. Fiscal Space for Health in Malawi and the Potential for "Innovative Financing." Washington, DC: World Bank.

Table 4 presents a summary of findings from a study conducted by the World Bank on the effects of the PFM system on achieving healthcare service delivery goals. The results, rated on a scale of A+ (Best) to D- (worst) show under-performance of the PFM system as a tool for achieving public healthcare services delivery goals. These goals are discussed in the sections below.

2.4.2. Budget Formulation in the Malawi Public Health Sector

Strategic budgeting for healthcare services is limited in Malawi because medium-term expenditure framework (MTEF) estimates are not used in budget designs even though the Treasury releases them. Also, there is limited use of epidemiological and cost-effectiveness results in deciding what to purchase. For instance, the HIV epidemiological model has not influenced the funding levels and areas for HIV; in addition, budget evaluation results do not inform the next budget. Programme-based budgeting is used to formulate budgets, but there is huge mismatch between indicators and the amount of public funding available.

A new health inter-governmental fiscal transfer formula for distributing resources to districts, based in part on equity, has been approved. Use of this formula will likely enhance both equity and allocative efficiency. However, budgeting within health remains a challenge at the subnational level, as there is no specific formula for distributing resources to health centres and communities. Although the district planning templates provide for unified budget formulation, district-based partners rarely contribute to it.

2.4.3. Budget Execution in the Malawi Public Health Sector

Several inefficiencies in healthcare service delivery also exist with respect to budget execution in the country. There are no formal cost-effective regulatory commodity purchasing mechanisms;[26] which contributes to cost and technical inefficiencies. Insufficient budgets and cashflow contribute to accumulation of arrears, interest payments, and reduced supplier trust, with a consequent increase in prices to cover risk. However, due to the principles of cash budgeting, available funds may not necessarily match the anticipated cashflow, which affects budget execution and the predictability of funding flow.

Purchasing services through the public budget is not strategic, but rather reflects historical input-based prospective payments to district health offices (DHOs). Subnational health facilities do not have budget execution autonomy, suggesting that these facilities do not have control over the quantity, quality, and timeliness of supplies delivery. This further implies that it is difficult to link service delivery outputs and outcomes to the public budget, thus limiting service delivery accountability. There are also misalignments and maldistributions of human resources for health in public facilities.

[26] These mechanisms are prepayment of orders; designated financing sources for commodities; exemption from value-added taxes and handling fees for publicly procured health commodities; procurement from the lowest-cost reputable provider, regardless of source; pooled health commodity procurement across government agencies; and centralised procurement.

2.4.4. Budget Evaluation in the Malawi Public Health Sector

The Ministry of Finance (MoF) provides oversight to ensure that health spending remains within limits. Health centre management committees (HCMCs) have been established and strengthened to support the accountability aspects of the PFM mechanism, especially with respect to medicines. However, as these committees are not universally available in all facilities, instances of leakages of medicines and supplies still occur. In addition, oversight of HCMC members is largely restricted to medicines, as they are not involved in allocation decisions. Although civil society organisations (CSOs) aim at providing accountability for the use of resources, they lack a formal platform at national and district levels.

The formal institutions for public budget accountability are the National Audit Office (NAO) and the Central Internal Audit (CIA). Both the NAO and the CIA are critically under-funded, which affects the accountability for funds. Although one of the key mandates for the CIA in the Ministry of Health (MoH) is to help departments achieve their programmatic goals, internal audits focus on operations and/or financial audits, not goal achievement.

2.4.5. PFM and Health Emergencies

According to the International Monetary Fund (2020), PFM systems have two major health-related functions[27] in responding to health emergencies:

i. Supporting the delivery of emergency health services (including the direct provision of healthcare services); purchasing supplies and equipment; and putting in place the human resources needed to monitor, contain, and mitigate the emergency

ii. Ensuring ongoing delivery of essential public services that may come under stress during an outbreak

Recent experience with the COVID-19 emergency revealed that the PFM system is not well designed to quickly respond to health emergencies. Planning and budgeting for emergencies has not been readily available, and budget execution initially operated without much PFM guidance, although this situation has improved over time. Budget evaluation also has faced issues of financial accountability and limited auditing of funds.

[27] There are four PFM objectives for the COVID-19 emergency response (two are health related and other two are macro-fiscal related).

3. HEALTH FINANCING AND UNIVERSAL HEALTHCARE COVERAGE

3.1. The Malawi Healthcare System

3.1.1. Health System Performance

Table 5 presents selected indicators on key health system performance targets.

Table 5: Selected Health System Indicators in Malawi

Key Performance Indicator	Baseline	2030 Target	Baseline Source (Year)
Infant mortality rate per 1,000 live births	40	25	Multiple Indicator Cluster Survey (MICS) (2021)
Stunting prevalence rate (%)	36%	0%	MICS (2021)
Underweight prevalence rate (%)	2.5%	0%	MICS (2021)
Maternal mortality rate (per 100,000 live births)	439	70	Malawi Demographic and Health Survey (MDHS) 2016
Percentage of children ages 0–59 months with diarrhoea in the last two weeks and treated with oral rehydration salt solution (ORS)	51%	100%	MICS (2021)
Out-of-pocket (OOP) payment for health as a share of THE	11.9%	7%	National Health Accounts (2022)
Medical impoverishment rate	3.75%	1.88%	UHC report
Total expenditure on primary health care as a % of THE	39.7%	60%	National Health Accounts (2022)
Client satisfaction[28] with treatment from health facility staff	80%	98%	Harmonised Health Facility Assessment (HHFA) (2019)
Client satisfaction with availability of staff	81%	98%	HHFA (2019)
Client satisfaction with availability of medicines	74%	98%	HHFA (2019)

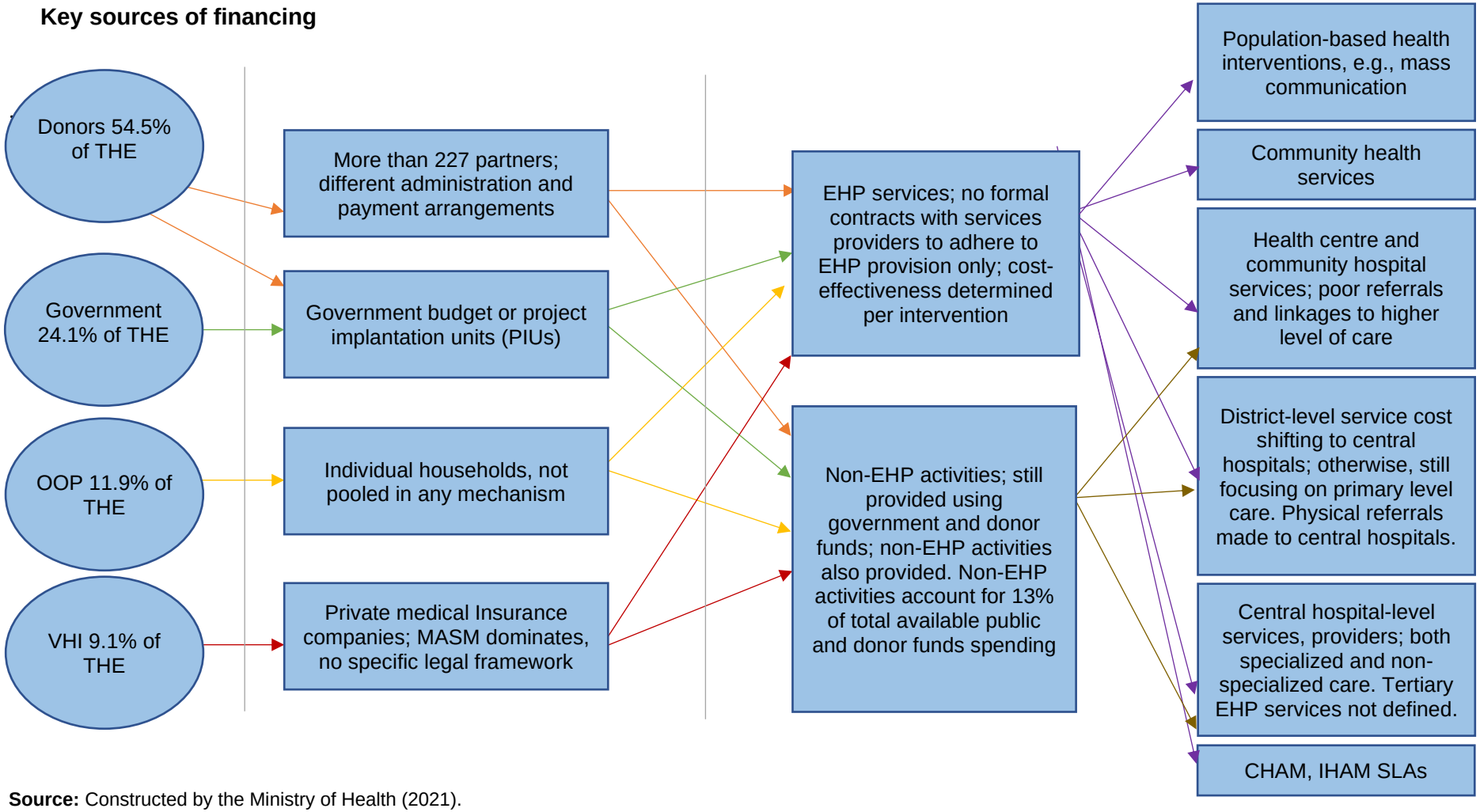
In general, the Malawi health system is under-performing, especially with respect to health outcomes. It is meeting its financial risk protection and client satisfaction goals relatively well, although the results are below the national targets.

3.2. Health Financing Structure in Malawi

The organisation of the Malawi health financing structure is presented in Error! Reference s ource not found.. Donors are major funders of the Malawi health sector, but they channel their resources mostly towards implementing partners other than government ministries. The government contributes 24 percent of total health expenditure (THE) and uses PFM structures for financing healthcare. All sources of finance are committed towards both EHP and non-EHP services, reflecting lack of adherence to EHP principles.

[28] The client satisfaction score in HSSP II was aggregated; the figure was 85 percent. However, in surveys conducted by ombudsmen, several additional dimensions have been introduced; we have indicated only a few of them.

Figure 1: Simplified Current Health Financing Architecture



Source: Constructed by the Ministry of Health (2021).

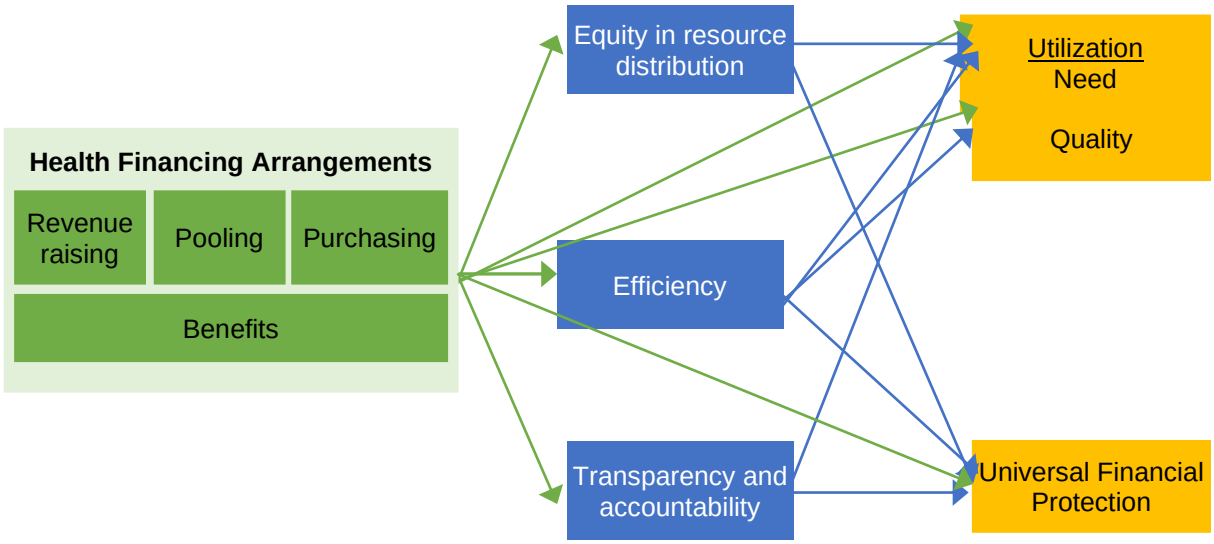
NOTE: CHAM = Christian Health Association of Malawi; **EHP** = Essential Health Package; **IHAM** = Islamic Health Association of Malawi; **MASM** = Medical Society of Malawi; **OOP** = out-of-pocket expenditure; **PIU** = project implementation unit; **THE** = Total health expenditure; **VHI** = voluntary health insurance.

3.3. Universal Health Coverage Framework and Health Financing

The foundational goal of both the HSSP III and National Health Policy is to move towards UHC, with the aim of improving health status, financial risk protection, and client satisfaction. UHC is defined as a situation in which everyone, irrespective of their ability to pay, receives the healthcare services they need, of good quality in a timely fashion, and without suffering any undue financial hardship because of receiving such care. It is therefore critical that the HFS should be founded on the principles of supporting UHC goals. Figure 2**: UHC Framework Goals and Objectives of UHC that the Health Financing System Can Influence**

presents a framework for UHC in relation to the healthcare financing system.

Figure 2: UHC Framework Goals and Objectives of UHC that the Health Financing System Can Influence



Source: McIntyre D., and J. Kutzin. 2016. *Health Financing Country Diagnostic: A Foundation for National Strategy Development*. Health Financing Guidance No. 1. Geneva: World Health Organization.

3.4. Current Performance on Universal Health Coverage (UHC)

3.4.1. The Malawi UHC Index

Malawi has developed a summary index of UHC[29] to capture progress towards achievement of Sustainable Development Goal 3.8: "Ensure healthy lives and promote well-being for all at all ages"; targets include progress towards UHC **(Target 3.8.1.)**. The UHC summary index comprises two summary measures of financial risk protection and service coverage, which are weighted equally. The UHC summary index (**Error! Reference source not found.**) is scored o n a scale of 0 to 100. Preliminary results of the index indicate that Malawi has a UHC score of

[29] Ministry of Health. 2020. *Developing Malawi's Universal Health Coverage Index*. Lilongwe: Department of Planning and Policy Development, MoH.

69.77 percent after adjusting for inequities, and a UHC score of 75.28 percent before adjustment.

Table 6: Summary of UHC General Performance in Malawi

Domain	Unadjusted Score for Equity (%)	Adjusted Score for Equity (%)
Service coverage	53.99	51.74
Financial risk protection	97.45	94.1
UHC score	75.28	69.77

Source: Ministry of Health (2021).

3.4.2. Service Coverage

The UHC service coverage index[30] measures the proportion of the population that can access essential quality health services, selected as tracer indicators, including reproductive, maternal, neonatal, and child health (RMNCH); infectious and noncommunicable diseases; and service capacity and access. In 2021, Malawi had an unadjusted (for equity) UHC service coverage index of 53.99 percent and a UHC service coverage index, adjusted for equity, of 51.74 percent.[31] This percentage compares to an average of 46 percent in WHO's Africa region and 66 percent globally.[32]

3.4.3. Financial Risk Protection

Financial risk protection in health occurs when individuals who receive the healthcare services they require do not suffer undue financial hardship as a result. The financial risk protection index is very high, at 97.45 percent (unadjusted for equity) and 94.1 percent (adjusted for equity).[33] However, recent data show that financial risk protection in Malawi is worsening, although it is still outperforming the global average:

- In 2017, 4.2 percent of the population paid more than they could afford on health[34] (more than 10 percent of their annual household consumption), compared to 1.6 percent[35] in 2015 and 12.3 percent in 2015.
- The percentage of households that spent at least 25 percent of their total income consumption on healthcare also rose, from 0.1 percent in 2015 to 0.9 percent in 2017.

[30] The UHC indicator is calculated using two indices: a health services coverage index and a financial protection coverage index. The health services coverage index is a composite indicator calculated from 16 indicators across four health services categories, whereas the financial services indicator uses the proportion of the population with high household expenditures on health as a share of total household consumption expenditure or income. This indicator is a composite that measures the availability, acceptability, and affordability of health services (prevention, promotion, treatment, rehabilitation, and palliative) to those who need them without their experiencing financial hardship or catastrophic expenditure.

[31] Ministry of Health, 2020. *Developing Malawi's Universal Health Coverage Index*. Lilongwe: Department of Planning and Policy Development, MoH.

[32] World Health Organization. 2019. "Primary Health Care on the Road to Universal Health Coverage." Available at: https://www.who.int/docs/default-source/documents/2019-uhc-report.pdf.

[33] This high financial protection index could also be due to the non-use of services by the poor. Given that the quality of care is poor in most public facilities due, inter alia, to lack of medicines, poor households may forego care from private facilities or even buying prescription medicines because they cannot afford it.

[34] World Health Organization. 2019. "Primary Health Care on the Road to Universal Health Coverage." Available at: https://www.who.int/docs/default-source/documents/2019-uhc-report.pdf.

[35] World Health Organization and the World Bank. 2017. "Tracking Universal Health Coverage: 2017 Global Monitoring Report." Available at: 1811_Tracking UHC in the SDG era_2017 for Web.pdf (who.int).

Globally, the percentage of people who paid more than 10 percent of their annual household consumption was at 2.9 percent in 2015.

- The percentage of the population pushed below the international poverty line of US$1.90 per day (in 2011 purchasing power parity) because of household expenditure on health has increased from 0.5 percent in 2015[36] to 1.3 percent in 2016.[37] Globally, the percentage of people impoverished by healthcare spending in 2015 at the US$1.90 threshold was at 1.66 percent.
- The poverty gap increases due to out-of-pocket (OOP) health spending expressed as a percentage of the international poverty line of US$1.90 per day in 2011 purchasing power parity was at 0.73 percent in 2016. Globally, the poverty gap increase due to OOP expenditure was at 1.1. percent in 2015.

3.5. Health Financing Functions and UHC

Modern health financing literature[38] recognises four major functions of the healthcare financing system:

i. Resource mobilisation
ii. Resource pooling
iii. Purchasing of health services
iv. Benefit design

In addition, stewardship and governance are key ingredients for successfully executing health financing functions. We briefly discuss them below.

3.5.1. Resource Mobilisation

Funding sources: The Malawi healthcare financing system predominantly uses prepaid sources of funds in the form of government contributions (24.1 percent of THE) and external financing (54.5 percent of THE).[39] OOP expenditure is at 11.9 percent of THE, whilst private healthcare insurance is at 9.1 percent of THE.

With respect to equity in mobilising resources, the overall resource mobilisation architecture for Malawi has been rated as "progressive."[40] This rating implies that the poor are largely not negatively affected by resource mobilisation measures for health. However, available funding

[36] World Health Organization and the World Bank. 2017. "Tracking Universal Health Coverage: 2017 Global Monitoring Report." Available at: 1811_Tracking UHC in the SDG era_2017 for Web.pdf (who.int).

[37] World Health Organization. (2019). Primary Health Care on the Road to Universal Health Coverage. Available at: https://www.who.int/docs/default-source/documents/2019-uhc-report.pdf.

[38] For example, World Health Organization. 2020. "Assessing Country Health Financing Systems: The Health Financing Progress Matrix." Health Financing Guidance No.8. Available at: https://www.who.int/publications/i/item/9789240017405.

[39] Ministry of Health. 2020. National Health Accounts. Lilongwe: Department of Planning and Policy Development, MoH.

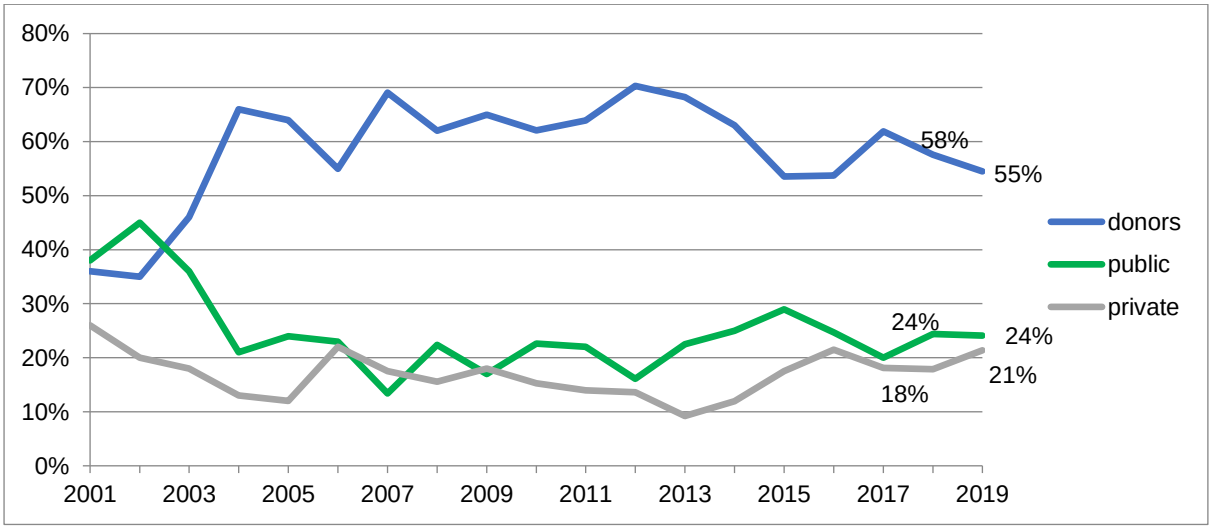
40 Ministry of Health. 2018. Malawi Health Financing Situation Assessment. Lilongwe: Department of Planning and Policy Development, MoH.

is inadequate. For instance, during implementation of the HSSP II, funding gaps were largely above 50 percent of the total costs.

The Malawi health sector does not have any solid strategies for actively mobilising resources. For instance, although the district health management teams (DHMTs) are mandated to mobilise supplementary resources for the health sector at the district level, they do little active mobilisation of resources, and it is done mostly through nascent optional paying services.

Predictability of funding levels: Malawi's health financing system is largely donor dependent, which makes it unpredictable. For instance, donor financing as a percentage of THE has fluctuated more than government financing, especially between 2013–2014 and 2014–2015, when a public finance management scandal came to light (see **Error! Reference source not found.**3).

Figure 3: Trend Analysis of Sources of Health Financing in Malawi



Source: National Health Accounts for Malawi (2022).

Per capita health expenditure has been relatively stable but low since 2012, at US$40, against the WHO-recommended threshold of US$86 for an effective minimum package of cost-effective interventions. Health funding for emergencies is also largely donor funded. For instance, the total COVID-19 health expenditure in 2020 comprised 80.6 percent donor funding, 10.2 percent government funding, and 9.2 percent other private sources.

Fiscal measures for inducing healthy behaviours: Malawi currently does not have hypothecated "sin" taxes that would encourage healthy behaviours. In 2017, the World Bank assessed the possible introduction of sin taxes on alcoholic beverages and tobacco. The recommendations were that Malawi should not pursue these taxes because the revenue generation would not be sufficient and because of the potential for an increase in smuggling these goods.

Efficiency: Efficiency has been classified as a resource mobilisation measure because of the cost savings that would be realised. Efficiency gains can be divided into two broad categories:

allocative efficiency[41] and technical efficiency. Studies conducted by the World Bank in 2017,[42] Oxford Policy Management Limited in 2016,[43] and the Royal Norwegian Embassy in 2013[44] showed that the Malawi healthcare system is characterised by gross technical and allocative inefficiency. A recent Global Fund application cycle revealed that in-service training generates inefficiencies through lack of a coordinated, common approach to the training. Potentially, up to MK1 billion could be saved per year with proper in-service training mechanisms.[45] Key areas of inefficiency include the supply chain of medicines and medical supplies, weaknesses in project and contract management, poor quality of care and human resources for health, inadequate planning for healthcare services, and fragmented data systems.

3.5.2. Resource Pooling

Role of pooling structures in redistribution of prepaid funds: Table 7 provides information on the status of pooling mechanisms in Malawi.

Table 7: Status of the Pooling Function in Malawi

Scheme	Pooled Funds (as % of THE)	Managed Funds[46] (as % of THE)
Government	40.3%	39.2%
Nonprofit institutions serving Households (NPISH)[47]	57.1%	34.5%
VHI	9.1%	9.1%
Out-of-pocket	11.9%	11.9%
Rest of the world and other enterprise financing schemes	1.4%	0.5%

Source: Malawi National Health Accounts (2022).

Malawi is conversant with the international best practices for pooling resources and has advocated for them in several policy documents, such as the National Health Accounts (NHA).[48] The government pooling mechanism manages a total of 39.2% percent of THE. However, although the government manages close 40% of THE, some challenges still exist: the allocation formulae for government-managed funds, especially for districts and central hospitals, are dysfunctional. This issue has translated into huge unexplained discrepancies in public per capita resources, ranging from US$3 per year in Mangochi to US$12 in Likoma;[49]

[41] *Allocative efficiency* is essentially ensuring that countries purchase the right things; i.e., whether funding is properly aligned with the costed need as identified in the HSSP II.

[42] World Bank. 2017. *Fiscal Space for Health in Malawi and the Potential for "Innovative Financing."* Washington, DC: World Bank.

[43] Oxford Policy Management Limited. 2016. National Health Insurance Feasibility Assessment for Malawi.

[44] Government of Norway (unpublished 2013). *Health Commodity Leakage in Malawi: A Quantitative and Qualitative Study on National Leakage of Medicines and Health Supplies.*

[45] MoH Department of Planning and Policy Development initial estimates; equivalent to US$1.23 million a year, using the 2020 exchange rate of 1 US$:MK730.

[46] Management of funds involves receipt of resources from a financing scheme and administering the same to a purchasing agent.

[47] May include nongovernmental organisations as well as donors providing the services.

[48] See, for example, Ministry of Health. 2020. *National Health Accounts*. Lilongwe: Department of Planning and Policy Development, Ministry of Health.

[49] At US$1: MK730.

also, some funds are earmarked for specific programmes, such as HIV/AIDS, malaria, and tuberculosis, thereby limiting the effect of the pooled funds.

The NPISH is the largest pool of health resources (57.1 percent) but manages 34.5 percent of total health resources. The key challenges with the NPISH-managed scheme include a great deal of fragmentation, with more than 200 organisations managing the resources; funds usually are earmarked for specific populations and specific geographic areas. The advantage of the NPISH scheme includes the high accountability towards both resource use and results.

VHI share as a percentage of THE is small (9.1 percent) but growing. The role of VHI has been defined in government policy as complementary and an important source of revenues. In practice, VHI serves the richer populations in formal employment who can access better-quality care in private health facilities. Whereas VHI serves as a resource mobilisation platform, as it frees up some resources that could otherwise be used by the rich, it does not contribute to equity in accessing the quality of health services. VHI also is not properly regulated, and the MoH or other service provision regulators do not have much regulatory authority regarding VHI schemes.

Pooling of resources also is affected by the suboptimal absorption capacity of pooled funds, including the Health Services Joint Fund (HSJF), the Global Fund (e.g., 23.7 percent of funds not absorbed), and public funds for health (14 percent of budgeted funds not utilised between 2015–2016 and 2018–2019). However, a recent study conducted by the MoH shows that the absorption capacity of donor funds is improving.[50]

Integration of health system and financing functions across schemes: Malawi uses the central data repository health management information system known as the DHIS2. However, it does not contain patient-level data systems or health financing information and may not be used by all implementing partners. Central hospital data are also not included in the DHIS2.

An aid coordination function was established in the MoH but has not been influential in integrating donor funding priorities or the priorities set by national health policies and plans. The result of this lack of influence is that at least 13 percent of total available resources are allocated towards activities that do not support implementation of the EHP.[51] In addition, it has also contributed to the less than full integration of service provision despite it being a critical health financing recommendation.

Flow of funds and budget execution: Public financing is relatively predictable regarding the flow of funds. External financing, in contrast, is relatively unpredictable. External funds may not always be used to fund on-plan activities, and thus introduces a significant element of unpredictability in the flow of funds. Two mechanisms—the HSJF and the government-to-government financing mechanism—have been established to provide direct support to on-plan activities without using the PFM system. However, the funds from these mechanisms are still not substantial.

[50] MoH (2021). Forthcoming.

[51] Government of Malawi. Resource Mapping Round 6.

3.5.3. Purchasing

Resource allocation and population health needs: There is a link between the burden of disease (BoD) and programmatic resource allocation, but the link is not exactly linear. For instance, 67.5 percent of health spending was allocated to three areas (HIV and AIDS, malaria, and reproductive health), which are responsible for 32.8 percent of the BoD.[52] However, diarrhoeal diseases received 1.9 percent of THE but contribute 4.8 percent to BoD, whilst injuries received 4.8 percent of THE but contributed to 9.2 percent of total BoD.

Funding towards services is oriented against primary healthcare services and capital investments. Providers of ambulatory primary healthcare services get 11.7 percent of THE as opposed to hospitals, which get 24.3 percent, and providers of health system administration and governance, which get 25.6 percent, indicating an orientation against more cost-effective primary care.[53] Relatively low capital expenditures are made, as evidenced by only 5.1 percent of THE spent on capital expenditure[54] and an 84 percent annual deficit for medical equipment and health infrastructure.[55] Inequities exist in total available annual health sector funding as a percentage of funding needs across districts, with Zomba (50 percent) and Mulanje (48 percent) having the highest proportion of funded activities, whilst Ntchisi and Likoma have the lowest, both at 16 percent.[56]

Purchasing mechanisms and provider performance: In general, in Malawi, providers who are paid for outputs for service-level agreements (SLAs), such as private health facilities and the Christian Health Association of Malawi (CHAM), are better in meeting service delivery goals than public facilities paid for inputs.[57] A study of Malawi's mixed-provider payment system observed that the most powerful tool to improve outcomes through purchasing is a focus on performance management.[58] Currently, purchasing mechanisms do not sufficiently incentivise provision of quality services, provision of services that would improve poor health outcomes, or pro-poor services. Although performance-based financing mechanisms were approved as a policy option in Malawi, no uptake has occurred.

Service shifting occurs from lower-tier facilities to higher-tier (usually central hospital) facilities. Informal payments to access services occur, especially surgical and gynaecological services, resulting in preferential treatment for the payers. However, there is no evidence of cost shifting in the public health service despite the introduction of optional paying services in public health facilities.

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[52] Ministry of Health. 2022. *Malawi National Heath Accounts Report for Fiscal Year 2018/19.* Lilongwe, Malawi: Ministry of Health, Department of Planning and Policy Development

[53] ibid

[54] Ibid

[55] HSSP II Operational Plan for Fiscal Year 2020/21.

[56] HSSP II Operational Plan for Fiscal Year 2020/21.

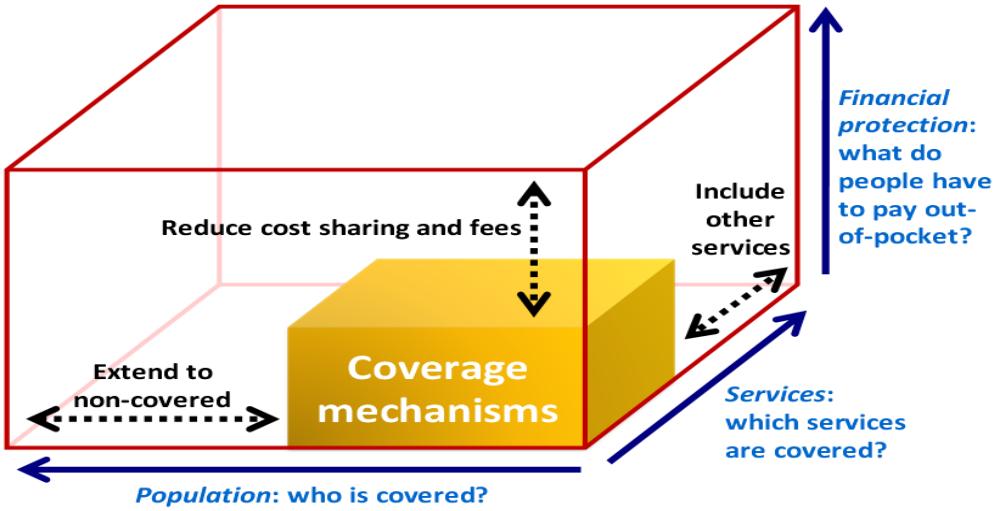
[57] World Bank. 2020. *Malawi Public Expenditure Review 2020: Strengthening Expenditure for Human Capital*. Washington, DC: World Bank. Available at: Malawi Public Expenditure Review 2020: Strengthening Expenditure for Human Capital (worldbank.org).

[58] Carlson, C., N. Hall, and T. Mwalyambire. 2019. *Assessment of the Mixed Provider Payment System*. Lilongwe: Development Management Associates.

3.5.4. Benefit Design

Figure 4 provides considerations for designing a UHC health benefits package (HBP).

Figure 4: Dimensions to Consider when Moving Towards Universal Health Coverage



Source: World Health Organization. 2010. *The World Health Report–Health Systems Financing: The Path to Universal Coverage*. Geneva: World Health Organization.

Population coverage: In Malawi, all Malawians are eligible to benefit from the EHP. However, the population is not formally aware of their entitlements and those services to which they are not entitled. There is also a key policy question that needs to be answered with respect to population entitlements for those under CHAM catchment areas.

Service coverage: Malawi has an explicitly defined health benefits package (the HBP), which is funded through both public and external resources. The HBP for HSSP III has been defined using a platforms of care approach which defines a positive list of programmes[59] to be provided at each level of care. The process for defining the HBP was transparent and involved different stakeholders. Key principles of the current HBP are health maximisation, equity, continuum of care, and complementarities of services.

Financial risk protection: Services in the HBP are provided free of charge at the point of care in all public health facilities. Selected demographics in the CHAM and Islamic Health Association of Malawi catchment areas also receive predetermined HBP services free at the point of service. There are no specific user fees for services not covered in the HBP, which makes its enforcement difficult. The pressure to provide all services free of charge has led to informal payments to access key services, such as gynaecological and surgical services.

[59] Benefit packages can be defined as either positive or negative lists. A positive list implies that the package clearly states the conditions to be financed, whilst the negative list states those conditions not covered.

3.5.5. Stewardship of the Healthcare Financing System

Stewardship in relation to healthcare financing means ensuring health funding is directed to achieving health outcomes, does not have adverse impacts or involve wasteful expenditure, and is sustainable and able to meet future needs. The Health Financing Technical Working Group (TWG) provides overall policy coordination in matters of health financing in the health sector. It thus is responsible for ensuring that the health financing architecture responds to key challenges and opportunities relating to health outcomes and efficiencies. However, the TWG has not been fully executing its terms of reference and conducting monitoring and evaluation of health financing.

The MoH recently established the Health Financing Division (HFD). The division will provide technical leadership in health financing in Malawi and act as a secretariat to the Health Financing TWG. The senior management team of the MoH remains responsible for uptake of key health financing policies in the health sector.

Stewardship also entails making decisions based on data and research. The recently established Health Economics Policy Unit (HEPU) at the College of Medicine and the Health Economics Association of Malawi are key independent organisations for conducting health financing research in Malawi. The MoH will collaborate with these organisations to commission research or undertake joint policy-relevant research.

3.6. Financing for Health Emergencies

3.6.1. Role of Health Financing in Health Emergencies

The role of health financing in emergency responses increasingly is being recognised as urgent and requiring reforms to achieve better focus and coordination.[60] WHO identifies health emergency response as one of its three core targets[61] and is in the process of including health security as one of the UHC goals.[62] In global health, responding to health emergencies is considered cost-effective and yields a high return in investments of US$8.30 per dollar invested.[63]

International Health Regulations (IHR) are a set of internationally agreed-upon goals which every signatory country is supposed to achieve in averting health emergencies, including global pandemics. Financing for IHR in Malawi is very low, at 20 percent of the required amount.[64] The Department of Disaster Risk Management in Malawi is responsible for overall national coordination of emergencies, including health emergencies. The Public Health Institute of Malawi coordinates the response to health-specific emergencies.

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[60] Vageesh, J. 2020. "Financing Global Health Emergency Response: Outbreaks, Not Agencies." *Journal of Public Health Policy* 41: 196–205. Available at: https://doi.org/10.1057/s41271-019-00207-z.

[61] WHO. 2018. *A Healthier Humanity: The WHO Investment Case*. Geneva: World Health Organization. (WHO/DGO/CRM/18.2). Licence: CC BY-NC-SA 3.0 IGO.

[62] WHO. 2020. *Assessing Country Health Financing Systems: The Health Financing Progress Matrix*. Geneva: World Health Organization. (Health financing guidance, no. 8). Licence: CC BY-NC-SA 3.0 IGO.

[63] Available at: WHO/Europe | Health systems for emergencies - Financing.

[64] WHO. 2020. "Health Financing Progress Matrix." Available at: Health Systems Governance and Financing (who.int).

4. HEALTH FINANCING STRATEGIC DIRECTIONS

4.1. Vision, Goal, and Guiding Principles

4.1.1. Vision

A fully functional healthcare financing system that supports the achievement of UHC aspirations espoused in the Constitution, the National Health Policy, and health sector strategic plans.

4.1.2. Goal

To set up a well-governed health financing architecture able to mobilise adequate resources, distribute the resources in an efficient and equitable way, and strategically purchase services based on a well-defined benefit package in pursuit of UHC goals.

4.1.3. Objectives

The following are the key strategic objectives of the HFS:

i. Mobilise adequate, sustainable, and predictable funds for the health sector to optimally deliver essential health services

ii. Improve efficiency and equity in pooling and managing resources for the health sector

iii. Develop and implement strategic purchasing measures across the healthcare service delivery continuum

iv. Establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system

4.2. Strategies

The strategies proposed herein are designed to support achievement of the vision, goals, and objectives of the HFS, and will be implemented within the new HFS architecture.

4.2.1. Objective 1: Mobilise adequate, sustainable, and predictable funds for the health sector to optimally deliver essential health services

Strategy 1.1. Improve efficiency across all health system functions at all levels of the healthcare delivery system

- Conduct biennial efficiency analysis across programmes to inform reallocation of resources, focusing on high-expenditure areas, such as HIV/AIDS, malaria, reproductive health, the expanded programme on immunization, tuberculosis, and COVID-19
- Rationalise implementation of in-service training
- Promote supply chain integration
- Promote end-to-end tracking of medicines and medical supplies (e.g., to monitor potential expiry of medicines)

- Build drug theft investigation capacity at the council level
- Improve contract management of public health infrastructure projects
- Establish active price monitoring mechanisms to support efficient procurement of medicines through development of a national and international wholesale medicines price monitoring system
- Lobby for the enforcement of direct sourcing of medicines—e.g., buying as a regional bloc; this strategy is particularly important for medicines for rare diseases, such as some cancers
- Lobby for termination of the Buy Malawi Strategy for medicines and medical equipment not manufactured in Malawi
- Introduce flexibility into the medicines budget at the district level to purchase medicines from prime vendors when there is a stock-out at the Central Medical Stores Trust (CMST)
- Introduce an e-procurement mechanism at the CMST
- Implement CMST reforms based on CMST efficiency analysis
- Enforce adherence to the Capital Investment Plan (CIP)
- Establish a medicines manufacturing plant for medicines in high demand and use, including antiretrovirals, anti-malarial drugs, and reproductive health products; the plant could be either in-country or regional

Strategy 1.2. Enhance participation of communities in financing of public health services

i. Develop grant making and governance capabilities for decentralised and community health oversight structures and mechanisms (e.g., HCMCs; community-led monitoring, and access to health facility information by communities)

ii. Facilitate community-level (including district and private sector) revenue mobilisation mechanisms for health, emphasising in-kind community contributions using community-level structures; sources of funds will include individual contributions, the community development fund, economic activities within the community, a public works programme hypothecated tax, and a mobile money hypothecated tax (Mudzi Wathu model)

iii. Mobilise citizen engagement in innovative financing mechanisms—e.g., citizen involvement in health funds as contributors and efficiency watchdogs

Strategy 1.3. Improve and scale up optional paying services in public facilities

- Improve infrastructure, human resources, medical equipment, and medical supply capacity for optional paying services
- Improve the financial management and accountability of optional paying services
- Improve stakeholder engagement in optional paying services; stakeholders include CSOs, communities, the MoF, and donors
- Revise guidelines for optional paying services in public health facilities
- Improve monitoring of optional paying services

- Conduct economic evaluation of optional paying services

Strategy 1.4. Increase external funding to the health sector

- Devise and implement sustainability mechanisms for donor-funded interventions, emphasising the introduction of co-financing models between the government and donors
- Introduce incentives to individuals and institutions to encourage external resource mobilisation
- Develop the capacity for proactive external resource mobilisation to meet domestic gaps

Strategy 1.5 Improve financing of the healthcare system, including family planning (FP) services, using domestic resources

- Introduce mutually binding co-investments between donors and the GoM in selected health sector activities, including procurement of FP products, health infrastructure, and medical equipment
- Improve the performance of budget execution of co-financed programmes, including through actual allocation of agreed-upon finances under the co-financing agreement
- Institute joint programme and budget accountability measures for co-financed activities
- Increase research and training on the interface of health financing and population growth
- Increase advocacy amongst stakeholders[65] on FP and population growth as key health financing issues

Strategy 1.6. Introduce innovative health financing mechanisms

- Implement public-private partnerships (PPPs) in health across all health system functions to achieve efficiency and mobilise additional financing
- Introduce social bonds for health
- Explore debt2health[66]
- Explore hypothecated taxes on mobile money payments, road funds, alcohol, sugary drinks, tobacco, and other potential areas for "sin taxes"

4.2.2. Objective 2: Improve efficiency and equity in pooling and managing resources for the health sector

Strategy 2.1. Reduce the fragmentation of health sector funding

- Design and implement an enhanced HSJF mechanism (Health Multi-Donor Fund) managed by a fiduciary agent
- Coordinate budget planning, allocation, execution, and evaluation between partners and the GoM at all levels, including through the HSSP Operational Plan

[65] Stakeholders include the government, local and national leaders, religious leaders, and community groups.

[66] Debt2Health is a mechanism that targets additional funds to health systems through debt relief. Instead of repaying debt owed in the future to creditor countries, debtor countries invest in health systems in the present using the funds that it owed. It usually involves a third party such as the Global Fund to guarantee that the cancelled debt is being used to fund aspects of a debtor country's health system.

- Develop a standard bylaw for all district councils in collaboration with the Ministry of Local Government (MoLG) on enforcing the compliance of implementing partner-to-partner coordination requirements set by the council
- Introduce sector budget support to the district health budget

Strategy 2.2. Strengthen leadership, governance, and accountability mechanisms to ensure harmonisation of health financing decision making across all levels of the health system

- Scale up DHMT leadership and management curricula to additional districts and cadres (e.g., other council members, health centre managers, programme coordinators, community hospital managers) at the district level, including subsequent coaching and mentorship, with a focus on partner coordination
- Revisit the requirements for leadership at the district level through the functional review process
- Create a real-time aid coordination platform at central and decentralised levels of the health system

Strategy 2.3. Improve management and accountability of government and donor funds

- Reduce the administrative burden of the approval process by seeking efficiencies in the internal controls process
- Decentralise management of donor funds under management of the government (e.g., Global Fund, GAVI, HSJF)
- Enhance the capacity for fiduciary risk assessment and management
- Incentivise optimal disbursements and the execution of government and donor funds
- Capacitate national and subnational levels to undertake government and donor-funded procurements
- Conduct periodic absorption capacity assessments

4.3.1. Objective 3: Develop and implement strategic purchasing measures across the healthcare service delivery continuum

Strategy 3.1. Define and implement benefit packages for all levels of care

- Clearly articulate the parameters involved in redefining the new HBP for primary/secondary/tertiary care; set conditions, governance structures, and timelines for revisions
- Revise the essential medicines, must-have, and tracer medicines lists to align with the new HBP and disseminate it
- Revise the essential equipment list to align with the new HBP and disseminate it
- Disseminate and monitor implementation of the new tiered HBP

Strategy 3.2. Develop and implement effective strategic resource allocation and use measures across the healthcare delivery system

- Facilitate implementation of the district resource allocation formula, including for donor or partner resources
- Develop a resource allocation framework for tertiary care
- Develop a resource allocation framework for tertiary care (using the central hospital resource allocation formula and reimbursement mechanism)
- Define, implement and monitor central hospital resource allocation formula
- Develop an intra-district resource allocation formula
- Monitor the effectiveness of informing the devolution of budget planning, execution, and evaluation at the council level
- Monitor the effectiveness of using the PFM system as a tool for strategic allocation and use of resources
- Digitise healthcare delivery in a way that integrates and captures healthcare provision, health financing, and expenditure information

Strategy 3.3. Develop and implement effective provider payment mechanisms

- Decentralise the district health budget to sub-district health facilities (provider level)
- Negotiate with the Treasury to modify PFM rules to allow for purchaser-provider splits and spending flexibility
- Establish a regulatory council for medical schemes to regulate tariffs, ensure ethical healthcare delivery, and adjudicate disputes between providers and payers
- Strengthen financial management and accounting capacity at the district council and sub-district levels
- Roll out PBF implementation mechanisms

4.3.4. Objective 4: Establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system

Strategy 4.1. Strengthen institutional capacity in health financing and the PFM to implement the HFS effectively

- Develop and sustain active purchasing capacity in the HFD
- Capacitate relevant government institutions to coordinate, implement, and monitor the HFS
- Capacitate councils to implement the HFS
- Develop and sustain collaboration mechanisms between key ministries, departments, and agencies (MDAs) for effective implementation of the HFS
- Develop capacity for donor and aid coordination at all levels
- Develop and sustain TWG governance arrangements for health financing at all levels

Strategy 4.2. Strengthen generation and use of evidence in health financing decision making at all levels

- Develop capacities in health financing analysis and evidence use at all levels of the health system
- Develop capacities of health economics and financing research institutions
- Institutionalise resource tracking studies at all levels of decision making
- Develop capacity in the HFD to conduct biennial UHC studies
- Conduct a needs assessment and commission studies in key areas of health financing of the HFS
- Develop the capacity of the HFD to lead in health PPPs

Strategy 4.3. Strengthen the advocacy capacity for the HFS

- Develop an advocacy and communication plan for the HFS
- Develop and sustain the capacity of advocacy institutions (advocacy institutions for health financing are mostly CSOs and academia)
- Develop and sustain advocacy platforms, including the biannual CSO/MoH forum, quarterly Health Donor Group (HDG)/MoH forum on health financing, forum for the Honourable Minister of Health and donors on health financing, forum for the Honourable Minister of Health and CSOs, and the MoH/academia forum on shaping the health financing agenda
- Facilitate resource mobilisation and the communication function of the advocacy strategy for health financing
- Undertake advocacy and communication activities based on the HFS and the related communication plan for it

Strategy 4.4. Strengthen the legal, regulatory, and policy frameworks for health financing

- Introduce legislation on national health financing to aid implementation of community and individual contributions towards health financing, enforceability of the HBP, and improved provider payment mechanisms
- Introduce legislation on VHI to guide the sector and firmly establish the health sector's role in private health insurance
- Introduce regulations on strategic health purchasing
- Introduce the public health budget accountability forum
- Introduce a law establishing a trust fund for health
- Introduce regulations or policies requiring economic evaluation for new and current programmes to aid the achievement of efficiency
- Update terms of reference for the Health Financing TWG so it can carry out its mandate effectively

- Revise the memorandum of understanding with faith-based organisations in pursuit of UHC goals and value for money
- Introduce regulations or policies for allowing limited purchase of essential medicines from preselected prime vendors if the CMST does not have such medicines or commodities in stock
- Reintroduce the annual health financing summit

5. REFORMS IN THE HEALTH FINANCING ARCHITECTURE

5.1. The New Health Financing Architecture

To achieve the above strategic vision, goals, and objectives, a new health financing architecture has been designed (Figure 4).

The proposed health financing architecture is expected to do the following:

i. Sustain and increase tax and donor financing as the main sources of health financing for Malawi's health system, thereby continuing to guarantee the solidarity principle underpinning the country's health financing

ii. Promote and formalise a community-led resource mobilisation initiative and oversight towards self-reliance and sustainability of the health system

iii. Introduce structured financing mechanisms for health, such as debt2health and PPPs

iv. Promote efficiency of the public pools including donor financed pools

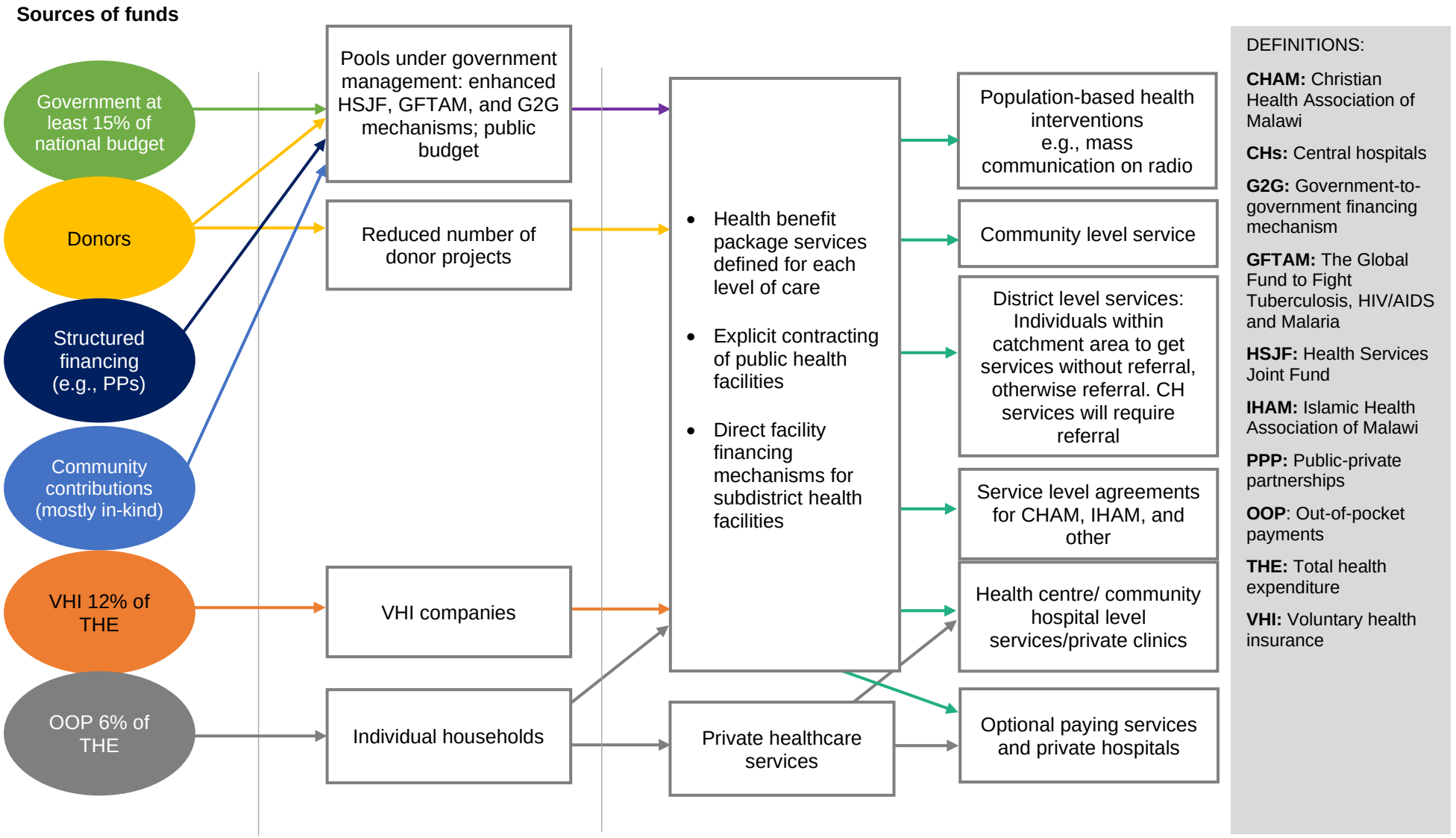
v. Promote efficiency of private and social insurance pools to complement the highly constrained tax financing for healthcare

vi. Facilitate contributions of the non-poor in the informal sector—those who currently have the capacity to contribute but lack the framework to do so

vii. Contain formal and informal OOP payments within an acceptable proportion of under 7 percent of THE

viii. Provide the minimum PFM arrangements for ensuring viability of the health financing arrangements suggested

Figure 5: The New Health Financing Architecture



5.2. New Revenue Mobilisation Structure

5.2.1. Government Revenue

The UHC orientation of the National Health Policy and HSSP III will require optimal and sustained increases in tax financing of health services.[67] Tax financing will primarily support investment across health systems' building blocks and catalysing delivery of an HBP that can be accessed free of charge at the point of care. The MoH thus will continue to lobby for increased and sustained government allocations to reach the Abuja target of 15 percent of total government budget to demonstrate its commitment to sustainability of the health sector. Hypothecated tax regimes will be introduced for health programmes.

The Multi-sectoral Committee on Sustainable Health Financing[68] will provide the platform for advocating for policies that facilitate economic growth and implementation of evidence-based health financing modalities that do not negatively impact the growth prospects of the economy. Government revenue also will be critical for financing innovative measures, such as debt2health, social bonds, and PPPs.

5.2.2. Donor Financing

Donor financing will continue to be a significant source of health financing in Malawi, accounting for 54.5 percent of THE. With per capita health expenditures at US$39.90 per year, coupled with low levels of domestic resources, donor financing will remain an important source of funding for the HSSP III. The major focus will be to develop the capacity of the district health system to manage donor funds, thus empowering communities to proactively provide oversight of health funds; co-financing also will be important.

5.2.3. Private Health Insurance

Private health insurance will be encouraged (1) as a source of financing for optional coverage for taxpayers who may opt out of public healthcare consumption, leaving the limited tax and donor funding to cover those living in poverty; and (2) to provide additional health cost coverage for services not in the HBP. A regulatory framework for private insurance will be developed, such as a medical insurance law.

5.2.4. Decentralised Resource Mobilisation and Management Arrangements

Optional paying services will be encouraged in both central and district hospital settings. Additional revenue will come from imposing fees on food handler certification, provision of fumigation services, and contracting with employers to provide medical fitness certification.

[67] World Bank. 2019. High-Performance Health Financing Universal Health Coverage - Driving Sustainable, Inclusive Growth in the 21st Century.

[68] The Multi-sectoral Committee on Sustainable Health Financing includes members from the MoH, MoF, and MoLG. The Committee meets at least once a quarter.

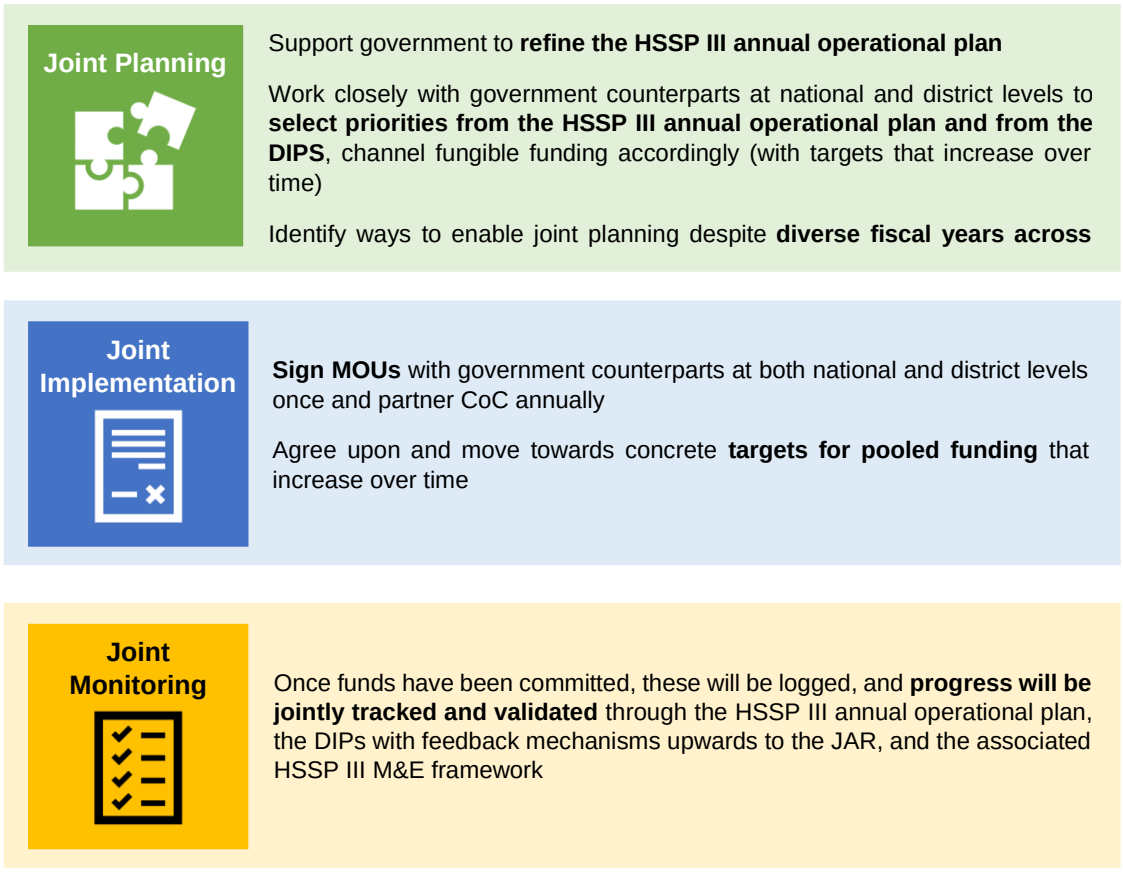
5.3. New Pooling Mechanism Structure

5.3.1. The "One Plan, One Budget, and One Monitoring and Evaluation" Framework

The new health financing architecture places strict requirement for stakeholder alignment to the strategies and activities of the HSSP III. The rationale for the *"One Plan, One Budget, One M&E Report"* is that it will enable implementation of jointly agreed priorities across the health sector, guarantee partner alignment, and harmonize implementation procedures and information sharing. Memoranda of understanding (MoUs) and partner codes of conduct (CoCs) will be used for enforcing adherence to the *"One Plan, One Budget, One M&E Report"* principle amongst stakeholders.

The new health financing architecture means that all health systems activities will be jointly planned, prioritized, implemented, and monitored. Annual operational plans, associated budgets, and monitoring and evaluation frameworks will be developed to operationalize the *"One Plan, One Budget, One M&E Report"* principle. As presented in Figure 6, joint planning will be conducted using the HSSP III annual operational plan and the district implementation plans (DIPs). Joint implementation will be enforced through MoUs and CoCs. Joint monitoring will be done using the associated monitoring and evaluation frameworks of the DIPs, HSSP III annual operational plan, and the joint annual review sessions.

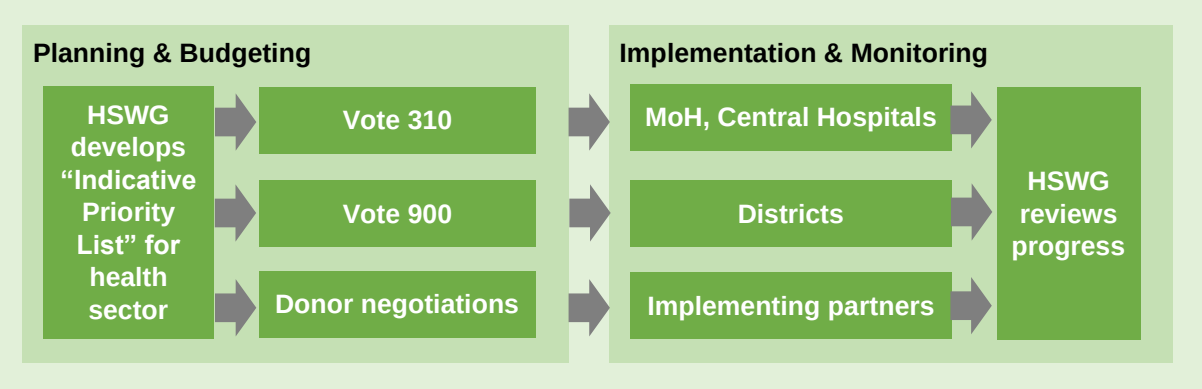
Figure 6: Key Aspects of Joint Planning, Joint Implementation, and Joint Monitoring



5.3.2. Process for Implementing the "One Plan, One Budget, and One Monitoring and Evaluation"

Figure 7 provides a summary of the operational framework of the *"One Plan, One Budget, One M&E Report"*.

Figure 7: Summary Process for Implementing the "One Plan, One Budget, and One M&E" Principle



The following steps will be implemented to operationalize the *"One Plan, One Budget, One M&E Report"* principle:

i. The HSSP III will form the framework for the annual operational plan on which the *"One Plan, One Budget, One M&E Report"* is premised.
ii. From the HSSP III, the Health Sector Working Group (HSWG) will develop an annual "Indicative Priority List" based on a set of mutually agreed criteria.
iii. The HSWG will jointly endorse and adopt the "Indicative Priority List" subject to available financing. The amount of resources available will be determined through the resource mapping and national health accounts exercises.
iv. The "Indicative Priority List" will be used as the foundation for planning and budgeting processes and negotiations across all stakeholders. Internally, this includes processes in advance and preparation of Vote 310 (Ministry of Health) and Vote 900 series (District Councils) budgets. Externally, this includes partner negotiations and the signing or re-confirming of memoranda of understanding (MOUs) and the partner code of conducts (CoCs).
v. All stakeholders will finalize their plans and budgets for the year and share with their respective technical working groups to avoid duplication
vi. The Health Sector Working Group (HSWG) and the district stakeholder forum will provide continued multi-sectoral and multi partner coordination during implementation. At the national level, the Secretary to Health (SH) oversees implementation of the health system and is supported by directors. Directors will provide technical guidance for relevant areas and oversee budget execution, while TWG will provide technical guidance and coordinate with partners.
vii. The review process will be joint conducted through the district platforms, technical working groups, and the joint annual review process.

5.4. New Purchasing Arrangements

5.4.1. Resource Allocation within the Health Sector

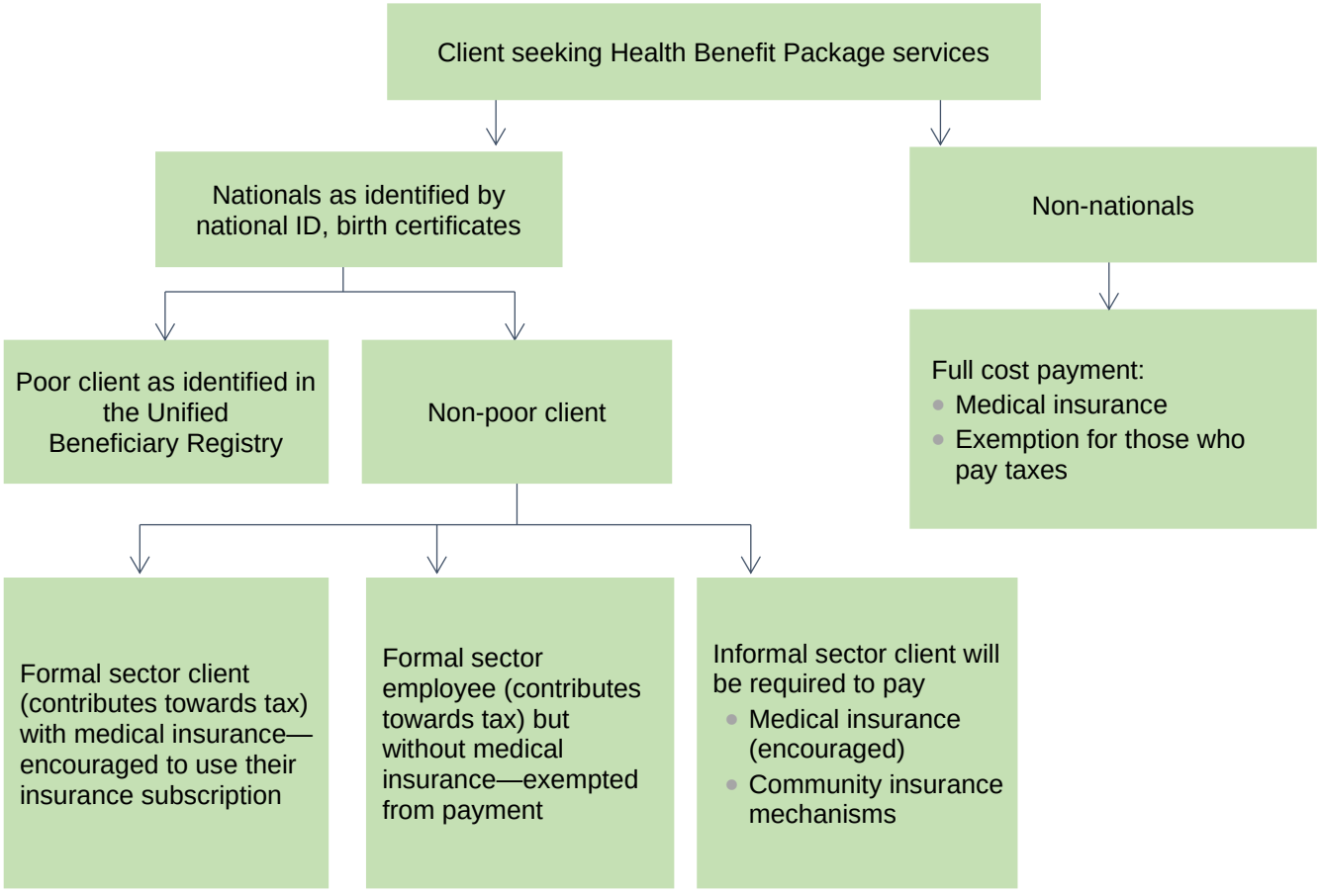
At the national level, a three-stage resource allocation process will be followed. First, the total budget from government and donor pools will be established through an aggregate resource mapping before the annual budget preparation process. The second stage will involve allocating the budget across national, tertiary, and district levels. For tertiary hospitals, allocations will be based on the designated mandate, planned output, and predetermined performance measures. The third stage will involve resource allocation to departments at the tertiary level and across the levels of service delivery at the district level. Allocation shall be made to both state and contracted non-state providers. To preserve the value of the health sector budget and guarantee the maintenance of volume and quality of services, budgets for service providers at each level should be increased each year by not less than 10 percent of the nominal total health sector budget of the previous year.

5.4.2. Provider Payment Arrangements

5.4.2.1. Health Benefits Rationing Mechanisms and Basis for Entitlement

Several key principles will inform access to care in public health facilities: (1) enforcement of the HBP, (2) use of national identification cards for service provision, and (3) a unified beneficiary registry to determine which populations and people are exempted from initial and additional payments when accessing care. A diagrammatic presentation of the health benefits rationing mechanisms is in Figure 8 below.

Figure 8: Financing Mechanisms for Access to the Health Benefit Package



5.4.2.2. Identified Poor and Vulnerable Groups

Clients identified as being in poor and vulnerable groups will qualify for free services and access to the HBP free of charge at public health facilities. Identification of these clients will be based on producing a national ID and evidence from the Unified Beneficiary Registry.

5.4.2.3. Formal Sector Employees without Health Insurance Coverage

Malawian formal sector employees without any health insurance will access the HBP free of charge at public facilities, as they have already made their contributions through Pay as You Earn (PAYE). Catchment populations whose only service provider is a government contracted faith-based provider shall be exempted from paying the user fees on services covered under SLAs. Access to government and CHAM facilities by this group will require the person producing a combination of national ID, employer ID, and Taxpayer Identification Number to identify the user.

5.4.2.4. Formal Sector Employees on Private Health Insurance Scheme

The solidarity principle is based on risk pooling of the poor and non-poor, sick and healthy, and young and old. The pooled funds will allow for an HBP consistent with the total pooled revenue. All formal sector employees covered by medical insurance schemes will use health services in the public sector only when they produce a health insurance ID. For insured services, providers will claim from the insurance companies. For non-covered services, free access will be confined to the services in the HBP.

5.4.2.5. Non-Poor Informal Sector

To use a government or contracted faith-based service provider, the non-poor in the informal sector will be required to contribute to the cost of care through a mandatory community- owned social insurance scheme for the informal sector, including prepayment. Services will require producing a national ID.

5.4.2.6. Non-nationals

All non-nationals with residency status for six months or more will be able to access public or contracted facilities when they produce (1) a residence permit, (2) proof of insurance coverage, or (3) proof of exemption (for example, PAYE certification). Non-residents and those staying for less than six months will require comprehensive health insurance coverage to access health services in the public sector.

6. FINANCIAL COSTS AND FINANCING ARRANGEMENTS

6.1. Introduction

Financial cost estimates for implementing the HFS have been developed for the entire period (eight years). The costs have been developed based on the perspective of the health system. This chapter provides the methods used for costing, the cost estimates, and financing of the HFS.

6.2. Methods

The activity-based costing method was used to develop the financial cost estimates. We used a costing tool developed by the Clinton Health Access Initiative. Unit costs in the tool were reviewed and updated to reflect current market prices. NHA institutionalisation costs were taken from the NHA Institutionalization Roadmap. Second- to eighth-year costs were adjusted for a 14.9 percent inflation rate. This rate was chosen because it represents the average[69] annual inflation rate between 2001 and 2021.

6.3. Cost Estimates

The total cost for implementing the HFS is US$420,309,375.76. Table 8 presents the total costs of the HFS by objective.

Table 8: Cost Estimates per Objective

Objective	Cost (US$)	Percentage of total cost
Objective 1: Mobilise adequate, sustainable, and predictable funding for the health sector to deliver essential health services optimally	95, 462, 254.86	23.1%
Objective 2: Improve efficiency and equity in pooling and management of resources for the health sector	22, 367, 986.99	5.9%
Objective 3: Develop and implement strategic purchasing measures across the healthcare service delivery continuum	260, 964, 491.71	62.1%
Objective 4: Establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system	37, 503, 424.73	8.9%

6.4. Cost Drivers

Strategic Objective 3 (Develop and implement strategic purchasing measures across the healthcare service delivery continuum) comprises 62.1 percent of all costs. Under this objective, Strategy 3.3, "Develop and implement effective provider payment mechanisms" accounts for 45.63 percent of all total strategy costs (or 73 percent of total Objective 3 costs). Direct facility financing (29 percent of total strategy costs) and performance-based financing

[69] Arithmetic mean.

(12.6 percent) are the major activity costs in the strategy. Both are designed to directly improve healthcare service delivery at facility and community levels.

Costing of the strategy also assumes independence of activities. In practice, as a way of achieving better use of resources, some activities will be done concurrently to reduce costs. Also, given that the HFD is relatively new, the costing also assumes a substantial use of consultants/technical assistants. This assumption is realistic, especially for the first three years, as the HFD builds its capacity to undertake activities at the expert level.

6.5. Financing Arrangements

The strategy will be financed by all stakeholders, including the GoM, the private sector, and donors. Pooled funding with associated accountability mechanisms will be promoted as a principal way of financing the HFS.

The GoM will meet staff costs of new members of the HFD staff to be recruited as part of implementing the HFS. The government will also fund most feasibility analyses of PPPs, the sustenance of advocacy platforms at the national level, and implementation of and eventual takeover of financing health facility improvement grants. The GoM will also co-fund key activities, such as joint NHA/Resource Mobilisation/National AIDS Spending Assessment studies, VHI law and policy development, and staff time for performing key health financing functions.

7. IMPLEMENTATION ARRANGEMENTS AND MONITORING, EVALUATION, RESEARCH, AND LEARNING

7.1. Introduction

The HFS states that the *"what"* is defined by the specific strategies to improve health financing. Implementation mechanisms and processes determine *how* Malawi plans to implement the strategy to fulfil its vision and achieve its goals and objectives. Implementation of the HFS is therefore a complex process involving a range of different operational plans, programmes, and agencies. To realise the specific health financing strategies elaborated in this document, implementation is categorised into four elements: implementation plans, prioritisation, and sequencing; institutional structure, roles, and relationships; building human and institutional capacity; and a communication plan.

7.2. Health Financing Strategy Implementation Framework

7.2.1. Implementation Plans, Prioritisation, and Sequencing

The HFS will serve as an implementation strategy for the HSSP III. Implementation plans will be formulated with short-, medium-, and long-term targets and timelines. These plans will undergo continuous review and revisions so they are always updated to respond to any changes that may affect the successful implementation of the strategy. Given that there are many activities that must be implemented under each strategy, prioritisation will be ongoing throughout the implementation process. Each specific strategy will make an important contribution, and the keys to success will be a comprehensive approach and development of synergies between all tasks to reduce weak links in the health financing chain.

7.2.2. Institutional Structures, Roles, and Relationships

7.2.2.1. Organisational and Institutional Arrangements

To implement the HFS, the MoH will work within existing structures and mechanisms, and establish new ones only where needed. In addition, the MoH will embark on strengthening the skills and competencies of human resources in health financing and financial management at different levels, as required. A wide range of stakeholders will be involved in implementing this strategy, as described briefly below. Their roles and responsibilities also are described.

a) Ministry of Health

The Department of Planning and Policy Development (DPPD) in the MoH will provide overall oversight and leadership for implementation. All other relevant structures in the MoH will also participate in different aspects of implementing the HFS, including key directorates, TWGs, policy advisory groups, senior management, and others. Any new structures established to participate in the implementation of the strategy will be established within the Department of Planning to ensure clear leadership and guidance. Within the DPPD, the HFD will be the lead division for implementation of the HFS.

b) Health Financing Technical Working Group (TWG)

The Health Financing TWG is one of six recommended TWGs. It coordinates all partners in the health financing space in matters related to policy, planning, implementation, monitoring, evaluation and learning, and research on health financing. The Health Financing TWG reports to the Health Sector Working Group (HSWG).

The Health Financing TWG will therefore be the principal coordinating mechanism of the HFS, ensuring its approval and implementation. It will achieve this function by having a proper secretariat in the MoH that is well resourced and capacitated for the purposes of coordination. The secretariat for the TWG will be the HFD in the Department of Planning and Policy Development of the MoH. The Health Financing TWG will be responsible for identifying resources for implementation of this strategy.

The Health Financing TWG will also be responsible for monitoring and evaluating progress made under the HFS and advising on key steps to take to implement it in pursuit of UHC goals. The Health Financing TWG will report to the HSWG on progress and key challenges faced in implementing this strategy.

c) Other Line Ministries, Departments, and Agencies (MDAs)

The multisectoral approach that has been emphasised in health policies and plans will guide implementation of this HFS. In addition to the MoH, other line ministries and institutions of the government will be crucial in implementing the HFS, including the MoF, MoLG, Ministry of Justice, and the Office of the President and Cabinet (OPC).

The MoF is the custodian of the PFM system. It will therefore be responsible for implementing the public budget cycle activities needed to achieve UHC goals. It is also a key stakeholder in PFM reforms. The MoLG, including the National Local Government Finance Committee (NLGFC), is a key stakeholder for district health financing. Together with the MoH, the MoF, MoLG, and NLGFC will form the core of the Inter-ministerial Committee on Health Financing.[70]

The Ministry of Justice will be responsible for reviewing contracts with external partners. It will also be responsible for advising on contracting mechanisms with DHOs. The OPC will be responsible for coordinating health financing legislation and policies that require the cabinet's attention. The National AIDS Commission will coordinate HIV/AIDS financing efforts.

d) Health Donor Group (HDG)

Given the central role of the HDG in financing the health sector, it will have a critical role in implementation of the HFS. The programmes and interventions of development partners should be aligned and synchronised with HFS objectives and outcomes. The MoH will use the HDG platform to advocate for the efficiency of donor programmes and their full alignment to government priorities.

[70] Members of the Interministerial Committee on Sustainable Health Financing are the MoH, MoF, and MoLG.

e) Donor Implementing Partners

Donor implementing partners are critical in implementation of this strategy because they are an important source of technical assistance in health financing. In addition, they will provide financing for some activities outlined in the HFS.

f) Civil Society Organisations (CSOs)

CSOs are critical in implementing this strategy, especially in advocacy of health financing reforms, accountability, and effectiveness/impact on realisation of desired health outcomes resource use. CSOs will therefore need to be strengthened and given an appropriate platform to effectively monitor implementation of the HFS—for instance, through community-led monitoring approaches.

g) Private Not-for-Profit Sector

The private-not-for-profit sector will be responsible for service provision, mobilisation of resources, and health systems strengthening as its contribution to achieving UHC goals. The key players under this sector include CHAM, the Islamic Health Association of Malawi, and nongovernmental organizations.

h) Private for-Profit Sector

The private for-profit sector includes the VHI industry, healthcare providers, and other corporate entities. The insurance industry is important because it mobilises resources and offers limited pooling of resources for service delivery. These corporate entities will be responsible for corporate social responsibility and mobilising resources, especially through enrolment of their staff into VHI schemes complementary or supplementary to the HBP. We will also engage both domestic and external corporate entities in PPPs for health.

i) Health, Academic, and Research Institutions

The Research Department in the MoH, the HEPU at the College of Medicine, the Malawi Liverpool Wellcome Trust, and the Economics Department at Chancellor College are some of the key research organisations that will be critical in providing evidence for implementation of the HFS. The HFD will collaborate with these organisations to conduct implementation research and evaluate the performance of the health financing structure, especially in light of UHC goals.

j) Public-Private Partnerships Commission

PPPs are central for successful implementation of the HFS. The PPP policy provides a framework for them. Within the health sector, the PPP Commission is the coordinating arm for any resolutions concerning the private sector. Implementation of the HFS will utilise these existing institution frameworks to enhance partnerships.

k) Community Engagement

Partnerships with the community to make them part of the process of governance, accountability, and monitoring performance is necessary for implementing the HFS. The HFD, in collaboration with relevant stakeholders, will actively pursue these partnerships. Mechanisms exist for engagement of communities with the health system through community

health workers, health centre management committees, representation through the local government system, and stakeholders on health service engagement through community-led monitoring findings.

7.3. Building Human and Institutional Capacity

To effectively implement the HFS, key stakeholders will be trained on selected topics. The focus will be on economic evaluation, various methods of resource mapping and expenditure tracking, and resource mobilisation. The key training participants will be members of the DPPD, district council officers, members of the Health Financing TWG, and other MoH senior management, as well as communities, through CSOs.

We will also focus on developing capacities at academic and research training institutions. We will focus on establishing specialised postgraduate courses in health financing and health economics, as well as fellowships with a health financing policy focus, in selected academic and research institutions.

7.4. Communication Plan

Appropriate and effective communication is an enabling factor in ensuring successful implementation of the HFS, and a communication strategy will be an integral element. The communication and advocacy strategy will aim to create linkages between the strategic and operational levels, and seek to sensitise all stakeholders as follows:

1. Ensuring that all stakeholders are fully informed about and understand the HFS
2. Ensuring buy-in from stakeholders to encourage their effective participation in HFS implementation
3. Enhancing strategic consultation with agencies in achieving set outcomes
4. Monitoring the HFS through community-led monitoring approaches and conducting advocacy meetings with stakeholders based on community findings

A detailed communication plan encompassing intended actions and their timing and responsibility will be developed as one of the key documents for facilitating HFS implementation. The communication plan will articulate the following:

1. The key messages for communicating to key stakeholders
2. The method by which these messages are communicated to stakeholders
3. The actual communication activities to be conducted
4. Resources needed to undertake the communication tasks
5. Communication risks
6. Methodology and timeframe for evaluating the effectiveness of communication

7.5. Monitoring, Evaluation, Research, and Learning

To effectively monitor the performance of the HFS during the implementation period, a results framework for monitoring and evaluation has been developed (see Annex 1). The framework will monitor progress towards the goals outlined in this strategy. The results framework uses two major types of indicators: those required in international health financing and those not required as standard but important for achieving results under this HFS.

Evaluation, as applied policy research, will also be an integral aspect of implementation and learning for the strategy. Routine health financing studies, such as the NHA, resource mapping, and a public expenditure review, will need to be institutionalised to obtain relevant and up-to-date data that can inform progress on health financing. In addition, a mid-term review of the strategy will take place in 2024–2025 to check on progress and make changes as appropriate.

ANNEX 1: MONITORING AND EVALUATION FRAMEWORK

Indicator	Indicator Level	Baseline/ Recent Estimates	Target 2030	Data Sources	Period of reporting
Equity-adjusted UHC Index score	Impact (utilisation based on need)	69.68%	85%	Malawi UHC Index Report	Biennial
Equity-adjusted RMNCH Index score	Impact (utilisation based on need)	57.6%	81.4%	Malawi UHC Index Report	Biennial
Benefit-incidence ratio	(utilisation based on need)	NA		Benefit Incidence Analysis Study Report	Biennial
Percentage of households making catastrophic payments for healthcare using the 10 percent of total consumption basket spent on healthcare	Impact (financial risk protection)	4.2%	2.1%	Malawi UHC Index Report	Biennial
Proportion of households with catastrophic OOP expenditure exceeding 40 percent of non-food expenditure	Impact (financial risk protection)	1.34%	0.67%	Malawi UHC Index Report	Biennial
Medical impoverishment rate	Impact (financial risk protection)	3.75%	1.88%	Malawi UHC Index Report	Biennial
Proportion of health facilities with essential tracer medicines during annual quality assessments	Impact (quality of care)	38%	75%	Health Technical Support Services Report	Biennial
Share of public spending on medicines and medical supplies in the public health budget	Impact (quality of care)	16%	24%	National Budget	Annual
Share of public spending on wages in the public health budget	Impact (quality of care)	54%	40%	NHA; National Budget	Annual
% of facilities able to deliver full HBP based on their level	Impact (quality of care)	73%	90%	Malawi Harmonized Health Facility Assessments	5 years
Proportion of facilities able to perform basic diagnostic tests	Impact (quality of care)	47%	75%	Malawi Harmonized Health Facility Assessments	5 years
Financing for the implementation of international health regulations capacities	Impact (health security)	20%	40%	WHO Health Financing Progress Matrix (Health Systems Governance and Financing (who.int)	Annual
Per capita health expenditure (US$)	Outcome	US$39.4	US$86	NHA	Biennial
General government domestic THE as % of total government expenditure (GGHE-D/GGE)	Outcome	8.8%	15%	NHA	Annual
Government expenditure on health as percentage of THE (%)	Outcome	23.9%	40%	NHA	Biennial
OOP expenditure on health as percentage of THE (%)	Outcome	11.9%	5.95%	NHA	Biennial

Indicator	Indicator Level	Baseline/ Recent Estimates	Target 2030	Data Sources	Period of reporting
Share of voluntary health insurance in THE	Outcome	9.1%	15%	NHA	Biennial
Cost of drugs wasted due to expiry as a percentage of annual total drug cost	Outcome (efficiency)	NA	1%	Health Technical Support Services Reports	Biennial
Proportion of resources mobilised by the community as a share of total district health budgets	Outcome	NA	5%	District Health Implementation Plan (DIP)	Annual
Revenues from optional paying services as a share of total public hospital budget	Outcome		20%	Performance reports on optional paying services	Annual
Percentage of key donors (accounting for more than 90% of all donor resources) submitting annual resource mapping and expenditure data	Outcome	NA	100%	Health Financing Division Report	Annual
Share of health resources under the management of a government resource pool as a percentage of THE	Outcome	48%	72%	NHA	Biennial
Percentage of health resources harmonised towards the “one plan” (HSSP III)	Outcome	NA	95%	Resource mapping	Annual
Budget execution rates for MoH central level	Outcome	85%	100%	MoH expenditure reports	Annual
Budget execution rates of the public health budget	Outcome	88%	95%	NHA and resource mapping; budget and IFMIS reports	Annual
Budget execution rates for government-managed grants	Outcome		100%	Absorption capacity analysis	Biennial
Total expenditure on primary healthcare as a % of THE	Outcome	39.7%	60%	NHA	Annual
Number of policy briefs on the links between health financing and population growth per year	Output	0	1	HFD Report	Annual
Percentage of public health facilities formally contracted to provide HBP services	Output	0%	50%	HFD Report	Annual
Percentage of subdistrict health facilities receiving direct facility financing	Output	0%	90%	HFD Report	Annual
Percentage of total direct facility financing expenditure that are performance based	Output	0%	50%	HFD Report	Annual
Percentage of subdistrict health facilities receiving direct facility financing that submit annual performance reports	Output	0%	90%	HFD Report	Annual
Number of NHA products per two years	Output	0	3	HFD Report	Biennial
Number of resource mapping products per two years	Output	0	1	HFD Report	Biennial
Number of HSSP Operational plans produced	Output	1	1	HFD Report	Annual

ANNEX 2: TOTAL COSTS (US$) PER ACTIVITY (2023–2030)

Activity	Total Cost (US$)
Objective 1. Mobilise adequate, sustainable, and predictable funds for the health sector to deliver essential health services optimally	
Strategy 1.1. Improve efficiency across all health system functions at all levels of the healthcare delivery system	
Conduct biennial efficiency analysis across programmes to inform reallocation of resources, focusing on high-expenditure areas such as HIV/AIDS, malaria, reproductive health, expanded programme on immunization, tuberculosis, and COVID-19	485,751.52
Rationalise implementation of in-service training	547,611.30
Promote supply chain integration	9,853,256.52
Promote end-to-end tracking of medicines and medical supplies (e.g., to monitor potential expiry of medicines)	1,161,626.81
Build drug theft investigation capacity at the council level	365,500.24
Improve contract management of public health infrastructure projects	10,109.31
Establish active price monitoring mechanisms to support efficient procurement of medicines	75,202.99
Lobby for the enforcement of direct sourcing of medicines—e.g., buying as a regional bloc; this strategy is particularly important for medicines for rare diseases, such as some cancers	63,770.18
Lobby for termination of the Buy Malawi Strategy for medicines and medical equipment not manufactured in Malawi	14,565.23
Introduce flexibility in the medicines budget at the district level to purchase medicines from prime vendors when there is a stock-out at CMST	145,099.99
Introduce e-procurement mechanism at the CMST	421,510.96
Implement CMST reforms based on CMST efficiency analysis	7,414,582.25
Enforce adherence to the CIP	95,164.80
Establish a medicines manufacturing plant for medicines in high demand and use, including antiretrovirals, anti-malarial drugs, and reproductive health products; the plant could be either in-country or regional	59,699.84
Strategy 1.2. Enhance participation of communities in financing public health services	
Develop grant-making and governance capabilities for decentralised and community health oversight structures and mechanisms (e.g., HCMCs, community-led monitoring, and access to health facility information by communities)	4,645,397.89
Facilitate community-level revenue mobilisation mechanisms for health, emphasising in-kind community contributions using community-level structures; sources of funds will include individual contributions, economic activities within the community, a public works programme hypothecated tax, and a mobile money hypothecated tax (Mudzi Wathu model)	10,912,563.39
Mobilise citizen engagement for innovative financing mechanisms—e.g., citizen involvement in health funds as contributors and efficiency watchdogs	21,091,200.03
Strategy 1.3. Improve and scale up optional paying services in public facilities	
Improve infrastructure, human resources, medical equipment, and medical supply capacity for optional paying services	512,784.28
Improve the financial management and accountability of optional paying services	737,584.24
Improve stakeholder engagement in optional paying services; stakeholders include CSOs, communities, the MoF, and donors	164,369.05
Revise guidelines for optional paying services in public health facilities	1,023,021.32
Improve monitoring of optional paying services	25,599.97

Activity	Total Cost (US$)
Conduct economic evaluation of optional paying services	35,104.40
Strategy 1.4. Increase external funding to the health sector	
Devise and implement sustainability mechanisms for donor-funded interventions, emphasising the introduction of co-financing models between the government and donors	161,837.49
Introduce incentives to individuals and institutions to encourage external resource mobilisation	54,719.53
Develop capacity for proactive external resource mobilisation to meet domestic gaps	508,652.47
Strategy 1.5. Improve financing of FP using domestic resources	
Increase domestic resources for procurement of FP products and implementation of FP programmes by introducing mutually binding co-investments in FP products	1,342,872.96
Improve performance of budget execution of FP products and programmes, including through actual allocation of agreed-upon finances under the co-financing agreement	1,535,784.36
Increase research and training on the interface of health financing and population growth	1,204,932.12
Increase advocacy amongst stakeholders on FP and population growth as key health financing issues	1,452,676.31
Strategy 1.6. Introduce innovative health financing mechanisms	
Implement PPPs in health across all health system functions to achieve efficiency and mobilise additional financing	28,417,531.95
Engage financiers and the Treasury to introduce social bonds for selected health issues	375,779.39
Explore the possibility of health debt buy-downs	375,779.39
Explore hypothecated taxes on mobile money payments, alcohol, sugary drinks, tobacco, and other potential areas for “sin taxes”	170,612.38
Objective 2. Improve efficiency and equity in pooling and management of resources for the health sector	
Strategy 2.1. Reduce fragmentation of health sector funding	
Design and implement an enhanced HSJF mechanism managed by a fiduciary agent	1,033,069.67
Coordinate budget planning, allocation, execution, and evaluation between partners and the GoM at all levels, including through the HSSP operational plan	497,285.97
Develop a standard bylaw for all district councils, in collaboration with the MoLG, on enforcing the compliance of implementing partner-to-partner coordination requirements set by the district councils	2,158,598.45
Introduce sector budget support to the district health budgets	12,373,505.99
Strategy 2.2. Strengthen leadership, governance, and accountability mechanisms to ensure harmonisation of health financing decision making across all levels of the health system	
Scale up DHMT leadership and management curricula to additional districts and cadres (e.g., other council members, health centre managers, programme coordinators, community hospital managers) at the district level, including subsequent coaching and mentorship, with a focus on partner coordination	2,158,589.45
Revisit the requirements for leadership at the district level through the functional review process	834,361.51
Create a real-time aid coordination platform at central and decentralised levels of the health system	275,952.03
Strategy 2.3 Improve management and accountability of government and donor funds	
Reduce the administrative burden of the approval process by seeking efficiencies in the internal controls process	1,941.86
Decentralise management of donor funds that are under the management of the government (e.g., Global Fund, GAVI, HSJF)	668,278.44

Activity	Total Cost (US$)
Enhance capacity for fiduciary risk assessment and management	2,040,160.64
Incentivise optimal disbursements and execution of government and donor funds	36,694.95
Capacitate national and subnational levels to undertake government- and donor-funded procurements	183,877.26
Conduct periodic absorption capacity assessments	105,670.77
Objective 3. Develop and implement strategic purchasing measures across the healthcare service delivery continuum Improve efficiency and equity in pooling and management of resources for the health sector	
Objective 3.3. Develop and implement strategic purchasing measures across the healthcare service delivery continuum	
Clearly articulate the parameters involved in redefining the new HBP for primary/secondary/tertiary care; set conditions, governance structures, and timelines for revisions	60,152,751.32
Revise the essential medicines, must-have, and tracer medicines lists to align with the new HBP and disseminate it	1,812,593.80
Revise the essential equipment list to align with the new HBP and disseminate it	1,796,918.48
Disseminate, implement, and monitor implementation of the new tiered HBP	1,726,334.66
Strategy 3.2. Develop and implement effective strategic resource allocation and use measures across the healthcare delivery system	
Facilitate implementation of the district resource allocation formulae, including for donor or partner resources	375,254.10
Develop a resource allocation framework for tertiary care (central hospital resource allocation formula and reimbursement mechanism)	130,572.69
Monitor implementation of the central hospital resource allocation formula	246,356.37
Develop an intra-district resource allocation formula	103,765.49
Monitor the effectiveness of informing the devolution of budget planning, execution, and evaluation at the council level	560,551.67
Monitor the effectiveness of using the PFM system as a tool for strategic allocation and use of resources	1,479,183.47
Digitise healthcare delivery in a way that integrates and captures healthcare provision, health financing, and expenditure information	809,487.34
Strategy 3.3. Develop and implement effective provider payment mechanisms	
Decentralise the district health budget to subdistrict health facilities (provider level)	124,005,479.90
Establish a regulatory council for medical schemes to regulate tariffs, ensure ethical healthcare delivery, and adjudicate disputes between providers and payers	403,800.44
Negotiate with the Treasury to modify PFM rules to allow for a purchaser-provider split and flexibility of spending	12,088,877.51
Strengthen financial management and accounting capacity at the district council and subdistrict levels	2,409,463.02
Roll out PBF implementation mechanisms	52,863,101.44
Objective 4. Establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system	
Strategy 4.1. Strengthen institutional capacity in health financing and the PFM to implement the HFS effectively	
Develop and sustain active purchasing capacity in the HFD	3,704,375.12
Capacitate relevant government institutions to coordinate, implement, and monitor the HFS	1,131,147.71

Activity	Total Cost (US$)
Capacitate councils to implement the HFS	6,933,170.04
Develop and sustain collaboration mechanisms between key MDAs for effective implementation of the HFS	819,945.39
Develop capacity for donor and aid coordination at all levels	547,333.95
Develop and sustain TWG governance arrangements for health financing at all levels	50,176.99
Strategy 4.2. Strengthen generation and use of evidence in health financing decision making at all levels	
Develop capacities in health financing analysis and evidence use at all levels of the health system	2,744,763.32
Develop capacities of health economics and financing research institutions	4,460,647.22
Institutionalise resource tracking studies at all levels of decision making	5,868,005.98
Develop capacity in the HFD to conduct biennial UHC studies	124,269.66
Conduct a needs assessment and commission studies in key areas of health financing of the HFS	2,687,702.77
Develop the capacity of the HFD to lead in health PPPs	467,043.36
Strategy 4.3. Strengthen the advocacy capacity for the HFS	
Create a coherent framework for communicating key messages of the HFS	960,150.24
Develop and sustain the capacity of advocacy institutions; advocacy institutions for health financing are mostly CSOs and academia	3,075,475.57
Develop and sustain advocacy platforms, including the biannual CSO/MoH forum, quarterly HDG/MoH forum on health financing, forum for the Honourable Minister of Health and donors on health financing, forum for the Honourable Minister of Health and CSOs, and the MoH/academia forum on shaping the health financing agenda	844,475.57
Facilitate the resource mobilisation and communication function of the advocacy strategy for health financing	290,442.32
Strategy 4.4. Strengthen the legal, regulatory, and policy frameworks for health financing	
Introduce legislation on national health financing to aid the implementation of community and individual contributions towards health financing, enforceability of the HBP, and improved provider payment mechanisms	1,559,902.12
Introduce legislation on VHI to guide the sector and firmly establish the health sector's role in private health insurance	40,636.75
Introduce regulations on strategic health purchasing	166,221.91
Introduce the public health budget accountability forum	217,907.65
Introduce a law establishing a trust fund for health	119,606.22
Introduce regulations or policies requiring economic evaluation for new and current programmes to aid the achievement of efficiency	97,745.92
Update terms of reference for the Health Financing TWG so it can effectively carry out its mandate	-
Revise the memorandum of understanding with the private sector, including faith-based organisations, in pursuit of UHC goals and value for money	332,414.86
Introduce regulations or policies for allowing limited purchase of essential medicines from preselected prime vendors if the CMST does not have such medicines or commodities in stock	320,657.48
Reintroduce the annual health financing summit	183,712.35