Republic of Malawi

Ministry of Health

Summary of the National Health Financing Strategy (2023–2030)

1. INTRODUCTION

The 2023-2030 National Health Financing Strategy (HFS) of Malawi provides detailed mechanisms through which the National Health Policy (2018–2030) and the Health Sector Strategic Plan (HSSP) III (2023–2030) will be financed. It sets out the key health financing strategies that will enable the country to improve on its universal health coverage (UHC) indicators.

2. SITUATION ASSESSMENT

Macroeconomic Performance

Macroeconomic performance for Malawi is generally poor. From 2016 to 2020, economic growth averaged 3.2 percent per year, far below the required 6 percent rate for sustainable poverty reduction.[1] This finding suggests that Malawi will likely remain a low-income country for the foreseeable future and require continued donor support to provide adequate and good-quality healthcare services.

Table 1: Macroeconomic Performance for Malawi (2016–2020)

Variable	2016	2017	2018	2019	2020
Gross domestic product (GDP) per capita, (current US$)	316	506	545	592	637
Annual GDP growth rate (%)	2.5	4.0	4.4.	5.4	0.8
Inflation (annual %)	19.5	13.5	6.1	7.7	10.2
Total government revenue (% of GDP)	14.8	15.8	15	14.8	14.7
Tax revenue (% of GDP)	15.5	12.2	12.2	12	11.7
Total government pending (% of GDP)	19.7	21	19.4	19.3	22.8

Source: World Bank. 2022. “World Development Indicators 2022.” Available at: Malawi | Data (worldbank.org).

[1] International Monetary Fund. 2017. “Malawi Economic Development Document.” IMF Country Report No. 17/184. Available at: https://www.imf.org/en/Publications/CR/Issues/2017/07/05/Malawi-Economic-Development-Document-45037.

In addition, Malawi has low fiscal capacity for improving its expenditure on public services, including health. The share of total government revenue in the gross domestic product (GDP), the share of tax revenue as a percentage of GDP, and total government spending as a percentage of GDP all point to a very limited fiscal space for the government to improve its expenditure on health in absolute terms.

Universal Health Coverage Performance

Table 2: Summary of UHC General Performance in Malawi

Domain	Unadjusted Score for Equity (%)	Adjusted Score for Equity (%)
Service coverage	53.99	51.74
Financial risk protection	97.45	94.1
UHC score	75.28	69.77

Source: Ministry of Health (2021).

Malawi is performing relatively well in the UHC score index, largely because of its very high financial risk protection score. It is therefore important to maintain the solidarity principle whilst ensuring increases in domestic financing.

Health Financing System Performance

The solidarity principle is a key feature of Malawi healthcare system financing. It is realised through tax contributions and donor financing, which ensure that individuals unable to pay for services can access the same for free at the point of care. Table 3 presents key health financing data for Malawi.

Table 3: Selected Health Financing Indicators for Malawi

Variable	Current Value
Per capita total expenditure on health (US$)	39.9
Total health expenditure (THE) as % of GDP	8.8%
Government expenditure on health as % of THE	24.1%
Donor expenditure on health as a % of THE	54.5%
Government per capita THE (US$)	9.6
Government THE as % of total government expenditure	8.4%
Total private health insurance spending as % of THE	9.1%
Out-of-pocket expenditure on health as % of THE	11.9%
Total expenditure on primary healthcare as a % of THE	39.7%
Percentage of THE pooled under government financing scheme	40.3%
Percentage of THE managed by government agents	39.4%
Percentage of THE spent on HIV/AIDS	40%

Source: Malawi National Health Accounts (2022).

The Malawi health system is heavily under-resourced, with per capita total health expenditure at an estimated US$39.90 compared to the recommended public sources expenditure of US$86 for low-income countries such as Malawi. The system's financing is highly donor dependent, with 54.5 percent of all resources coming from donors; 40.3 percent of all resources are pooled under the government scheme. However, the percentage of resources managed by the government is slightly less, at 39.4 percent of THE, indicating less control by the government in making direct expenditure decisions.

Allocative inefficiency is demonstrated by low expenditure on primary healthcare entities and preventive healthcare expenditures, standing at 39.4 percent. However, this situation likely occurs because secondary- and tertiary-level healthcare providers also predominantly provide primary healthcare services, thus compounding the efficiency challenges.

Public Financial Management (PFM) and Healthcare Service Delivery

Table 4: PFM Performance, by Budget Phase with Respect to Health Service Delivery Goals in Government Health Facilities

Budget Phase	**Health Service Delivery Goals**			
	Efficiency	**Equity**	**Quality**	**Accountability**
Formulation	D+	C	C	D+
Execution	B	B	C+	B
Evaluation	C	D	B	C

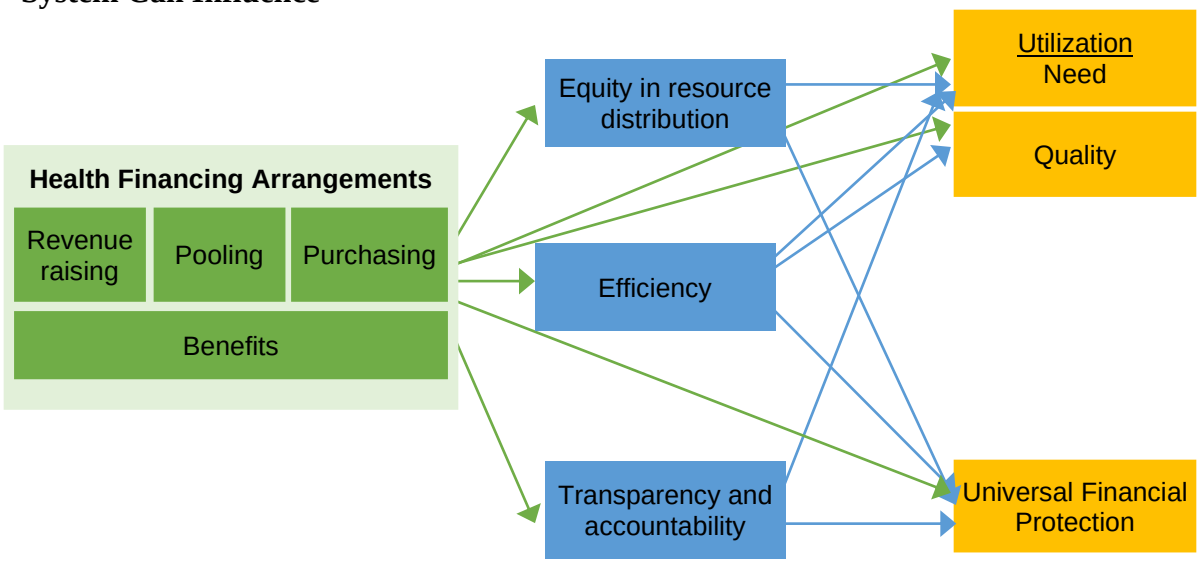
Source: Adapted from World Bank. 2021. "Public Financial Management in the Health Sector: An Assessment at the Local Government Level in Malawi." Washington, DC: The World Bank. Available at: World Bank Document.

The performance of the Government of Malawi (GoM) is very weak in its PFM of the budgeting cycle for achieving public health service delivery goals in the country, especially at the budget formulation stage, where efficiency and accountability are weakest, as shown in Table 4.

3. THEORY OF CHANGE

The fundamental reason for the GoM to develop the HFS is to provide key tools to policymakers and other stakeholders to achieve UHC in a systematic manner. Figure 1 provides the pathways from health financing to the achievement of UHC goals.

Figure 1: UHC Framework-Goals and Objectives of UHC that the Health Financing System Can Influence



Source: McIntyre D., and J. Kutzin. 2016. Health Financing Country Diagnostic: A Foundation for National Strategy Development. Health Financing Guidance No. 1. Geneva: World Health Organization.

The theory of change is that if the Malawi health system raises adequate funds and pools them towards implementing a UHC-oriented plan—thus reaching intermediate objectives on the pathway to UHC, such as equity in resource distribution, efficiency, transparency, and accountability—users of the health system will be financially protected and able to access quality health services as they need them without incurring undue financial hardships.

4. STRATEGIC FRAMEWORKS

Vision

A fully functional healthcare financing system that supports the achievement of UHC aspirations as espoused in the constitution, the National Health Policy, and health sector strategic plans.

Goal

To set a well-governed health financing architecture able to mobilise adequate resources, distribute the resources in an efficient and equitable way, and strategically purchase services based on a well-defined benefit package in pursuit of UHC goals.

Objectives

i. Mobilise adequate, sustainable, and predictable funds for the health sector to optimally deliver essential health services

ii. Improve efficiency and equity in pooling and managing resources for the health sector

iii. Develop and implement strategic purchasing measures across the healthcare service delivery continuum

iv. Establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system

Objective 1: *Mobilise adequate, sustainable, and predictable funds for the health sector to optimally deliver essential health services*

The dominant strategic thrusts under this objective are "more health for the money," and "more money for health,". Under "more health for the money," the strategy will focus on achieving efficiencies and equity in resource use and outcomes. Efficiencies and equity will be pursued in the area of medicines, such as achieving better integrated supply chains, establishing national or regional plants to manufacture medicines in high demand and use, purchasing medicines as part of a regional bloc, and moving away from inefficient Buy Malawi strategies. Other areas of efficiency reforms will be made in in-service trainings, service integration, and public health infrastructure management.

Under "more money for health," the HFS will focus on getting the government to contribute more funding through co-financing mechanisms and demonstrating key achievements gained through government financing. The co-financing will be primarily targeted at infrastructure, family planning products, HIV/AIDS, and medical equipment. Community contributions towards the cost-of-service delivery and health system maintenance will be formally promoted. External assistance will remain important for the next eight years and will be pursued more actively, including by district health system officials. Innovative financing, such as public-private partnerships (PPPs), debt2health, earmarked taxes, and social bonds will be pursued.

Objective 2: *Improve efficiency and equity in pooling and managing resources for the health sector*

The key principle guiding the HFS is "one plan, one budget, and one monitoring and evaluation plan." To this end, the HFS will ensure a reduction in project-based implementation, with a greater focus on enhancing direct financing mechanisms such as government-to-government (G2G) initiatives and the transforming the Health Services Joint Fund (HSJF) into a multi-donor fund. Also, a real-time, transparent aid coordination mechanism will be implemented across all levels. District leadership will be supported with necessary regulations, bylaws, and policies to ensure that district-based partners are in line with government priorities as set out in the HSSP III and respective district implementation plans (DIPs). In addition, absorption of donor funds under government management will be enhanced through capacity building in procurements, infrastructure management, and in-service trainings.

Objective 3: *Develop and implement strategic purchasing measures across the healthcare service delivery continuum*

A new health financing mechanism will focus on active purchasing of services through strict enforcement of the Health Benefit Package[2] (HBP) financing provisions, direct disbursement of funding to subdistrict facilities, performance-based financing (PBF), and explicit financing formulae for district and central hospitals. Active purchasing will entail signing specific contracts with public providers of care to provide the HBP with specific details of payment modalities.

Direct facility financing will be designed similarly to the primary school improvement grants (PSIG). However, these will be augmented by PBF mechanisms to get additional value from the financial autonomy accorded to subdistrict public facilities. Explicit resource allocation and reimbursement formulae will be applicable to central and district hospitals.

Objective 4: *Establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system*

Building capacity in health financing across stakeholders will be a key undertaking in the HFS. Capacity will be strengthened in human, technological, and financial resources, amongst other key areas. The Health Financing Division (HFD) will be a key beneficiary of this capacity building; staff numbers will need to grow and staff capacity built in health financing research and analysis. In addition to the HFD, other stakeholders singled out as requiring capacity building in the area of health financing are civil society organisations (CSOs) and academia, in their respective areas of health financing needs. For CSOs, a specific health financing advocacy strategy and curriculum will be developed, and a platform for CSO engagement with policymakers on health financing will be established. For academia, capacity will be built in the areas of policy-relevant health financing research.

The proposed new health financing architecture will require new laws, regulations, and policies. A health financing law has been proposed to allow for effective community contributions, use of national identification in accessing services, and improved provider payments, amongst other possibilities. In addition, new laws on medical aid insurance, health trust funds, and national health insurance have been proposed. Regulations also will be developed to guide strategic purchasing of services, a requirement for economic evaluation evidence before implementing key programmes and establishing prime vending lists for private suppliers. Specific health financing platforms, such as an annual health financing summit, a multisectoral committee on sustainable health financing, and ministerial health financing fora will also be established.

[2] In HSSP III, the Health Benefit Package (HBP) replaces the essential health package.

5. THE NEW HEALTH FINANCING ARCHITECTURE AND ITS IMPLEMENTATION ARRANGEMENTS

Implementation of the laws, regulations, and policies mentioned above will lead to a new health financing structure (Figure 2) featuring the following key elements:

i. Gradual replacement of traditional donor funding with new mechanisms of donor and domestic financing, such as structured financing (e.g., PPPs, debt2health) and more community involvement in health financing, hypothecated taxes

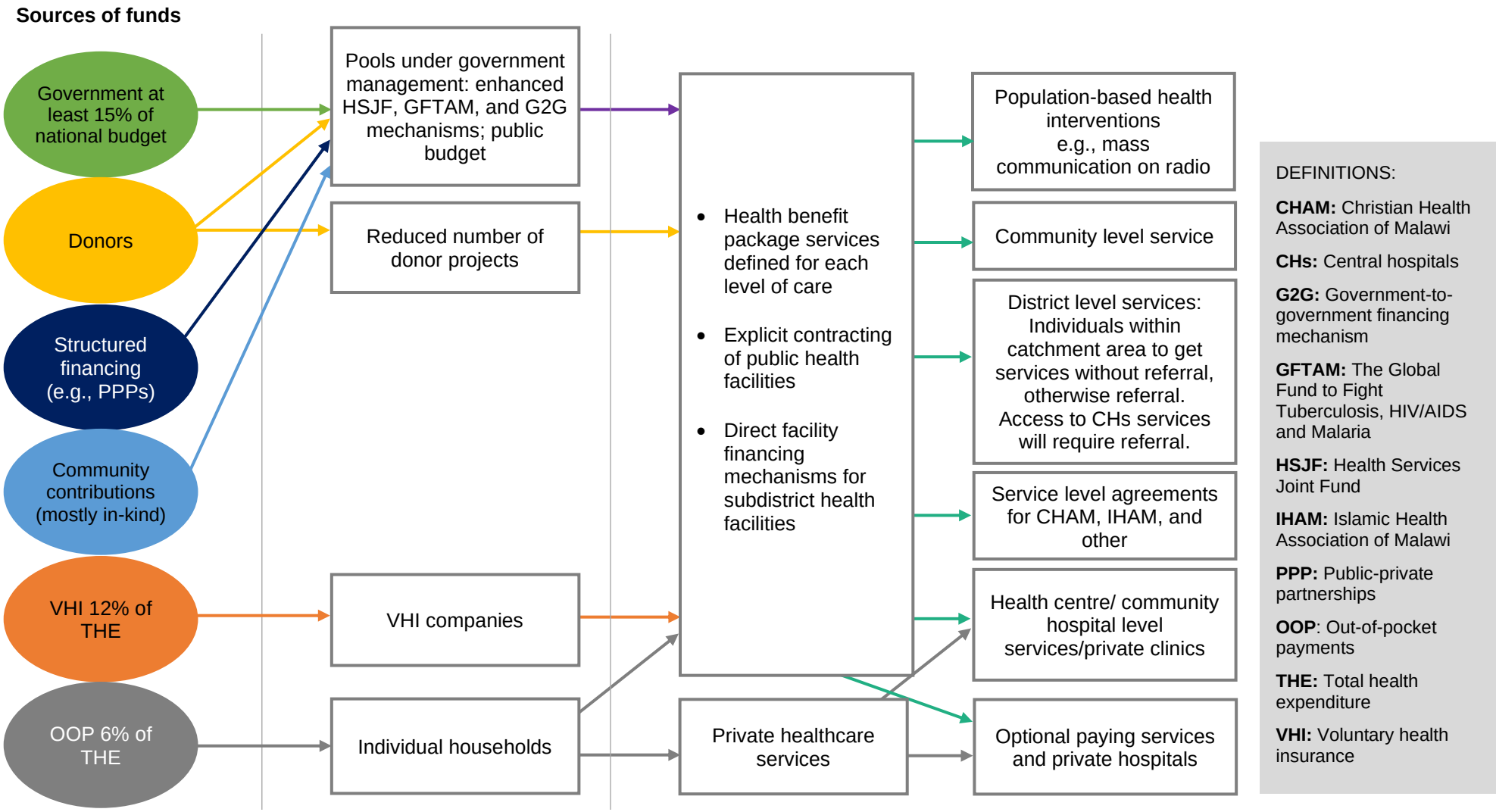
ii. Emphasis on "one plan, one budget, one monitoring and evaluation framework," with the plan being the HSSP III; the financing mechanism will therefore shift to more pooled funding under the HSJF, G2G financing, and better coordination with discrete funders

iii. Health benefit packages defined at all levels of care for each level (health service delivery platform); these packages will be enforced through formal contracts in public healthcare delivery centres.

iv. Access to care in public health facilities will be guided by the following principles:
   - Use of national identification
   - Use of a unified beneficiary registry to identify the poor
   - Use of medical aid insurance by formal-sector employees who have it to pay for public health services; those without insurance but who contribute using pay as you earn (PAYE) will be exempted
   - A requirement that informal-sector non-poor contribute towards healthcare through making a payment upon accessing services or using prepayment mechanisms, such as private medical insurance
   - A requirement that non-nationals purchase medical aid insurance upon entry into the country

v. Intentional capacity building of stakeholders, especially the HFD, to manage and implement the new health financing structure

Figure 2: The New Health Financing Architecture



6. STAKEHOLDERS

The key stakeholders are as follows:

i. Department of Planning and Policy in the Ministry of Health (MoH), which serves as the custodian of the HFS

ii. Health Financing Technical Working Group, within which coordination of health financing issues and activities takes place

iii. Ministry of Finance and Economic Affairs, which serves as the custodian of public financial management policies and the government's funds

iv. Ministry of Local Government, which serves as the policy holder for decentralisation

v. PPP Commission, which is legally mandated to oversee PPP transactions in Malawi

vi. Members of the health donor group, who contribute towards health sector financing

vii. Private sector players, including academia, CSOs, providers of healthcare services, and private financiers

7. MONITORING AND EVALUATION

The following are the key selected indicators for the strategy.

Variable	Current Value	2030 Target
Equity-adjusted UHC Index score	69.68%	85%
Equity-adjusted Reproductive Maternal Neonatal Child Health Coverage Index score	57.6%	81.4%
Percentage of households making catastrophic payments for healthcare using the 10% of total consumption basket spent on healthcare	4.2%	2.1%
Equity-adjusted financial risk protection score	94.1%	97.05%
Proportion of households with catastrophic out-of-pocket expenditure exceeding 40% of non-food expenditure	1.34%	0.67%
Medical impoverishment rate	3.75%	1.88%
Percentage of facilities able to deliver the full EHP, based on their level	73%	90%
Per capita health expenditure (US$)	US$39.40	US$86
General government domestic THE as % of total government expenditure (GGHE-D/GGE)	8.8%	15%
Total expenditure on primary healthcare providers and preventive services as a % of THE	39.7%	60%

Variable	Current Value	2030 Target
Percentage of resources managed by government agents	39.4%	78.8%
Percentage of key health financing stakeholders whose financial resource tracking data are routinely available in the DHIS2 (for simplicity, key stakeholders will be defined as all district health offices, all central hospitals, key donors [10], National Aids Commission, and MoH)	0%	100%
Number of health financing laws enacted (voluntary insurance law, health trust funds law, national health financing law	0	3