Concept Note

Review of Existing Evidence on Health Reforms and Support for Decision Making in Malawi

Background

Malawi's population has grown rapidly from almost 4 million in 1966 to a projected figure of about 16.3million in 2015[1]. The country's GDP growth has been growing at an average of x% over the past 5 years but it has been insufficient to provide adequate income opportunities for the growing population, and improved standards of living. As a result, Malawi remains one of the world's poorest countries. Statistics from the World Bank[2] indicate that head count poverty prevalence using the national poverty line was at 65% in 1997, reducing to 52% in 2004 and 51% in 2010. Poverty rates are much higher using the US$1.25 a day at purchasing power parity (PPP) international poverty line, with about 72% of the population living below the poverty line in 2010. And for a country with high population density and poor infrastructure development, deprivation to social services is widespread. Despite the country registering significant gains in health outcomes, the health sector remains saddled by a number of constraints such as insufficient stocks of essential drugs, inadequate infrastructure and shortage of adequately trained health professionals.

In recent years, the Government of Malawi (GOM) has been taking bold steps including revisions to institutional arrangements and decentralisation in an attempt to improve access to social services. The government with support from development partners developed the Sector Wide Approach (SWAp) Program of Work (2004-10) to guide the implementation of interventions in the health sector followed by Malawi Health Sector Strategic Plan (2011-16). The delivery of the Essential Health Package (EHP) costed at US$44.4 per capita per annum is central to the SWAp. The EHP highlights the local burden of disease and mortality, and provides guidance in both planning and funding of health service delivery in line with the identified priorities at different levels of the health system. In essence, the EHP demonstrates Government's intention to achieve allocative efficiency and universal health coverage (UHC)[3].

In terms of health financing, total health expenditure in Malawi increased from about US$168 million in 2002 to about US$632 million in 2012[4] and is one of the factors that has contributed to improved health outcomes[5]. However, the 2013 National Health Accounts (NHA) show that the country's total health expenditure averages US$37.8 per capita per annum (2009-2012) which is far below the World Health Organization (WHO) estimate for a basic package of cost-effective interventions of US$54 per capita per annum in low income countries such as Malawi. The country's total health expenditure is also below the

[1] National Statistical Office (NSO). 2010. Analytical Report: Volume 7, Population Projections (Zomba, Malawi: NSO, 2010)
[2] http://data.worldbank.org/country/malawi visited 22/04/15
[3] GoM. 2011. Malawi Health Sector Strategic Plan 2011 – 2016: Moving towards equity and quality
[4] Ministry of Health, 2014. Malawi National Heath Accounts with subaccounts for HIV/AIDS, Malaria, Reproductive Health, and Child Health for Financial Years 2009/10, 2010/11, and 2011/12. Ministry of Health, Department of Planning and Policy Development, Lilongwe, Malawi.
[5] DFID, SWAp phase 1 evaluation report

US$44.4 per capita per annum required to implement the EHP[6]. Furthermore, expenditure from the Government (average of US$7.6 per capita per annum declined by 13.4% between 2009 and 2012 while donor funding increased by an average of 6.5% per year over the same period.

Donor funding at 68%[7] of the total health expenditure accounts for the largest share of spending, rendering health financing unsustainable and vulnerable to external factors. For example, following allegations of financial irregularities, which were unearthed in 2013 (also known as the cashgate scandal), several donors contributing to the health sector suspended their sector budget support (SBS) and tried to channel their support through alternate means. While suspension of funding has caused uncertainty and liquidity problems, the actual effect on total health spending requires further assessment. And considering that measures to tighten fiduciary control systems and to regain donor confidence takes time, Malawi's health programme could be at risk if alternative measures to mobilize domestic resources to fill the funding gap are not urgently implemented. However, health financing in Malawi has been problematic and even prior to the cashgate scandal it had been recommended that Malawi needed to identify and implement alternative financing mechanisms for resource mobilization, allocation, and management (MoH, 2013 NHA).

It is against this background that the GOM intends to reform the financing and organization of the health sector. The main objective of the reform agenda is to increase access to quality services through increased equitable financing and service availability. The process consists of four reforms related to health financing as follows: (1) Establishing a health insurance scheme; (2) Creating a Health Fund; (3) Reviewing the public-private partnership between the GOM and the Christian Health Association of Malawi (CHAM); and (4) Undertaking three (3) interrelated health reforms focusing on the decentralization of health services at district level reforming central hospitals.[8]

The proposed reforms are based on the solidarity principle whereby every citizen pays according to his/her ability to pay and not according to need. Work has been going on since XXXX, including a process to formulate a Health Financing Strategy. The health financing reform options were identified and evaluated in May 2013[9] and a draft Strategy developed in May 2014[10]. In July 2014, the GOM hosted a Health Financing Summit attended by the President of Malawi, A. P. Mutharika, and the Minister for Health, J. Kalilani. Their party, the DPP, had campaigned the May 2014 election with a plan to introduce health insurance in Malawi.[11] A performance contract between the Malawian President and the Minister for Health has also been agreed and was publicized in March 2015.

Rationale of this Review

Taking into account previous works and political commitment, the GOM has continued to develop its thinking on the proposed health reforms by establishing expert panels and commissioning studies on the

[6] Ministry of Health, 2014. Malawi National Heath Accounts with subaccounts for HIV/AIDS, Malaria, Reproductive Health, and Child Health for Financial Years 2009/10, 2010/11, and 2011/12. Ministry of Health, Department of Planning and Policy Development, Lilongwe, Malawi.

[7] WHO - Global Health Expenditure Database, Malawi 2013

[8] https://www.facebook.com/malawimoh/posts/791177664271084

[9] Ministry of Health, 2013. Malawi Health Financing Strategy: Technical Evaluation of Options. Ministry of Health, Department of Planning and Policy Development, Lilongwe, Malawi.

[10] Ministry of Health, 2014. Malawi Health Financing Strategy – Draft 3, May 2014. Ministry of Health, Department of Planning and Policy Development, Lilongwe, Malawi.

[11] http://news.dppmalawi.com/wp-content/uploads/2014/04/DPP-Manifesto-2014-Final.pdf, p.10 & 35

four reform areas. The MOH is now looking to build on these studies to generate the necessary evidence for informed decision making. The rationale behind this review is to assist the GOM in reviewing the quality of the existing evidence/reports including assessment of gaps in evidence, data interpretation, and contextualization of findings to Malawi. Based on this review, viable options would then be identified to guide specific activities and deliverables that would be carried out by June 2016. For example, this work will help to select feasible options for health financing reform in order to update and finalize the draft Health Financing Strategy, and to define implementation modalities. While the entry point and common thread for reviewing the reform areas is Health Financing, the conceptual framework guiding the review and support activities under the four work packages shall be Universal Health Coverage (UHC).

Coordinated under the umbrella of the P4H Network[12] and based on the priorities of the GOM,[13] this concept note serves as a joint support plan outlining the objectives and resource requirements for technical assistance, as well as the roles, responsibilities and contributions of partners. This includes the World Bank Group, the World Health Organization (WHO), UNICEF, UNAIDS, GIZ, USAID, and others.

Purpose

The main objective of the proposed analysis is to support the GOM in making decisions on four (4) areas of health reforms, particularly on health financing, by reviewing existing evidence. This will include the potential role of health insurance, earmarked tax financing, user fees, institutional re-organization, and efficiency potentials. The specific objectives are:

1. Advocacy and joint support to the government in engaging in an inclusive and consultative process;
2. Assessing the financial and technical feasibility of the various health reforms currently under discussion. This includes a review of how each reform option will contribute to health financing, systems strengthening (including decentralization), social protection, and national development goals;
3. Provide guidance on how best to implement each reform option; and
4. Assistance in the development of an implementation plan, and strengthening implementation capacity.

It is critical that the choice of reform option(s) and/or a combination of options sustains the gains that the country has made towards the MDG goals and Malawi's medium term development plans as spelt put in the Malawi Growth and Development Strategy (MGDS) II. The selected option(s) would need to balance the need to ensure universal health coverage, equitable distribution of quality health care infrastructure and human resources and to protect individuals seeking care against detrimental healthcare expenditure especially among the poor.

Methodology and Scope of Work

Using the existing studies in Malawi, all the four (4) priority reform areas will be reviewed. This is summarized in Table 1. Each of the work packages will be analyzed separately through a comprehensive desk review and secondary analysis of existing reports. The reviews will be done systematically by

[12] Providing for Health (P4H) is a global network of multi-/bilateral development partners (WHO, WBG, ILO, GIZ, KfW, USAID, etc.) supporting countries on their path towards UHC/SHP with a focus on health financing reform.
[13] See minutes of meeting between MoH and DPs on 31 July 2015

looking at the policy objectives, evidence, and recommendations. All partners working in the health sector in Malawi will be given a chance to review existing papers on all the four (4) reform areas. However, based on a partners' area of expertise or comparative advantage, one or two partners will be identified to lead each reform area as outlined in Table 1. The key areas of focus under each reform area will be: (i) data sources, (ii) quality of data, (iii) methodological approach, and (iv) whether Malawi's country context would accommodate the proposed reforms in the short to medium term. Triangulating evidence from regional and international studies will also be used to gather best practices that will help to inform the review and recommendations.

On the other hand, the review will also provide guidance on how best to implement the various options as well as how to strengthen implementation capacity. There will also be emphasis on the development of an implementation plan. Such an implementation plan will add value beyond the analyses by outlining the implementation steps in moving forward with further analysis to address any identified gaps.

Duration

The assignments are expected to be completed by June 2016.

Table 1: Work Packages and Scope of Work

Work Package (GOM / DP lead)	**Review process / key activities**	**Resources needed / contributions**	**Roles and responsibilities of partners and core team**	**Timeline**
1. National Health Insurance (.../GIZ [Kai Straehler-Pohl])	**5-steps** 1. Define scenarios for assessment incl. important parameters influencing institutional design and processes (and with this: costs) of reform options.	staff time	GIZ and USAID (SSDI)	01- 30 Sep 15
	2. Conduct a financial feasibility analysis of each reform scenario (income-expenditure analysis) 2.1. Potential revenue assessment 2.2. Health Insurance / purchaser design & cost estimate 2.3. Review EHP 2.4. Define Insurance Benefit Package & Actuarial assessment NB: 2.4 only if 2.1&2.2 indicate financial feasibility	2.1&2.2: ~EUR60-80k 2.3: ??? 2.4: ~EUR50-60k	GIZ (primary responsible; funding & contracting of experts); SSDI? (local expert knowledge; staff time?) WHO primary responsible? who to support? GIZ (primary responsible; funding); / SSDI? (local expert knowledge; staff time?) / ILO? (actuarial expert?)	1 Oct – 31 Jan 15 1 Oct – 31 Jan 15 1 Feb – 31 May 16
	3. Assess implementation capacities and review experiences of comparator countries in building up the capacities	~EUR20-25k	GIZ (primary responsible; funding; contracting); / SSDI? (local expert knowledge; staff time?)	1 Feb – 31 Mar 16
	4. Health systems, decentralization and national development objective check by expert review	staff time	Suggestion: MOH & WHO to lead process, supported by P4H Coordination Desk; contributors: World Bank / USAID / GIZ / Unicef / Oxfam? / others?	1-30 Jun 16
	5. Political feasibility check 5.1. Stakeholder analysis Collect detailed stakeholder responses to selected scenarios in order to assess political feasibility 5.2. Develop Communication Strategy based on Stakeholder Analysis	5.1 ~EUR15-20k 5.2 ~EUR 15-20k	5.1&5.2 GIZ (primary responsible; contracting, funding); SSDI (local expert knowledge; staff time?); Unicef?	1 Jul – 31 Aug 16
2. Health Fund	Review the existing body of work on the creation of a Health Fund to ascertain the quality of work and any gaps in the existing evidence. i. Establish whether the overall and specific		WBG (lead), UNAIDS (co-lead)	

	objectives of the Fund will be met in the short to long term: a. Mobilizing additional revenue for the health sector; b. Funding critical inputs aimed at improving quality health care; c. Equalizing fund to support the District Health System; and d. Increasing efficiency in resource mobilization and use. ii. Establish whether the Fund will be adequately ring-fenced vis-à-vis other Government priorities; iii. Critically analyse the revenue generation potential and break-even point (level of revenue, tax percentage (low to high case scenarios), time horizon, and adverse effect for the eleven (11) proposed sources of ear-marked taxes; iv. Review all the four (4) proposed methods for collecting revenue for the Health Fund; v. Review the appropriateness of setting up a Statutory Corporation with a separate Board of Directors and CEO to manage the Health Fund as compared to the other two options which were originally proposed by the Expert Panel i.e. Trust Fund and Treasury Fund; and vi. Review the financial sustainability of the Fund over a twenty (20) year period by comparing the cost of administering the Fund to the revenues collected, and to the overall financing landscapes i.e. external and domestic support, GDP growth etc.			
3. Decentralization and Central Hospital reform	Review existing evidence on the three (3) interrelated health reforms focusing on: (i) Decentralization of health services; (ii) Delinking non-core hospital		WHO (lead)	

	services; and (iii) Central hospital autonomy. Reviewers will also look at how the three (3) pieces link up to the over health reform agenda. i. Cost efficiency is the primary reason for out-sourcing/delinking non-core hospital services from district and central hospitals in Malawi. Thus, this sub-section will critically analyse the overall and specific objectives of this reform by: a. Assessing each non-core hospital service that has been earmarked for delinkage by looking at the inclusion criteria; b. Analysing the economic and social environment for the targeted hospitals, volume of patients and general economic status of the patients, proposed prices and market potential; c. Review how delinking non-core hospital services will bring about cost reduction, reduced thefts and overall risks, efficiency, and promote public-private partnerships in reference to national, regional and global experiences; d. Review the adequacy of the existing legal framework and institutional arrangements for outsourcing, through a desk review of practical experiences from some of the central hospitals which have already out-sourced non-core hospitals services such as cleaning, security and laundry; and e. Pursuant to the above, review the preparedness of the GOM and the health sector as a whole in delinking hospital services particularly if the required resources are present, linkages to the Essential Health Package, and risks associated with management and financial probity. ii. Review the extent to which the MOH has			

	articulated and planned for the devolution of hospital services to District Assemblies (DAs) as part of the Government-wide Decentralization process. a. Assess how the health sector decentralization plan seeks to address power relations between the DA, district level health managers, and the communities. This shall include a review of the time horizon, transitioning arrangements and long term management responsibilities, resource allocation and funds flow, and how health services will be delivered; b. Assess whether indeed the decentralization implementation plan is articulated in a manner that can increase community participation, create efficiency, promote equity in resource allocation and use, and provide opportunities to address social determinants of health in a multi-sectoral manner. iii. Assess how the objective of improving efficiency, equity and quality of services offered at Central Hospitals by establishing Public Hospital Boards for Central Hospitals will be realised. a. Explore the extent to which the evidence supports the notion that Hospital Boards will fill the gap that will be created when the MOH ceases to be involved in the delivery of tertiary level hospital services. This shall include a review of the time horizon, transitioning arrangements and long term management responsibilities, resource allocation and funds flow, and how health services will be delivered;			

	b. Review the evidence that was used to conclude that pushing primary and secondary level care out of Central Hospitals will strengthening the referral system, improve quality and equity of access to specialist care, and teaching and research environment. c. Based on the country context and best practices worldwide, review the three (3) options that were considered on the best way of managing central hospitals (independent management of central hospitals, maintaining the status quo, and turning the central hospitals into teaching hospitals).			
4. Partnership with CHAM	Review existing evidence on the proposed revision of the public-private partnership with the Christian Health Association of Malawi (CHAM). Areas of focus will be on the cost implications and impact on service delivery, and equity of access.		UNICEF and DFID (lead)	