Efficiency Savings for UHC: Decentralizing the Health System

Ministry of Health
Health Reform Stakeholder Forum
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Introduction

- Malawi's Health Sector remains grossly underfunded;
- Various studies have demonstrated substantial leakages and inefficiencies in the health sector;
- Tackling inefficiencies and eliminating leakage of public health sector resources remains the single most important way of improving progress towards UHC and achieving/sustaining better progress in health outcomes;
- Reforms under the Decentralization area focusing on improving the organization of the Health System, Improving the regulation, payment, and behaviours of the actors in the health sector
- The overall goal is to improve efficiency, quality and access to health services, thereby improving health outcomes, client satisfaction, and risk protection

Reform Area 1: Full Decentralization of the District Health System

- Decentralization policy approved in 1999;
  - MoH has moved faster than rest of GoM;
  - ORT Budget fully devolved to DAs;
  - PE Budget yet to be devolved
- Decentralization if not properly implemented, can result in decentralization of theft in ways that are complex to identify and address;
- Challenges with the Current Decentralization
  - Slow devolution of budgets by other sectors;
  - Inadequate ring-fencing of health sector budget;
  - Lack of clarity on the roles of different structures of the decentralized DHS;
  - Weak emphasis on prevention services

Reform Proposals

- Upgrade community structures of the District Assembly into Health Boards with oversight responsibility over the health status and health care within their communities;
- Fill the post of Director of Health and Social Services at the District Assembly to strengthen coordination of the DHS;
- Develop and implement separate resource allocation formula for EHP service provision at primary and secondary level to efficiently and equitably allocate resources based on community needs and expected volume of services;
- Create separate cost centres for secondary and primary health care facilities;
- Create separate cost centres for City and District Councils in districts with Cities.

Reform Area 2; Central Hospital Autonomy

- Background
  - Decentralisation Policy requires MOH to specialise in formulation of policy, setting standards and providing oversight;
  - Currently MOH manages CH's directly;
  - CH's mandate to provide tertiary level but largely provide primary and secondary level care;
  - CH's also used for teaching by Health Training Institutions;
  - CH's cover more than one District;
  - Budget allocations to Central Hospitals largely historical with no relationship to volume of service;

Previous Autonomy Reform

- Previous attempts to implement Central Hospital reform culminated into the development of a draft Hospital Autonomy Bill which was not approved by Cabinet because:
  - The proposal was confused with the then on-going and largely unpopular privatization of public assets;
  - There was no clear guidance on what would become of staff working in the Central Hospitals in the event the reform was implemented;
  - District Hospitals were yet to be constructed in Cities of LL and BT, and;
  - Gateway clinics providing primary health care, were not in place, and urban primary health services were yet to be strengthened to accommodate the service gap to be created.

Proposed CH Reform

- Aims to improve efficiency of CHs by making them concentrate on their core competence which is provision of tertiary services;
- Aims to make CHs accountable to the Citizenry
- Proposes establishment of Central Hospital Boards (CHB)/Public Trusts
  - CH management to be answering to Board
  - Decentralised decision making likely to increase managerial efficiency and monitoring;
  - Board members to comprise members from the General public;
  - Under the reform, CHBs will be mandated to ensure CH focus on provision of Tertiary Care;
  - Establishment of Gateway Clinics will be the responsibility of City Councils

Delinking of Non-Core Services

- Overall objective of the reform is to improve efficiency of CHs;
- Premised on assumptions
  - Private sector has clear competencies with production processes in some services that are not core to the Health Sector;
  - There are adequate competitors in each of the proposed areas for outsourcing;
  - CH managers will be able concentrate on provision of services within their competencies

Proposed Areas for Outsourcing

- Catering
- Laundry;
- Hospital cleaning
- Mortuary
- Estate and Facilities management
- Landscaping
- Security
- Pharmacy
- Pottering
- Revenue Collection
- Administration, Accounts/Financial Management;
- Information and technology
- Accounts
- Ambulance

Cross-Cutting HSS initiatives

- Tackling wastage and pilferage of Public Health Sector Resources remains main strategy for tackling inefficiencies; e.g.
- Evidence on inefficiencies
  - Overall efficiency (OPTIONS);
  - Study ORT utilization (SSDI)
  - Drug Leakage Study (CHAI)
- Ministry following up on recommendations
  - SH, SLG, ED CMS, ED NLGFC have been on District meetings with Chairpersons of DAs, DCs, DHOs, Head of Police, Head of Judiciary
- Minister has directed setting up a Drug Theft Investigation Unit within the Internal Audit Department
  - Criminal Investigator, legal practitioner, and SCM Specialist

Thank you for listening.
Questions?