Overview of Malawi Health Reforms and Progress To-date

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MINISTRY OF HEALTH
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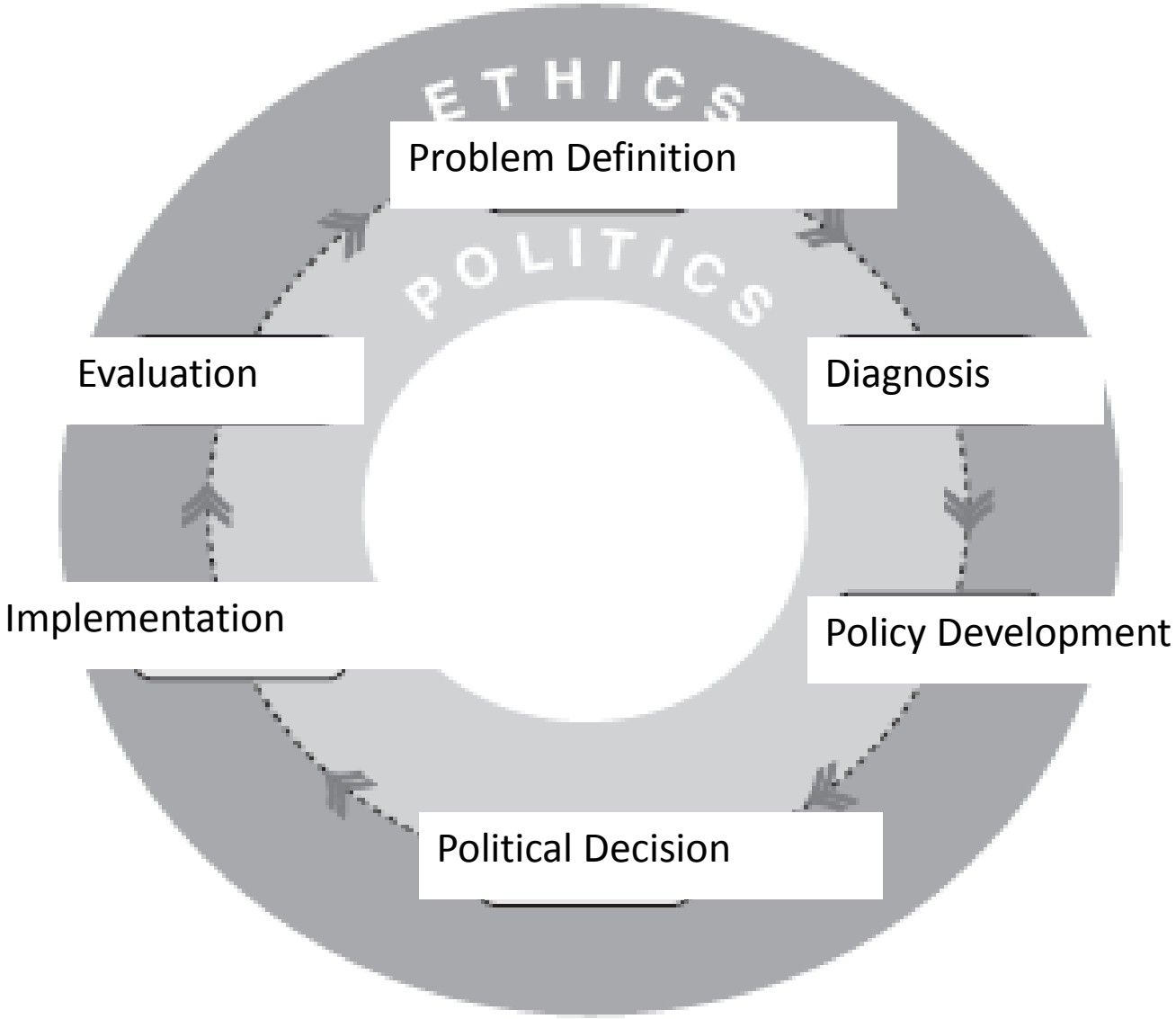
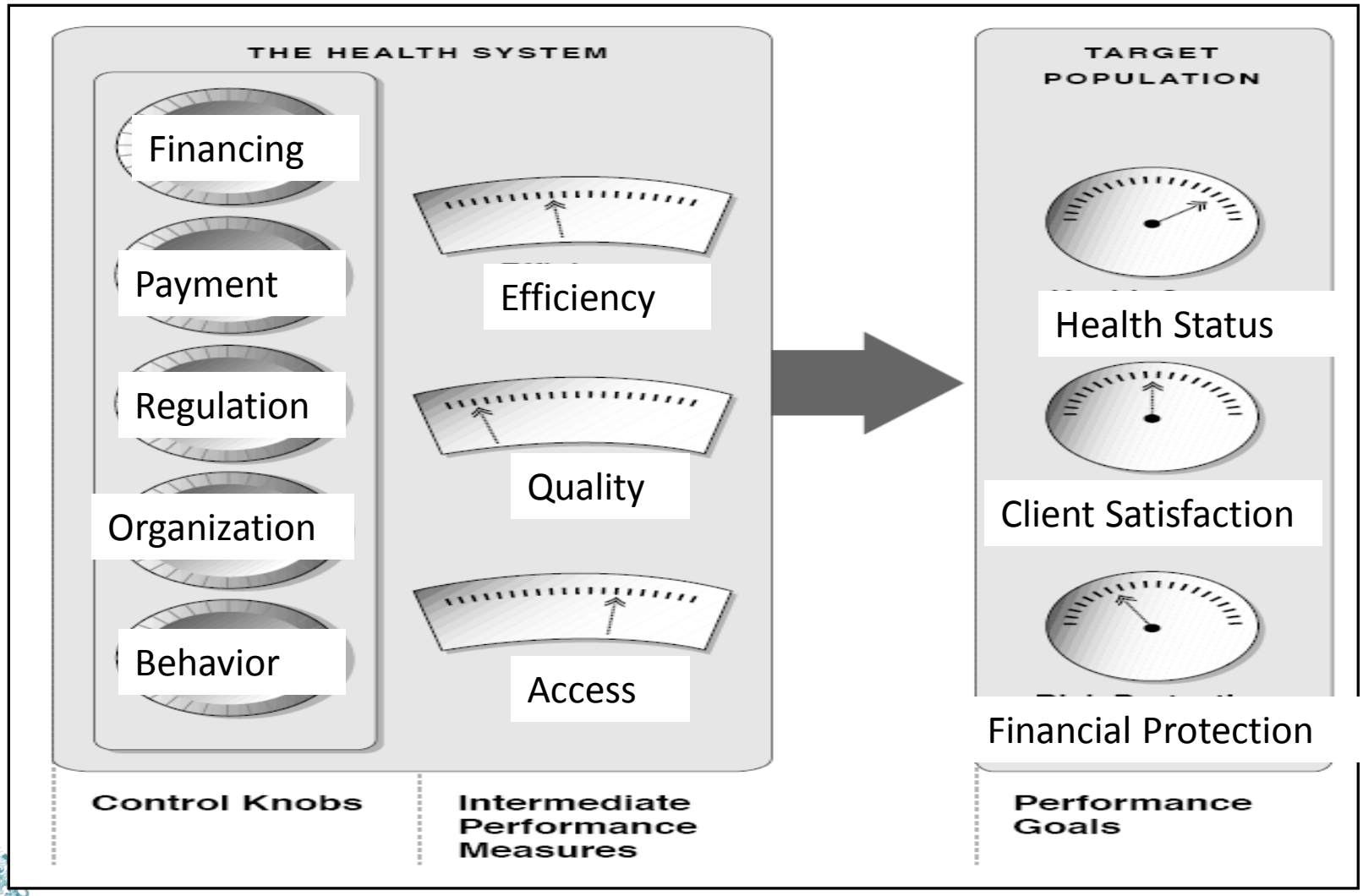
INTRODUCTION

- Reform programme signed in Feb 2015;
- Overall **Goal** of the reform is to improve health status, financial risk protection, and public satisfaction with the country's health system;
- Two Official Signatories in the MOH with HE, and SH with Chief Secretary to Cabinet;
- The objective is to achieve universal coverage of essential health services through
  - improving access to essential health services;
  - Improving efficiency of the health system; and
  - Improving quality of health care

The Policy Cycle



Reform Model and Focus Areas



Challenges

- Health outcomes have improved since 2000 but still amongst the worst in the world;
- Low client satisfaction levels;
- Inadequate Financial Risk protection;
- Intermediate Causes of poor performance:
  - Inadequate access (SPA 2014);
  - Poor quality (JICA, EGPAF, EPOS, MOH); and
  - Inefficiencies (Carlson et al)
- Root Causes:
  - low financing;
  - weak provider payment mechanisms;
  - poor organization;
  - weak regulation; and
  - poor behaviors (client, provider and household)

INITIAL CONTRACT REFORM AREAS

- **The revision of the partnership agreement between the Ministry of Health and Christian Health Association of Malawi (CHAM)** to improve access to and equity of essential health services in areas with no public health facilities and thereby contribute to the Government's goal of moving towards Universal Health Coverage (UHC);

- **Reforming Central Hospital operations and the District Health System** to improve efficiency, quality, and access to primary, secondary and tertiary health services;

- **Proposal to establish a Health Fund** to mobilise additional revenue for the public health sector to finance the UHC initiative; and

- Exploring the establishment of a **National Health Insurance Scheme** to mobilise additional domestic resources for the health sector to finance the UHC goal of the Malawi Government.

New MOU with CHAM

- Goal of the reform is to improve access to CHAM catchment populations through removal of user fees paid by poor clients;
- Reform will reduce out-of-pocket payments made by poor clients, hence increase financial risk protection;
- Reform will also improve equity in health care access
- MOH and CHAM have been implementing SLAs since 2004, but these have been limited in terms of coverage;
- There is no clear guidance on the allocation of Service Level Agreements across CHAM facilities.
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PROGRESS ON MOH-CHAM REFORM

1. Guidelines on SLAs have been updated to reflect the revised MOU;
2. New price list has been developed and endorsed;
3. A list of approved CHAM facilities for salary grant and SLAs has been developed and endorsed;
4. A resource allocation framework has been developed and endorsed;
5. DPPD has developed proposed annual budgets for each SLA based on 3;
6. A mechanism for paying providers has been endorsed;
7. A verifier for SLA payments has been hired by OPTIONS and overseeing payments under HSJF;
8. A Cost Benefit Analysis is underway with support from Palladium

Decentralisation Reforms

Enhancing efficiency through stronger accountability and transparency mechanisms

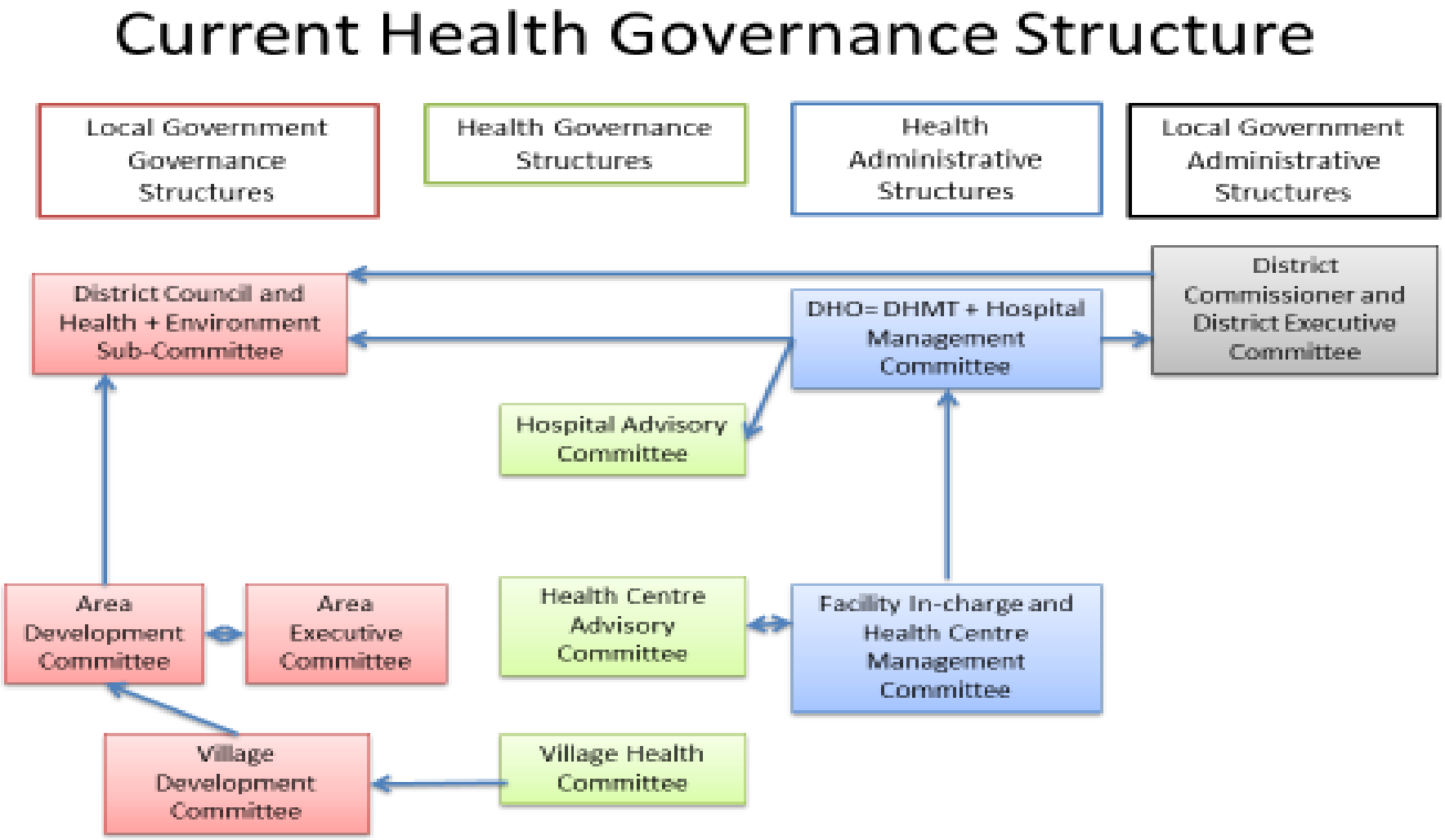
Decentralisation

- Key public sector reform agenda
- Introduced to improve the efficiency and effectiveness of service delivery
- Decentralisation Policy and Local Government Act of 1998 provide the policy and legal framework for decentralisation by devolution
- Hypothesis – Partial decentralization can lead to complex inefficiencies than those trying to solve
- Solution: full decentralization of health services, with communities at the core of the oversight of the health system

District Health System Challenges

- Weak health financing
- Poor financial management
- Weak accountability mechanisms including:
  - Weak performance management
  - Inconsistent supervision
  - Lack of coherent mechanisms for rewarding good practice and sanctioning bad practice
  - The dominance of informal rewards and sanctions controlling incentives in the health system
- Poor provider attitudes towards clients
- A 'closed' health which inhibits participation
- Weak participation in health matters inhibiting a sense of ownership of health facilities and that access to quality health services is a right for all
- Poor household behaviours/attitudes
- Weaknesses of citizen led accountability structures
- Limited understanding of and engagement in health system functions, resource availability

Current Structure at District level



Challenges with Current Structure

- No direct link between the community voice and facility management
- Health facility staff are only accountable to superior public service officials
- Role of District Councillors are not articulated in the current set-up
- No feedback loop from the Community to the District Council and back to the Community
- Reduces the power of communities as agents of health sector development, accountability and transparency
- Does not place health promotion/preventive health within the responsibility of households

KEY PROPOSED REFORM TO THE DISTRICT HEALTH SYSTEM

- Elevate the status of all Advisory Committees' at the Hospital and Health Centre to elected Governance Boards with some level of statutory authority of how health services (curative, preventive and promotive) are being delivered;
- Decentralise approved health budget to Facility Boards by ring-fencing funding to each facility;
- Decentralize Human Resources to facility boards;
- Implement performance based contracts with Facility Boards with greater emphasis on preventive and promotive aspects of health and enhanced community participation and engagement in the health system;
- Align with local government governance structures from the village to the District Council level

Central Hospital Autonomy

Background to CH Autonomy

- Current Status: Devolved ORT but not Capital Budget, HR still managed by MOH HQ;
- CHs not covered under Decentralization;
- Proposal: Establish Central Hospital; Boards as Public Trusts.

Current progress on CH Autonomy

- Concept Paper on Hospital Autonomy;
- Stakeholder Analysis
  - Solicit opinions of various stakeholders on proposed Central Hospital Autonomy Reform
  - Identify strengths of the support or opposition for each of the potential options
  - Use findings to draw appropriate recommendations

Stakeholder analysis

Main findings of the Stakeholder Analysis

- 92% support Central Hospital Autonomy
- 80% prefer Central Hospital Trust
- >95% support key aspects of autonomy such as full control of financial and human resources
- 21% did not support the Boards to determine the type of services and fee structure

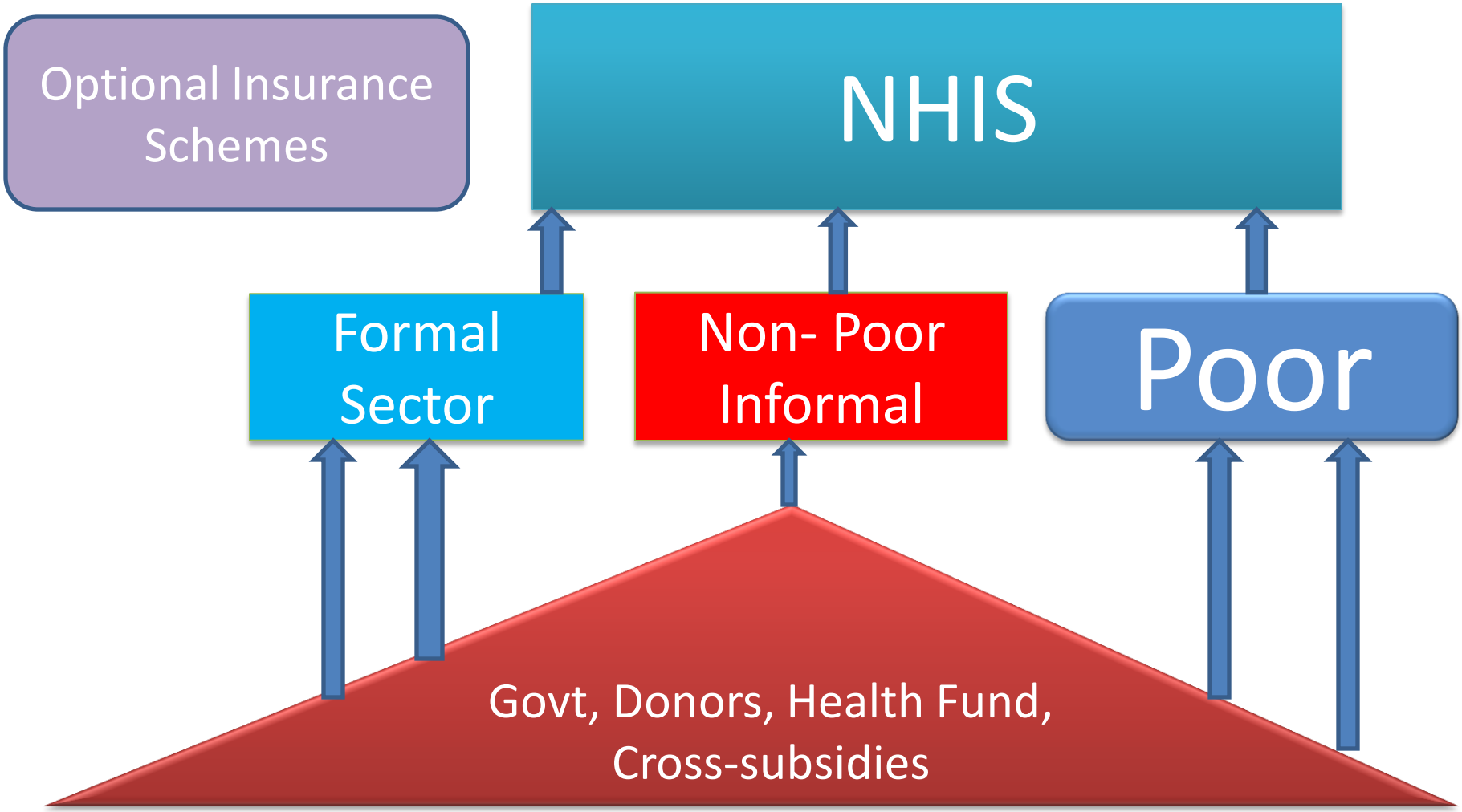
Progress on CH Autonomy

- Cabinet paper presented by Minister early August, good idea and well received;
- MOH has drafted a paper on the operational modalities of a central hospital trust
  - HR management
  - Financial management
  - Relationship with MOH, CMST, etc.
  - Criteria for appointing Boards of Trustees
  - Financial implications of the Boards

HEALTH INSURANCE REFORM

- Goal is to mobilize additional revenue for UHC;
- Malawi's Health Care System is modeled on the principal of solidarity whereby every Malawian contributes to health care financing based on their ability to pay but uses health care based on medical need;
- Current system does not sufficiently provide the non-poor Malawians in informal sector the opportunity to contribute to health financing;
- Under the proposed NHIS formal and non-poor informal sectors will contribute;
- The poor, as defined by Government, will have their NHI contributions covered by Govt;
- The proposal is to have the beneficiaries identified using the National Identification System, and the poor identified through a UBR under social protection.

UHC Framework with NHI



National ID System; Unified Beneficiary Registry

NHIS - PROGRESS

- Concept Paper endorsed by Expert Panel;
- GIZ providing technical assistance under P4H;
- Consultant hired to undertake detailed designs and cost-benefit analyses;
- Consultants undertook initial stakeholder consultations from 7th - 17th June 2016;
- Consultants have produced an inception report;
- Key stakeholders have been consulted individually;
- Final report was expected ready by mid Sept 2016.

NEW REFORM AREAS

- Additional Reform Areas to improve quality of care and efficiency
  - **Total Quality Management Reforms** to improve quality of services in the public health sector
    - Establishment of the QMU
    - Draft QM Policy and Matrix for Strategy produced
    - Delivery mechanisms for quality being established
  - **Procurement and Supply Chain Management Reforms** including the establishment of the Drug Theft Investigation to make medicines available especially for the poor

REFORM AREAS IN THE REFORM FRAMEWORK

- **Health Financing reforms**
  - Health Fund; NHIS; Efficiency Savings
- **Payment Reforms**
  - Performance based financing (SLAs); Ring fencing Budgets for each health facility
- **Organizational Reforms**
  - CHAM MOU; Decentralization of the DHS; Central Hospital Autonomy
  - Establishing of cost centres at each health facility
- **Regulatory Reforms**
  - Establishment of Quality Management Unit
  - Re-enforcement of sanctions and rewards on quality
- **Behavior Reforms**
  - Drug Theft Investigation
  - Strengthened citizen reporting

Conclusions

- Malawi is at a stage where business as usual is no longer an option;
- Health Sector over-reliant on donor funding but no simple solution;
- Need for sustainably and efficiently increasing domestic financing for the health sector: these will require hard decision from all Malawians, and support from Parliament; and;
- BUT; in the short term, financing gaps will be reduced largely through tackling inefficiencies and pilferage;
- In the longer term, Malawi needs to create adequate fiscal space through sustained real growth of the economy.