



MINISTRY OF HEALTH

# Malawi National Health Accounts

## A Summary Brief of Fiscal Years 2015/16, 2016/17, and 2017/18

August 2020

### Background

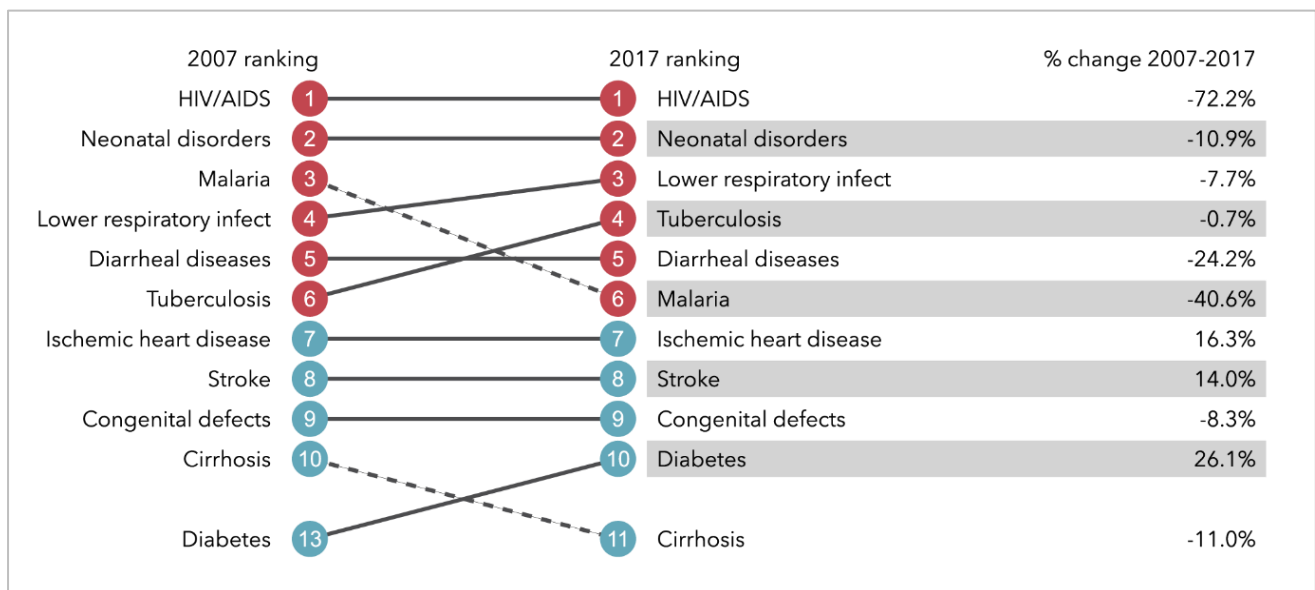
This brief provides a summary of the key findings from Malawi’s seventh round of National Health Account (NHA) studies for fiscal years 2015/16, 2016/17, and 2017/18 (MOH, 2020). These studies, which provide a methodical, wide-ranging, consistent tracking of resource flows within the country’s health sector, are a key source of information for policymakers who are interested in ensuring equitable allocation of scarce resources to areas of high impact.

### Policy Goal and Epidemiological Profile

The policy goal of Malawi’s healthcare system is to achieve high-quality, equitable, affordable, universal health coverage, with the aim of improving health status, financial risk protection, and client satisfaction of its citizens. This policy goal has been explicitly stated in the *National Health Policy* and the *Health Sector Strategic Plan II*. Expenditure tracking through NHA studies is one important way of measuring progress made toward achieving this goal.

Figure 1 captures Malawi’s current epidemiological profile. HIV/AIDS and neonatal disorders remain the leading causes of mortality, though there have been decreases in both of these figures—by 72.2 percent and 10.9 percent, respectively—between 2007 and 2017. At the same time, deaths from ischemic heart diseases and diabetes increased during this time period.

Figure 1. Leading Causes of Death in Malawi, 2007 versus 2017



Source: IHME, 2017

## Study Methodology

The System of Health Accounts (OECD et al., 2011) informed the methods for the NHA study. Generic classifications in the NHA production tool were customized to reflect the context of Malawi's health sector. The data collection process was undertaken between April and September 2019.

The NHA survey questionnaire was sent to 146 nongovernmental organizations (NGOs); 130 large employers; 28 district councils; 27 donors; 10 ministries, departments, and agencies; and 6 health insurance companies. Household expenditure data for 2016/17 were obtained from the Fourth Integrated Household Survey. Data were adjusted for inflation and annual exchange rate variation to estimate household expenditure data for 2015/16 and 2017/18.

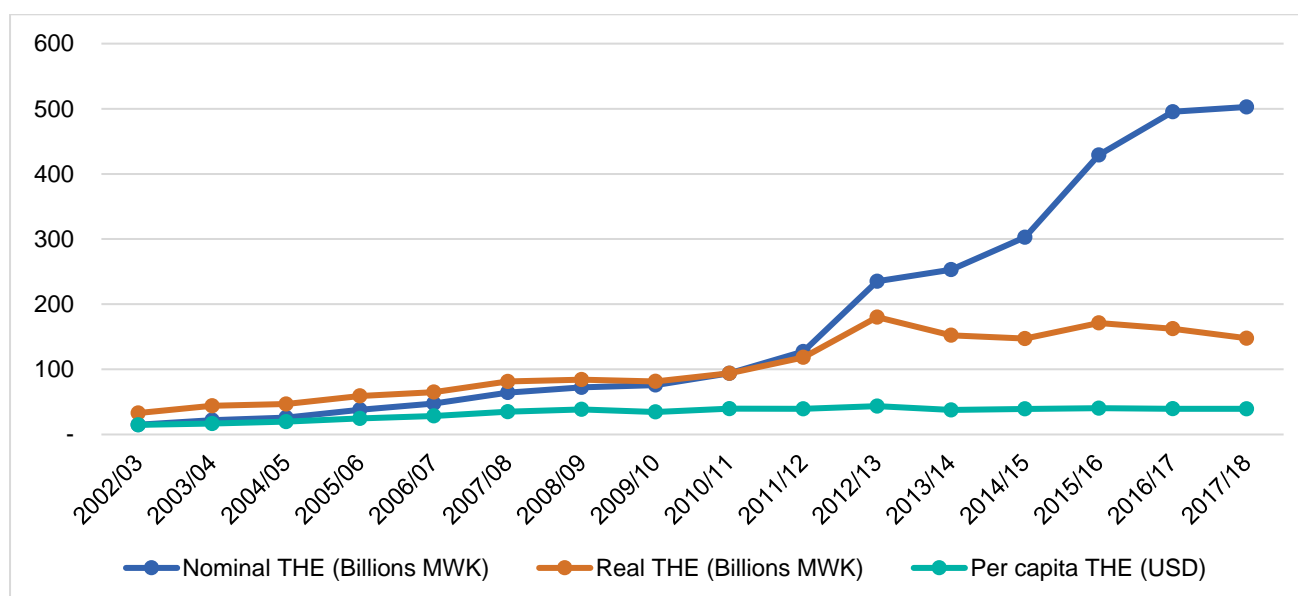
Exchange rate data were collected from the website of the Reserve Bank of Malawi (RBM, n.d.). For each year of analysis, an average exchange rate (U.S. Dollar to Malawian Kwacha) was calculated from July to June to coincide with the Malawian fiscal year. In 2015/16, this rate was USD 1 to MWK 623. In 2016/17, the exchange rate was USD 1 to MWK 723; in 2017/18, it was USD 1 to MWK 725.

## Results

### Trend in Total Health Expenditure

In nominal terms, total health expenditure increased from MWK 429.1 billion in 2015/16 to MWK 502.8 billion in 2017/18 (Figure 2). In real terms,<sup>1</sup> however, total health expenditure fell during the three-year period, from MWK 171.2 billion in 2015/16 to MWK 147.8 billion in 2017/18. Nominal average per capita total health expenditure for the period was USD 39.8, which is slightly higher than the USD 39.2 that was recorded for the preceding three-year period (2012/13–2014/15). Realized per capita total health expenditure for Malawi (USD 39.8) is comparable to per capita total health expenditure in low-income countries, which is USD 41 per year (WHO, 2019).

Figure 2: Trend Analysis of Total Health Expenditure (THE) in Malawi's Health Sector



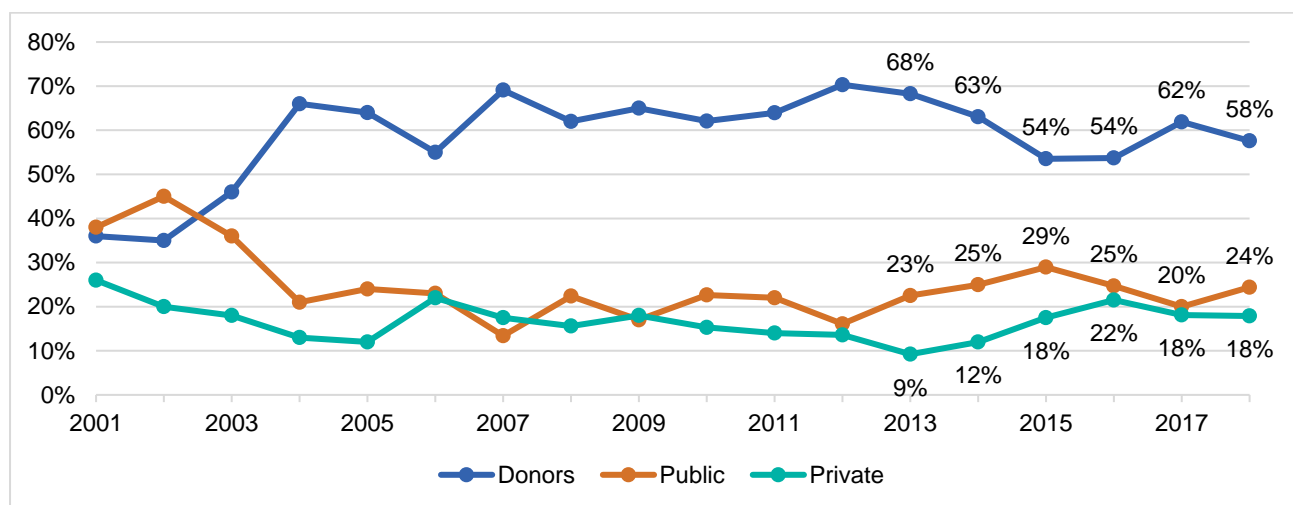
<sup>1</sup> 2010 Consumer Price Index is set at 100 (World Bank, 2019). This implies that all nominal total health expenditures have been adjusted for inflation with 2010 as a base year.

The realized nominal per capita total health expenditure falls short of the World Health Organization’s recommended threshold of USD 86 per capita per year for the implementation of a minimum set of cost-effective interventions in low-income countries (WHO, 2015). The amount is also far lower than the 2016 Southern Africa Development Cooperation average of USD 200.8 per capita. Due to this gap, Malawi may not be able to provide all key essential services to its people. In addition, countries in the Southern Africa Development Cooperation region that have lower maternal mortality rates tend to have relatively high per capita spending, which implies that Malawi will likely struggle to bring down the maternal mortality rate without increasing per capita spending.

### Who is Funding the Malawi Health System?

Donors have continued to provide the majority of resources in the health sector, at 58.6 percent of total health expenditure during the period of study, though this is a decrease from an average of 61.6 percent between 2012/13 and 2014/15 (Figure 3). Public funds have also decreased during the period of study, from 25 percent of total health expenditure to 23.9 percent. Private health expenditure, which consists of household out-of-pocket expenditure, medical insurance, and other corporate funds, rose from an average of 13.4 percent of total health expenditure between 2012/13 and 2014/15 to 17.5 percent of total health expenditure during the period of study. The major source of increases in private expenditure was the rise in household out-of-pocket expenditures on health, from an average of 8.6 percent of total health expenditure between 2012/13 and 2014/15 to 12.6 percent during the period of study. This suggests that the sustainability of healthcare financing in Malawi is relatively weak as it relies on a high percentage of funds from external sources and high out-of-pocket expenditure.

Figure 3: Trend Analysis of Sources of Health Financing in Malawi



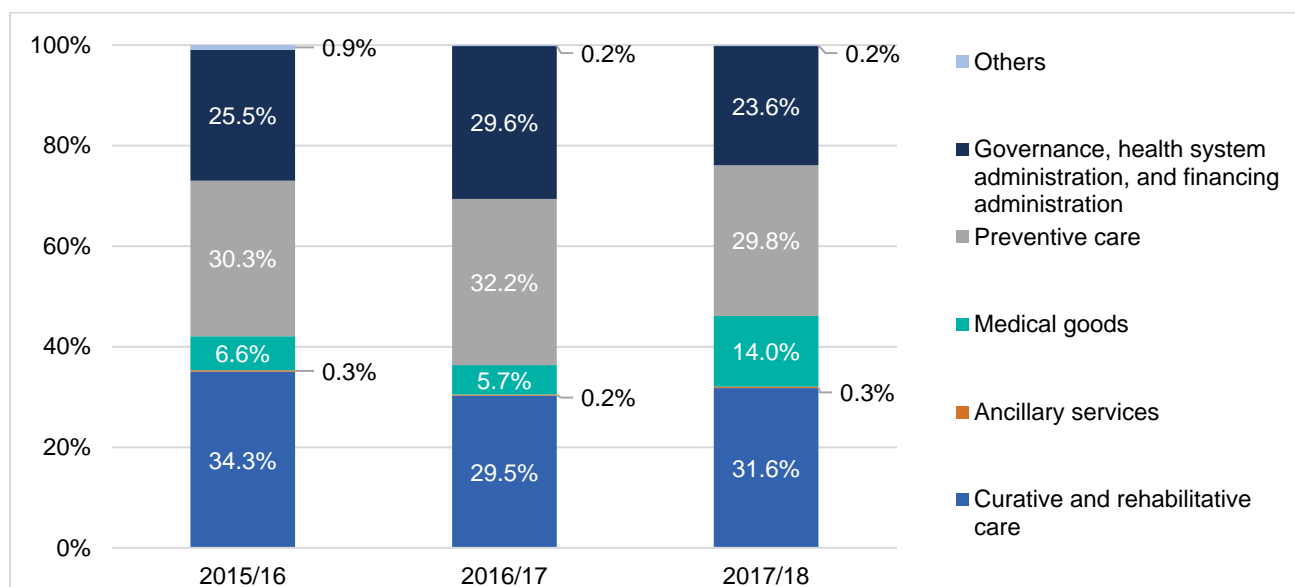
Although the Malawian healthcare system has a larger share of donor spending compared to other low-income countries (58.6 percent compared to 27 percent) (WHO, 2019), the decreasing trend in donor support is worrisome given the lack of corresponding increases in funding from other sources. It is therefore important that the government institute and enforce good financial management to regain donor confidence. Increases in out-of-pocket expenditure are also of significant concern as this implies a lack of risk pooling across the population, as well as a lack of financial risk protection for patients.

### Health Spending per Function: What are the Patterns?

Curative and rehabilitative care and preventive care have the highest spending as a percentage of total health expenditure (Figure 4). Significant resources are also spent on governance and administration, averaging 26.2 percent of total health expenditure over the period of analysis. A higher share of curative care spending implies potential inefficient spending as preventive interventions are typically

more cost-effective (WHO, 2014). It is therefore important to re-orient healthcare service spending toward preventive and/or primary healthcare functions to gain efficiencies. The relatively high share of spending on governance and administration is largely due to the pooling fragmentation of non-state actors. Stronger public financial management should provide more confidence in government systems and—ideally—increase adoption of these systems by donors.

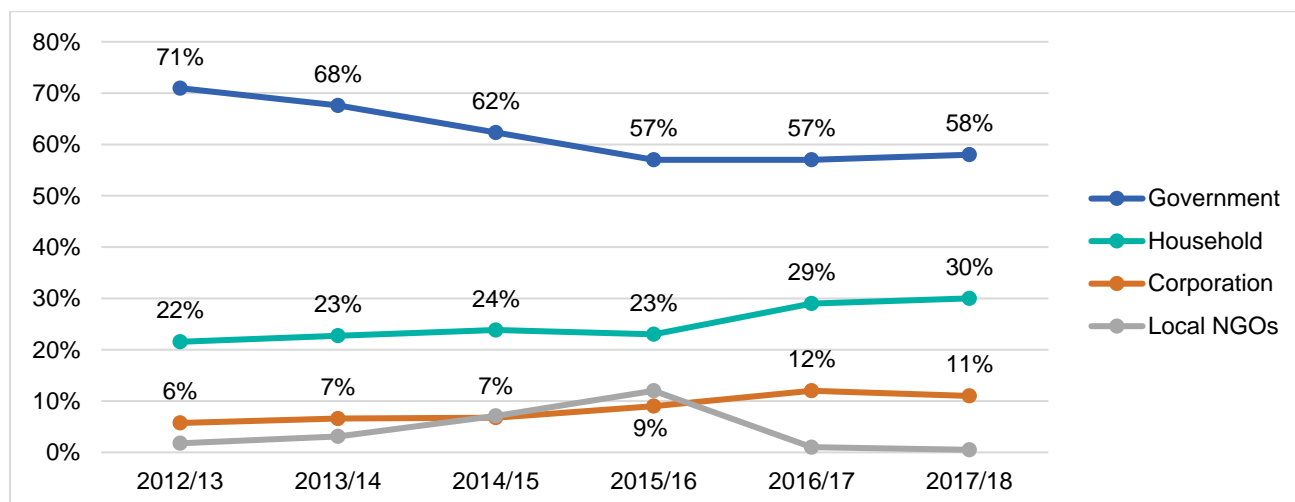
Figure 4. Health Spending per Healthcare Function (as a Percentage of Total Health Expenditure)



### Financial Burden on Households Relative to Domestic Expenditure on Health

The percentage share of health funding from households with respect to total domestic resources, which is a source of inequities in financing, has been increasing since the last NHA study period. Health financing contributions by households' out-of-pocket payments relative to domestic resources averaged 30.5 percent over the three years of study (Figure 5). A key possible reason for this is the unavailability of essential medicines or commodities in public facilities, which forces individuals to buy medicines themselves and/or seek care elsewhere where they pay out-of-pocket. The situation is not in line with the World Health Organization's health financing policy recommendations for universal health coverage, which recommends that countries move toward predominantly prepaid funds to provide financial protection to the poor.

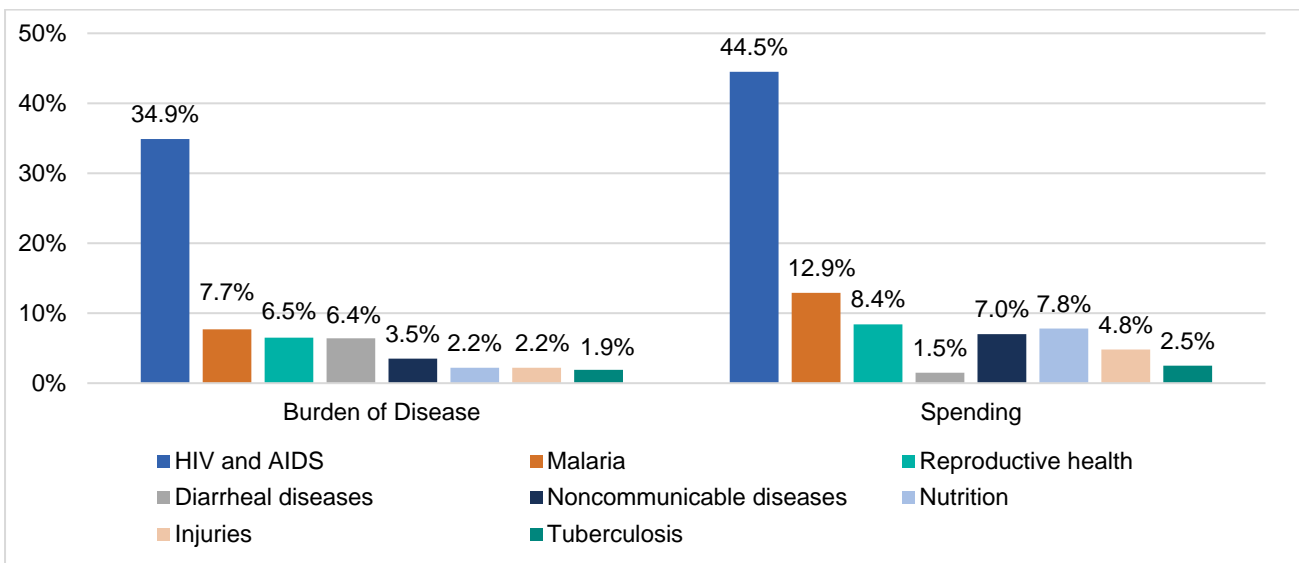
Figure 5. Percentage Share of Household Funds Devoted to Health against Total Domestic Resources



## Burden of Disease versus Resource Allocation

As shown in Figure 6, HIV/AIDS, malaria, and reproductive health collectively account for 66 percent of total health expenditure. This corresponds to the fact that these programmatic areas are the greatest contributors to Malawi’s burden of disease, which stands at 58 percent, collectively. A public expenditure review of these three areas could unearth key drivers of spending. A study by the World Bank (2016) showed that there are allocative inefficiencies within HIV/AIDS spending—which, if addressed, could improve epidemiological outcomes and reduce the level of spending required. Diarrheal diseases account for 1.5 percent of total health expenditure; however, their contribution to burden of disease is four-fold, at 6.4 percent. Greater spending in this area may produce significant health gains and alleviate its contribution to Malawi’s burden of disease.

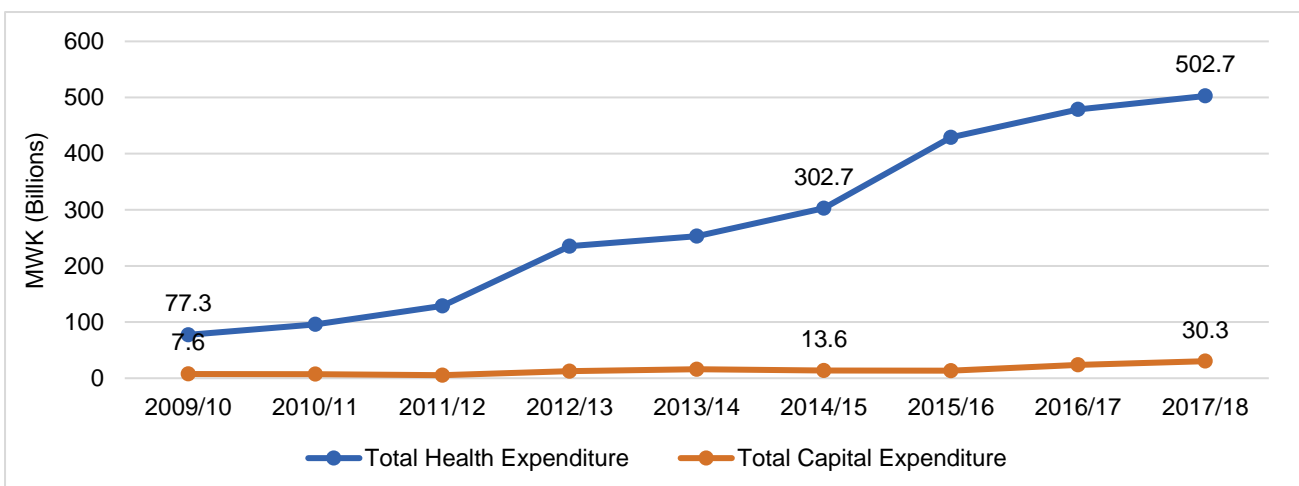
Figure 6. Comparison of Burden of Disease versus Spending (as a Percentage of Total Health Expenditure)



## Capital Expenditure versus Total Health Expenditure

As displayed in Figure 7, nominal total health expenditure has been increasing since 2009/10. However, nominal capital expenditure has remained relatively constant. According to a 2016 assessment, Malawi’s health infrastructure stock is aging and has suffered from a lack of maintenance over many years, leading to a deterioration in conditions and, in some cases, directly affecting service delivery (MOH, 2018).

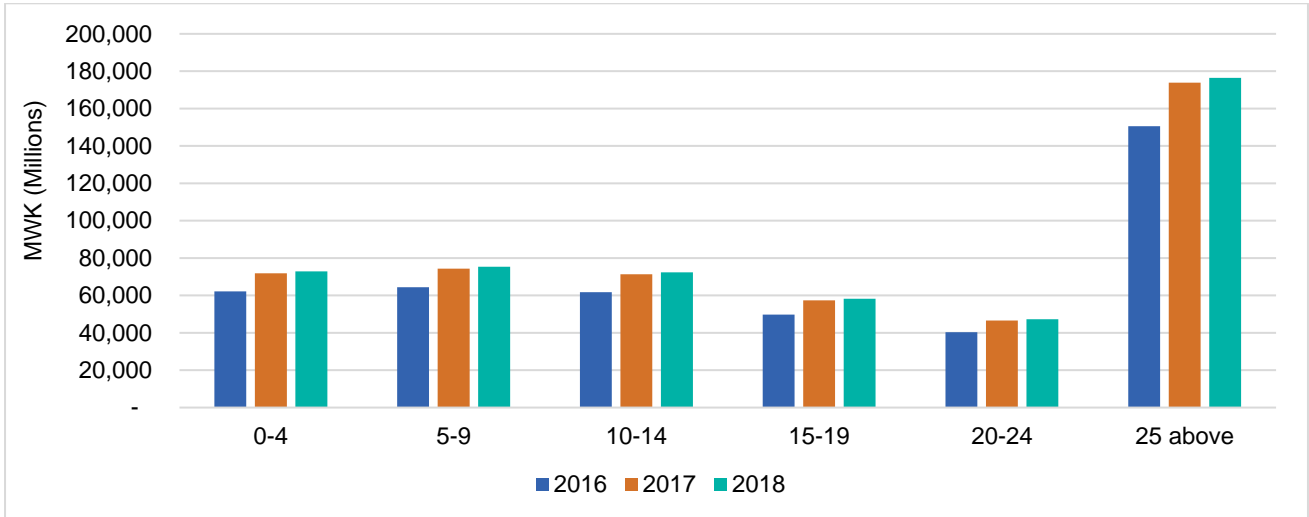
Figure 7. Trend Analysis of Capital Health Spending against Total Health Expenditure, 2009/10–2017/18



## Spending by Beneficiary Characteristics (Age and Sex)

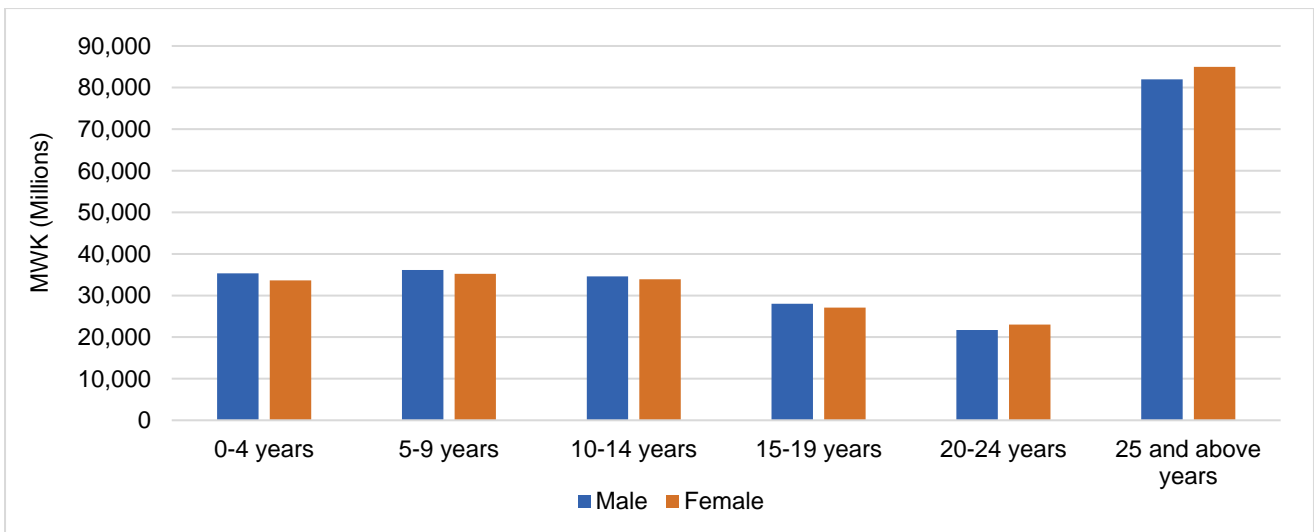
Across age groups, similar spending patterns are apparent for those who are 0–4, 5–9, and 10–14 years of age (Figure 8). Spending is relatively lower for those between 15 and 19 years of age and is lowest amongst those ages 20–24. Spending is highest for individuals age 25 and above. Given that 50 percent of all Malawian women ages 15–19 have started childbearing, existing resources and further investments in this age group should focus on family planning and comprehensive sexuality education.

Figure 8. Spending by Age Group



Between ages 0–19, spending is marginally higher in males than in females (Figure 9). Among those age 20 and above, spending is marginally higher among women. These slight differences could be explained by consumption of maternal health services by women age 20 and above. Increasing spending on contraceptives in the 15–19-year age bracket could result in higher overall spending by this cohort; however, this may also reduce the age-specific fertility rate for this group and therefore the consumption of maternal services.

Figure 9. Spending by Age Group, Disaggregated by Sex



## Key Policy Recommendations

- The NHA exercise shows that donor funding and out-of-pocket payments are relatively high in terms of domestic financing of Malawi's health sector. This has implications for both sustainability and equity. Opportunities should be identified to mobilize additional domestic resources and focus on allocation of budgets within the health sector so that available funds are used efficiently and equitably.
- The health financing structure, which is very diverse, could potentially be enhanced by providing donor on-budget support to fund key priorities identified jointly with the government. The Health Services Joint Fund is a good example of this.
- The Ministry of Health should focus on improving allocative efficiencies in the areas of HIV/AIDS, malaria, and reproductive health. This could entail focusing on preventive activities (World Bank, 2016). The ministry should also conduct efficiency analyses on whether high spending in nutrition and injuries and low spending in diarrheal diseases as compared to their burdens of disease represents inefficiencies and/or high marginal costs of providing these services.
- The Ministry of Health and its donor partners should focus health spending on primary healthcare and preventive health services that are generally considered to be more cost-effective and would be a good investment of scarce resources.
- The Ministry of Health and its donor partners should increase allocation and spending on capital items such as infrastructure, medical equipment, training, and research, which could lead to improved quality of health services.
- The Ministry of Health and its donor partners should invest more in family planning services for the adolescent age group, which would have a beneficial impact on high fertility rates (and other social impacts of early parenthood).

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## Acknowledgments

This brief has been developed with technical assistance from the U.S. Agency for International Development (USAID) through the Health Policy Plus (HP+) project. The full report was funded by UKAID through USAID's HP+ project and the World Health Organization (WHO). The Ministry of Health would like to thank UKAID, USAID, and WHO for their contributions.