Budget Brief
Health
**KEY MESSAGES AND RECOMMENDATIONS**

**Allocation to the health sector increased in nominal terms by 24%**

From 2014/15 revised estimates of MK69 billion to about MK86 billion in the 2015/16 approved budget. More than half of the health budget allocation is off-budget, bringing the estimated allocation to the sector to MK131.95 billion.

*All aid should be recorded on budget in order to continue to strengthen the public finance management system.*

**The share of health sector expenditure declined from 12% in 2012/13 to 9.2% in the 2015/16 national budget.**

About the same resources in real terms are available to the health sector in 2015/16 compared with 2014/15.

*There is a need to ensure that allocations to the health sector do not decrease in real terms in order to address prevalent challenges in the sector.*

**On-budget per capita expenditure allocation is MK5,432 (US$12.17) in 2015/16.**

With an estimated MK45.95 billion off budget, the per capita expenditure is about MK8,342 (US$18.69). This is far below the US$33.4 per capita required to achieve the goals set out in the Essential Health Package (EHP).

*There is a need to accelerate efforts to identify alternative health financing to ensure EHP (and successor) objectives are adequately financed.*

**The 2015/16 budget allocation to the health sector gives most weight to curative health services**

which account for 36% compared to the 17% allocated to preventive health services.

**There is need to increase the share of preventive/promotive health services in order to reduce the medium to long-term burden on the curative health services.**

**In the 2015/2016 health budget allocation, 83% is allocated for recurrent expenditures while only 17% is allocated for capital expenditures. While the share of capital expenditure allocation has steadily increased from 8% in 2012/13 to 17% in 2015/16, these are still not enough to meet capital investment needs of the health sector.**

*The government should consider committing more resources to capital expenditure allocation in order to provide for upgrading of referral hospitals and also on procurement of medical supplies and equipments which are currently in archaic state.*

**Allocations to districts do not reflect a needs-based prioritisation, resulting in lower allocations to the most deserving districts.**

Mangochi (MK360.46) and Mbelwa (MK401.26) have the lowest per capita allocation and have poor health outcomes (under-five mortality rate of 97 and 108 deaths per 1,000 live births respectively, compared to the national rate of 85).

*Heath sector resource allocations per district should be responsive to each district’s health profile, particularly the need to provide health services where they are most needed while sustaining services already being provided. There is a need to review and consider the district allocation formula proposed by the National Local Government Finance Committee, which reflects district-specific health indicators.*
1. How is the Health sector defined?

The health sector is one of seven priority areas in the current Malawi Growth and Development Strategy (MGDS II). The sector is guided by the Health Sector Strategic Plan (HSSP), running from 2011 to 2016. The HSSP aims at improving the health status of the people of Malawi by addressing the burden of disease with curative services, while also emphasising public health interventions such as health promotion, disease prevention and increasing community participation. The Essential Health Package (EHP) is at the core of the HSSP in delivering cost-effective health services to the poor and under-served populations of Malawi.

The health sector budget is programmed through four channels or budget votes, namely: i) Ministry of Health (MoH), ii) National AIDS & Nutrition Department, iii) district councils, iv) subvented organisations (health regulatory bodies). As from the 2015/16 fiscal year¹, the National AIDS & Nutrition Department vote has no separate allocation; the funds are now channelled through the Ministry of Health budget vote.

---

¹ July to June
The resource flow in the health sector is partially decentralized. Although the Ministry of Health is accountable for the health sector funding, cost centers like referral hospitals, Christian Health Association of Malawi (CHAM) facilities and the Health Service Commission get their funding directly from the Ministry of Finance. Non-salary recurrent expenditure for primary health centers is distributed through the district councils, while salaries are paid directly from the Ministry of Finance.

In 2015/16, the health sector was allocated a total of MK85.86 billion, about 9% of the national budget of MK930 billion. About 95% of the health sector allocation is programmed through the Ministry of Health, 5% through district councils and a very small percentage to the health regulatory bodies. The allocation of 9% to the sector is well below the Abuja\(^2\) target of 15% share of national budget to the health sector.

The health sector receives off-budget support from development partners of about MK45.95 billion in 2015/16. The on-budget expenditure amounts to about MK5,432 (US$12.17\(^3\)) per capita. Adding the off-budget support, the estimated per capita amount is about MK8,342 (US$18.69), still far below the US$33.4 per capita required to achieve the goals set out in the EHP.

---

**2. What trends emerge from the Health sector budget?**

Budget trends reflect government priorities over time. This trend analysis looks at the period from 2012/13 within the current MGDS (MGDS II, 2011-2016). 2011/12 is excluded because of a major devaluation of the Kwacha during that financial year.

Overall, the health sector on-budget allocation increased in nominal terms by 24% from the 2014/15 revised estimates of MK69 billion, to about MK86 billion in the 2015/16 approved budget. The increase from the 2014/15 budget is similar to the average inflation rate of 22% experienced during the 2014/15 fiscal year. Thus, roughly the same resources in real terms are available to the health sector in 2015/16 compared to the previous year. Figure 1 summarizes the approved allocations within the health sector over the past four years.

---

\(^2\) Malawi is party to the Abuja Declaration (2001) that calls for African governments to assign at least 15% of their budget allocation to the health sector.

\(^3\) Using July 2015 official exchange rate of 446.334MK/1US$. Source: RBM
While resources increased in nominal terms, the share of health expenditure in the total national budget declined from 12% in 2012/13 to 9.2% in 2015/16 budget. Malawi surpassed the Abuja target of 15% in 2007/8 (16.6%), 2009/10 (15.1%) and 2010/11 (15.8%). Since then the expenditure share to health has been decreasing; however, 2015/16 shows a marginal increase from a low of 8.7% in 2014/15. Figure 2 shows that the nominal growth in the health budget has not kept pace with the nominal growth in the overall budget. The trend for the approved allocation in the national budget is steeper (black line) compared to the trend in the health budget, which is relatively flat (red line). While the overall budget has grown in nominal terms by over 128% between 2012/13 and 2015/16 budget allocations, the health sector budget has only grown by 76%. The budget for Nutrition, HIV/AIDS and National AIDS Commission were removed from the 2015/16 national budget because its resources in 2015/16 were programmed through the Ministry of Health. Prior to the 2015/16 budget Nutrition, HIV/AIDS and National Aids Commission received resources through a separate vote.
3. How are Health sector resources spent?

The balance between capital and recurrent expenditure is a key consideration in budget formulation. This means that a delicate balance between capital, operational and labour inputs has to be achieved to ensure that the MDAs do deliver on their mandates. Underspending in development can impair the operational activities and outputs, because it results in technologically inappropriate facilities or equipment. Conversely, there may be large, newly equipped hospitals, with adequate maintenance and utilities funding, but with few qualified doctors and nurses, or with many health cadres lacking in skills. Imbalances may also develop within recurrent expenditures; health workers may be sufficient in terms of numbers, but they may lack the materials and drugs needed to deliver the health services. Since the withdrawal of budget support, recurrent expenditure is financed by domestic resources, while development expenditure is financed by both domestic and foreign resources. As illustrated in figure 3 below, recurrent expenditure accounts for 83% of the 2015/16 health sector budget allocation, made up of 53% in personnel costs (MK45 billion) and 25% (MK22 billion) in Other Recurrent Transactions or Expenditure (ORT). The share of personnel costs increased from 39% in 2012/13 to 53% in 2015/16, largely explained by salary increases rather than an increase in staffing levels.

The allocation to cover ORT is only about MK25.6 billion in 2015/16, below the 2012/13 allocation of about MK26.2 billion. Taking into account inflation during this period, this means that the real term amount of domestic funding allocated to buy es-

---

3 Ministries, Departments and Agencies

---

FIGURE 2: Malawi Health Sector and the Budget 2012-2015

- Health share: 48,829, 76,251, 65,443, 85,866
- Education share: 75,370, 114,421, 129,327, 157,396
- Agriculture share: 66,509, 119,793, 141,908, 135,218
- Transport share: 35,031, 44,508, 63,623, 77,908
- Energy share: 9,245, 10,618, 33,444, 42,754
- Other share: 173,407, 272,560, 314,383, 430,858
- Health budget: 48,829, 76,251, 65,443, 85,866
- Overall budget: 408,391, 638,151, 748,128, 930,000

Source: MoF, detailed budget 2014; author’s calculations
sential medicine has sharply decreased. The ORT allocation in the budget covers only 22% of the projected EHP direct cost (drugs and supplies only) resource based budget and only 16% of the EHP direct cost ideal budget, assuming that all the ORT (for running costs such as utilities, administration and consumables) is directed to EHP. With low levels of government resources allocated to ORT, the procurement of medicines, including for HIV/AIDS and nutrition treatment and prevention, is largely donor funded in Malawi. Reliance on donor funds puts the country at risk, for the importing of medicines and recurrent expenditure on medical products are essential for saving lives.

Capital expenditure accounts for 17% of the health sector budget. The trend of increasing capital expenditure is significantly linked to external funding. There has been a steady upward trend from 8% in 2012/13. While the number of health facilities has grown with the increasing budget share, from around 600 in 2011 to over 1,000 in 2013, there is still limited access to health facilities for many people in rural areas of the country where about 80% of the population live. Only 46% of citizens live within a 5 km radius of any kind of health facility. These health facilities are further not well managed due to limited human resources. On average, there are only 2 physicians per 10,000 population and 3.4 nurses and midwives per 10,000 population, a factor that limits delivery of quality health care services. Malawi needs to further develop the health infrastructure, especially in rural areas where facilities may be absent or ill-equipped.

Over half (MK8.5 billion of MK15 billion) of the development funding is financed by foreign resources. Increasing dependency on external funding for development expenditure leaves the sector vulnerable. Foreign development expenditure has more than doubled from MK3.3 billion in 2014/15 to MK8.5 billion in 2015/16. While domestic funding almost doubled from 2013/14 to 2014/15, the latest increase in development expenditure was as a result of foreign funding (Table 1).

5 Costed with a view of what is possible within Malawi’s resource environment
6 Costed on the basis of what is needed to address all the aspects comfortably

FIGURE 3: 2015/16 Health Budget (MK Millions)
Table 1: Health sector development expenditure (MK millions)

<table>
<thead>
<tr>
<th>Development Expenditure</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Development Expenditure (Dev 1)</td>
<td>311.48</td>
<td>4,561.40</td>
<td>3,259.44</td>
<td>8,492.78</td>
</tr>
<tr>
<td>Domestic Development Expenditure (Dev 2)</td>
<td>3,461.00</td>
<td>3,150.00</td>
<td>6,150.00</td>
<td>6,500.00</td>
</tr>
<tr>
<td>Total Development budget</td>
<td>3,772.48</td>
<td>7,711.40</td>
<td>9,409.44</td>
<td>14,992.78</td>
</tr>
<tr>
<td>% Share development in national budget</td>
<td>8%</td>
<td>10%</td>
<td>14%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Source: MoF, various detailed budgets

The 2015/16 budget allocation to the health sector gives more weight to curative health services, which account for 36% of the total, compared to preventive health services at 17%. Management and administration account for 28%, while health technical services and infrastructure account for only 19% (Figure 3). (Programme definitions have been changed over the years to allow for a consistent trend analysis.)

Figure 4: Distribution of Health Sector Budget by Programme

- 28% Management & Administration
- 17% Preventive Health Services
- 19% Health Technical Services & Health Infrastructure Development
- 36% Curative Health Services & Local Councils
- 0% Health Service Regulatory
- 0% Mgt for Human Resources for Health
4. To what extent has Health expenditure devolved to the districts?

The Ministry of Local Government & Rural Development (MoLGRD) through the district councils is responsible for the delivery of health services at the district level under the devolution policy. Funding to local district hospitals and health centers for other recurrent expenditure is channelled through district councils via the District Health Office (DHO). The DHOs allocate these funds between the district hospitals and health centres to cover medical supplies and other running costs.

Health expenditure to local councils has been cut by about half, from 9% in 2014/15 to 5% in 2015/16 (Figure 1). This is as a result of MoH taking back some of the funding and roles such as drugs procurement, which followed reports of funding meant for drugs procurement being diverted to staff allowances. This is a step backwards in the path to full devolution; the Service Provision Assessment (2014) had lauded the progress in devolution of health expenditure to districts. That Assessment found that decentralized expenditure enabled local solutions to health problems to be developed and implemented, leading to more efficient use of resources.

The decentralized health resources from the 2014/15 budget to districts are not linked to health outcomes and the burden of disease (Figure 4 and 5). Neno (MK1,099.12), Blantyre (MK1,035.73) and Mwanza (MK1,092.37) received the highest per capita expenditure. On the other hand, Mangochi (MK360.46), Machinga (MK353.68) and Kasungu (MK365.50) received the lowest. Looking at health outcomes from the 2014 MDGS Endline Survey, Neno and Mwanza have below national average under-five mortality (78 and 67 deaths per 1,000 live births respectively) and stunting prevalence (42% and 39% respectively). This is in contrast to Mangochi and M’belwa which fare worse than the average in terms of under-five mortality rate (97 and 108 deaths per 1,000 live births respectively), compared to the national average of 85 deaths per 1,000 live births. These results show that the current distribution of devolved resources is not aligned to needs. It is therefore necessary to revise the allocation formula, in order to reduce the inequalities and ensure that budgets respond to needs.

---

**Fast Facts**

- Health expenditure to local councils has been cut by about half, from 9% in 2014/15 to 5% in 2015/16 (Figure 1).

- The decentralized health resources from the 2014/15 budget to districts are not linked to health outcomes and the burden of disease (Figure 4 and 5).
5. How well has the Health sector executed its past budgets?

In 2014/15, the health sector received less resources than planned: for example, only 20% of the revised allocation to Nutrition, HIV/AIDS and the National AIDS Commission (NAC), and 94% of the allocations to the Ministry of Health were disbursed by Treasury. This is against an overall annual budget performance of 89% of the 2014/15 revised budget. By mid-year 2015/16, release of resources to the key health sector votes was above the national budget average, at 95% compared to an overall budget average of 80%. Timely release of resources is critical for Ministries, Departments and Agencies (MDAs) to deliver against their mandates. In addition, MDAs need to ensure they are both remaining within their allocation and reporting to Treasury for their expenditure on a regular basis.

Domestic development expenditure is the least predictable allocation, often performing below projections. Given the tight 2015/16 fiscal environment, health facility rehabilitation and equipment maintenance are likely to suffer. By the 2015/16 mid-year budget review, Ministry of Health had received 30% of their projected domestic development expenditure (Figure 7).

Source: MDG Endline Survey 2014 and District budget allocations 2014/15
6. How does Malawi’s Health sector expenditure compare with neighbouring countries?

While neighbouring countries all increased their overall per capita expenditure in the health sector by at least 30% between 2010 and 2013, Malawi’s per capita expenditure\(^1\) has decreased by over 20% during the same period. Mozambique has almost doubled its per capita expenditure in health and now surpasses Malawi. Figure 8 shows trends based on the World Bank compilation of per capita expenditure in health (both public and private resources) covering the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health, in Malawi, Mozambique, Zambia and Tanzania (Source: See http://data.worldbank.org/indicator/SH.XPD.PCAP).

Current levels of public expenditure in health shift the burden to individuals, who will have to pay more through out of pocket payments to access health services. With current public expenditure in health at about US$11.33 in 2014/15 budget and about US$12.17 in 2015/16, resources will remain seriously constrained in public health facilities. The drugs shortage in the public facilities accessed by the poor looks likely continue in 2015/16. **This is likely to discourage many Malawians from accessing health care**\(^2\) in Malawi, especially among the poor who are in greater need and rely more on government facilities.

---

\(^1\) Includes public and private expenditure in health

\(^2\) Declining quality of services leads to people losing trust, which means they become less likely to use the system
Fast Facts

While neighbouring countries all increased their overall per capita expenditure in the health sector by at least 30% between 2010 and 2013, Malawi’s per capita expenditure has decreased by over 20% during the same period.

Current levels of public expenditure in health shift the burden to individuals, who will have to pay more through out of pocket payments to access health services.

This is likely to discourage many Malawians from accessing health care in Malawi, especially among the poor who are in greater need and rely more on government facilities.
CONCLUSION

The health sector share of the national budget has been declining in recent years. Although the expenditure allocations have been increasing in nominal terms, this has not translated to a significant change in resources allocated in real terms.

Allocations to the health sector at the district level do not reflect a needs-based prioritisation, resulting in lower allocations to the districts with some of the poorest health indicators. Health sector resource allocations per district should be responsive to each district’s health profile.

Government priority in the sector has shifted more to paying salaries, yet severe shortages of health workers exist across the health cadres. Other recurrent expenditure has suffered in the process, resulting in constrained operations, evidenced by drug shortages in all facilities and hospitals failing to provide meals.

9.2% of the national budget goes to the health sector.

Mangochi has an under-5 mortality rate 97 per 1,000 live births (national average 85) but it receives an extremely low per capita district allocation (MK360.46).

Preventive health services receive 17% of the total health sector budget, compared with 36% to curative services.

Glossary of Budget Terms Used

Approved budget: budget passed by parliament at the beginning of fiscal year, usually by June
Revised budget: budget revised usually at mid-year and approved by parliament, usually in February
Allocation: approved budget used to guide expenditure. May be different from outturn