1 Malawi has made significant gains in the health sector, but more still needs to be done if SDG 3 is to be achieved. For example, under-five and neonatal mortality rates are currently 2.5 and 2.7 times higher than the relevant SDG targets.

**Recommendation:** The Government is encouraged to build on the momentum generated during the MDGs era by harnessing public and private resources from domestic and international sources, especially for maternal, new born and child health.

2 Mainly due to limited fiscal space, health sector allocations have modestly increased since fiscal year (FY) 2012/13. Allocations however fall short of sector requirements by about three-fifths, based on cost estimates in the second Health Sector Strategic Plan (HSSP II).

**Recommendation:** Given limited fiscal space, the Government is encouraged to focus on enhancing value for money by improving efficiency and accountability in health spending, including at sub-national level.

3 Disparities exist in child health outcomes amongst District Councils, between rural and urban populations and wealth quintiles.

**Recommendation:** The Government should investigate underlying causes of existing health inequalities and is also encouraged to review the district health resource allocation formula for it to be responsive to current realities.

4 The health sector is advanced in fiscal decentralisation, but benefits thereof may be derailed by persistent shortages of staff, medical equipment and supplies as well as budget execution challenges such as delays in disbursements of funds, lack of predictability of funding from Treasury, low absorption and weak financial reporting and accountability.

**Recommendation:** The Government should prioritize recruitment of key district health personnel, including community health workers, and strengthen financial reporting and accountability systems at the local level.
Part 1 Introduction

This budget brief explores the extent to which the 2018/19 national budget addresses health needs of children in Malawi. Specifically, it analyzes the size, composition and equity of allocations to the health sector in fiscal year (FY) 2018/19, through children’s lens. The brief concludes with a set of recommendations on how the Government of Malawi (GoM) can increase the size and improve quality of public spending on health, including by enhancing efficiency, effectiveness and equity in the allocation and utilization of health sector resources to benefit all children in Malawi.

The analysis in this budget brief is based on a review of budget documents, especially Detailed Budget Estimates and Program Based Budgets (PBBs) for FY2018/19. Approved budget allocations as presented in the Detailed Estimates of Expenditures and Program Based Budget (PBB) were used for FY2018/19 while revised budget estimates were used for previous years. The base fiscal year used for the analysis is FY2012/13, especially for inflation adjustments. The analysis was augmented by review of Government, donor and NGOs reports on health financing. Total health budget is defined as the sum of budget allocations to the Ministry of Health and Population (MoHP) (Vote 310), transfers to Local Authorities for other recurrent transactions (ORT), personal emoluments (PE) through the National Local Government Finance Committee (NLGFC) (Vote 121) and allocations to Subvented Health Organizations (SHOs) (Vote 275). The trend analysis spanned from FY2012/13 to FY2018/19.

Malawi has made significant gains in the health sector, especially in child health. The key achievements include the meeting of Millennium Development Goals (MDGs) on infant and under five (U5) mortality. Infant mortality in 2016 was recorded at 42 deaths per 1000 live births against the MDG target of 44.7 while U5 mortality was recorded at 63 deaths per 1000 live births against the MDG target of 78. Stunting also went down by ten percentage points from 47% in 2010 to 37% in 2016.2

Despite these gains, a lot still needs to be done to achieve SDG 3 on health and well-being for all. U5 mortality rate is approximately 2.5 times the SDG 3.2 target of 25 deaths per 1,000 live births while the neonatal mortality rate of 27 is 2.3 times the SDG 3.2 target of 12 deaths per 1,000 live births by 2030. The health sector is still grappling with several challenges including inadequate health personnel, especially at district level. For nearly all cadres, there is a large gap between current staffing levels and the establishment. Table 1 gives an overview of the gap between the current health workforce, the immediate workforce need and the establishment, for all cadres. The World Health Organisation (WHO) ranks Malawi as one of the countries facing acute shortage of health workers with a doctor to patient ratio of 1:1666 and nurse-to-patient ratio of 1:2941.3

Part 2 Health Sector Overview

Health and Population is one of the five priority areas of the Government of Malawi as outlined in the Third Malawi Growth and Development Strategy (MGDS III). Through the MGDS III, the Government has committed itself to improve access, equity and quality of primary, secondary and tertiary health services. In recent years, the Government developed robust health sector policies and plans to guide its interventions and to inform health sector resource mobilization and allocation. In 2017, the Government launched the second Health Sector Strategic Plan (HSSP II), Essential Health Package (EHP) (2017-2022), Sexual and Reproductive Health Policy (2017-2022), National Community Health Strategy (2017-2022) and the Multi-Year Plan for the Expanded Program on Immunization (2017-2021). In 2018, the Health Policy was finalized and the mandate of the Ministry of Health was expanded to include population.

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2 Malawi Demographic and Health Survey (MDHS) (2016).
3 This data was reported by World Bank (2017) based on WHO Global Health Estimates.
demonstrates the Government’s commitment to improving health outcomes for its citizens, including children. While the proposed national budget for FY2018/19 had to be downsized by MK50 billion during the approval stage, allocations to health were not affected. As a share of the total budget, the FY2018/19 health sector allocation is the fourth highest (9.8%) after education (23.7%), debt repayment (12.6%) and agriculture (10.4%).

| Source: Human Resources for Health (HRH) Strategic Plan (2018-2022), pp 53 |

### Table 1: Number and Percent Gap between Current Health Workforce, Immediate Workforce Need, and Establishment

<table>
<thead>
<tr>
<th>Cadre</th>
<th>Number of Current Health Workers (A)</th>
<th>Number of Health Workers Required in Workforce Targets (Immediate Need) (B)</th>
<th>Number of Health Workers in Establishment (C)</th>
<th>Percent of immediately needed positions that are filled (A/B)</th>
<th>Percent of establishment positions that are filled (A/C)</th>
<th>Number of additional health workers needed to fill immediate need (B-A)</th>
<th>Number of additional health workers needed to fill establishment (C-A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officer / Specialist</td>
<td>558</td>
<td>814</td>
<td>784</td>
<td>69%</td>
<td>71%</td>
<td>256</td>
<td>226</td>
</tr>
<tr>
<td>Clinical Officer / Technician</td>
<td>1306</td>
<td>1881</td>
<td>3956</td>
<td>69%</td>
<td>33%</td>
<td>575</td>
<td>2650</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>1213</td>
<td>2144</td>
<td>1739</td>
<td>57%</td>
<td>70%</td>
<td>931</td>
<td>526</td>
</tr>
<tr>
<td>Nurse/Midwifery Officer</td>
<td>990</td>
<td>2593</td>
<td>1498</td>
<td>38%</td>
<td>66%</td>
<td>1603</td>
<td>508</td>
</tr>
<tr>
<td>Nurse Midwife Technician</td>
<td>4451</td>
<td>5980</td>
<td>12701</td>
<td>74%</td>
<td>35%</td>
<td>1529</td>
<td>8250</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>66</td>
<td>545</td>
<td>98</td>
<td>12%</td>
<td>67%</td>
<td>479</td>
<td>32</td>
</tr>
<tr>
<td>Pharmacy Technician</td>
<td>159</td>
<td>616</td>
<td>832</td>
<td>26%</td>
<td>19%</td>
<td>457</td>
<td>673</td>
</tr>
<tr>
<td>Pharmacy Assistant</td>
<td>81</td>
<td>649</td>
<td>472</td>
<td>12%</td>
<td>17%</td>
<td>568</td>
<td>391</td>
</tr>
<tr>
<td>Lab Officer</td>
<td>94</td>
<td>99</td>
<td>83</td>
<td>95%</td>
<td>113%</td>
<td>5</td>
<td>-11</td>
</tr>
<tr>
<td>Lab Technician</td>
<td>351</td>
<td>719</td>
<td>821</td>
<td>49%</td>
<td>43%</td>
<td>368</td>
<td>470</td>
</tr>
<tr>
<td>Lab Assistant</td>
<td>116</td>
<td>719</td>
<td>610</td>
<td>16%</td>
<td>19%</td>
<td>603</td>
<td>494</td>
</tr>
</tbody>
</table>

### Key Takeaways

- The Government has made significant gains in the health sector. Sustained funding to the sector is therefore key to consolidate gains made and to achieve SDG 3.
- Human resource challenges in the health sector persist. There is need for the Government to strengthen deployment and incentive systems for health personnel especially in rural areas.

### PART 3  HEALTH SECTOR SPENDING TRENDS

In FY2018/19, the health sector was allocated a total of MK142 billion\(^4\) up from a revised estimate of MK127 billion in 2017/18 (Figure 1).\(^5\) Compared to the previous year, this allocation is nominally higher by 12% and 1% in real terms. Whilst total FY2018/19 health sector budget increased by 12%, the total national budget increased by 10.7%, which demonstrates the Government’s commitment to improving health outcomes for its citizens, including children. While the proposed national budget for FY2018/19 had to be downsized by MK50 billion during the approval stage, allocations to health were not affected. As a share of the total budget, the FY2018/19 health sector allocation is the fourth highest (9.8%) after education (23.7%), debt repayment (12.6%) and agriculture (10.4%).

\(^4\) The total health sector allocation goes down to MK141 billion if the allocation to Malawi College for Health Sciences (MK801.5 million) is removed. This however does not significantly affect the share of health sector budget to total budget and GDP.

\(^5\) The base fiscal year used in Figure 1 and all analysis is FY2012/13. If 2012/13 is used as base year, the margin for real increase becomes high.
**Figure 1**  
**Trends in Health Sector Spending** (in nominal and real MK billions, base fiscal year is FY2012/13)

Source: Detailed Budget Estimates (FY2012/13-2018/19)

**Figure 2**  
**Health Sector Budget as a % of Total Budget and of GDP**

Abuja Commitment, 15% of total budget

Source: Detailed Budget Estimates (2012/13-2018/19)
Malawi is a signatory of the Abuja Declaration, held in 2001, which committed ratifying countries to allocate at least 15% of their national budgets to improve the health sector. Since FY2012/13, however, the Government has allocated about 10% of its annual budget to health, 5% points below the Abuja target (fig.2). Similarly, public health spending as a share of GDP has not changed much since FY2012/13, averaging around 3%.

The FY2018/19 health sector budget allocation is roughly three-fifths below sector requirements as outlined in the HSSPII. At MK142 billion (US$196 million, current prices), the FY2018/19 health allocation is roughly two-fifths (38%) of the FY2018/19 health sector funding requirements of US$521 million as costed under the HSSPII (Figure 4). The health sector financing gap in FY2018/19 has not changed much compared to 2017/18 when public health spending was US$173 million against sector requirements of US$504 million, leaving a financing gap of 65%. The development budget for health in FY2018/19 stands at US$35 million, which is 44 percentage points below the FY2018/19 estimated capital expenditure requirements of US$62 million under the Capital Investment Plan (CIP) of the HSSPII (Figure 4). At US$10.4, the FY2018/19 per capita public health allocation is just about a third of the HSSPII annual per capita cost requirement estimated at US$30 (Figure 3). Health spending per capita is 8.2 times lower than the WHO recommended US$86, which is considered the minimum necessary per capita investment to provide basic health services.7

6 The five-year cost of the HSSPII is estimated at US$2,613 million with annual costs estimated to increase from $504 million in 2017/18 to $540 million in 2021/22. Per capita health spending is estimated to remain constant at about US$30 over the five-year period (2017-2022) (HSSPII Final Document, pp. 60)


The health sector financing gap in FY2018/19 has not changed much compared to 2017/18.
The health sector financing gap is likely to continue at roughly three-fifths over the five-year HSSP II period (2017-2022). It is important to note, however, that financing gaps are relatively higher, at 84% (US$249 million) for the essential health package (EHP) and 95% (US$14 million) for environmental health and promotion (Figure 4). The figure however excludes significant resources that are channelled to communities through off-budget means. It is regrettable that information about donor commitments which is recorded in the Malawi Aid Management Platform (AMP) is not regularly updated.

Latest data from the World Bank for the period 2010-15 shows that after combining public and private resources, the per-capita health spending in Malawi is the fourth lowest in SADC (Figure 5). Per-capita health expenditures in Malawi averaged US$35 between 2010 and 2015. This is significantly lower than the SADC average of US$209 even though comparable to neighboring countries notably Tanzania (US$37) and Mozambique (US$28) (Figure 5). Even combining donor and private contributions, per capita health spending in Malawi is 2.4 times lower than the minimum expenditure (US$86) required to ensure priority health services for everyone in the context of Low Income Countries (LIC). This means Malawi has a long way to go in achieving quality UHC for its citizens and children.

Total per-capita health expenditures in Malawi averaged US$35 between 2010 and 2015. This is significantly lower than the SADC average of US$209.

**Figure 4** FY2018/19 Health Sector Allocations Compared to HSSP II Cost Estimates in US$ millions

<table>
<thead>
<tr>
<th>Health Sector requirements</th>
<th>Government allocation</th>
<th>Funding gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>USD $ (Millions)</td>
<td>USD $ (Millions)</td>
<td>USD $ (Millions)</td>
</tr>
<tr>
<td>Total Health Sector</td>
<td>-326</td>
<td>521</td>
</tr>
<tr>
<td>Health infrastructure spending</td>
<td>-27</td>
<td>196</td>
</tr>
<tr>
<td>EHP services</td>
<td>-249</td>
<td>62</td>
</tr>
<tr>
<td>Social Determinants of Health</td>
<td>-14</td>
<td>35</td>
</tr>
</tbody>
</table>

Source: Detailed Budget Estimates and HSSP II pp.62

**Key Takeaways**

- **The Government’s current financial commitment to the health sector falls short of the Abuja Declaration target and is insufficient to meet the financing needs of the HSSP II.**
- **Average per capita health spending in Malawi is relatively low compared to its SADC comparators and is below recommended minimum per capita health spending for LICs.**
PART 4 COMPOSITION OF THE HEALTH SECTOR BUDGET

The majority of health sector resources are for recurrent costs. In FY2018/19, about 82% of health sector resources (MK116 billion) were allocated to recurrent expenditures compared to 79% in 2017/18 (Figure 6). It is however important to note that the development share of the budget has been steadily increasing since FY2012/13. About 59% of the recurrent health budget is for personal emoluments (PE), with the remainder (41%) going to other recurrent transactions (ORT) namely drugs, medical supplies and operations.

The development budget for health in FY2018/19 has witnessed a nominal decline for the first time since FY2012/13. This is mainly due to a decline in on-budget support by donors. In FY2018/19, MK25.45 billion was allocated for development projects in the health sector. The nominal decline is approximately 2% from a revised estimate of MK25.96 billion in 2017/18 and a 12% decline in real terms. Health infrastructural needs in the country remain significant. In light of this, the Government is encouraged to create the necessary conditions for resumption of budget support by donors.

Majority of health sector resources are allocated to the Ministry of Health (53%), with 44% being channeled through District Councils, mainly for personnel emoluments (PE). The remainder (3%) is allocated to subvented health

\[\text{The development budget for health is entirely centralized and funds are channeled via the Ministry of Health.}\]
organizations (SHOs).\(^9\) In the current financial year, allocations to SHOs increased by 310% from MK1 billion in 2017/18 to MK4 billion. The significant increase is largely explained by the fact that NAC, until last year under MoH, is now part of the SHOs. The share of budget allocation to District Councils has gone up from 39% in FY2017/18 to 44% in FY2018/19 while allocations to MoH have declined from approximately 60% to 53% over the same period (Figure 7). This decline is explained by increased share of resources going to District Councils. In nominal terms, budget allocations to MoH decreased by 1.6% from MK76 billion in FY2017/18 to MK75 billion in FY2018/19 while allocations to District Councils increased by 24.6% from MK50 billion to MK63 billion over the same period. However, as was the case in FY2017/18, the majority (64%) of the resources for District Councils in FY2018/19 are for PE.

Nearly half (47%) of the MoH budget goes to finance the EHP, with two fifths (40%) going to support service delivery (Figure 8). Although the Government is commended for coming up with a specific budget line on EHP in line with HSSP II, allocation is far below program requirements. EHP Services were allocated a total of MK35 billion\(^10\) in 2018/19. This is equivalent to USD48 million, which is 84 percentage points below the 2018/19 program cost requirement of US$297 million as costed under HSSP II. Essential Health Package services account for 97% of the allocation to Health Services, while the remaining 3% supports quality of care for services not included in the EHP. About two-thirds of the allocation to Health Services is for PE while 27% is for medical supplies and expenses (Figure 9).

Approximately two-thirds of the budget for ‘support to service delivery’ (Program 26) is for health infrastructure (Figure 10). The budget does not however provide sufficient details on the type of infrastructure. This budget line was allocated a total of MK30 billion, which is 9% lower than the 2017/18 budget in real terms. Medicines and pharmaceuticals consume 26% of this budget line (Figure 10). MK9 billion (8%) was allocated for medical equipment.

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\(^9\) Health Services Regulatory Authority, Kadhere Rehabilitation Centre, which mainly provides rehabilitation health services to people with disabilities (PwDs), Malawi College of Health Sciences and National AIDS Council.

\(^10\) PBB for FY2018/19, pp.372
The Government is commended for coming up with a specific budget line on Environment and Sanitation (Program 22) in line with HSSPIII, but allocation is 95% below program requirements. This program aims at reducing environmental and social risk factors that have direct impact on health, among other things. The program was allocated MK0.54 billion or about 1% of MoH total budget. At US$75,200, the allocation is only 5% of the 2018/19 program cost requirement of US$14.9 million as costed under the HSSP II (refer to Figure 4).

Key Takeaways

- Most of the health sector resources are recurrent. The Government is encouraged to review the allocation mix within the sector with the aim of prioritizing low-cost, but high impact primary health care.

- Whilst the Government is commended for coming up with a specific budget line on Environment and Sanitation (Program 22), allocation is insufficient to meet the financing needs of HSSPIII.
PART 5 EQUITY OF HEALTH SECTOR SPENDING

Significant variations in child health outcomes exist amongst districts and depending on residence and socio/economic status. For example, U5 mortality is higher in rural than urban areas (77 deaths per 1,000 live births compared to 61 deaths per 1,000 live births, respectively). By region, U5 mortality is highest in the Central (81 deaths per 1,000 live births) and lowest in the Northern (57 deaths per 1,000 live births). Stunting in under five children is 46% among children in the lowest wealth quintile, 37% among those in the middle wealth quintile and 24% for children in the highest wealth quintile. Vaccination coverage ranges from 32% in Mangochi to 81% in Mwanza.\

The district health sector resource sharing formula is not sufficiently responsive to morbidity as well as geographic, age and gender related disparities. Several stakeholders in the health sector have suggested that the formula be revised to address current challenges. The formula is a key tool for achieving equity in health financing. In FY2018/19, per capita health sector ORT transfers to District Councils range from as low as MK385 in Kasungu to MK3,018 in Likoma, the least populated Island district. It is important to note that districts such as Likoma are outliers due to its geographic location. Excluding these outliers, however, there is not so much difference in per capita allocations to District Councils.

There is hardly any information on whether off-budget health expenditures are equitable. This is partly because most development partners, including NGOs, have not been submitting health expenditure information to the Aid Management Platform (AMP). Reports from partners however seem to suggest that off-budget resources are mostly earmarked and sometimes not equitably distributed, as some districts apparently receive more donor support than others. For example, Program Mapping for Community Health found inequitable distribution of program interventions. In Mangochi District, for instance, 2-4 bicycles are allocated to a health surveillance assistants (HSAs), compared to no bicycles for some. The MoHP conducted a comprehensive Resource Mapping exercise and updated its National Health Accounts in 2018. Data from these processes will help improve understanding of financial planning and budgeting.

Key Takeaways

- There are disparities in child health outcomes amongst districts, between rural and urban populations and wealth quintiles. Unfortunately, the district health sector resource sharing formula is not sufficiently responsive to these disparities.
- Information on whether off-budget health expenditures are equitable is hardly available, but reports from partners seem to suggest inequitable resource allocation.
- The Aid Management Platform as well as the Health Sector Joint Fund are crucial opportunities for the Government to enhance coordination of off-budget programs.
- A periodic resource mapping is a key tool for tracking resource allocations to the health sector.
Figure 11: Per capita ORT Transfers to the Health Sector per District in FY2018/19.
Figure 12  Age Appropriate Vaccination Coverage by District (MDHS, 2015/16)

Age Appropriate Vaccination Coverage to Health Sector by District (%)

- 62+ (Very good)
- 50-61 (Good)
- 0-49 (Poor)

Source: Budget Estimates, NLGFC
Health is amongst the few sectors that are relatively advanced in terms of fiscal decentralization. District Councils now independently purchase drugs through the Central Medical Stores (CMST), with funds disbursed through the National Local Government Finance Committee (NLGFC). Salaries for local level staff are now paid directly by District Councils. This has determined a modest increase in the budget allocation for District Councils from FY2017/18 (Figure 13). In FY2018/19, District Councils were allocated MK63 billion. This is 44% of total allocation to health sector and is 12% higher in real terms compared to MK50 billion allocated in FY2017/18. The increase in allocation to District Councils is driven by drugs and salaries which both increased by 28% in nominal terms while ORT budget increased by only 5%.

The majority (64%) of the health sector budget allocation to District Councils is for Personnel Emoluments (PE). The remaining 36% is shared between drugs (23%) and ORT (13%). The combined ORT budget to District Councils is composed of MK14.3 billion for drugs and MK8.4 billion for other medical supplies and services (Figure 14). Potential benefits of fiscal decentralization are however likely to be derailed by persistent shortages of staff, medical equipment and supplies as well as budget execution challenges such as delays in disbursements of funds, leakages and weak financial reporting and accountability. Concerns have also been raised on the quality of district plans and governance systems, which do not match the challenges emerging with decentralization including weak planning and coordination skills.

### Key Takeaways

- Health is amongst the few sectors that are relatively advanced in terms of fiscal decentralization.
- Ensuring that fiscal decentralization contributes to improved health outcomes requires the Government to prioritize recruitment of key district health personnel, including health accountants.
Health sector institutions generally have a good spending rate, although recent trends indicate over-spending in some budget lines, especially recurrent costs. In FY2017/18, for example, by the third quarter, total expenditures for the health sector had exceeded projections by 12%. If not curbed, over-spending may force Government into deficit financing. Such practices are suggestive of fiscal indiscipline.

Persisting budget execution challenges adversely impact the efficiency and effectiveness of health spending. Challenges such as late disbursement of funds, weak financial reporting by District Councils, wastages and leakages are commonly reported despite concerted efforts by the Government to curb them. For example, drugs and other items are sometimes issued to patients without being properly recorded. In several facilities, health records are not consolidated nor standardized across commodities and departments. Some health sector resources are also wasted through non-maintenance of assets. For example, an Inventory Assessment by Physical Assets Management (PAM) carried out by the Ministry of Health in 2016 showed that 20-25% of medical equipment is out of service.

There are also procurement challenges. There are two main parallel procurement systems in Malawi: the one used by development partners, and the one of the Government through the Central Medical Stores (CMST). This fragmentation represent an obstacle to economies of scale that a single purchaser could otherwise achieve. Moreover, stakeholders have reported leakages and accountability challenges within the CMST supply chain. For example, orders to CMST are placed at the facility level with limited communication among the key stakeholders, thus creating accountability and transparency challenges between CMST, central hospitals and DHOs.

The Ministry of Health now holds an additional population function. This requires additional resources for effective delivery of population services as outlined in the MGDS III. There is increasing demand for the Government to pay attention to population issues given significant population increase. Population results from the 2018 Housing and Population Census (released in January 2019) show that Malawi’s population has increased by 35% from 13 million in 2008 to 17.6 million in 2018. The results also show that Malawian population is very young, with 51% below the age of 18.

16 This challenge is also acknowledged by the Ministry of Health in the HSSP II report (See HSSP II final document, pp. 21)

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Health Budget Performance in 2017/18: Q1-Q3 in millions of current MK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Expenditure (Total)</td>
<td>64,809</td>
</tr>
<tr>
<td>Wages</td>
<td>17,412</td>
</tr>
<tr>
<td>Local Council Wages</td>
<td>23,178</td>
</tr>
<tr>
<td>ORT</td>
<td>19,454</td>
</tr>
<tr>
<td>MoH ORT</td>
<td>13,469</td>
</tr>
<tr>
<td>Local Assemblies ORT</td>
<td>5,985</td>
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<tr>
<td>Subvented Organisations</td>
<td>293</td>
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<tr>
<td>Development Expenditure</td>
<td>4,473</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance Social Sector Expenditure Tracker Update to Q3 of FY2017/18

Key Takeaways

- **Strengthening procurement and financial reporting and accountability systems at the local level is key to ensuring that decentralization achieves intended health outcomes.**
- **With the additional population portfolio in health, the greatest challenge now is setting up an effective forecasting and commodity security system for family planning supplies.**

16 Ibid
17 Inventories Report by Physical Assets Management (PAM) Team for Q3/Q4 of 2016 as reported on page 16 of the HSSP II final document.
Although the majority of health sector resources (87%) reported in the national budget come from domestic sources, the development part of the budget\textsuperscript{20} is largely donor-funded. In the current year, MK19 billion (75\%) of the development budget comes from donors while only a quarter (MK6.4 billion) is from GoM (Figure 16). Notwithstanding this skewed development-funding pattern, it is commendable that the Government’s own contribution to the health development budget has been trending upwards since FY2016/17. While donor funding for health projects went down in both nominal and real terms, Government funding went up by 2.7\% in nominal terms although it is 7.4\% lower once accounting for inflation. The nominal increase in the Government contribution is in line with a general rebalancing of Government budgets to increase the proportion of development expenditures, which over the past few years, had remained lower than the 25\% threshold, which the Government set for itself.

\textsuperscript{20} Health sector development expenditures are entirely decentralized and managed by the Ministry of Health, with virtually no allocations going through District Councils for health-related development expenditures. In FY2018/19, the MoH was allocated MK25 billion for development programs, of this amount, 75\% (MK19 billion) is expected to come from donors (Document No. 4: Detailed Estimates for FY2018/19, pp. 461).

Fiscal space challenges have been worsened by weak revenue performance and declining on-budget support from donors.
Malawi receives significantly more donor resources for health than most countries in SADC. Data from the Malawi Aid Management Platform (AMP)\(^1\) shows that between 2012 and 2015, the health sector received the largest share of all donor flows to Malawi. Donor resources alone constitute approximately 25% (MK19 billion) of the MK75 billion allocated to Ministry of Health in FY2018/19. This percentage does not consider most of the off-budget expenditures through non-Governmental organizations (NGOs). Data from World Bank (2010-2015) shows that Malawi received US$63 current external expenditures on health per capita.\(^2\) This is higher than the SADC average of US$44 and the averages in two of Malawi’s neighbours – US$45 in Tanzania and US$39 in Mozambique (Figure 17). Although important in a fiscally constrained environment, over-dependency on external sources creates sustainability challenges in the delivery of health services due to their unpredictability which makes the health sector vulnerable to any sudden funding changes.

The current health sector funds (Global Fund and Health Sector Joint Fund (HSJF)) face absorption challenges. A report by the Office of the Inspector General (OIG) in 2016 noted significant issues with the absorption of grants in Malawi. For instance, Grant implementers only utilized 30% (US$36 million) of funds disbursed under the Global Fund for the implementation of grant activities (US$124 million) from 2009 to 2015.\(^3\) Also, the most recent Global Fund Grant, which started in January 2016, recorded a low absorption rate of less than 1% at the time of the inspection. The low absorption rate was attributed to ineffective program management by the implementers and inefficiencies in managing the portfolio by the Global Fund Country Team. With regards to HSJF, its alignment to the HSSP II holds the potential to have a substantial impact on health outcomes in Malawi. However, for this to happen there is need to improve the absorption of funds.

Recognizing that there is limited fiscal space to increase health financing, the Government of Malawi has been considering several policy options including earmarked taxation, innovative financing mechanisms and national health insurance.\(^4\) Recent studies, however, have shown that the high levels of unemployment, the size of the informal economy, a high proportion of the population living in rural areas, and a slow economic growth make the introduction of a national health insurance scheme difficult. On the other hand, additional taxes under the auspices of innovative financing mechanisms are likely to hit poor people the hardest. Moving forward, each proposed measure to increase health sector finances should be carefully assessed against criteria of progressivity, cost-efficiency, sustainability and overall potential, given the Malawi socio-economic context. This is important to avoid a situation whereby the burden of financing health services becomes too heavy on poor families.

\(^{1}\) Donors are encouraged to report their health expenditures in the Aid Management Platform to improve transparency
\(^{2}\) According to World Bank, this refers to current external expenditures on health per capita expressed in international dollars at purchasing power parity (PPP). The definition of external sources includes direct foreign transfers and foreign transfers distributed by Government encompassing all financial inflows into the national health system from outside the country (World Bank definition).
**Figure 17** Average Per-Capita Health Expenditures in SADC Countries (2010-2015) (in USD)

Source: UNICEF, based on data from WHO Global Expenditure Database

**Key Takeaways**

- **Limited fiscal space hampers UHC efforts in Malawi.** The Government is therefore encouraged to explore different policy options to expand its fiscal space, including by improving efficiency of tax collection and leveraging international public and private resources.

- **Addressing problems of absorption associated with existing health sector funds such as the Global Fund and Health Sector Joint Fund is crucial in improving value for money.**

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