HEALTH FINANCING PROFILE

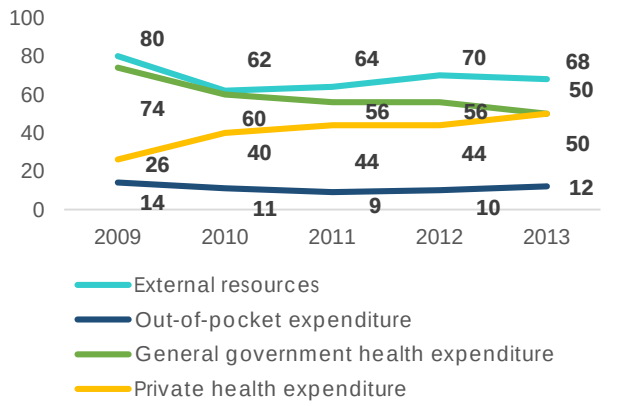
MALAWI

May 2016

Key Indicators	
Population (2015)	18.0 million
GDP per capita (2015, current USD)	$1,200
Income classification	Low
Health Financing (FY 2011/12, nominal dollars)	
THE per capita (USD)	$39.3
THE as % of GDP	9%
GHE as % of THE	16.1%
GHE as % of GGE	6.2%
OOP as % of THE	10.2%
DAH as % of THE	68%
Pooled private as % of THE	N/A
HIV Financing (FY 2011/12, nominal dollars)	
Adult HIV/AIDS prevalence (2014)	10%
DAH for HIV as % of TAE	75.9%
TAE per PLHIV (USD)	$222
GAE as % of GGE	1.9%
GAE as % of TAE	13.4%

Source: WHO, 2015; MOH, 2014.
THE = total health expenditure, GDP = gross domestic product, GHE = government health expenditure, GGE = general government expenditure, OOP = out-of-pocket, DAH = development assistance for health, TAE = total AIDS expenditure, PLHIV = people living with HIV, GAE = government AIDS expenditure.

Figure 1: Shares of Total Health Expenditures (THE)



Source: WHO, 2015.

Overview

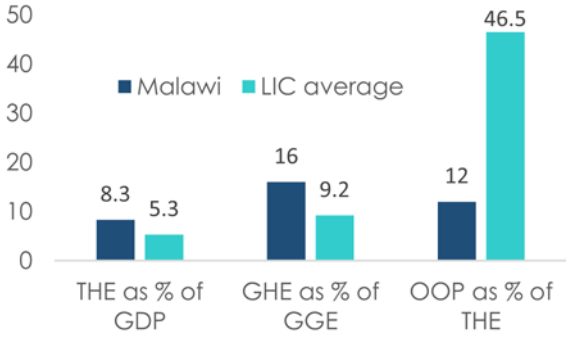
Malawi's health sector is heavily dependent on foreign resources. Based on its revised estimates, the government of Malawi (GOM) allocated 9.7% of its fiscal year (FY) 2014/15 budget to health (Mwansambo, 2015). This allocation reflects a much reduced on-budget support from donors; GOM represented 92% of the total health allocation. For FY 2011/12, the purely domestic government allocation was only 6.2% of the total GOM budget (MOH, 2014). With on-budget support from development partners in a state of historic decline—due mostly to the impact of the 2013 "Cashgate" government spending scandal—and with limited potential for GOM to grow its revenue, Malawi is facing a fiscal crisis in the health sector. Between 2009 and 2012, the period prior to the Cashgate crisis, government health expenditure as a percentage of total health expenditure (THE) declined from 22% to 16%. External resources increased as a share of THE, from 62% to 70% in 2012. Out-of-pocket expenditure remained almost stable and relatively low (Figures 1 and 2), whereas other private health expenditure declined slightly, from 4% to 3.2%, suggesting only a minor role for private nonprofit and for-profit institutions as financing sources.

Given the reduction in available health funding, GOM has instituted "bypass" fees for patients to skip referral and directly access care at major public hospitals. Malawi is considering expanding the fee-for-service wings in higher-level public hospitals to follow neighboring Zambia's example. This does not suggest a broad move toward universal user fees, since an expert panel on health sector reforms chose not to reintroduce them in 2015. Broadening protection and addressing the population that accesses care from the nonprofit sector, the GOM is also exploring reimbursement to Christian Association of Malawi (CHAM) facilities, estimated to constitute 28% of all primary healthcare facilities (MOH, 2014), to provide a free essential package of health services.

Per capita government expenditure on health in FY 2011/12 was estimated at US$6.30, compared to US$39.30 from all sources (current dollars). Government per capita allocation to health for FY 2014/15 was US$10.10 in current dollars, based on the Treasury budget for health (Mwansambo, 2015). Total health resources per capita may have declined in nominal terms, at around US$35 in FY 2015/16, due to rapid population growth and limited financing sources (GOM, 2015). The GOM has been considering several measures in the context of overall health sector reforms pointing toward universal health coverage:

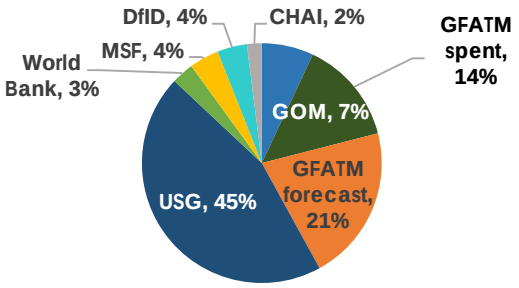
- *Establishment of a health fund by 2016*: Revenue-generating measures include "sin taxes;" a portion of visa fees; and levies on fuel, extractive industries, and communication services.
- *Introduction of a national health insurance scheme (NHIS) by 2017*: This mandatory medical insurance scheme is for those in formal sector employment, beginning with the public sector.

Figure 2: Comparative Health Expenditure (2013)



Source: WHO, 2015.

Figure 3: HIV Resources (2014–2017)



Source: PEPFAR, 2015.

It eventually will expand to cover private sector wage-based employees and the informal sector. NHIS expansion will tie in with plans to expand fee-for-service wings in public hospitals.

- *Reform in hospital operations by 2016*: Reform includes improving the efficiency and quality of major public hospitals by increasing their autonomy—allowing them to be run as "public trust hospitals," overseen by independent boards. This reform would not change existing user fee policies. Hospitals would benefit from new professional management and could attract other funding—for example, through private sector partnerships. GOM would still finance capital expenditure.
- *New agreement with the CHAM by mid-2016*: This agreement would focus future service-level agreements with CHAM facilities outside of the eight-kilometer radius of an existing GOM facility, suggesting more rational contracting. For such facilities, GOM would cover the cost of the essential package of health services, thus eliminating user fees.

Health Financing Functions

Revenue contribution and collection

For FY 2014/15, GOM resource mapping suggested that US$650 million in current dollars was available for health (Mwansambo, 2015). Projections for the proposed health fund, given the trend in underlying sources of revenue, suggest GOM could mobilize US$70–224 million in FY 2016/17 in nominal terms at the current exchange rate, increasing to US$128–440 million by FY 2020/21. These projections assume that all revenue-generating measures are executed. Of the current US$650 million budget, 26% was in the Ministry of Health pool, including sector-wide approach (SWAP) resources. Within the SWAP pool, GOM mobilized 92% from its own budgetary resources and 8% from Norway and Belgium.

Pooling

Estimates of the resource mapping study suggest that only 26% of all health resources are in any form of pool. Current penetration of health insurance in Malawi is extremely limited and does not represent any risk pools. The proposed NHIS is at a very early stage and would enroll mandatory scheme members from late 2016 if legislation and implementation occur as planned. The 2013 labor force survey suggests that, of the 5.5 million employed, 11% were in the formal sector—about 620,000 individuals (NSO, 2014). This number suggests the maximum amount of contributors that would be in the pool before recruitment from the informal sector.

Purchasing

The recently signed agreement with CHAM would allow GOM to purchase services from this nongovernmental organization more rationally, focusing on areas outside of current public facility catchments and on the essential package of health services. This purchasing would be supported by the contribution of development partners. Strategic purchasing practices of the anticipated NHIS still are unknown. Central hospitals in Malawi increasingly will outsource their non-core services.

HIV Financing

External resources for HIV in 2015 were about US$260 million in current dollars (PEPFAR, 2015). The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) procured nearly 100% of antiretrovirals in FY 2014/15 and 73% of laboratory reagents. GOM contributions for HIV (GAE) were estimated to be 1.9% of all government spending (GGE) in FY 2011/12 versus 21% of disease burden (IHME, 2016). This ratio for GAE is comparable to levels in Zambia (2.1% of GGE in 2015) and higher than Kenya (0.6% of GGE in FY 2012/13). From 2014–2017, the Global Fund and PEPFAR are estimated to jointly account for 80% of HIV resources (Figure 3). Based on national strategic plan estimates, a gap of US$269.3 million exists for 2015–2020 (NAC, 2014).

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