Better Health Outcomes from Limited Resources

Focusing on Priority Services in Malawi

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Better Health Outcomes from Limited Resources:

Focusing on Priority Services in Malawi

Oscar F. Picazo

Africa Region
The World Bank
The views expressed herein are those of the author and do not necessarily reflect the opinions or policies of the World Bank or any of its affiliated organizations.

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Cover design by Tomoko Hirata.
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Foreword

In order to identify appropriate policy and administrative measures to address development issues in the health sector, it is helpful to have access to country-specific knowledge that sheds light on the key weaknesses in the health system. In a large number of Sub-Saharan countries, however, such a knowledge base remains sparse, reflecting the absence or sometimes systematic neglect of analytical work in the past. The present report deals with health financing issues in Malawi and analyzes trends in health expenditures in the 1990s, along with the prospects for improving resource mobilization, allocation and use in the health sector of that country.

Malawi's major public health issues include HIV/AIDS, poor reproductive health and severe constraints in the availability of health personnel, drugs and other supplies, in conjunction with a very limited capacity of the Government to define and implement good health policies. The most pressing challenges include defining a cost-effective and sustainable package of health services that the Government can commit itself to finance, reaching a consensus on an appropriate division of responsibility between the public and private sectors for financing and delivering health services, setting sustainable levels of health worker remuneration, and creating institutional arrangements for efficient management. Reform in these areas are key to improving the quality of health services in Malawi.

The Government of Malawi has committed itself to addressing the deficiencies in the health system under its proposed debt relief program. In order to do so, an infusion of additional resources, from both domestic and international sources, may well be needed. However, an equally important issue is ensuring that currently available resources are used efficiently and equitably. The evidence suggests that in Malawi, as in many Sub-Saharan countries, substantial scope for progress exists in this regard. The Government of Malawi indeed has begun formulating a reform program to improve the performance of the health system, including a "fast-track" approach to produce more trained health workers (especially nurses), restructure the pharmaceutical distribution system, increase government financing of key health sector recurrent inputs, gradual decentralization of health services, and a more coordinated approach to donor assistance in the health sector. However, much more remains to be done, particularly in tackling the institutional and human-resource capacity constraints.

The publication of this health expenditure review for Malawi is intended to contribute to our collective knowledge about the country's health sector and the nature of the policy challenges, and
to share that knowledge where possible. It is my hope that as new knowledge emerges in the course of implementing the country's poverty reduction strategy, this knowledge will be instrumental in overcoming the constraints in the health sector that currently impede poverty reduction in Malawi.

Ok Pannenborg
Senior Health Advisor and Sector Leader for Health, Nutrition and Population
Human Development
Africa Region
Better Health Outcomes from Limited Resources:

Focusing on Priority Services in Malawi

Africa Region Human Development Working Paper Series
Introduction

Malawi is one of the poorest countries in the world, with a per capita income of around US$180 in 1996. Its demographic profile exhibits a population that is high growth (2.8 percent a year), young (47.5 percent are below 15 years of age), mostly rural (77.7 percent), and has a very high dependency ratio (97 dependents for every 100 adults of working age). Malawi's public spending on health has historically been high (at least until 1993/94) relative to other Sub-Saharan countries and developing nations with comparable GNP per capita, but the country's living conditions are among the poorest in the world. Although physical access to a health facility has improved over the years, access to functional health services continues to be limited as indicated by low provider-to-population ratios and often severe unavailability of drugs, contraceptives, and other supplies. As much as 54 percent fell below the given household-income poverty line in the mid-1990s. There is no recent update on poverty, but given the poor economic performance throughout the 1990s, one can infer that the situation has not improved dramatically. Life expectancy at birth has fallen from 45 years in 1982 to 42 years in 1998, due largely to the AIDS epidemic. The economic slowdown that began in 1994/95 and the continuing decline in the international price of Malawi's key export (tobacco) on which a large proportion of Malawians depend, have added to the complexity of making appropriate recommendations to improve health sector performance.

This health expenditure review (HER) provides occasion to take stock of Malawi's performance in the health sector. The paper reviews the status of the country's health expenditures, identifies issues on the level and quality of these expenditures, and provides recommendations to improve resource mobilization, resource allocation, and organizational efficiency. Section 2 of the paper summarizes the key findings and recommendations. The next four sections deal with the various sources of health financing: section 3 on government health expenditures, section 4 on extra-budgetary funds, section 5 on private sector financing, and section 6 on donor financing. Section 7 analyzes the implications of the Malawi National Health Plan while section 8 examines reform proposals related to sector efficiency and improvement.
### Table 1
**Key socioeconomic and health indicators in Malawi: various years**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Latest Year Available</th>
<th>Latest Year Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>mid-1999</td>
<td>10.8 million</td>
</tr>
<tr>
<td>Avg. annual growth of pop.</td>
<td>1990-1998</td>
<td>2.8 percent</td>
</tr>
<tr>
<td>Percent urban population</td>
<td>1998</td>
<td>22.3 percent</td>
</tr>
<tr>
<td>Growth of urbanization</td>
<td>1990-98</td>
<td>9.5 percent</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>1998</td>
<td>6.4 children</td>
</tr>
<tr>
<td>Crude birth rate</td>
<td>2001</td>
<td>47 per 1,000 population</td>
</tr>
<tr>
<td>Crude death rate</td>
<td>2001</td>
<td>23 per 1,000 population</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>1998</td>
<td>42 years</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>1998</td>
<td>134 per 1,000</td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>1998</td>
<td>229 per 1,000</td>
</tr>
<tr>
<td>Maternal mortality rate</td>
<td>1999</td>
<td>620 per 100,000</td>
</tr>
<tr>
<td>Adult HIV-1 seroprevalence per 100 adults</td>
<td>End-1999</td>
<td>16.1</td>
</tr>
<tr>
<td>Children 0-1 immunized against DPT</td>
<td>1998</td>
<td>96 percent</td>
</tr>
<tr>
<td>Children 0-1 immunized against measles</td>
<td>1998</td>
<td>90 percent</td>
</tr>
<tr>
<td>Oral rehydration therapy use among under-5 children</td>
<td>1992-93</td>
<td>50 percent</td>
</tr>
<tr>
<td>Percent of infants with low birth weights</td>
<td>1991-94</td>
<td>10 percent</td>
</tr>
<tr>
<td>Population per physician</td>
<td>1990-96</td>
<td>33,344</td>
</tr>
<tr>
<td>Population per hospital bed</td>
<td>1990-96</td>
<td>625</td>
</tr>
<tr>
<td>Percent of births attended by trained health personnel</td>
<td>1990-95</td>
<td>57 percent</td>
</tr>
<tr>
<td>GNP per capita (Atlas dollars)</td>
<td>1999</td>
<td>US$180</td>
</tr>
<tr>
<td>Public health expenditures as percent of GDP</td>
<td>1990-97</td>
<td>3.3 percent</td>
</tr>
</tbody>
</table>

This review highlights the need to further prioritize the activities under the Malawi National Health Plan so that the plan will be a basis for government policy and budgetary commitments and also an instrument to marshal and orchestrate donor support to the sector. Once the government has determined that its core function under the Plan is the provision of an essential package of health services, it needs to translate this policy aim into budgetary allocations at both the central and district levels. It also needs to ensure that inputs, especially drugs, medical supplies, and trained staff, are made available to support the delivery of the package. Health services not included in the package should be subject to fees, either on a modest cost-sharing or on a full-cost recovery basis. The fiscal crisis has underscored the importance of fee revenues to cushion the impact of declining budget allocations to health facilities. Finally, the government needs to focus more on the financing and delivery of district health services and providing for their legal and administrative framework.

The resource envelope and health sector performance

For the first half of the 1990s, Malawi’s health sector enjoyed relatively robust financing as the Government of Malawi (GOM) deliberately increased public funding of social services. In 1993, as much as 7.4 percent of central government expenditures was devoted to health which compared favorably with 4.2 percent for similar countries in Sub-Saharan Africa and 4.8 percent for developing countries with similar GNP per capita. The economic contraction from 1994-95, however, ushered in the budget crunch that continues to this day, dramatically altering the financing picture. Since FY94/95, government health spending has barely kept pace with inflation and population growth, with real per capita expenditures of the Ministry of Health and Population (MOHP) actually declining from MK (Malawi Kwacha) 45.12 to only MK40.91 in FY98-99 (Table 2). Investments made in the first half of the decade (expansion of physical infrastructure) are now wanting in recurrent costs. The government was slow to tap extra-budgetary sources of funds (user fees) to arrest the decline in real per-capita public spending; it was also slow to reconfigure its budget to focus on those services that provided the greatest health impact (promotive and preventive services), choosing instead to allocate the increasingly meager resources to a broad set of services, and allowing donor-funded new capital investments that required additional running costs that could not be provided adequately in the recurrent budget.

Donor resources have risen significantly in nominal terms since FY95/96, which somehow cushioned the adverse impact of a stagnant real per capita MOHP spending. However, since these resources were not designed to directly support the budget except for limited amounts that went to departmental support, donor-funded projects were
Table 2
MOHP recurrent and donor expenditures in the health sector: FY94/95-FY98/99

<table>
<thead>
<tr>
<th>Items</th>
<th>FY94/95</th>
<th>FY95/96</th>
<th>FY96/97</th>
<th>FY97/98</th>
<th>FY98/99</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOHP recurrent expenditures (MK millions)</td>
<td>244.929</td>
<td>334.763</td>
<td>590.747</td>
<td>668.569</td>
<td>753.265</td>
</tr>
<tr>
<td>Donors’ expenditures (US$ millions)</td>
<td>28.2</td>
<td>35.7</td>
<td>50.0</td>
<td>47.1</td>
<td>n.a.</td>
</tr>
<tr>
<td>Number of MK =US$1.0</td>
<td>8.7</td>
<td>15.3</td>
<td>15.3</td>
<td>17.5</td>
<td>43.0</td>
</tr>
<tr>
<td>Donors’ expenditures (MK millions)</td>
<td>245.34</td>
<td>546.21</td>
<td>765.00</td>
<td>824.25</td>
<td>n.a.</td>
</tr>
<tr>
<td>Total expenditures (MK millions)</td>
<td>490.269</td>
<td>880.973</td>
<td>1,355.747</td>
<td>1,492.819</td>
<td>n.a.</td>
</tr>
<tr>
<td>Pop. of Malawi (millions)</td>
<td>9.96</td>
<td>10.25</td>
<td>10.57</td>
<td>10.91</td>
<td>11.24</td>
</tr>
<tr>
<td>MOHP recurrent expenditures per capita (MK)</td>
<td>24.59</td>
<td>32.66</td>
<td>55.89</td>
<td>61.28</td>
<td>67.02</td>
</tr>
<tr>
<td>Donors’ expenditures per capita (MK)</td>
<td>n.a.</td>
<td>53.28</td>
<td>72.37</td>
<td>75.55</td>
<td>n.a.</td>
</tr>
<tr>
<td>MOHP and donors’ expenditures per capita (MK)</td>
<td>n.a.</td>
<td>85.94</td>
<td>128.26</td>
<td>136.83</td>
<td>n.a.</td>
</tr>
<tr>
<td>Price index (1995=1.000)</td>
<td>0.545</td>
<td>1.000</td>
<td>1.354</td>
<td>1.517</td>
<td>1.638</td>
</tr>
<tr>
<td>MOHP recurrent expenditures per capita, at constant 1995 prices (MK)</td>
<td>45.12</td>
<td>32.66</td>
<td>41.27</td>
<td>40.40</td>
<td>40.91</td>
</tr>
<tr>
<td>Donors’ expenditures per capita, at constant 1995 prices (MK)</td>
<td>n.a.</td>
<td>53.28</td>
<td>53.45</td>
<td>49.80</td>
<td>n.a.</td>
</tr>
<tr>
<td>MOHP and donors’ expenditures per capita, at constant 1995 prices (MK)</td>
<td>n.a.</td>
<td>85.94</td>
<td>94.73</td>
<td>90.20</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

Note: There is no consistency between the population figures used by the GOM and those reported in international bodies (such as Population Reference Bureau, the World Bank). The latest Malawi National Census has not yet been finalized. This table uses the GOM population figures.

Source: This review.

kept running well while the government health service delivery system remained underfunded. Also, inflation has reduced the sizeable nominal increase in donor spending, with real per capita donor spending tending to decline.

The difficult economic prospects for Malawi require greater fiscal prudence and better resource allocation in the health sector. Donors continue to show willingness to support the sector (with a large percentage of allocated amounts remaining undisbursed), but a new way of providing and managing donor assistance is imperative. Surveys also show household willingness to contribute to the financing of health care. Finally, nongovernment organizations (for-profit and nonprofit providers alike) can be tapped by the government in pursuit of national health goals. The challenge for the government is to orchestrate these domestic resources, to capitalize on the continuing goodwill of donors, and to explore alternative financing and service-delivery modalities so that health services can be improved.

Though the level of per capita health spending in Malawi has declined since the mid-1990s, it still compares favorably with its neighboring countries. Based on available data, government and donors’ health expenditures per capita in Malawi was US$7.82 in FY97/98 while it was US$4.72 in Kenya and US$8.90 in Tanzania in the mid-1990s (Table 3). As the HER will show, the allocation of Malawi health expenditures by levels of care is not unduly unbalanced and also compares favorably with these countries. But sector performance data indicate that Malawi’s health spending seems not to be yielding the expected health outcomes commensurate with the country’s level and allocation of health expenditures, or commensurate with the reported coverage rates of its health programs. Among four compari-
### Table 3
Malawi health spending and performance compared to other countries in Sub-Saharan Africa: various years

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Malawi</th>
<th>Kenya</th>
<th>Tanzania</th>
<th>Zambia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population in millions (mid-1997)</td>
<td>11.24</td>
<td>28.0</td>
<td>33.3</td>
<td>9.4</td>
</tr>
<tr>
<td>Gov’t expenditures on health per capita (US$)</td>
<td>3.50</td>
<td>3.56</td>
<td>4.23</td>
<td>8.12</td>
</tr>
<tr>
<td>Donor expenditures on health per capita (US$)</td>
<td>4.32</td>
<td>1.16</td>
<td>4.67</td>
<td>5.94</td>
</tr>
<tr>
<td>Gov’t + donors’ expenditures on health per capita (US$)</td>
<td>7.82</td>
<td>4.72</td>
<td>8.90</td>
<td>14.06</td>
</tr>
<tr>
<td>Percentage of HH expenditures per capita spent on health care (1993)</td>
<td>8.0</td>
<td>5.0</td>
<td>n.d.</td>
<td>3.0</td>
</tr>
<tr>
<td>Percentage of children immunized against DPT (1993-95)</td>
<td>98</td>
<td>40</td>
<td>79</td>
<td>76</td>
</tr>
<tr>
<td>Percentage of children immunized against measles (1993-95)</td>
<td>99</td>
<td>35</td>
<td>75</td>
<td>78</td>
</tr>
<tr>
<td>Percentage of births attended by trained health worker (1990-93)</td>
<td>41</td>
<td>n.d.</td>
<td>n.d.</td>
<td>43</td>
</tr>
<tr>
<td>Population per physician (1990-94)</td>
<td>45,737</td>
<td>21,970</td>
<td>n.d.</td>
<td>10,917</td>
</tr>
<tr>
<td>Life expectancy at birth in years (1996)</td>
<td>43</td>
<td>58</td>
<td>50</td>
<td>44</td>
</tr>
<tr>
<td>Infant mortality rate per 1,000 live births (1992-93)</td>
<td>133</td>
<td>61</td>
<td>84</td>
<td>107</td>
</tr>
<tr>
<td>Childhood mortality rate per 1,000 live births (1992-93)</td>
<td>225</td>
<td>94</td>
<td>167</td>
<td>190</td>
</tr>
<tr>
<td>Maternal mortality rate per 100,000 live births (1993)</td>
<td>620</td>
<td>170</td>
<td>410</td>
<td>n.d.</td>
</tr>
</tbody>
</table>


In comparison countries in Sub-Saharan Africa, Malawi has the lowest life expectancy at birth, the highest infant and childhood mortality rates, and the highest maternal mortality rate. And although the country’s immunization coverage is high, child mortality remains high.

There is clearly a conundrum that policymakers in the health sector need to face. Poor sector performance cannot be blamed entirely on the low level of health spending (some comparison countries have lower spending per capita), or on the allocation of these expenditures (other countries have more skewed resource allocation). Explanations for this conundrum should be sought in technical efficiency (how well the system and individual facilities are managed), in the incentive structure for staff and program managers (salary levels, degree of autonomy, appropriateness and mix of skills, counterproductive coping mechanisms of staff), and in the overall institutional environment (the ability of MOHP to plan, marshal, and deploy resources to areas and services in greatest need). The quality of health services being provided also need to be examined further, and remedial measures taken. This HER provides a broad macro/sectoral picture of the level and allocation of resources, but much more remains to be done to analyze and address the micro/facility-specific problems plaguing the delivery of health services.

### The government budget

The GOM is the biggest provider of health services, though funding has been eroded over the past few
years by a chronic budget crisis and a limited capac-
ity to plan health services. In FY95, the MOHP
began budgetary reform under the Medium-Term
Expenditure Framework (MTEF) aimed at keeping
the scope and level of health services in line with
available budgetary resources. However, the MTEF
experience up to 2000 indicates that the process
remains a mechanistic “budget cut-and-defend”
exercise that is not central to the MOHP’s concep-
tion of its long-term strategic role in the sector.
Incremental budgeting continues to be practiced,
budget protection is based on maintaining the cur-
rent level of investments (especially hospitals), and
the MOHP operations remains far wider than it can effectively fund and adequately super-
vise. As a result, no dramatic budget reallocation
towards more cost-effective preventive and promo-
tive health services has occurred. In fact, there are
indications from the donor survey conducted for
this study that donors may be crowding out the
government from funding what should be its core
function (preventive and promotive health), and
that as a result, a greater proportion of government
resources are flowing to tertiary-care institutions.

Admittedly, the level of government health allo-
cation is too low, but instead of focusing on cost-
effective services with large public-health impact,
the government has opted to finance all existing
health programs and infrastructure including cost-
ineffective interventions. Some donors have con-
tributed to the crisis by offering infrastructure
expansion with little regard for their recurrent-cost
implications. The MOHP should use the budget
crisis and the MTEF process as an opportunity to
rethink its role, scope, and focus. Towards this end,
the following actions are recommended:

**Further refine the National Health Plan as
the basis for priority setting, programming,
and budgeting**

GOM launched the Malawi National Health Plan
(NHP) in May 1999, embodying the government’s
vision 2007 “to provide every Malawian with an
affordable package of essential health services
(EHS) based on intensified community efforts and
backed by upgraded health centers and appropriate
district hospitals.” As the funding gap analysis
below shows, the NHP’s financial requirements are
far greater than the available resources forecast for
the medium term. There the focus of the Plan must
be sharper.

Implementation of the NHP first requires translat-
ing the EHS into policy. This entails (a) definition of
and agreement on the package that the GOM is com-
mitted to fund; (b) the political and administrative
approval of the EHS package; and (c) official policy
on the provision and funding of nonessential or non-
package health services. The absence of such a policy
on nonessential services is tantamount to the gov-
ernment’s acquiescing to continued unplanned infra-
structure construction and system expansion.

The policy on the EHS package then needs to be
translated into its programmatic requirements,
which entails (a) costing out the package itself;
(b) identifying and costing out the support services
and other incremental inputs needed to implement
the package (staff training, information and educa-
tion campaigns, supervision and monitoring, infor-
mation systems support); (c) adjusting the services
included in the package on the basis of their costs
and available fiscal resources over the next three to
five years; and developing an implementation plan
to carry out the approved strategy.

Finally, the EHS program costing exercise needs
to be translated into the government budget, which
entails actual government allocation for the pack-
age (both at central and district levels); government
commitment not to divert the budget for nonpack-
age services; and use of the refined NHP and its
implementation plan as the basis for marshalling
additional external donor support.

**Tighten the coordination and institutional
locus of planning and budgeting**

The scarcity of resources demands more circum-
spect policymaking, planning, programming, budg-
eting, and releasing functions and tighter coordi-
nation of these functions. Discussions are needed
within the government on the budgetary implica-
tions—especially recurrent cost implications—of
each health policy, program, service, or function.
The MOHP must routinely undertake an exercise of
making alternative choices given alternative fund-
ing scenarios. Key actions in this area involve:
• Synchronizing the mandate and membership of the MTEF Committee and the Cash Budget Committee so that there is less variability in the planning/budgeting and cash-releasing functions. Releases should be governed by the agreed-upon budget priorities.

• Decentralizing some of the MOHP functions to districts and regional offices (such as monitoring and supervision) to free senior officers for more strategic policy concerns, rather than having them occupied with day-to-day management.

• Integrating the recurrent and development budgets, or at least making both of them as transparent and comprehensive as possible. Until the merger of the Ministry of Finance (MOF) and the National Economic Council (NEC), these two activities were disconnected, with recurrent budgeting mainly the purview of the MOF and development budgeting mainly the purview of the NEC. This bifurcation made it difficult to formulate a rational forward-looking budget that took account of the recurrent-cost implications of all capital investments. The merger of the two ministries into the Ministry of Finance and Economic Planning should at least provide the institutional locus for a more consistent budgeting exercise.

• Strengthening the capacity of the MOHP Planning Unit to undertake health needs, costing, and cost-effectiveness analyses; to analyze budgetary, service-performance, demographic, and socioeconomic data and propose adjustments on expenditure flows; and to analyze the recurrent-cost implications of major health investments (donated or not) and recommend the best course of action on these proposed investments.

Rationalize capital investments

Given a limited planning and regulatory capacity, a Malawi NHP that is essentially a “wish-list” for infrastructure projects undermines any rational approach to sector investments because it leaves open the possibility of investors and donors offering projects to the government, even if such projects worsen the recurrent-cost situation of the budget. A key tactic in solving the recurrent-cost problem is to rationalize capital investment decisions.

Key actions in this area involve:

• Exerting moral suasion at the highest levels in donor headquarters so that uncalled-for medical investments in Malawi are deferred unless the donor is willing to fully or partly cover the running costs of the infrastructure in the medium term, or until such time that the budget crisis has abated. Imposing policy conditions in donor projects can also rationalize investments.

• Enforcing a thorough and comprehensive financial analysis of the recurrent-cost implications of any new government- or donor-funded project, and developing stringent health-planning and public-finance standards to appraise these projects. In this regard, the National Economic Council, working with the MOHP, should specify project-approval criteria that can then be used to set national investment priorities. In the medium-term, MOHP also needs to explore the political feasibility of enacting a Public Health Investment Act to set the parameters for health-sector investments, along the lines of “certificate-of-need” or similar approaches.

• Reducing or waiving counterpart funds, or designing counterpart-fund requirements so that they occur more in the out-years of projects rather than up-front, or until such time that the existing budgetary crisis has abated.

Extra-budgetary sources of funds

The GOM’s inability to finance the health needs of Malawians through tax revenues should encourage it to explore other financing modalities that are compatible with the population’s ability to pay.

Expand program on drug revolving funds

Pilot-testing of drug revolving funds (DRFs) under the International Development Association’s (IDA) Population, Health and Nutrition (PHN) Project has shown that they can be a viable source of sus-
tainable financing and can facilitate community access to basic pharmaceutical supplies. There are potentially 600 villages that can participate in these schemes. Key actions in this area involve (a) conducting more DRF training programs on community organization and DRF management, and (b) reviving the stalled reforms to restructure the Central Medical Stores (CMS). The sustainability of DRFs hinges on the availability of drugs, which in turn hinges on the institutional and financial sustainability of CMS, which procures drugs for DRFs.

**Implement formal cost-sharing programs in government hospitals**

Despite years of intent, government hospitals have not formally established institutionally sustainable fee programs. Existing efforts are haphazard and uncoordinated; they have not been properly evaluated. Current disparities exist between MOHP facilities, which do not formally impose fees, and district-designated mission and local-authority health facilities, which do. Partly because no fees are charged at the hospital level, and partly because government primary-care facilities are ill-funded, all tertiary government facilities are clogged with patients who bypass the referral system.

To jump-start the fee initiative, the first key action is to conduct a thorough and comprehensive review of existing formal and informal fee schemes. A Japanese PHRD grant is currently supporting the review of the cost-sharing programs of the central hospitals. In May 1999, a DFID-funded consultancy completed a draft health financing strategy for Malawi (LATH: 1999). Based on the findings of these analyses, MOHP needs to develop a national government fee policy covering district hospitals, district-designated Christian Hospital Association of Malawi (CHAM) facilities receiving government subventions, and local-authority facilities. The national fee policy should permit (a) central and district hospitals to impose fees and have private wards based on fees; (b) permit 100 percent retention of fee revenues at the hospital level; (c) permit hospital use of fee revenues subject to specified guidelines from MOHP and spending authorities designated by the government; (d) synchronize fee schedules among the different levels of care; and (e) specify waived or exempted health services, persons, or areas to protect the poor.

The second key action is to develop guidelines on the accounting, safekeeping, and utilization of fee revenues, including the phases of the fee programs, the schedule of fees to be charged, staff tasks and responsibilities, and the planning and use of generated revenues. The guidelines should also define the waiver and exemption system at central and district hospitals and the procedures that staff need to follow on means-testing, waiving, and exemption.

The third key activity is to restructure the Central Medical Stores so that drugs are made available on a sustainable basis. Fee programs depend crucially on the availability of drugs, which is a major indicator of quality of health services in Sub-Saharan Africa.

**Improve health insurance reimbursement**

Although health insurance coverage is small nationwide, it represents a significant pool of those with the ability to pay and thus provides a potentially major payment system for hospitals. GOM hospitals need to review their fee schedules and reimbursement rates to patients under medical aid schemes or health insurance coverage to align them with actual costs and remove unnecessary government subsidy for these patients with the ability to pay.

The government needs to study the administrative, financial, and economic feasibility of converting the current government-funded Referral of Cases Abroad into a medical aid scheme for civil servants or a health insurance contract with a private insurer.

**Private health expenditures**

Private health expenditures are a significant, though largely unstudied, source of health financing in Malawi. There is a well-established nonprofit sector (Christian Hospital Association of Malawi or CHAM) and a burgeoning for-profit sector, mainly private clinics.
Learn from nonprofit health providers

A third of CHAM resources are from user charges and sale of drugs generated from modest fee schedules that do not deny poor patients access to care. GOM should learn from these institutionalized systems and practices. GOM also needs to reconsider reviving the CHAM subvention program (which grew from MK4.6 million in FY90/91 to MK22.2 million in FY94/95) but was eliminated with the onset of the budget crisis in FY95/96. It should be noted that CHAM facilities provide services to more than a third of the Malawi population, mostly in rural areas where there are no government providers.

Encourage but regulate private for-profit health providers

Serious issues with respect to equity, pricing, and quality of care have emerged in the wake of the health-sector privatization and liberalization. GOM needs periodically to evaluate the impact of opening the medical sector to private practice.

The government should assist the Medical Aid Society of Malawi (MASM) address the issue of provider-driven over-consumption of health services. This problem is manifested through over-prescription, over-examination, and prolonged length of stay for patients with health insurance coverage. It can be addressed through better monitoring of providers and more stringent professional guidelines and discipline.

Finally, AIDS care should be addressed in the context of health insurance as well as public finance. Though AIDS is a national epidemic, the issue of financing AIDS care is being flagged more actively by private insurance schemes. These programs fear that they will collapse under the impact of large-scale clamor for expensive treatment will raise premiums to an unaffordable level. The increasing international clamor to provide financing and coverage for expensive antiretroviral drugs highlights the importance of this issue.

Promote household expenditures, but improve protection systems for the poor

A UNICEF-commissioned survey in 1995 reveals substantial freeloading (households with capacity to pay for health services but do not) and under-coverage (households with scant capacity to pay but who do) in health facilities across the country. Informal fee programs without official sanction or with scanty supervision tend to worsen these problems. Fee programs need to be formally established, especially in urban facilities where nonpoor households are mostly located. But the waiver and exemption systems of these programs should be strengthened, staff should be trained in them, and a vigorous information campaign should be launched so that patients know which persons or conditions are eligible for free care.

Donor financing and expenditures

Donors account for about half of health expenditures in Malawi. As of the end of FY97, as much as US$246.5 million were allocated to the sector, of which only US$115.7 million had been expended. The slow disbursement rate (46.9 percent as of end-FY97) is a cause of concern, especially in the current budget crisis when donor resources ought to cushion the impact of fiscal stringency. Here are several recommended actions to improve the use of donor funds:

Improve project pipeline management and disbursement

The administrative bottlenecks at MOHP headquarters should be eased. Within government, delegation authority must be established for officials who are away, and whose signatures are necessary to move the paperwork. Government capacity has to be strengthened to manage and follow up required actions in order for donor funds to flow or for procurement to proceed. Both government and donors need to review time-consuming and onerous procurement procedures, improve understanding of these procedures, and train more staff in all aspects of procurement and financial management. A procurement unit within MOHP may be called for. MOHP needs to draw up a project monitoring chart for each of the donor-funded projects, monitor disbursements more closely, and pay close attention to slow-moving projects. Tighter coordination is required among the MOHP, the Ministry of Finance,
local governments, and nongovernmental organizations (NGOs). Periodic review and flagging of issues can speed compliance with legal, policy, program, or administrative requirements and conditions for disbursement. A regular portfolio review between the government and the Bank appears to be yielding positive results; such a practice needs to be expanded to other donors.

**Tighten central coordination of donor-funded projects**

The plethora of projects is beginning to ‘balkanize’ Malawi’s health sector as each donor stakes its claim on a district or vertical project. The tendency is for each donor-funded district to have its own health priorities, training thrusts, information requirements, and financial systems, with little regard for national-system requirements, eventual data aggregation, or service standards. This trend must be stopped, but this can only be done with strong, central MOHP coordination.

The geographic distribution of donor-funded projects must be rationalized. The inventory of these projects shows that donors tend to locate in better-off areas, with remote districts having little access to donor-funded services. GOM has to establish explicit criteria and guidance on where donor projects should locate to ensure greater equity.

Similarly, donor-funded training needs to be rationalized. Donors are spending a staggering amount (US$4.5 million annually) on long- and short-term training (workshops, conferences), with little documentation of their impact on health service quality. Future training activities should be based on a sector-wide human resource development plan and should include (a) a program for synchronizing and harmonizing existing training programs and possibly combining similar ones; and (b) a mechanism for evaluating their impact.

**Improve management of project managers and contractors**

There is an increasing trend towards privatizing or contracting the supervision and management of donor projects. Given the perceived costliness of nongovernment management of projects, GOM and donors should work together in (a) setting standards for consultant fees, technical assistance contracts, and contract provisions to achieve greater cost-effectiveness, quality control, and equity; (b) synchronizing project design, supervision, and evaluation activities to save costs; and (c) drawing up a code of conduct for NGOs and contractors, including their financial responsibilities.

**Explore the feasibility of a multidonor budget or expenditure support program**

The sheer number of donor projects and activities (at least 34) overburdens the constrained capacity at central MOHP and may account for slow disbursements. The design, appraisal, management, monitoring, and evaluation requirements of individual projects are immense and tend to overburden the Malawian bureaucracy. In addition, individual donor projects may in fact worsen the recurrent-cost problem as GOM can ill-afford to provide the 10-15 percent of government counterpart funding. The situation is worse for capital projects as GOM needs to set aside their running costs, which are increasingly becoming unavailable in the current fiscal squeeze. Finally, donor-funded projects in principle do not provide salary supplements, yet the low level of salaries is probably the single most important factor that accounts for the poor quality of health services. A way out of this conundrum of “cash-rich” donor projects and “cash-starved” GOM may be a multidonor budget or expenditure support program that can be made contingent upon GOM’s commitment to prioritize its budget to provide an essential package of health services, and to launch policy and administrative initiatives to support such service-delivery focus. The MOHP’s preliminary discussions with donors on a sector-wide approach (SWAp) is a step in this direction.

**Sectoral efficiency improvement**

In addition to budgetary reform, three other areas can be pursued to improve efficiency in Malawi’s health sector: restructuring the Central Medical Stores (CMS); granting of hospital autonomy to selected tertiary facilities; and further decentralizing the health service. All of these improvements
involve profound systems change and institutional development and therefore have inherent risks and costs, especially during the transition. The government needs to carefully weigh the options within each reform area to minimize transition costs.

**Pursue the stalled pharmaceutical sector reforms**

Drug availability is the lynchpin that joins major flanks of any health sector reform. If drugs are unavailable, community drug revolving funds cannot operate and fee-based cost-sharing programs cannot succeed. Without a good revenue base from fees to cushion the impact of reduced budgetary support, tertiary hospitals cannot become autonomous. Given the centrality of pharmaceuticals in the whole health sector reform effort, the government needs to pursue the stalled restructuring of the CMS to make it more autonomous, sustainable, and efficient. Without these CMS reforms, the financing, procurement, and distribution of drugs will continue to be imperiled.

The supply-side reforms in pharmaceuticals need to be supported by corresponding improvement in consumption patterns. This can be achieved through a variety of mechanisms including improving physician-prescription behavior through better training and monitoring, imposing partial or full-cost fees on prescription drugs at government facilities, and establishing therapeutic committees and drug registers at hospitals to keep track of drug consumption, reduce theft, and encourage the development of demand-driven (rather than the current inefficient supply-driven) system.

**Grant hospital autonomy to selected hospitals**

The Working Group on Hospital Autonomy has identified three specific proposals, which should be supported. First, undertake a feasibility study to underpin the hospital reform strategy. The study should (a) analyze the degree of autonomy that candidate hospitals currently have with respect to management, staffing and personnel, budgeting and financial resource base, procurement, and quality improvement; (b) discuss the legal, policy, organizational, management, and financial requirements for expanding their autonomy; (c) set quantitative targets for the feasible reduction of government subsidy and for increased alternative revenue sources such as fees, insurance reimbursement, official and private philanthropic grants, and nonmedical revenues; and (d) set service-delivery targets that can be used in the planned health service “contracts” between the Government and the hospital boards.

Second, on the basis of the results of the study and stakeholder consultations, provide legal autonomy to the three central hospitals and seven “busy” district hospitals (Rumphi, Mzimba, Kasungu, Dedza, Mangochi, Machinga, and Mulanje), and establish an enabling policy environment to make them self-financing. An Act of Parliament is required to grant full autonomy to these facilities. The Act should also redefine the role of the MOHP with respect to autonomous hospitals. In lieu of very specific instructions, regulations, control, and supervision of most aspects of hospital management, the MOHP should establish goals, targets and policies for hospital services to be provided, and then fund hospitals according to these requirements through a health-service contract with each of them. This arrangement distinguishes between MOHP as purchaser and regulator of services and the autonomous hospitals as providers of services.

The Working Group on Hospital Autonomy’s third proposal is to establish a Council of Hospital Boards comprising representatives from the individual hospital boards. The Council should be perceived as a trade organization acting in the interests of the autonomous hospitals in their dealings with the MOHP in such areas as staff salaries, pensions, and benefits; hospital fee schedules; staff training; bulk procurement and equipment sharing; and coordination of management systems and procedures.

Hospital autonomy should be implemented in the context of hospital financing reform based on a realistic assessment of the budget and available extra-budgetary resources; the essential and cost-effective clinical services that these hospitals should provide; and the cost-effective ways of providing ancillary services including contracting. Finally, these reforms should be underpinned by hospital renovation or refurbishment, staff retraining, drug availability, and other visible signs of quality im-
provement. (Any fee-based program supportive of hospital autonomy is bound to fail without requisite improvement in quality.)

**Carry out planned activities to support health service decentralization**

With the passage of the Local Government Act, the holding of local elections, and the establishment of local councils, the legal and political structure for devolution have been set in motion. The greater challenge now is to institutionalize the fiscal framework for decentralization so that central grants and transfers are channeled appropriately to peripheral areas and key health priorities are adequately funded on time. The flow of bilateral and multilateral assistance to the districts is particularly knotty since there are many donors, each with specific requirements. So far, no adequate mechanism has been defined for this purpose.

The extent and pace of decentralization would depend on the capacity of local authorities to manage decentralized health services, as well as MOHP’s ability to support and supervise these functions. Key issues in this area are the availability of skilled staff at the local level, and the status of civil servants to be “absorbed” by local authorities. The roles and functions of private providers under a decentralized setup should also be defined. The key issues in this regard are:

- the revitalization of the subvention program and possible conversion of such traditional and informal relationship into a more formalized health-service contract between the GOM as funder and mission hospitals as providers, with specific responsibilities and deliverables defined in terms of target coverage, cost, and quality; and

- the wider participation of CHAM and NGOs in service delivery in their respective health districts, and in health policy at the national level.

**Monitor and evaluate the contracting of health services**

The Government is in the process of contracting out ancillary health services such as cleaning, transport, building and ground maintenance, laundry, security, catering, audit, and mortuary. These are novel experiments in Malawi and need to be closely monitored and evaluated in terms of efficiency and cost-effectiveness relative to the status-quo (that is, self-provision). So far, contracting of clinical services is not yet under discussion, but given the burgeoning private medical practice, the Government should consider it. Lessons learned from nearby countries (South Africa) should inform the design of contracts, price negotiation, and other considerations.
MOHP budget and expenditures

Allocation trends

In the first half of the 1990s, the GOM made a deliberate effort to increase public spending in health, raising the health budget from MK83 million in FY91 to MK415 million in FY95. As a result, the proportion of the MOHP budget to the total government budget increased from 9 percent in FY91 to 11 percent in FY95 (Mwambaghi 1996). Because of relatively modest inflation during the period, at 1990 prices the budget rose from MK72 million in FY91 to MK108 million in FY95. Per capita, the GOM health budget at 1990 prices increased from MK7.94 in FY91 to MK10.25 in FY95.

These successes began to unravel towards the middle of the decade in the wake of political uncertainties, the economic downturn in 1994-95, a large currency depreciation, and the inflation that ensued. By 1996, forecasts made by the Ministry of Finance incorporating economic growth and expected tax and other revenues showed that liberal increases in the health budget were no longer possible (Marshall 1996). At that time, the health budget was expected to be MK760 million in FY97, MK865 million in FY98, and MK970 million in FY99. At these levels, the health budget was expected to retain its 15 percent share of voted expenditures and 12 percent to 13 percent of total GOM budget.

These forecasts turned out to be optimistic; in fact, actual health expenditures (at current prices) were only MK334.8 million for FY95, MK590.7 million for FY96, and MK668.6 million for FY97. For FY98, the MOHP’s budget ceiling was pegged at MK753.3 million (Table 4). Reckoned in real prices, the Ministry’s tight level of health spending is even more stark: while the absolute and per capita levels of recurrent expenditures more than doubled nominally, at 1995 constant prices, per capita MOHP spending has remained constant at around MK40 during the past three years.

MOHP expenditures by level of institution

Under the MTEF, dramatic changes were made in MOHP budget accounting and presentation, making it difficult to analyze MOHP recurrent expenditures by level of institution. The data presented in Table 5, therefore, should be interpreted with care; they are meant to be impressionistic.

For FY98, MOHP requested a budget of MK753.3 million, of which more than a third (35.9 percent) was for central HQ, a minuscule 1.7 percent was for the three regional offices, around 17.1 percent was allocated for the four central hospitals, and close to a half (45.3 percent) was devoted to the 24 district health offices (inclusive of district hospitals, rural hospitals, and preventive and promotive care services delivered in their catchment areas). Contrary to the stated policy thrust of greater decentralization, the central MOHP HQ dramatically increased its share of allocation. On the other hand, the share of resources devoted to district health offices shrank from more than a third (67.7 percent) of actual expenditures in FY95 to only 45.3 percent of the
Table 4
MOHP recurrent expenditures and per capita expenditures in current and real terms:
FY95/96-FY98/99 (in million Malawi Kwacha)

<table>
<thead>
<tr>
<th>Items</th>
<th>FY95/96</th>
<th>FY96/97</th>
<th>FY97/98</th>
<th>FY98/99</th>
<th>Percent change FY95/98</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOHP recurrent expenditures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in current prices (MK m)</td>
<td>334.763</td>
<td>590.747</td>
<td>668.569</td>
<td>753.265</td>
<td>125.0</td>
</tr>
<tr>
<td>Price index (1995=1.000)</td>
<td>1.000</td>
<td>1.354</td>
<td>1.517</td>
<td>1.638</td>
<td>63.8</td>
</tr>
<tr>
<td>MOHP recurrent expenditures in real prices, 1995=100 (MK m)</td>
<td>334.763</td>
<td>436.298</td>
<td>440.718</td>
<td>459.869</td>
<td>37.4</td>
</tr>
<tr>
<td>Population (m)</td>
<td>10.25</td>
<td>10.57</td>
<td>10.91</td>
<td>11.24</td>
<td>9.7</td>
</tr>
<tr>
<td>Per capita MOHP recurrent expenditures in current prices (MK)</td>
<td>32.66</td>
<td>55.89</td>
<td>61.28</td>
<td>67.02</td>
<td>105.2</td>
</tr>
<tr>
<td>Per capita MOHP recurrent expenditures in real prices, 1995=100 (MK)</td>
<td>32.66</td>
<td>41.27</td>
<td>40.40</td>
<td>40.91</td>
<td>25.3</td>
</tr>
</tbody>
</table>

Notes: (a) Malawi’s FY is from April 1 to March 30 the following year. (b) Population is based on mid-calendar year estimates. (c) FY95/96 to FY97/98 figures are actual expenditures; FY98/99 figures are budget allocations submitted to Parliament as of June 30, 1998.

Source of basic data: MOHP Planning Unit.

allocated amount in FY98. The share of resources going to regional health offices was also down (4.4 percent in FY95 to 1.7 percent in FY98). Some of these drops might have been due to accounting changes (for example, certain budget items were "recentralized" for accounting purposes and cost-center responsibility, or portions of the Regional and District Medical Offices budgets were transferred to central administration), but the magnitude of the numbers involved raises serious concerns.

The four central hospitals, which used to account for around 25 percent of MOHP’s budget got a smaller share in FY98. Budgetary resources devoted to the two largest hospitals (Queen Elizabeth and Lilongwe Central), however, remain large: one tertiary hospital (with an average annual budget of MK45 million) consumes as much as three district hospitals (each with an average annual budget of MK15 million). The government needs to find alternative ways of funding these large urban-based institutions so that critical health services in the periphery are not crowded out of funding. The government also needs to ensure that institutions stick to their budgets. Recent experiences on allocations versus expenditures show that MOHP HQ and central hospitals tend to overspend while district health offices tend to underspend, indicating that the government’s bias towards urban areas and curative care has increased in a tight fiscal situation.

MOHP expenditures by level of cost center

For FY98, MOHP rewrote its budget to reflect identified priority programs. The results of this exercise are shown in Table 6. District health offices provide preventive/promotive services and primary/secondary curative services, which together accounted for roughly 45.7 percent of the FY98 budget allocation. The central hospitals provide tertiary curative as well as rehabilitative health services, which together accounted for roughly 17 percent of the FY98 budget. The remaining 35 percent of the budget went for technical and administrative services provided by central HQ and regional offices.

These budget figures, however, mask the real type of health services rendered by health facilities. For instance, hospital managers say that around three-fourths of patients at central hospitals are primary-care patients who should have been treated at lower level facilities. The ill-functioning referral system (largely made inoperative by poorly funded
Table 5
MOHP recurrent expenditures by level of institution: FY95/96-FY98/99
(in million Malawi Kwacha)

<table>
<thead>
<tr>
<th>Items</th>
<th>FY95/96</th>
<th>FY96/97</th>
<th>FY97/98</th>
<th>FY98/99</th>
<th>Percent change FY95/98</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central HQ</td>
<td>21.653</td>
<td>83.921</td>
<td>73.125</td>
<td>270.409</td>
<td></td>
</tr>
<tr>
<td>Regional health offices (all three)</td>
<td>14.758</td>
<td>15.455</td>
<td>21.882</td>
<td>12.676</td>
<td>(16.4)</td>
</tr>
<tr>
<td>Average per regional health office</td>
<td>4.919</td>
<td>5.152</td>
<td>7.294</td>
<td>4.225</td>
<td></td>
</tr>
<tr>
<td>Central hospitals (all four)</td>
<td>71.540</td>
<td>142.428</td>
<td>166.619</td>
<td>129.114</td>
<td>80.5</td>
</tr>
<tr>
<td>of which Queen Elizabeth CH</td>
<td>29.000</td>
<td>n.a.</td>
<td>n.a.</td>
<td>46.134</td>
<td>59.1</td>
</tr>
<tr>
<td>of which Zomba CH</td>
<td>11.166</td>
<td>n.a.</td>
<td>n.a.</td>
<td>28.031</td>
<td>151.0</td>
</tr>
<tr>
<td>of which Zomba Mental Hosp.</td>
<td>6.349</td>
<td>n.a.</td>
<td>n.a.</td>
<td>10.842</td>
<td>70.8</td>
</tr>
<tr>
<td>of which Lilongwe CH</td>
<td>25.025</td>
<td>n.a.</td>
<td>n.a.</td>
<td>44.107</td>
<td>76.3</td>
</tr>
<tr>
<td>District health offices (all 24)</td>
<td>226.813</td>
<td>348.942</td>
<td>406.945</td>
<td>341.066</td>
<td>50.4</td>
</tr>
<tr>
<td>Total</td>
<td>334.763</td>
<td>590.747</td>
<td>668.569</td>
<td>753.265</td>
<td>125.0</td>
</tr>
<tr>
<td>of which percent Central HQ</td>
<td>6.5</td>
<td>14.2</td>
<td>10.9</td>
<td>35.9</td>
<td></td>
</tr>
<tr>
<td>of which percent regional health offices</td>
<td>4.4</td>
<td>2.6</td>
<td>3.3</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td>of which percent central hospitals</td>
<td>21.4</td>
<td>24.1</td>
<td>24.9</td>
<td>17.1</td>
<td></td>
</tr>
<tr>
<td>of which percent district health offices</td>
<td>67.7</td>
<td>59.1</td>
<td>60.9</td>
<td>45.3</td>
<td></td>
</tr>
</tbody>
</table>

Notes: (a) FY96 and FY97 are revised actual figures; (b) FY98 based on budget submitted to Parliament. The details of FY98 figures are not directly comparable to the details of the earlier fiscal years due to changes in definition of accounts and cost centers, e.g., some items previously under "Central Hospitals" were later placed under "Central MOHP." (c) For this and other tables, details may not exactly add up to totals due to rounding.

Source of basic data: MOHP Planning Unit.

rural health centers and dispensaries) perpetuates this massive and distorted health-seeking behavior, with large financial implications. The preference of policymakers, at least as revealed through annual budget allocations, has been to expand tertiary care to accommodate primary-care patients, rather than to improve lower-level health facilities. Government’s long hesitance to institute a modicum of fees at the highest levels of care, even as it encourages fees for drugs under community revolving funds, has also engendered a perverse incentive structure in the health system.

The proportion of FY98 budget allocation to preventive/promotive care was nominally 14.2 percent. However, since the cost of providing such services is unknown and the magnitude of primary-care needs are also unknown, it is difficult to assess whether the government is providing enough resources for them. Recently, the Working Group on Essential Health Package proposed the following services to receive core funding from the government: Expanded Program on Immunization; community-based primary health care (village health committee, income generating activities, traditional birth attendants); family planning; safe motherhood; nutrition; control of malaria; prevention and control of HIV/AIDS and other sexually transmitted diseases; control of tuberculosis; control of diarrheal diseases; control of acute respiratory infections; and management of other common illnesses and conditions (such as eye infections, skin diseases, and minor injuries). It behooves the MOHP to
fully fund these programs to avert expensive hospitalization and thereby begin to gradually reduce allocations to the hospital sector in favor of lower-level facilities.

**MOHP expenditures by economic classification**

Personal emoluments accounted for more than a third (36.9 percent) of the FY98 budget allocation (see Table 7). Personal emoluments include salaries, wages for non-established staff and temporary employees, and a significant amount for housing allowance.

There are no basic staffing norms (range of skills and services to be provided at each level of care) in Malawi. As a result, the appropriate mix of health workers required is unknown. Analysis of the MOHP plantilla, however, shows that the majority (51.8 percent) are low-skilled workers doing ancillary duties (Table 8). By its sheer number, the cost of maintaining such workforce must be significant. For higher-skilled workers, the vacancy rate is high due to low salaries and the difficulty of filling staff positions in rural areas where housing amenities are often unavailable. Proposals have been made to build staff houses at regional/district offices and student accommodations at central hospital/training institutions. A few donors are also mulling over the possibility of providing salary supplements to health staff in rural areas.

The low salary of civil servants should be addressed. In the absence of a suitable resolution, some workers may be adopting counter-productive behavior to augment their meager salaries (attendance at as many workshops as possible, travel under the guise of supervision). Though this issue has been discussed at senior levels, a thorough-

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### Table 6

**MOHP recurrent expenditures by level of cost center: FY98/99 (in million Malawi Kwacha)**

<table>
<thead>
<tr>
<th>Items</th>
<th>Coverage</th>
<th>Amount</th>
<th>Percent Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Preventive and promotive services</td>
<td>Human resources, child health, nutrition, reproductive health, environmental health, communicable disease control, noncommunicable disease control, health education</td>
<td>107.025</td>
<td>14.2</td>
</tr>
<tr>
<td>b. Primary curative services</td>
<td>Human resources, patient care, special services (ambulance, mortuary), construction/rehabilitation</td>
<td>45.844</td>
<td>6.1</td>
</tr>
<tr>
<td>c. Secondary curative services</td>
<td>Human resources, patient care, special services (ambulance, mortuary), hospital management, construction/rehabilitation</td>
<td>191.549</td>
<td>25.4</td>
</tr>
<tr>
<td>d. Tertiary curative services</td>
<td>Human resources, patient care, special services (ambulance, mortuary, CSSD), hospital management, construction/rehabilitation</td>
<td>121.713</td>
<td>16.2</td>
</tr>
<tr>
<td>e. Rehabilitative health services</td>
<td>Human resources, physio/occupational therapy, psychiatric services, prosthetic services, home-based care</td>
<td>6.259</td>
<td>0.8</td>
</tr>
<tr>
<td>f. Health technical support services</td>
<td>Human resources, lab services, radiology services, pharmaceutical services, physical-assets maintenance</td>
<td>223.425</td>
<td>29.7</td>
</tr>
<tr>
<td>g. Administrative and technical services</td>
<td>Human resources, general administration, planning and evaluation, financial management, clinical services, nursing services, support to preventive services</td>
<td>47.204</td>
<td>6.3</td>
</tr>
<tr>
<td>h. Support to other institutions</td>
<td>Subventions and subscriptions to local and international organizations</td>
<td>9.840</td>
<td>1.3</td>
</tr>
<tr>
<td>i. Population services</td>
<td>—</td>
<td>0.406</td>
<td>Negl.</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>All</strong></td>
<td><strong>753.265</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*Source of basic data: MOHP Planning Unit.*
Table 7
MOHP recurrent expenditures by economic classification: FY95/96-FY98/99
(in million Malawi Kwacha)

<table>
<thead>
<tr>
<th>Itemsa</th>
<th>FY95/96 amount</th>
<th>FY95/96 percent</th>
<th>FY96/97 amount</th>
<th>FY96/97 percent</th>
<th>FY97/98 amount</th>
<th>FY97/98 percent</th>
<th>FY98/99 amount</th>
<th>Percent change FY95/96-FY98/99</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal emoluments</td>
<td>132.402</td>
<td>39.6</td>
<td>277.808</td>
<td>36.9</td>
<td>109.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of which administration, technical support and RHO</td>
<td>12.404</td>
<td>3.7</td>
<td>25.348</td>
<td>3.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of which four central hospitals</td>
<td>39.298</td>
<td>11.7</td>
<td>66.927</td>
<td>8.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of which district health offices</td>
<td>78.312</td>
<td>23.4</td>
<td>185.533</td>
<td>24.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of which training institutionsb</td>
<td>2.388</td>
<td>0.7</td>
<td>0</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goods and services</td>
<td>191.200</td>
<td>57.1</td>
<td>452.078</td>
<td>60.0</td>
<td>136.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>administration, technical support and RHO</td>
<td>14.042</td>
<td>4.2</td>
<td>243.903</td>
<td>32.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of which, four central hospitals</td>
<td>39.504</td>
<td>11.8</td>
<td>58.866</td>
<td>7.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of which, district health offices</td>
<td>131.615</td>
<td>39.3</td>
<td>149.309</td>
<td>19.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of which, training institutionsb</td>
<td>6.039</td>
<td>1.8</td>
<td>0</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital transfers</td>
<td>4.651</td>
<td>1.4</td>
<td>9.840</td>
<td>1.3</td>
<td>111.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital formation</td>
<td>6.510</td>
<td>1.9</td>
<td>13.539</td>
<td>1.8</td>
<td>108.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>334.763</td>
<td>100.0</td>
<td>753.265</td>
<td>100.0</td>
<td>125.0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: (a) Expenditures for the three regional offices are included under admin. & tech. support. (b) Training institutions have been made autonomous and were taken off the MOHP budget in 1997/1998.
Source of basic data: MOH Planning Unit.

Going “right-sizing” of the bureaucracy is yet to be implemented. Meanwhile, personal emoluments as a share of total MOHP expenditures continued to decline (from 39.6 percent in FY95 to 36.9 percent in FY98), reflecting the number of staff leaving the civil service as well as those dying of AIDS and other diseases.

**MOHP’s medium-term expenditure framework**

In FY95, in response to the extremely tight budget situation, MOHP was one of the four ministries to develop and execute a Medium-Term Expenditure Framework (MTEF) to keep health services in line with available budgetary resources. The aim of the MTEF exercise to help ministries prioritize the services they will provide. Despite the initial difficulties, certain positive aspects have been incorporated to rationalize the MOHP’s budget and public expenditure management.

**Development of sector objectives**

In FY96, the Ministry conducted a logical framework exercise, developed sector objectives, and initiated the move away from incremental budgeting and towards a more programmatic approach. On the basis of the existing program portfolio, however, it appears that MOHP used the logframe exercise to justify cramming all the existing programs within the framework, rather than to prioritize. Thus, the logframe became an “all-inclusive” device rather than an exercise to streamline operations and do away with the lowest priorities. According to MOHP planning staff, the elimination of “less priority” programs was never discussed in the early years of the MTEF as the
Table 8
MOHP staff breakdown: FY97/98

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number of estimated posts</th>
<th>Number of filled and funded posts</th>
<th>Percent to total filled and funded posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>S2/P2</td>
<td>9</td>
<td>9</td>
<td>0.1</td>
</tr>
<tr>
<td>S3/P3</td>
<td>4</td>
<td>4</td>
<td>Negl.</td>
</tr>
<tr>
<td>S4/P4</td>
<td>31</td>
<td>31</td>
<td>0.3</td>
</tr>
<tr>
<td>S5/P5</td>
<td>42</td>
<td>43</td>
<td>0.5</td>
</tr>
<tr>
<td>S6/P6</td>
<td>5</td>
<td>5</td>
<td>Negl.</td>
</tr>
<tr>
<td>S7/P7</td>
<td>68</td>
<td>68</td>
<td>0.7</td>
</tr>
<tr>
<td>S8/P8</td>
<td>89</td>
<td>89</td>
<td>0.9</td>
</tr>
<tr>
<td>CEO/CTO/PO/AO</td>
<td>335</td>
<td>347</td>
<td>3.6</td>
</tr>
<tr>
<td>D1-8</td>
<td>87</td>
<td>89</td>
<td>0.9</td>
</tr>
<tr>
<td>SEO/STO</td>
<td>361</td>
<td>381</td>
<td>4.0</td>
</tr>
<tr>
<td>EO/TO</td>
<td>941</td>
<td>824</td>
<td>8.7</td>
</tr>
<tr>
<td>SCO/STA</td>
<td>520</td>
<td>520</td>
<td>5.5</td>
</tr>
<tr>
<td>CO/TA/DP3/2</td>
<td>2,177</td>
<td>2,172</td>
<td>22.8</td>
</tr>
<tr>
<td>SC1-IV</td>
<td>4,924</td>
<td>4,933</td>
<td>51.8</td>
</tr>
<tr>
<td>Total</td>
<td>9,493</td>
<td>9,515</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source of data: Budget submission.

Ministry hoped that a more robust budget the next year could be used to protect existing programs. In FY96, the budget crisis continued but the elimination of programs, services, and functions remained taboo within MOHP. Given the extremely limited budget provided by the Ministry of Finance, the relationship between the Treasury and MOHP continued to take the form of a budget “cut and defend” approach.

**New budget accounting system and classifications**

Under the old/transitory accounting system, objectives were defined in accounting terms and tended to lump together institutions doing different things. The new accounting system attempts to lump similar institutions/functions based on a program; the definition of cost centers also clarified financial responsibility. It is possible that by bringing the “Cost Center” closer to the “Program” rather than to the “Activities”, the budget accounting system may be more performance-oriented rather than input-oriented, but this conjecture needs to be verified by results.

MOHP also developed new program budget classifications in FY96 that made it relatively easier to see program priorities and were better than classifications in use until FY95. The old (transitory) classifications were based on objectives that reflected accounting inputs; the new classifications were based on programs, that is, they unified accounting functions that were similar (preventive care, curative care). The new classifications were considered more transparent.

**Introduction of cash budgeting**

In theory, the introduction of cash-based budgeting and lump-sum releases under MTEF should have
encouraged ministries to prioritize their spending. However, according to MOHP planning staff, the cash budgeting system may unduly create adverse incentives within MOHP to spend quickly; it also engenders aggressive lobbying by program managers and hospital directors, which can subvert allocations based on strategic considerations. Some MOHP informants believe the cash-based budgeting system preserves the status quo, and in fact does not lead to real reallocation based on cost-effectiveness criteria. These adverse incentives are exacerbated by the fact that the members of the MOHP's MTEF Committee (which prepares the budget) do not also sit on the Cash Budget Committee (which allocates funds made available by the Treasury). Real power lies within the Cash Budget Committee, whose priorities do not necessarily reflect those by the MTEF Committee.

**Stopping virement**

MOF has stopped all ministries from the practice of virement, that is, using a line item to fund expenditures in another line item that has been exhausted. Virement prohibition is intended to instill greater fiscal discipline, though under very extreme financial situations, virement is often used to meet emergencies and contingencies. The prohibition of virement, while admirable in itself, can be rendered ineffective by the Treasury's and/or the Cash Budget Committee's delay of releases to specific programs or budget items. A program could be severely underfunded during the year if the Cash Budget Committee decides to use the available funds for something else, even one that is of less priority.

**Continuing challenges in the MTEF process**

Given the tight budget situation, GOM cannot fully fund all health services that it has traditionally provided. It appears that the government has not taken this to heart and is spreading its resources too thinly by service and program area. Even under three to four years of MTEF, MOHP's scope of services and programs remains broad, ranging from preventive/promotive programs, to basic and specialist curative services, to such programs and funded activities as rehabilitative care (physiotherapy and occupational therapy, psychiatric services, and prosthetic services), cancer registry, oral health, mental health, the maintenance of high-tech equipment, treatment abroad, free mortuary, and transport of the dead.

Analysis of the past budgets under MTEF shows MOHP prefers to run most if not all of its traditional programs and to distribute the meager budget across all these programs, rather than cut away less necessary programs and focus on those services that are justified epidemiologically, cost-effectively, and on the basis of equity. This broad rather than focused approach hurts all programs, poorly protects cost-effective primary-care services, and leads to the unfortunate drying up of key interventions that are aimed more at the poor and rural areas, such as extremely limited budgets for key interventions in malaria, tuberculosis, and other promotive/preventive services. There are also indications that health services under local authorities, which ought to provide first-level contact, are far more underfunded than MOHP hospitals.

**Macro constraints**

The continuing breadth of MOHP operations, even under MTEF, can be explained by political, institutional, administrative, and technical problems that need to be addressed in order to realize the fruits of better management of public expenditure. First, MOHP has suffered because MOF does not officially announce its budget ceiling early. The late official announcement of ceiling has been going on since FY94 and was true at least until 1998/99. It appears that the MOF finds it politically difficult to announce the ceiling early as it will come under very strong pressure from politicians and technical ministries lobbying for higher ceilings.

Second, the recurrent and capital development budget processes have historically been bifurcated: MOF is principally involved in the recurrent budget while the NEC takes care of the development budget. In general, donor-funded expenditures remain reckoned within the development budget, even though much of these expenditures are recurrent. Similarly, the Recurrent Budget that MOHP prepares for MOF approval includes capital
formation, which ought to be under the Develop-
ment Budget. The MTEF exercise aims to consolidate 
these two processes, but full consolidation remains 
to be completed. Since MTEF began, heavy focus has 
been placed on recurrent expenditures. Consolid-
on of the recurrent and development budgets is 
extremely important as it will show how GOM and 
donor resources are being allocated and which 
programs are relatively well-funded and which are 
not. Historical trends indicate GOM’s heavy bias 
toward curative care while donors in general focus 
on preventive and promotive care. A sector ex-
penditure plan that lays out the anticipated 
resources from both government and donors over 
the next three to five years is clearly needed to 
inform the annual MTEF exercise. The recent unifi-
cation of the Treasury and the NEC into the Ministry 
of Finance and Economic Planning should also 
augur well for a more comprehensive and consistent 
budgeting exercise.

Institutional and political constraints

The government and MOHP policymakers appear 
unable to face the budget inadequacy squarely, 
according to planning staff. Capital investments, 
especially in the hospital sector, are largely physi-
cian-driven or politician-driven or sometimes 
donor-driven, with the lobbying sponsor having 
little regard for the recurrent-cost implications of 
these investments or for the alternatives for which 
the funds could be used, especially for ill-funded 
preventive/promotive health programs. A few 
donors are also prone to offer capital investments 
with little regard for their recurrent cost implica-
tions, thereby forcing the government to budget 
funds to maintain this new infrastructure rather 
than use those funds for the more cost-effective 
interventions. MOHP needs to be more aware of the 
cost implications of these choices, to be prepared to 
assess the projects that are offered, and to resist 
political pressures to accept them. Donors should 
also be educated on the adverse recurrent-cost 
impact of their capital investments. Due to the very 
fragile budget situation now and in the near future, 
both donors and GOM ought to be extremely wary 
of the cost implications of even the most modest 
capital investments in the sector.

To assess how the recurrent costs and counter-
part funding requirements exacerbate the MOHP 
budget crisis, this study calculated (a) the recurrent-
cost implications of health investments, especially 
hospitals, using an R ratio – the ratio of recurrent 
expenditure requirements to total investment cost – 
of 0.247, based on a Malawi study (Heller 1997); and 
(b) the required counterpart funding of donor-
funded projects in the PHN sector, which is typi-
cally 10-15 percent. Based on these rough calcula-
tions, the implied recurrent cost requirements for 
MOHP capital expenditures rises threefold from 
MK24.1 million in FY95 to MK74.9 million in FY97. 
On the other hand, based on a 12.5 percent counter-
part-fund requirement, MOHP needed at least 
MK40 million a year in the past three fiscal years 

Technical constraints

The health sector’s MTEF exercise as practiced in 
the late 1990s has been more “strategic”. MOHP 
consulted with stakeholders (program managers 
and district health officials) but these consultations 
were not done in the context of finalizing, budget-
ing for, and implementing the draft health sector 
strategic framework. Rather, budget consultations 
and cuts were made on the basis of existing pro-
grams and protecting the sunk costs of existing 
investments. MOHP Planning staff admit that the 
so-called MTEF, in spirit and in practice, is still 
largely an incremental budgeting approach and is 
far from the desired standard of budgeting on the 
basis of sector objectives. The inertia of incremental 
budgeting means that the MTEF process is simply a 
cutting-and-defending-the-budget exercise, rather 
than a means to give the GOM a way to strategi-
cally plan its core functions, namely, what it should 
be funding and providing cost-effectively to 
Malawians.

Limited technical data and skills hamper the 
MOHP from moving towards a more strategic 
approach. There are no unit costs available for pro-
gram costing exercises. Neither are effectiveness or 
output indicators available for programs, making it 
difficult to make rational choices about health-serv-
ice alternatives under alternative funding scenarios. 
In the absence of this information, prioritization
becomes a matter of lobbying by program managers, rather than of policymakers deliberately making strategic choices based on epidemiological needs, cost-effectiveness, and/or equity criteria. In addition, there are no practical means of allocating joint costs across programs, for example, the salaries of staff members involved in multiple programs have not been apportioned appropriately to those programs. Also, staff listed in one facility or district may in fact be working in another facility or district or in the central office.

Many of these problems can be resolved if MOHP takes a purposeful approach to developing its national health strategic plan that, among other things, (a) defines the Ministry’s role and core functions in health service provision and financing; (b) justifies these roles, functions and services in terms of well-established economic and cost-effectiveness criteria; and (c) based on these criteria, explicitly sets priorities based on the resource envelope available from the government budget, extra-budgetary resources, and donors’ contributions.

**Staff constraints**

The low pay of MOHP civil servants (generally US$80-100 per month) spawns coping practices that have a deleterious effect on service delivery, such as pilferage of drugs and other supplies, misuse of vehicles, reduced time in service, absenteeism, and informal fee charging. There are significant, albeit unquantified, inefficiencies engendered by these practices. More stringent controls are needed to curb them, but the long-term solution can only be with pay reform that is tied to civil service and system-wide “right-sizing”. Civil service retrenchment can generate savings that can be used to raise the salaries of the remaining work force, similar to what was done in neighboring Zambia. At present, the MTEF budget protects personal emoluments, and GOM appears not yet ready for retrenchment. However, deaths from the AIDS epidemic and staff resignations due to the low salaries are depleting the MOHP civil service. This may not be the best approach to MOHP right-sizing since the most skilled – and therefore marketable – staff often leave first. The retraining costs of new staff are also considerable, with significant impact on the MTEF budget.

**Recommendations for improved resource allocation and use**

The changes in budget titles and subprograms in the past few years make it difficult to compare the annual consistency in government priorities. However, based on principles of cost-effectiveness and the appropriate role of the government in the health sector, Table 9 provides a summary of recommendations for improved targeting and more effective use of government resources. The following need to be highlighted:

- **Referral of cases abroad** – These referrals cost MK2.8 million in FY95/96. Under such a system, GOM self-insures by directly funding the referral health services of senior civil servants. The economics of this system (in terms of medical and administrative costs, program benefits, and equity effects) compared to the alternative system of health insurance contracts should be analyzed and, if feasible, contracts should be implemented to replace direct funding.

- **Mortuary services and public transport of the dead** – Unlike other countries in Sub-Saharan Africa, GOM provides free mortuary and transport services, a policy that has probably prevented the development of a private-sector funeral industry. Mortuary and transport of dead bodies can be operated on a full or partial cost-recovery basis, as they are in neighboring countries.

- **External travel and external traveling allowance** – MOHP does not have information on how many of these trips are necessary and how many can be postponed or eliminated. A recent 2001 government circular, however, noted this problem and has specified actions to assess the level of importance of these trips.

- **Fuels and lubricants and maintenance of motor vehicles** – More stringent monitoring of the transport fleet is needed to reduce possible theft of fuels and lubricants and vehicle mismanagement.
### Table 9
Recommended key actions for improved use of MOHP resources

<table>
<thead>
<tr>
<th>Action</th>
<th>Illustrative programs, services or budget items</th>
</tr>
</thead>
</table>
| **Budget items or programs to be protected** | • Preventive and promotive services, primary curative services, secondary curative services  
• Disease outbreak investigation and management  
• Purchase of drugs and vaccines, subject to establishment of full or partial cost-recovery program for drugs dispensed in hospitals.  
• Maintenance of boreholes  
• Maintenance of plant and equipment  
• Water and sanitation  
• Subventions to local institutions providing preventive services promotive services |
| **Budget items or programs to be reduced or down-scaled** | • Personal emoluments (for 'excess' or redundant staff)  
• External travel and allowances  
• Workshops, seminars, other training  
• Fuels and lubricants, maintenance of motor vehicles (wastage)  
• Subscriptions to local and foreign institutions  
• Tertiary curative and rehabilitative services, in general  
• Administrative services deemed less necessary |
| **Budget items or programs to be deferred** | • All hospital construction, unless recurrent costs for their operation are assured  
• Hosting of international meetings |
| **Budget items or programs to be restructured** | • Imposition of full cost-recovery for patients with health insurance, patients utilizing high-tech medical services  
• Imposition of full or partial cost-recovery for specialist physician consultation, prescription drugs, radiology and lab services, hospital food, mortuary services and transport of the dead.  
• Ambulance services, use of operating theater, physio/occupational therapy, and prosthetic services  
• Contracting out of hospital preventive maintenance and other ancillary/support services  
• Conversion of direct-funded foreign referrals into a health insurance program, subject to copayments from members |
| **Budget items or programs to be eliminated** | • Referral of cases abroad  
• Cancer registry |

Source of data: This study.

Better fleet management is also called for, especially for vehicles separately funded by donors.

- Construction and rehabilitation – All new clinic or hospital construction should be deferred, unless adequate recurrent costs are found to operate them over the medium-term.

- Pharmaceutical supply – Potentially large efficiencies can be gained from better physician prescription, monitoring, and fees for prescription drugs. Informants cite the widespread free-drug policy in hospitals as the major cause of leakage of drugs to the private sector. Partial or full cost recovery is recommended.
The country’s narrow tax base and less-than-optimistic forecast of economic growth leaves little scope for a dramatic increase in health sector allocation in the medium-term. The central government is clearly unable to afford the continued financing of free health care at all levels especially with a rapidly growing population (Marshall 1996). The Technical Working Group on Health Financing, and more recently the DFID-commissioned technical work on health financing strategy, have identified extra-budgetary financing as one way of alleviating the adverse impact of the fiscal crunch. The key initiatives that can be pursued include community drug revolving funds, fee-based hospital revenue programs, and more aggressive claiming of health insurance reimbursements from medical aid schemes.

Drug revolving funds

About 600 villages can be tapped to establish drug revolving funds (DRF). The World Bank provides assistance under the PHN Project for the establishment of DRFs operating under a 100 percent cost-recovery target. Since June 1996, one community in each of the 10 priority districts under the PHN Project has begun DRFs and has distributed the initial stock of sulfadoxine/pyrimethamine (SP), paracetamol and aspirin. The village health committees managing these DRFs store and dispense the drugs, keep the funds generated, and order new supplies from the health centers.

Supervisory assessments of these funds indicate their good performance in distributing SP, paracetamol, aspirin, eye and skin ointments, and micronutrients. The communities keep good records, and for the items sold, the prices charged are far less than people would otherwise pay at private shops or the health center (WB 1996). To expand this program, MOHP plans to provide DRF seed money, give an initial stock of five basic drugs (anti-malarials, eye ointment, skin ointment, cotrimoxazole, and iron fortification) plus cotton wool and bandages; and to organize and train village health committees on DRF management. Funds from drug sales will be used to restock, improve physical condition of the clinics, and provide incentives to clinic staff.

The issues facing the DRF program are: (a) the financing, international sourcing, and replenishment of drug stocks once the PHN project ends; (b) the choice of drugs that will be under the revolving funds, and how specific needs of communities can be addressed; and (c) the stalled reforms with respect to the Central Medical Stores (CMS). The sustainability of DRFs hinges on the availability of drugs, which in turn depends on the institutional and financial sustainability of CMS.

Cost-sharing programs

Status

Government district hospitals operate general wards and, in general, impose no fees. Discussions
on instituting user charges within government hospitals were at an advanced stage in the early 1990s (Rep. of Malawi 1992) but they were never part of the policy component of the IDA-funded PHN Project, the government never introduced. Although cost-sharing programs at district hospitals and health centers were initiated any formal fee programs (though fees for drugs are being charged in a few sites). Tertiary hospitals do operate payment wards; these cost-sharing systems are currently being evaluated under a Japanese PHRD grant.

In contrast to government hospitals, CHAM facilities have sliding-scale fees so that indigent patients are not necessarily denied treatment (Ngalande 1994). Each hospital has a board that decides on the modest fee schedules. Though not all health units have cashiers, medical assistants and nurses are trained to collect the money. Fees generated are used to purchase drugs and medical supplies.

Local-authority health facilities that receive budgetary support from the Ministry of Local Government also charge fees. The lack of common policy between MOHP and local-authority facilities, and between government hospitals and subvented CHAM hospitals, has led to an anomaly where certain districts have fee programs while others do not.

Proposals

MOHP proposals call for a gradual approach of establishing fee programs, first at the central hospitals, then at the district hospitals, and finally at health centers and clinics. The government has indicated that urban middle- and higher-income groups should bear the cost of care at government hospitals.

A cursory examination of the services provided by central hospitals indicates considerable scope for fee revenues (Table 10). MOHP and hospital management need to focus on (a) strengthening the private patients’ paying scheme, which requires private patients to pay the actual cost of care received; (b) reviewing and updating reimbursement schedules for patients with private health insurance coverage; and (c) costing the hospital services that are amenable to fee imposition and developing fee schedules for them (such as high-tech medical services, prescription drugs, radiology and laboratory services, mortuary services, and physiotherapy and occupational therapy).

MOHP recently permitted district hospitals to introduce cost recovery in private wings. There are also discussions on the need to recover costs from services such as mortuary, ambulance, radiological and laboratory exams, prescription drugs, and use of amenity wards. Full cost-recovery should be pursued for members of medical-aid schemes and private insurance plans. Failure to do so results in an ill-funded government facility subsidizing private insurance plans. Partial cost-sharing for other hospital and health-center services should be considered. District hospitals should review fee schedules and reimbursement rates to patients under medical aid scheme or health insurance to align them with actual costs so that these patients are not unduly subsidized by the government.

Geographic or demographic targeting can protect the poor from fees. Poverty studies have well established the characteristics of the poor in Malawi. Poor households tend to live in rural areas, especially in dense central and southern regions and along the Mozambican border; some live in bomas (townships); others in pockets of cities especially Lilongwe. Poor households are almost always headed by someone with little or no education; the poor also tend to have a high dependency ratio. Assuming such a cost-sharing program gets implemented, what is the forecast for fee revenues? The Liverpool Associates in Tropical Health (LATH 1999) developed a simple model for assessing the potential revenue from user fees. The model’s hypothetical district comprised one district hospital, 12 health centers, four dispensaries, and 10 health posts. Table 11 shows five scenarios and their corresponding revenue uptakes (net of assumed running costs) for a typical district and nationwide.

Note that the most optimistic scenario (5), if done now, yields MK 7.9 million per district (or MK 189.6 million nationwide), which is equivalent to about 15 percent of the recurrent expenditure budget for FY2000/01. Note also that the above scenarios exclude central hospitals (Queen Elizabeth, Zomba Central, Zomba Mental, Lilongwe Central, and most recently Mzuzu Central), some of which have greater revenue potential than lower-level facilities. The above figures, therefore, should be viewed as lower-bound estimates for potential user-fee revenues of the entire government health system.
### Table 10
**Recommended restructuring of selected hospital services in Malawi**

<table>
<thead>
<tr>
<th>Services</th>
<th>Remarks</th>
<th>Proposed restructuring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with medical aid scheme or health insurance coverage</td>
<td>With ability to pay</td>
<td>Subject to full cost-recovery</td>
</tr>
<tr>
<td>Private patients paying scheme in amenity wards</td>
<td>With ability to pay</td>
<td>Subject to full or partial cost-recovery</td>
</tr>
<tr>
<td>High-tech medical services (CT-scan, dialysis, etc.)</td>
<td>Expensive and probably socially cost-ineffective</td>
<td>Subject to full cost-recovery</td>
</tr>
<tr>
<td>Specialist physician consultation</td>
<td>Fee basis in most countries</td>
<td>Subject to full or partial cost-recovery</td>
</tr>
<tr>
<td>Pharmaceutical supply</td>
<td>Fee basis for prescription drugs in most countries</td>
<td>Subject to full cost-recovery; reduce wastage through treatment protocols, drug registers, much-improved monitoring, and physician education; reorganize into Hospital Drug Capitalization Program</td>
</tr>
<tr>
<td>Radiology and lab services</td>
<td>Fee basis in most countries</td>
<td>Subject to full or partial cost-recovery</td>
</tr>
<tr>
<td>Food provision</td>
<td>Included in the per-diem cost in most countries</td>
<td>Reduce theft and wastage; subject to cost recovery; provide alternative cooking facilities</td>
</tr>
<tr>
<td>Mortuary services</td>
<td>Private business in most countries (funeral parlor)</td>
<td>Subject to full or partial cost-recovery</td>
</tr>
<tr>
<td>Transport of the dead</td>
<td>Private business in most countries (funeral parlor)</td>
<td>Subject to full or partial cost-recovery</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>Fee basis in most countries</td>
<td>Reduce abuse of transport; subject to full or partial cost-recovery</td>
</tr>
<tr>
<td>Use of operating theater</td>
<td>Fee basis in most countries</td>
<td>Subject to full or partial cost-recovery</td>
</tr>
<tr>
<td>Preventive maintenance, electromedical engineering and physical asset</td>
<td>On contractual arrangement in many countries</td>
<td>Contract out</td>
</tr>
<tr>
<td>management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physio/occupational therapy</td>
<td>Fee basis in most countries</td>
<td>Subject to full or partial cost-recovery</td>
</tr>
<tr>
<td>Prosthetic services</td>
<td>Private business in most countries</td>
<td>Privatize or subject to full or partial cost-recovery</td>
</tr>
</tbody>
</table>

Source: This study.

### Table 11
**Estimated revenues from cost-sharing program based on alternative scenarios**

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Revenue yield per district (in MK m)</th>
<th>Revenue yield nationwide (@24 districts in MK m)</th>
<th>Revenue yield nationwide (in US$ million @US$1=MK43)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 1: strengthening OPD1 and private amenity wings</td>
<td>MK 1.4 m</td>
<td>MK 33.6 m</td>
<td>US$ 0.78 m</td>
</tr>
<tr>
<td>Scenario 2: nominal fee and extended exemptions</td>
<td>MK 3.0 m</td>
<td>MK 72.0 m</td>
<td>US$ 1.67 m</td>
</tr>
<tr>
<td>Scenario 3: nominal fee and limited exemptions</td>
<td>MK 4.3 m</td>
<td>MK 103.2 m</td>
<td>US$ 2.40 m</td>
</tr>
<tr>
<td>Scenario 4: higher fee and extended exemptions</td>
<td>MK 5.3 m</td>
<td>MK 127.2 m</td>
<td>US$ 2.96 m</td>
</tr>
<tr>
<td>Scenario 5: still higher fees and extended exemptions</td>
<td>MK 7.9 m</td>
<td>MK 189.6 m</td>
<td>US$ 4.41 m</td>
</tr>
</tbody>
</table>

Private health expenditures

Mission/CHAM facilities

Nongovernmental organizations (NGOs) play a critical role in Malawi's health sector. Mission facilities, most of which are organized under the Christian Hospital Association of Malawi (CHAM), are the largest group, accounting for 19 percent of all facilities, 38 percent of beds, and 10 percent of outpatient visits (Table 12). Most of these church-sponsored health institutions predate the government health system and provide training for nurses and other health personnel. Though organized as a network, CHAM facilities operate autonomously. Hospital finances, including fee revenues, are managed by independent committees; fee schedules are made at the local level.

In districts where there are no government hospitals, CHAM facilities may be designated to fulfill their functions. These district-designated CHAM hospitals receive financial support (subvention) from the Ministry of Finance covering most of their salary costs. CHAM subventions dramatically increased from MK4.6 million in FY90/91 to MK22.2 in FY94/95, but the budget support program dried up the following year due to the fiscal crisis. In the mid-1990s, CHAM facilities claimed that 42.0 percent of their operating funds come from subvention grants, 25.5 percent from donations, and

<table>
<thead>
<tr>
<th>Type of provider</th>
<th>Number of facilities</th>
<th>Number of beds</th>
<th>Number of outpatient visits per year (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOHP</td>
<td>339</td>
<td>8,156</td>
<td>15.8</td>
</tr>
<tr>
<td>of which Queen Elizabeth CH</td>
<td>1</td>
<td>1,057</td>
<td>About 0.4</td>
</tr>
<tr>
<td>of which Lilongwe CH</td>
<td>1</td>
<td>700</td>
<td>About 0.4</td>
</tr>
<tr>
<td>Local governments</td>
<td>65</td>
<td>493</td>
<td>0.5</td>
</tr>
<tr>
<td>Missions/CHAM</td>
<td>164</td>
<td>5,648</td>
<td>2.1</td>
</tr>
<tr>
<td>For-profit providers and nonprofit NGOs</td>
<td>282</td>
<td>596</td>
<td>2.6</td>
</tr>
<tr>
<td>Total</td>
<td>850</td>
<td>14,893</td>
<td>21.1</td>
</tr>
</tbody>
</table>

32.5 percent from fees, sale of drugs, and other internally generated revenues.

All CHAM facilities charge fees. District-designated CHAM hospitals have private wings that generate revenues. Patients in general wards also pay but at a much-reduced rate. Fees are paid in cash though in-kind payments are also accepted. CHAM waives payment only in exceptional cases. The larger hospitals have written criteria and regulations on who can be waived or exempted, but these are not very transparent in smaller facilities. A study on outpatient paying patterns commissioned by UNICEF in 1995 indicates that 95 percent of all CHAM patients pay treatment fees, 19 percent pay associated health-service fees, and 22 percent pay for transport costs. In contrast, only a negligible percentage of MOHP patients pay treatment fees, only 12 percent pay associated health service fees, and only 9 percent pay for transport costs. CHAM fees are modest: a typical patient in 1995 paid MK1 for an access ticket, MK6 for medicines, MK2 for consultation, and MK 2 for lab exams.

CHAM facilities receive donations (in cash or in kind, such as, medical equipment and supplies). Expenditures on expatriate health workers and religious orders are unknown.

**Private for-profit health providers**

Private estates and corporations, especially those in far-flung areas, usually provide on-site health services to employees, their dependents, and sometimes non-employees and non-dependents. The Nchima Plantation, for instance, operates a clinic staffed with five nurses and one medical assistant and supplied with drugs from the UK, courtesy of the Nchima Trust. The clinic charges token fees, which are fixed for a course of treatment or service (MK25 for deliveries; MK2 for pediatric treatment; MK10 for adult confinement; and MK5 for child confinement). GOM should encourage private estates and corporations that do not currently provide health services to their employees and their dependents to set up such services. In spite of serious limitations in the public sector, there is very little discussion of the role of these in-plant health services.

Since GOM allowed private medical practice in 1991, the for-profit sector has dramatically expanded. As of the end of 1996, the Registry of Health Professionals listed 23 medical practitioners and seven dentists, all practicing in cities and large towns; 60 medical assistants; 30 clinical officers; 67 registered premises for private practice; and 19 licensed specialists, medical practitioners, and dentists in part-time practice. New regulations also made it possible for government health workers (doctors and medical officers) to have second jobs as private practitioners. As a result, moonlighting government doctors have shown up in cities and moonlighting paramedics in periurban areas. Drug shops are also a convenient source not only of pharmaceuticals but sometimes of medical advice. The College of Medicine graduates 20 doctors a year (96 have graduated since it opened in 1991), and the privatization of the medical sector could boost its output. So far, there has been no evaluation of how this liberalization of the health sector has affected health-service access, equity, or quality of care.

Traditional healers are well-established, charging as much as MK10-25 for eye problems, MK40-100 for pneumonia cases, and MK60 for common illnesses. An estimated 13,000 traditional healers practice in rural and urban areas. Some of them report seeing as many as 200 patients a month; at MK60 per patient, this patient volume translates to MK12,000 in fees collected a month, more than the salary of government doctors.

**Health insurance**

The slow structural transformation of the economy and a narrow base of formal employment constrain the development of social/compulsory or private/voluntary health insurance in Malawi. Nevertheless, unlike its neighbors Zambia (which made private health insurance illegal in the 1970s) and Tanzania (which followed a socialist path for much of its history), Malawi has a small established private health insurance industry.

The self-insuring agencies operate their own health insurance schemes – Federal Reserve Bank, the Post Office, National Bank, Inde Bank, Admarc, Levy Brothers, etc. The government encourages parastatals to establish health insurance and medical aid schemes for their employees. All parastatals currently have some form of health insurance for
senior staff, while a number operate clinics for junior staff. Scant information exists on the organization of these schemes, their number, coverage, benefit packages, or utilization patterns.

The Medical Aid Society of Malawi (MASM) is a subsidiary of the National Insurance Co. and was established in 1983 as a nonprofit organization under the Trustees Incorporation Act. MASM provides health insurance coverage to employees (and dependents) of large companies and better-off self-employed professionals. Contribution rates of employees and employers vary by company, but the benefit packages are standardized as shown in Table 13.

MASM's operating indicators are shown in Table 14. Though the membership base remains small, it is a profitable enterprise and expects market expansion. Recent and prospective activities include: (a) Acquisition a 15 percent share in the Mwaiwathu Hospital, probably the most modern hospital in Malawi, and (b) the plan to establish its own pharmacy, actions that will make MASM evolve towards a managed-care setup. Further, the self-insured companies have asked MASM to manage their schemes, in effect making MASM an "administrative services only" contractor to these schemes.

Moral hazard is a major issue facing MASM and other private insurance schemes in Malawi. Contracted private providers tend to over-use laboratories and x-rays, over-treat through prolonged confinement, and over-prescribe drugs. This problem

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**Table 13**

Benefits and contribution rates of different types of health insurance plans offered by the Medical Aid Society of Malawi

<table>
<thead>
<tr>
<th>Type of health insurance plan</th>
<th>Benefits</th>
<th>Illustrative contribution rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>100 percent of the cost of inpatient confinement in government and CHAM hospitals.</td>
<td>MK26/person/month</td>
</tr>
<tr>
<td>General</td>
<td>100 percent of the cost of inpatient confinement in government and CHAM hospitals; 80 percent if in private hospital. 100 percent of cost of outpatient consultations = 80 percent of cost of drugs.</td>
<td>MK106/person/month</td>
</tr>
<tr>
<td>Extended</td>
<td>100 percent of the cost of inpatient confinement in government, CHAM, and private hospitals. 100 percent of cost of outpatient consultations = 90 percent of cost of drugs. 50 percent of the cost of inpatient confinement abroad (South Africa and Zimbabwe), with a cap of MK100,000 per member.</td>
<td>MK350/person/month</td>
</tr>
</tbody>
</table>

Source of data: MASM.

**Table 14**

Operating indicators of the Medical Aid Society of Malawi: 1993/94-1996/97

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated membership (including family members)</td>
<td>16,000</td>
<td>17,000</td>
<td>18,000</td>
<td>20,500</td>
</tr>
<tr>
<td>Contributions (MK Mn)</td>
<td>20.50</td>
<td>30.11</td>
<td>40.55</td>
<td>42.47</td>
</tr>
<tr>
<td>Domestic claims (MK Mn)</td>
<td>15.44</td>
<td>25.54</td>
<td>30.40</td>
<td>34.46</td>
</tr>
<tr>
<td>Foreign claims (MK Mn)</td>
<td>1.38</td>
<td>3.00</td>
<td>0.58</td>
<td>1.47</td>
</tr>
<tr>
<td>Administrative costs (MK Mn)</td>
<td>3.87</td>
<td>4.61</td>
<td>5.15</td>
<td>5.60</td>
</tr>
<tr>
<td>Income (MK Mn)</td>
<td>—</td>
<td>—</td>
<td>6.70</td>
<td>4.60</td>
</tr>
<tr>
<td>Number of staff</td>
<td>15</td>
<td>17</td>
<td>19</td>
<td>20</td>
</tr>
</tbody>
</table>

Source of data: MASM.
encouraged MASM to take greater control of the provision of care through direct equity investments in a hospital and a pharmacy.

The second major problem has to do with AIDS. Insurance contracts exclude AIDS care, but to avoid losing clients, MASM currently does not strictly enforce this clause. This approach can continue as long as AIDS patients do not demand the expensive cocktail of AIDS drugs available in Western countries. As soon as they make such demands, the premium rates will have to be adjusted to such an impossibly high rate that private health insurance may become unviable, throwing such patients back into the ill-funded government system. This is a critical issue that GOM must address.

Fiscal difficulties have triggered proposals to explore social health insurance for the formally employed, but Malawi’s National Health Plan provides no specific actions to pursue it.

### Household health expenditures

Table 15 shows indicators of annualized household health expenditures based on a survey of one-month expenditures conducted in 1990-91. The expenditure pattern reflects the geographic pattern of income and wealth (as well as the presence of providers), with urban households spending 6.5 times as much as rural households on health services. The Blantyre figures are remarkably high, with a typical household spending MK107 (or US$40) on health care a year, in contrast to a typical rural household which spends only MK8-12 (US$3-5) a year. Rural household underspending can be alleviated with more intensive public spending, but the trend in MOHP expenditures does not point in this direction.

In March 1995, UNICEF conducted another survey (Table 16) showing the persistence of rural

#### Table 15
Annual household health expenditures in Malawi: 1990-91 (in Malawi Kwacha)

<table>
<thead>
<tr>
<th>Location</th>
<th>Hospital fees</th>
<th>Doctor and OPD fees</th>
<th>Dental and optical fees</th>
<th>Fees for paramedical healers</th>
<th>Pharmaceutical expenses</th>
<th>Other medical expenses</th>
<th>Health insurance contributions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blantyre City</td>
<td>28.32</td>
<td>48.60</td>
<td>7.56</td>
<td>5.88</td>
<td>12.24</td>
<td>0.84</td>
<td>3.60</td>
<td>107.04</td>
</tr>
<tr>
<td>Lilongwe City</td>
<td>0.24</td>
<td>23.64</td>
<td>0.00</td>
<td>4.32</td>
<td>12.00</td>
<td>0.24</td>
<td>14.16</td>
<td>54.60</td>
</tr>
<tr>
<td>Zomba Municipality</td>
<td>1.92</td>
<td>22.68</td>
<td>24.60</td>
<td>5.40</td>
<td>16.44</td>
<td>0.60</td>
<td>0.00</td>
<td>71.64</td>
</tr>
<tr>
<td>Mzuzu City</td>
<td>5.76</td>
<td>24.00</td>
<td>0.60</td>
<td>5.28</td>
<td>15.36</td>
<td>0.64</td>
<td>2.52</td>
<td>54.36</td>
</tr>
<tr>
<td><strong>Unweighted average for urban</strong></td>
<td><strong>9.06</strong></td>
<td><strong>29.73</strong></td>
<td><strong>8.19</strong></td>
<td><strong>5.22</strong></td>
<td><strong>14.01</strong></td>
<td><strong>0.63</strong></td>
<td><strong>20.28</strong></td>
<td><strong>71.91</strong></td>
</tr>
<tr>
<td>South, rural</td>
<td>0.24</td>
<td>3.00</td>
<td>0.12</td>
<td>1.80</td>
<td>2.76</td>
<td>0.00</td>
<td>0.00</td>
<td>7.92</td>
</tr>
<tr>
<td>Central, rural</td>
<td>0.48</td>
<td>4.80</td>
<td>0.12</td>
<td>2.88</td>
<td>4.44</td>
<td>0.12</td>
<td>0.36</td>
<td>13.20</td>
</tr>
<tr>
<td>North, rural</td>
<td>0.12</td>
<td>1.08</td>
<td>0.12</td>
<td>3.12</td>
<td>7.68</td>
<td>0.00</td>
<td>0.00</td>
<td>12.12</td>
</tr>
<tr>
<td><strong>Unweighted average for rural</strong></td>
<td><strong>0.28</strong></td>
<td><strong>2.96</strong></td>
<td><strong>0.12</strong></td>
<td><strong>2.60</strong></td>
<td><strong>4.96</strong></td>
<td><strong>0.04</strong></td>
<td><strong>0.12</strong></td>
<td><strong>11.08</strong></td>
</tr>
<tr>
<td><strong>Unweighted average for all</strong></td>
<td><strong>4.67</strong></td>
<td><strong>16.35</strong></td>
<td><strong>4.16</strong></td>
<td><strong>3.91</strong></td>
<td><strong>9.49</strong></td>
<td><strong>0.34</strong></td>
<td><strong>10.20</strong></td>
<td><strong>41.50</strong></td>
</tr>
</tbody>
</table>

Note: Annualized from reported monthly figures.

Memo item: The exchange rate to the US$ was MK2.7 in 1990 and MK2.8 in 1991.

### Table 16
Reported paying patterns of poor and nonpoor households for health services, by urban and rural location: 1995

<table>
<thead>
<tr>
<th>Income status</th>
<th>Reported poor</th>
<th></th>
<th></th>
<th>Reported nonpoor</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National</td>
<td>Urban</td>
<td>Rural</td>
<td>National</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>Percent of households reported not paying</td>
<td>47 percent</td>
<td>58 percent</td>
<td>56 percent</td>
<td>61 percent</td>
<td>47 percent</td>
<td>63 percent</td>
</tr>
<tr>
<td>Percent of households reported paying</td>
<td>43 percent</td>
<td>42 percent</td>
<td>44 percent</td>
<td>39 percent</td>
<td>53 percent</td>
<td>37 percent</td>
</tr>
<tr>
<td>Average monthly (Annual) amount paid by paying households</td>
<td>MK 12 (MK 144)</td>
<td>MK 31 (MK 372)</td>
<td>MK 9 (MK 108)</td>
<td>MK 23 (MK 276)</td>
<td>MK 60 (MK 720)</td>
<td>MK 15 (MK 190)</td>
</tr>
</tbody>
</table>

**Memo item:** The exchange rate to the US$ was MK15.3 in 1995.

**Source of basic data:** UNICEF, March 1995.

Households’ underspending on health services (MK180 a year) relative to urban households (MK720 a year). Analysis of survey results also indicates the degree of leakage and undercoverage of fee programs in Malawi. At the national level, as much as 61 percent of nonpoor households get health services without paying (leakage) while as much as 43 percent of poor households end up paying (undercoverage). Thus, many households with capacity to pay for health services are freeloading while just as many households with scant means are paying for care. These findings strongly indicate the need to sharpen the focus of fee programs (imposing fees on free-care urban facilities where those with capacity to pay are mostly located) and to establish clearer waiver and exemption systems in both urban and rural facilities. The survey did not disaggregate respondents by the type of facility used (MOHP, CHAM, local authorities, private for profit), making it difficult to recommend institution-specific reforms.
Malawi hosts five bilateral and eight multilateral donors in the health sector. From FY94-FY97, these had an aggregate country allocation of around US$1.4 billion (or around US$350 million a year), of which 19 percent was allocated to health. In terms of sector allocation, health was eclipsed only by "economic-management", which garnered 21 percent of total donor allocation during the period. Education and human resources took 15 percent, and agriculture, 14 percent. The respective percentage shares of the rest of the sectors (natural resources, transport, energy, social development, and so on) were less than 6 percent each.

Table 17
Donors' health sector allocations and expenditures in Malawi: FY94/95-FY97/98

<table>
<thead>
<tr>
<th>Items</th>
<th>FY94/95</th>
<th>FY95/96</th>
<th>FY96/97</th>
<th>FY97/98</th>
<th>Percent change FY94-FY97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donors' country budget allocation (US$ m)</td>
<td>319.3</td>
<td>376.0</td>
<td>331.9</td>
<td>375.6</td>
<td>17.6</td>
</tr>
<tr>
<td>Donors' actual expenditures (US$ m)</td>
<td>259.5</td>
<td>307.0</td>
<td>262.2</td>
<td>349.2</td>
<td>34.6</td>
</tr>
<tr>
<td>Donors' health sector allocation (US$ m)</td>
<td>50.4</td>
<td>57.1</td>
<td>72.3</td>
<td>86.0</td>
<td>70.6</td>
</tr>
<tr>
<td>Donors' health sector expenditures (US$ m)</td>
<td>28.2</td>
<td>35.7</td>
<td>50.0</td>
<td>47.1</td>
<td>67.0</td>
</tr>
<tr>
<td>Percentage of health sector allocation to total allocation</td>
<td>15.8</td>
<td>15.2</td>
<td>21.8</td>
<td>22.9</td>
<td>—</td>
</tr>
<tr>
<td>Percentage of health sector expenditure to total expenditure</td>
<td>10.9</td>
<td>11.7</td>
<td>19.1</td>
<td>13.5</td>
<td>—</td>
</tr>
<tr>
<td>Population of Malawi (m)</td>
<td>10.25</td>
<td>10.57</td>
<td>10.91</td>
<td>11.24</td>
<td>9.7</td>
</tr>
<tr>
<td>Donors' health sector expenditures per capita (US$)</td>
<td>2.58</td>
<td>3.38</td>
<td>4.58</td>
<td>4.19</td>
<td>62.4</td>
</tr>
</tbody>
</table>

Note: Donors have varying fiscal years: (a) Jan. 1-Dec. 31 - GTZ, EU, UNAIDS, UNDP, UNFPA, UNICEF, WFP, and WHO; (b) Apr. 1-Mar. 31 - CIDA, DFID, JICA, IDA; (c) Oct. 1-Sept. 30 - USAID. No attempt was made in this study to transform the original responses to conform with the Government of Malawi's fiscal year.

Source of basic data: Survey of donors.
Allocation vs. expenditures

Donors' allocation to health dramatically increased from 15.8 percent in FY94 to 22.9 percent in FY97 (Table 17), reflecting their collective commitment to the sector. By FY97, the share of health expenditures to total donor expenditures had reached 13.5 percent. The level and pace of donor health expenditures far exceeded population growth so that per capita donor health expenditures rose markedly over the four-year period to reach US$4.19 in FY97, after peaking at US$4.58 in FY96. It is largely due this increased donor-funding of the sector that total per capita health expenditures in Malawi have not declined in the face of drastic reduction of government health spending.

The multilateral agencies (IDA, UNAIDS, UNFPA, UNICEF, the World Food Program, WHO, and the European Union) account for around 48.4 percent of donor allocations in the health sector; the bilateral donors (CIDA, DFID, GTZ, JICA, USAID) contribute the remaining 51.6 percent. In all, there are 34 discrete projects currently implemented by donors (Table 18). The projects vary in size, the biggest ones being DFID's Malawi Reproductive Health Project; EU's Health Reform and Decentral-

Table 18
Budget allocation and expenditures of donor projects: as of end-FY97/98
(in thousand U.S. dollars)

<table>
<thead>
<tr>
<th>Donor/project name</th>
<th>Life of project*</th>
<th>Budget allocation</th>
<th>Expenditures to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIDA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family health project</td>
<td>4/96-3/98</td>
<td>1,032</td>
<td>1,032</td>
</tr>
<tr>
<td>Social sector grant</td>
<td>4/96-3/97</td>
<td>1,845</td>
<td>1,845</td>
</tr>
<tr>
<td>Southern Africa AIDS training</td>
<td>5/97-12/97</td>
<td>143</td>
<td>143</td>
</tr>
<tr>
<td>DfID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive supply and reproductive health</td>
<td>7/93-12/97</td>
<td>1,416</td>
<td>1,369</td>
</tr>
<tr>
<td>Anesthetic training and support</td>
<td>10/93-3/98</td>
<td>700</td>
<td>692</td>
</tr>
<tr>
<td>Technical assistance to health sector reform</td>
<td>8/94-7/98</td>
<td>600</td>
<td>564</td>
</tr>
<tr>
<td>Malawi reproductive health project</td>
<td>9/94-3/01</td>
<td>16,518</td>
<td>6,912</td>
</tr>
<tr>
<td>Support to national AIDS coordination program</td>
<td>7/95-12/97</td>
<td>404</td>
<td>384</td>
</tr>
<tr>
<td>Interim contraceptive supply project</td>
<td>8/96-12/97</td>
<td>1,180</td>
<td>972</td>
</tr>
<tr>
<td>Support to national tuberculosis control program</td>
<td>8/97-7/99</td>
<td>1,771</td>
<td>1,055</td>
</tr>
<tr>
<td>European Union</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural health program (building and equipment)</td>
<td>12/87-n.d.</td>
<td>8,882</td>
<td>7,078</td>
</tr>
<tr>
<td>STD prevention project</td>
<td>1/93-n.d.</td>
<td>1,104</td>
<td>995</td>
</tr>
<tr>
<td>Health sector project identification</td>
<td>8/94-n.d.</td>
<td>170</td>
<td>162</td>
</tr>
<tr>
<td>Technical assistance to MOHP</td>
<td>10/96-n.d.</td>
<td>481</td>
<td>108</td>
</tr>
<tr>
<td>Health reform and decentralization</td>
<td>10/96-n.d.</td>
<td>17,211</td>
<td>76</td>
</tr>
<tr>
<td>HIV/AIDS prevention</td>
<td>7/97-n.d.</td>
<td>718</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 18 continues on next page
Table 18 (continued)

<table>
<thead>
<tr>
<th>Donor/project name</th>
<th>Life of project*</th>
<th>Budget allocation</th>
<th>Expenditures to date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GTZ</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthening of Machinga district health services</td>
<td>1991-2000</td>
<td>12,000</td>
<td>8,521</td>
</tr>
<tr>
<td>Strengthening of Zomba district health services</td>
<td>1997-2000</td>
<td>2,000</td>
<td>0</td>
</tr>
<tr>
<td><strong>JICA</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community health science project</td>
<td>1994-1999</td>
<td>3,500</td>
<td>3,500</td>
</tr>
<tr>
<td><strong>USAID</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHICS</td>
<td>6/89-12/98</td>
<td>23,493</td>
<td>15,550</td>
</tr>
<tr>
<td>STAFH project</td>
<td>9/92-9/98</td>
<td>45,000</td>
<td>17,685</td>
</tr>
<tr>
<td>CHAPS project</td>
<td>9/95-9/00</td>
<td>15,000</td>
<td>53</td>
</tr>
<tr>
<td>COPE 1 project</td>
<td>7/95-9/97</td>
<td>539</td>
<td>538</td>
</tr>
<tr>
<td><strong>IDA</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHN project</td>
<td>1991-1999</td>
<td>55,500</td>
<td>23,000</td>
</tr>
<tr>
<td><strong>UNAIDS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistance to national AIDS control program</td>
<td>1/96-1/98</td>
<td>289</td>
<td>154</td>
</tr>
<tr>
<td><strong>UNDP</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health component</td>
<td>1/93-12/98</td>
<td>980</td>
<td>980</td>
</tr>
<tr>
<td><strong>UNFPA</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Census: basic data collection</td>
<td>1992-2001</td>
<td>1,743</td>
<td>912</td>
</tr>
<tr>
<td>Demography training</td>
<td>1992-2001</td>
<td>849</td>
<td>512</td>
</tr>
<tr>
<td>Population policy</td>
<td>1992-2001</td>
<td>2,658</td>
<td>1,605</td>
</tr>
<tr>
<td>Family planning</td>
<td>1992-2001</td>
<td>9,355</td>
<td>5,974</td>
</tr>
<tr>
<td><strong>UNICEF</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country program in health</td>
<td>n.a.</td>
<td>3,732</td>
<td>3,732</td>
</tr>
<tr>
<td><strong>World Food Program</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vulnerable group feeding</td>
<td>1996-1998</td>
<td>10,161</td>
<td>5,305</td>
</tr>
<tr>
<td><strong>WHO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical cooperation</td>
<td>1997-1998</td>
<td>300</td>
<td>300</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>246,484</td>
<td>115,693</td>
</tr>
</tbody>
</table>

* Months of initiation and termination of projects given when known.
Source of basic data: Survey of donors.
ization Project; GTZ's strengthening of district health services in Machinga and Zomba; USAID's PHICS, STAFH, and CHAPS Projects; IDA's PHN Project; and WFP's Vulnerable Group Feeding Project.

Project pipeline

An analysis of the lives of these projects indicates that most of them were planned to end within FY98 or in the next two fiscal years. However, due to the slower-than-planned disbursement rates, it is likely that they will be extended beyond their current closing dates. To date, the ongoing projects have collectively expended only US$115.7 million, or 46.9 percent of the aggregate budget allocation of US$246.5 million. In the period FY94-FY97, donors were able to spend only an average of 60.5 percent of their annual health sector allocation (Table 19).

For existing projects with closing dates beyond FY97, we calculated expected disbursements for FY98 to FY01, and the results are shown in Table 20. The analysis shows that even under the most optimistic management scenarios, there will be significant amounts of already-committed donor resources to be disbursed: US$72.5 million in FY98, US$32.3 million in FY99, US$15.5 million in FY00, and US$10.5 million in FY01. Given the projects now in the pipeline, as well as major projects being considered, designed, or negotiated (such as those of DfID, IDA, JICA, USAID), the government and its donor-partners should begin serious discussions about how donor health expenditures can be expedited, especially in light of the very tight government fiscal situation now and in the foreseeable future. Donor resources should come in handy during a budgetary crunch, but unless the government's capacity to absorb and donors' own ability to disburse are addressed, donor resources may not be able to quickly cushion the impact of government underspending in health.

The following issues hindering faster disbursements need to be addressed:

- GOM's constrained ability to meet counterpart funding requirements.

- Administrative bottlenecks at central MOHP HQ, especially the absence of signatories. Appropriate delegation authorities within government need to be established for officials who are away.

- Slow compliance with legal, policy, program, or administrative requirements and conditions for disbursement.

- Weak capacity to manage and follow up required actions for donor funds to flow or for procurement to proceed; loose coordination between the MOHP, Ministry of Finance, and local governments; miscommunication between donors and government or NGO counterparts.

- Time-consuming and possibly onerous procurement procedures, lack of understanding of these procedures, or lack of qualified staff knowledgeable in these procedures.

- The sheer number of projects and activities – 34 at present – that overburdens the already strained capacity at central MOHP HQ.

Health service focus of donor projects

Donor projects focus principally on primary, preventive, and promotive care. As Table 21 shows, 64.7 percent of the total number of projects, 84.2 percent of their budgets, and 87.3 percent of their expenditures to date are oriented to primary health services. The most frequently cited objectives of these projects are prevention of HIV/AIDS and other sexually transmitted infections, family planning, family health, and central- and district-level support to primary care interventions. In recent years, malaria and tuberculosis have received increasing focus.

Uses of donor resources

Donor response to the survey on the use of their health expenditures was poor; as a result, as much as a third of the recurrent and 7 percent of the capital expenditures cannot be classified. Of their total health expenditures in FY96 and FY97, donors claimed that around 87 percent were for recurrent and around 13 percent were for capital expenditures (Table 22). Thus, even though donor-funded projects are reported in the Development Account of the
### Table 19
Donors' budget allocation and expenditures in the health sector in Malawi: FY94/95-FY97/98
(in thousand U.S. dollars)

<table>
<thead>
<tr>
<th>Donors</th>
<th>FY94/95</th>
<th>FY95/96</th>
<th>FY96/97</th>
<th>FY97/98</th>
<th>Annual average FY94-FY97</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Budget allocation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIDA</td>
<td>1,923</td>
<td>1,923</td>
<td>3,778</td>
<td>3,778</td>
<td>2,851</td>
</tr>
<tr>
<td>DFID</td>
<td>4,768</td>
<td>4,768</td>
<td>3,263</td>
<td>4,000</td>
<td>4,200</td>
</tr>
<tr>
<td>EU</td>
<td>9,572</td>
<td>9,572</td>
<td>27,520</td>
<td>28,560</td>
<td>18,806</td>
</tr>
<tr>
<td>GTZ</td>
<td>4,000</td>
<td>4,500</td>
<td>1,667</td>
<td>2,520</td>
<td>3,172</td>
</tr>
<tr>
<td>JICA</td>
<td>2,510</td>
<td>3,260</td>
<td>3,610</td>
<td>3,971</td>
<td>3,338</td>
</tr>
<tr>
<td>USAID</td>
<td>7,085</td>
<td>11,547</td>
<td>9,573</td>
<td>12,826</td>
<td>10,258</td>
</tr>
<tr>
<td>IDA</td>
<td>11,000</td>
<td>11,000</td>
<td>11,000</td>
<td>17,700</td>
<td>12,675</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>0</td>
<td>0</td>
<td>69</td>
<td>220</td>
<td>72</td>
</tr>
<tr>
<td>UNDP</td>
<td>113</td>
<td>77</td>
<td>191</td>
<td>240</td>
<td>155</td>
</tr>
<tr>
<td>UNFPA</td>
<td>1,478</td>
<td>2,546</td>
<td>3,288</td>
<td>3,785</td>
<td>2,774</td>
</tr>
<tr>
<td>UNICEF</td>
<td>4,050</td>
<td>4,050</td>
<td>4,050</td>
<td>4,050</td>
<td>4,050</td>
</tr>
<tr>
<td>WFP</td>
<td>2,963</td>
<td>2,963</td>
<td>3,387</td>
<td>3,387</td>
<td>3,175</td>
</tr>
<tr>
<td>WHO</td>
<td>920</td>
<td>920</td>
<td>920</td>
<td>920</td>
<td>920</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>50,383</td>
<td>57,126</td>
<td>72,316</td>
<td>85,956</td>
<td>66,445</td>
</tr>
</tbody>
</table>

| **Estimated expenditures** |         |         |         |         |                         |
| CIDA    | 1,923   | 1,923   | 3,778   | 3,778   | 2,851                   |
| DFID    | 1,716   | 1,716   | 2,542   | 2,900   | 2,219                   |
| EU      | 5,965   | 6,341   | 7,400   | 8,385   | 7,020                   |
| GTZ     | 2,000   | 2,500   | 2,000   | 2,000   | 2,125                   |
| JICA    | 2,510   | 3,260   | 3,610   | 3,971   | 3,338                   |
| USAID   | 2,878   | 5,103   | 6,731   | 9,277   | 5,997                   |
| IDA     | 2,300   | 4,770   | 12,633  | 5,827   | 6,383                   |
| UNAIDS  | 0       | 0       | 35      | 118     | 38                      |
| UNDP    | 113     | 77      | 191     | 240     | 155                     |
| UNFPA   | 1,478   | 2,546   | 3,288   | 3,784   | 2,774                   |
| WFP     | 2,593   | 2,770   | 3,177   | 2,128   | 2,667                   |
| WHO     | 920     | 920     | 920     | 920     | 920                     |
| **Total** | 28,118 | 35,658  | 50,037  | 47,060  | 40,218                 |

**Ratio of annual expenditures to budget allocation (percent)**

<table>
<thead>
<tr>
<th></th>
<th>FY94/95</th>
<th>FY95/96</th>
<th>FY96/97</th>
<th>FY97/98</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>55.8</td>
<td>62.4</td>
<td>69.2</td>
<td>54.7</td>
<td>60.5</td>
</tr>
</tbody>
</table>

*Source of basic data: Survey of donors.*
Table 20
Pipeline analysis of major donor projects in the health sector in Malawi: FY98/99-FY01/02 (in million U.S. dollars)

<table>
<thead>
<tr>
<th>Donor/project</th>
<th>Closing date*</th>
<th>Pipeline to date</th>
<th>FY98/99</th>
<th>FY99/00</th>
<th>FY00/01</th>
<th>FY01/02</th>
</tr>
</thead>
<tbody>
<tr>
<td>DfID’s Malawi reproductive health project</td>
<td>3/01</td>
<td>9.6</td>
<td>2.4</td>
<td>2.4</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>DfID’s other projects</td>
<td>1999</td>
<td>1.0</td>
<td>.5</td>
<td>.5</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>EU’s health reform and decentralization project</td>
<td>2001</td>
<td>17.1</td>
<td>4.3</td>
<td>4.3</td>
<td>4.3</td>
<td>4.3</td>
</tr>
<tr>
<td>EU’s other projects</td>
<td>2001</td>
<td>3.0</td>
<td>.8</td>
<td>.8</td>
<td>.8</td>
<td>.8</td>
</tr>
<tr>
<td>GTZ’s strengthening of Machinga and Zomba district health services</td>
<td>2001</td>
<td>5.4</td>
<td>1.4</td>
<td>1.4</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>USAID’s PHICS project</td>
<td>12/98</td>
<td>7.9</td>
<td>7.9</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>USAID’s STAFH project</td>
<td>9/98</td>
<td>27.3</td>
<td>27.3</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>USAID’s CHAPS project</td>
<td>9/00</td>
<td>14.9</td>
<td>5.0</td>
<td>5.0</td>
<td>5.0</td>
<td>—</td>
</tr>
<tr>
<td>IDA’s PHN project</td>
<td>1999</td>
<td>32.5</td>
<td>16.3</td>
<td>16.3</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>UNAIDS’s assistance to NACP</td>
<td>11/98</td>
<td>.1</td>
<td>.1</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>UNFPA’s four population-related projects</td>
<td>2001</td>
<td>6.8</td>
<td>1.7</td>
<td>1.7</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>WFP’s vulnerable group feeding project</td>
<td>1998</td>
<td>4.9</td>
<td>4.9</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
<td>—</td>
<td>130.8</td>
<td>72.5</td>
<td>32.3</td>
<td>15.5</td>
<td>10.5</td>
</tr>
</tbody>
</table>

*Month of termination given when known.
Source of basic data: Survey of donors.

Table 21
Donor projects by health service focus in Malawi: as of end-FY97/98 (in thousand U.S. dollars)

<table>
<thead>
<tr>
<th>Health service focus</th>
<th>Number of projects</th>
<th>Total budget</th>
<th>Percentage of budget</th>
<th>Expenditures to date</th>
<th>Percentage of expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary, preventive and promotive care</td>
<td>22</td>
<td>207,605</td>
<td>84.2</td>
<td>101,021</td>
<td>87.3</td>
</tr>
<tr>
<td>Basic curative care/district health services</td>
<td>2</td>
<td>14,000</td>
<td>5.7</td>
<td>8,521</td>
<td>7.4</td>
</tr>
<tr>
<td>Tertiary care</td>
<td>1</td>
<td>700</td>
<td>0.3</td>
<td>692</td>
<td>0.6</td>
</tr>
<tr>
<td>Health reform, decentralization, census, technical cooperation not classified elsewhere, and other activities</td>
<td>9</td>
<td>24,179</td>
<td>9.8</td>
<td>5,459</td>
<td>4.7</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>246,484</td>
<td>100.0</td>
<td>115,693</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source of basic data: Survey of donors.

government budget, most of these are really recurrent rather than capital investment expenditures.

Of the US$43.6 million recurrent expenditures in FY96, as much as 16.6 percent was provided by six donors as departmental support to the MOHP, project monitoring units, vertical disease programs (AIDS, tuberculosis, primary health care), rural health units, and the Queen Elizabeth Hospital. The level of this direct departmental and administrative support was maintained in FY97, and two more ver-
Table 22
Donor expenditures by major classification: FY96/97 and FY97/98 (in thousand US dollars)

<table>
<thead>
<tr>
<th>Expenditure Classification</th>
<th>FY96/97</th>
<th>FY96/97</th>
<th>FY97/98</th>
<th>FY97/98</th>
<th>Key Donors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>amount</td>
<td>percent</td>
<td>amount</td>
<td>percent</td>
<td></td>
</tr>
<tr>
<td>Recurrent expenditures</td>
<td>43,574</td>
<td>87.1</td>
<td>40,523</td>
<td>86.1</td>
<td></td>
</tr>
<tr>
<td>Departmental support to MOHP and administration</td>
<td>8,487</td>
<td>16.6</td>
<td>7,788</td>
<td>16.5</td>
<td>CIDA, DfID, EU, IDA, UNDP, UNFPA</td>
</tr>
<tr>
<td>Subcontractors</td>
<td>1,106</td>
<td>2.2</td>
<td>1,951</td>
<td>4.1</td>
<td>DfID, USAID, UNFPA</td>
</tr>
<tr>
<td>Technical assistance</td>
<td>8,382</td>
<td>16.8</td>
<td>11,314</td>
<td>24.0</td>
<td>CIDA, DfID, JICA, USAID, IDA, UNAIDS, UNICEF</td>
</tr>
<tr>
<td>Research</td>
<td>205</td>
<td>0.4</td>
<td>245</td>
<td>0.5</td>
<td>JICA, USAID</td>
</tr>
<tr>
<td>Training</td>
<td>3,826</td>
<td>7.6</td>
<td>4,505</td>
<td>9.6</td>
<td>CIDA, DfID, JICA, USAID, IDA, UNFPA</td>
</tr>
<tr>
<td>Transport O&amp;M</td>
<td>670</td>
<td>1.3</td>
<td>824</td>
<td>1.8</td>
<td>DfID, IDA, UNICEF</td>
</tr>
<tr>
<td>Drugs and contraceptives</td>
<td>4,867</td>
<td>9.7</td>
<td>1,378</td>
<td>2.9</td>
<td>CIDA, DfID, USAID, IDA, UNFPA</td>
</tr>
<tr>
<td>IEC</td>
<td>206</td>
<td>0.4</td>
<td>627</td>
<td>1.3</td>
<td>DfID, EU, IDA, UNICEF</td>
</tr>
<tr>
<td>Other operating expenses</td>
<td>603</td>
<td>1.2</td>
<td>3,098</td>
<td>6.6</td>
<td>DfID, EU, USAID, IDA, UNDP, UNFPA</td>
</tr>
<tr>
<td>Unclassified recurring expenses</td>
<td>15,222</td>
<td>30.4</td>
<td>8,793</td>
<td>18.7</td>
<td></td>
</tr>
<tr>
<td>Capital expenses</td>
<td>6,463</td>
<td>12.9</td>
<td>6,537</td>
<td>13.9</td>
<td></td>
</tr>
<tr>
<td>Building construction and rehabilitation</td>
<td>926</td>
<td>1.9</td>
<td>1,680</td>
<td>3.6</td>
<td>DfID, JICA, IDA, UNICEF</td>
</tr>
<tr>
<td>Vehicles</td>
<td>108</td>
<td>0.2</td>
<td>768</td>
<td>1.6</td>
<td>EU, IDA, UNICEF</td>
</tr>
<tr>
<td>Office equipment</td>
<td>460</td>
<td>0.9</td>
<td>1,079</td>
<td>2.3</td>
<td>IDA, UNFPA</td>
</tr>
<tr>
<td>Medical equipment</td>
<td>1,626</td>
<td>3.2</td>
<td>717</td>
<td>1.5</td>
<td>DfID, JICA, IDA</td>
</tr>
<tr>
<td>Unclass. cap. exp.</td>
<td>3,343</td>
<td>6.9</td>
<td>22</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50,037</td>
<td>100.0</td>
<td>47,060</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Source of basic data: Survey of donors.

tical programs received support (malaria and schistosomiasis). Thus, there appears to be an increasing trend among donors to strengthen vertical disease interventions.

Subcontracts and technical assistance weighed heavily, with as much as US$9.5 million devoted to these two expenditure items in FY96, and increasing to US$13.3 million in FY97. Concern is being raised of the costliness of these inputs, but in view of the weak implementation capacity of the government, technical and management assistance may be a needed supplement it. As many as 16 projects or discrete activities are being managed by foreign agencies, NGOs, and contractors; three others are under African/local NGOs (Table 23). Together, NGOs – defined broadly – oversee more than half (55.9 percent) of the ongoing projects.

Training is also a major user of donor funds. Close to a tenth of all donor expenditures in FY97 went on training, which includes long-term training mostly out of the country (US$856,000), short-term training mostly out of the country (US$600,000), in-country and out-of-the-country workshops (US$2.2 million), and other unclassified training activities. The US$4.5 million annual cost of these training activities is staggering for a country the size of Malawi, a bureaucracy the size of MOHP, and an NGO community which is at best fledgling. (There
Table 23
Implementing agencies of donor projects in Malawi as of end-FY97/98

<table>
<thead>
<tr>
<th>Type of agency</th>
<th>Implementing agency</th>
<th>Number of projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>College of Medicine</td>
<td>1</td>
</tr>
<tr>
<td>government</td>
<td>District health offices</td>
<td>3</td>
</tr>
<tr>
<td>agencies</td>
<td>Family health unit</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MOHP</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Ministry of Local Government</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Ministry of Works</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Nat'l AIDS Control Program</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Nat'l Statistics Office</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Nat'l Tuberculosis Control Program</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Population Unit</td>
<td>3</td>
</tr>
<tr>
<td>African/local</td>
<td>Africare</td>
<td>1</td>
</tr>
<tr>
<td>NGOs</td>
<td>Banja la Mtsogolo</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CHISU</td>
<td>1</td>
</tr>
<tr>
<td>Foreign agencies, NGOs, and contractors</td>
<td>Canadian Public Health Assn.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Centers for Disease Control</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Project HOPE</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>International Eye Foundation</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>International Labour Org.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>John Snow, Inc.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Marie Stopes International</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Population Services Int'l</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Save the Children (UK)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Save the Children (US)</td>
<td>3</td>
</tr>
<tr>
<td>Total no. of projects/discrete activities</td>
<td></td>
<td>34</td>
</tr>
</tbody>
</table>

Note: Total does not tally with details due to double-counting, especially of MOHP involvement.
Source of basic data: Survey of donors.

is also a separate line item for training in the MOHP budget, in addition to the donor-funded training expenditures; in addition, around 15 percent of donor allocations are for a separate Human Resources item, apart from these health-dedicated training programs).

The continued sponsorship of these training programs in the absence of a human-resource development plan in the MOHP and in the NGO community, as well as the absence of any mechanism to measure the impact of these programs on health service delivery, is a serious concern. It is common knowledge that these training programs provide strong financial and other incentives to participants. If the objective of these training programs is implicitly to reward civil servants, a better mechanism – using the same level of resources – would be for sponsoring donors to provide these as direct salary supplements. The US$4.5 million would translate to US$473 salary increase for one year for each of the 9,500 civil servants (about US$40 per month, or 50 percent of the US$80 monthly salary of a typical civil servant). Salary supplements would probably have a more visible impact on health service delivery compared to training, which takes service providers away from their respective posts, sometimes for prolonged and recurrent periods. (In this regard, the greater use of on-site training programs is called for.)

Geographic distribution of donor projects

Absence of data precludes proper analysis of the geographic distribution of donor-funded projects. The donor survey, however, yielded the following illustrative information: Of the 34 donor-funded projects, 23 have nationwide application. Twelve districts host two or more donor-funded projects while six districts have at least one project each. Six districts, however, do not host a single donor-funded project (their access to donor-funded activities is limited to those donor projects that are nationwide in application). Donors are prone to locate in relatively nicer districts; it is also these districts that have multiple donor projects: Mangochi, five projects; Salima, four; Blantyre, two; Lilongwe, two;...
Zomba, two (See Table 24). Donors have much less tendency to locate in the northern and/or farther districts (such as Nkhotakota, Ntchisi, Nkhata Bay, and Chitipa in the north; Nsanje in the far south).

These results on locational patterns of donor health projects need to be examined further. The government must provide specific guidance and geographic criteria to donors in order to provide access to health services for populations in the most vulnerable areas, avoid duplication of donor activities in districts, and distribute donor health resources more equitably.

1. In addition, the African Development Bank (ADB), the German Kreditanstalt fur Wiedenraufbau (KfW), and the Chinese government provide significant assistance, mostly in capital construction. The European Development Fund (EDF), under the Second Family Health Project, has provided funds for functional literacy and IEC. Because they were not based in Malawi, these donors were not included in the survey of Malawi-based donors; thus, their activities, allocations, and expenditures were not quantified.
The Fourth Malawi National Health Plan was launched in May 1999, but its implementation has been delayed and ongoing services are being provided on the basis of the last plan (1984-94). The NHP does not clearly lay out how it relates to the recurrent and development budgeting process, and indeed it continues to lack an implementation arrangement. Nevertheless, it is instructive to analyze its implications on infrastructure, personnel, and overall recurrent costs because, although it has not been formally implemented, the NHP with improvement could be used by the GOM to marshal government as well as donor resources under a SWAp.

Infrastructure implications

Table 25 lays out the current inventory of health facilities; the number of facilities identified by the NHP as requiring upgrading, rehabilitation, or new construction; and standard facility/population ratios as established in Better Health for Africa (BHA). Using a population figure of 10 million for Malawi, it is clear that the Plan severely understates the need for health centers while giving relative preference to district/rural hospitals. In fact, the current number (82) of district/rural hospitals already exceeds the BHA standard of 66, if one counts both GOM and CHAM facilities, which do receive Government subvention and provide health services on behalf of the GOM. In contrast, the current number of health centers is more than 50 percent below the BHA standard. (Note, too, that the “current number” column excludes private and NGO clinics). Even if GOM-only facilities are considered (excluding CHAM facilities), the NHP still has strong preference for district/rural hospitals (38

<table>
<thead>
<tr>
<th>Facility type</th>
<th>BHA facility per population standard ratio</th>
<th>Number needed in Malawi (Pop.= 10 M)</th>
<th>Current number</th>
<th>NHP proposed number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central hospitals</td>
<td>No standard</td>
<td>No calculation made</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>District/rural hospitals</td>
<td>1 per 150,000</td>
<td>66</td>
<td>82 (38 GOM + 44 CHAM)</td>
<td>57</td>
</tr>
<tr>
<td>Health centers</td>
<td>1 per 10,000</td>
<td>1,000</td>
<td>417 (201 GOM + 216 CHAM)</td>
<td>195</td>
</tr>
</tbody>
</table>

Sources: (a) Tables 16 to 19 of the NHP; (b) Better Health in Africa.
existing vs. 66 needed, or 43 percent below standard) relative to health centers (201 existing vs. 1,000 needed, or 80 percent below standard). Clearly, the infrastructure focus of the NHP must be reexamined.

Of the total set of candidate facilities for upgrading, rehabilitation, or new construction, the NHP identifies the following “priorities” (52 facilities + support infrastructure) with their estimated costs (Table 26). Assuming that construction would be spread out over a five-year period, this means that an average of 10 facilities will be upgraded, rehabilitated, or constructed per year.

**Personnel implications**

Table 27 lays out the current and the proposed levels of staff under the NHP. Note that the existing and proposed number of personnel only consider GOM staff and exclude mission, NGO, and private for-profit health personnel. The proposed personnel additions would mean that the deficit in nurses (and probably medical assistants) would have been narrowed (probably even exceeded) relative to the required number if one counts similar personnel in the private sector. However, it would appear that even with the NHP additions, doctors would still be in short supply.

If one were to consider only the needs of health centers and rural/district hospitals, the estimated health personnel levels using the BHA standards (three nurses and one support staff for one health center serving 10,000 population, and three doctors, 35 nurses, and 22 support staff for one district/rural hospital serving 150,000 population) would be as shown in Table 28. The problem with this and the

**Table 26**

<table>
<thead>
<tr>
<th>Infrastructure program</th>
<th>Cost (US$ m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A: 164 boreholes, 12 health centers hooked to ESCOM, 206 solar paneling units installed, 185 radio communication units installed</td>
<td>5.45</td>
</tr>
<tr>
<td>Type B: 52 facilities (i.e., construct 2 new hospitals, replace 5 district hospitals, rehabilitate 9 district hospitals, rehabilitate 3 central hospitals, upgrade 9 dispensaries to full health centers, upgrade 17 health centers to community hospitals, rehabilitate 5 rural hospitals, construct 2 new health centers) and 5 new 20-unit apartment flats</td>
<td>178.75</td>
</tr>
<tr>
<td>Type C: Upgrade basic technology and equipment in all district and central hospitals</td>
<td>13.8</td>
</tr>
<tr>
<td>Total</td>
<td>198.0</td>
</tr>
</tbody>
</table>

Source: NHP.

**Table 27**

<table>
<thead>
<tr>
<th>Personnel type</th>
<th>Current number (a)</th>
<th>Population per personnel</th>
<th>NHP proposed addition (b)</th>
<th>Total number of personnel (a+b)</th>
<th>Population per personnel</th>
<th>Number needed in Malawi (*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>315</td>
<td>31,746</td>
<td>251</td>
<td>566</td>
<td>17,668</td>
<td>1,111</td>
</tr>
<tr>
<td>Nurses</td>
<td>2,053</td>
<td>4,871</td>
<td>2,842</td>
<td>4,895</td>
<td>2,043</td>
<td>5,000</td>
</tr>
<tr>
<td>Medical assistants</td>
<td>442</td>
<td>22,624</td>
<td>383</td>
<td>3,825</td>
<td>2,614</td>
<td>—</td>
</tr>
<tr>
<td>Other staff</td>
<td>523</td>
<td>19,120</td>
<td>747</td>
<td>1,270</td>
<td>7,874</td>
<td>—</td>
</tr>
<tr>
<td>H.S.A.s</td>
<td>3,431</td>
<td>2,915</td>
<td>3,109</td>
<td>6,540</td>
<td>1,529</td>
<td>—</td>
</tr>
</tbody>
</table>

(*) Number of personnel needed is based on BHA standard population per personnel ratio of 9,000 for doctors and 2,000 for nurses. Assumed population of Malawi=10 million.

Source: NHP and this study.
Table 28
Current vs. proposed number of personnel for health centers and district/rural hospitals in Malawi

<table>
<thead>
<tr>
<th>Personnel type</th>
<th>Health centers</th>
<th>District/rural hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current number</td>
<td>Needed number</td>
</tr>
<tr>
<td>Doctors</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nurses</td>
<td>574</td>
<td>3,000</td>
</tr>
<tr>
<td>Medical assistants</td>
<td>236</td>
<td></td>
</tr>
<tr>
<td>Other staff</td>
<td>175</td>
<td>1,000</td>
</tr>
</tbody>
</table>

Source: NHP and this study.

Other approach specified above, however, is that they do not consider the non-facility health program approaches (such as outreach, community based distribution, and mobile health teams) that may prove to be more cost-effective and have wider reach than facility-based approaches.

Recruent cost implications

The NHP shies away from calculating the would-be recurrent cost implications of the health infrastructure proposed for construction and rehabilitation as well as the implied personnel complement. Instead, the NHP focuses on (a) the calculation of PE based on the Management Change Agency Report of 1998, which assumes that two-thirds of the existing vacancies as of the report’s date would be filled in the first year of the plan, and in the second year, the remainder of the vacancies would be filled; and (b) the calculation of GS based on district health facility standards set in the BHA, and using Malawi population figures. Thus, the so-called “recurrent costs” were calculated outside (or independent of) the implied infrastructure network and personnel complement as proposed under the NHP. These are critical shortcomings of the Plan (which means that the “development budget” implied in the infrastructure plan is divorced from the “recurrent budget,” which was simply added using assumptions from different studies). Thus, the NHP financing calculations of the development and recurrent budgets remain bifurcated.

An even more serious shortcoming of the NHP calculation is that it probably double-counts the cost requirements of the health system by adding the NHP infrastructure cost + GS cost estimates derived by using the BHA standards + the PE costs derived from the Managed Change Agency Report of 1998 (as explained above). At first blush, this sounds reasonable enough, but the BHA standard unit cost per capita already includes capital cost + salary costs + nonsalary recurrent costs. There is some “netting out” in the NHP’s application of the BHA costing standard, but it is not clear how it was done. In any case, the combined PE and GS for the first year of the NHP will reach US$57.69 million, a staggering increase of almost double the US$26.9 million expenditure estimate for district/rural hospitals and health centers alone in FY98.

An alternative approach to calculating the recurrent cost implication would be to base such calculation itself on the proposed infrastructure program using suitable r-ratios and add this figure to the recurrent budget of the existing health system. Unfortunately, the NHP’s infrastructure program is merely a listing of the facilities and supporting civil works and equipment, with no program phasing. For purposes of the r-analysis, it is assumed that the infrastructure program is spread out evenly across five years and, using very conservative r-ratios, are as indicated in Table 29. The resulting estimates show that annual recurrent costs for these new investments would rise from US$6.41 million in Year 1 to US$32.05 million in Year 5.
Table 29
Estimated recurrent cost requirements of the NHP’s infrastructure program
(in million U.S. dollars)

<table>
<thead>
<tr>
<th>Year</th>
<th>Type A R=0.05</th>
<th>Type B R=0.17</th>
<th>Type C R=0.10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>0.05</td>
<td>6.08</td>
<td>0.28</td>
<td>6.41</td>
</tr>
<tr>
<td>Year 2</td>
<td>0.10</td>
<td>12.16</td>
<td>0.56</td>
<td>12.82</td>
</tr>
<tr>
<td>Year 3</td>
<td>0.15</td>
<td>18.24</td>
<td>0.84</td>
<td>19.23</td>
</tr>
<tr>
<td>Year 4</td>
<td>0.20</td>
<td>24.32</td>
<td>1.12</td>
<td>25.64</td>
</tr>
<tr>
<td>Year 5</td>
<td>0.25</td>
<td>30.40</td>
<td>1.40</td>
<td>32.05</td>
</tr>
<tr>
<td>Total: 5 Years</td>
<td>0.75</td>
<td>91.20</td>
<td>4.20</td>
<td>96.15</td>
</tr>
</tbody>
</table>

Source: Estimated in this study.

Total cost of the NHP and options for phasing

The NHP calculates the total cost of the plan to be US$504.45 million, excluding the recurrent cost implications of new investments, which it does not calculate. One could make the assumption that the construction program would be spread out evenly across the five years (that is, 10 facilities a year). In this case, the total cost translates to US$101 million a year. If one were to add in the recurrent cost requirements of the new investments from the analysis above, the annual cost of the NHP would be US$107.41 million for Year 1, US$113.82 million for Year 2, US$120.23 million for Year 3, US$126.64 million for Year 4, and US$133.05 million for Year 5. Clearly, from all indications, carrying out the NHP is a daunting task and the GOM ought to consider options for phasing investments to achieve consistency with available resources and with the government’s implementation capacity. The NHP “wishlist” needs to be translated into a prioritized, phased, and properly costed set of activities before it can be presented to the donor community as a basis to move forward with the SWAp. Based on an analysis of Malawi’s urgent needs, cost-effectiveness considerations, and the government’s implementation capacity, a simple prioritization rule could be:

- Priority 1: Rural health centers, equipping, staffing, supply.
- Priority 2: Equipping of existing district/rural hospitals, staffing, supply.
- Priority 3: Rehabilitation of existing district/rural hospitals.
- Priority 4: Selective rehabilitation of central hospitals.
- Priority 5: New hospital construction.

The NHP has been launched, but it is advisable to have an implementation plan to address the above concerns. In our view, the implementation plan must have the following features so that it can be made a basis for moving towards an eventual sector program/SWAp.

- An infrastructure program that (a) is prioritized according to available resources; (b) reflects the country’s ability to implement such a construction, upgrading and rehabilitation program; (c) is cognizant of the recurrent cost implications; and (d) takes account of the staffing and human resource requirements of rehabilitated/constructed facilities.
- A supporting service delivery strategy that is consistent with cost-effectiveness, burden of disease, and equity considerations (see Chapter 8).
• A more detailed and transparent costing that lays out all the assumptions used.

• A financing plan that has alternative scenarios of resource availability from GOM+donors. The financing plan must be consistent with the Medium-Term Expenditure Framework (see Chapter 8). In this regard, since the NHP upholds user fees as an alternative financing mechanism, the implementation plan should also state a timeframe for the development of a supportive policy framework on cost sharing.

• An explicit underlying logical framework with suitable monitoring indicators.

1. “The overall cost was annualized by adding the yearly costs of recurrent items, such as salaries and essential drugs, to the amortized costs of capital investments, such as buildings and equipment. Amortization is required to translate initial outlays of capital into an annual amount, thus yielding information about the yearly cost of paying off the outlays over time (assuming a loan was used to finance the capital outlay). Capital costs were annualized on the basis of the economic life of the assets at a 4 percent discount rate.” (Better Health in Africa 1994, p.129).

2. Our own calculations show US$486.45 million; it is difficult to check the accuracy of the figures because the NHP does not lay out the financing plan.
In addition to reform proposals involving greater resource mobilization, discussions are ongoing within GOM to improve health-sector efficiency. These are not adequately dealt with in the NHP, and it is useful to review some of the key issues here. The initiatives involve hospital autonomy, improving pharmaceutical procurement and distribution, decentralization of health services, contracting of health services, and enhancing the role of NGOs in the health sector.

**Hospital autonomy**

There are 42 MOHP hospitals which, together with stand-alone government clinics/health centers and subvented district-designated CHAM hospitals, are organized nominally in a pyramidal structure of referral. At the apex are the three tertiary hospitals which also act as training institutions: Lilongwe Central Hospital (with the attached Lilongwe School of Health Sciences which trains nurses, clinical officers, and hospital administrators); Queen Elizabeth Central Hospital (QECH) in Blantyre, the biggest of the three (with the attached College of Medicine which trains doctors and nurses); and Zomba Central Hospital (with the attached Zomba School of Nursing). The fourth central facility is the Zomba Mental Hospital. Below these are the 28 district hospitals (with the seven bigger and busier ones at Rumpfi, Mzimba, Kasungu, Dedza, Mangochi, Machinga, and Mulanje), and 10 rural hospitals.

The major problems of the government hospitals in Malawi concern structure, financing, and management. Although a nominal pyramidal structure exists, the referral system operates inefficiently. Tertiary hospitals devote most of their resources to basic or level I health care. It is estimated that only 10 to 15 percent of patients at these facilities receive level II or III. The Working Group on Hospital Autonomy indicated that QECH is mainly providing district health services to the Blantyre area (WGHA 1997). The poor state of primary-care services and the absence of "mid-level" regional hospitals between tertiary and district hospitals are major bottlenecks in rationalizing the system of referral.

In recent years, the number and size of government hospitals have grown beyond what the government budget can support. Such growth may be due to faulty budget allocation criteria. Historically, budgetary allocations to hospitals have been based on cost-per-bed, with little concern for quality outcomes, actual need, or efficient use of resources. This provides hospitals with the perverse incentive either to increase beds or to inflate costs; it does not provide incentive for hospitals to be resource-efficient. Indeed lower cost-per-bed hospitals may be penalized in the following year's budget by receiving smaller allocations while higher cost-per-bed hospitals may be unduly rewarded with bigger allocations. Though lack of data precludes rigorous analysis of this phenomenon, the use of cost-per-bed as a budget allocation method certainly needs to be reformed.
Poor referral and overall underfinancing of hospital care may also be due to the absence of a formal fee system that can rationalize hospital use and generate revenues for supplies, basic repairs, and other improvements. Though discussions on cost-sharing started in 1990, it has not been adopted as policy. Thus, fees have not been institutionalized even at tertiary facilities, where there is the biggest scope for revenue generation.

Hospital mismanagement is manifested in inadequate control of funds, drugs, medical and other supplies, and assets (building, equipment, and vehicles); low staff morale and poor attitude to patients; and generally poor standards of care. These symptoms originate from a deeper set of causes, including hospital managers' lack of authority to make key decisions, poor accountability, limited managerial capacity, ineffective structures and management systems, and organizational culture of top-down rules and regulations (WGHA 1997).

GOM is looking more closely at the problem of hospital management, increase their accountability, improve the quality of hospital services, and increase the level of internally-generated revenue. The MOHP has organized the Working Group on Hospital Autonomy (WGHA) to come up with preliminary policy reform and hospital restructuring proposals to achieve these objectives. The second health sector vision 2007 in the draft Strategic Health Plan is “to improve the quality of hospital care from central and large district hospitals by decentralizing their management to autonomous Hospital Boards.” In general, the reform proposals identified by Working Group on Hospital Autonomy are in the right direction and should be supported. These four proposals are:

1. Providing of legal autonomy to the three central hospitals and seven “busy” district hospitals (Rumphi, Mzimba, Kasungu, Dedza, Mangochi, Machinga, and Mulanje) and enabling legal and policy environment for this purpose. The autonomous hospital is defined in the context of Malawi as a legal corporate entity under the direction and control of a hospital board that is separate from the MOHP but accountable to it, as well as accountable to the communities it serves. The GOM’s goal is to make these hospitals self-financing autonomous bodies, but the granting of full autonomy will require an Act of Parliament.

2. Reconfiguring the referral system, possibly by having feeder hospitals for the central hospitals so that they can focus on real tertiary care rather than act as district hospitals.

3. Redefining the role of the MOHP with respect to autonomized hospitals. With autonomy granted to key hospitals, MOHP’s role is expected to change. Instead of instructing, regulating, controlling, and supervising most aspects of hospital management, the ministry will instead establish goals, targets and policies for hospital services that it wants provided, and then pay hospitals if they meet these requirements (WGHA 1997). The specific roles of MOHP under this scenario are: (a) to set national policies and plans for providing equitable hospital care; (b) to determine the level, type, and quantity of services that the ministry will pay the autonomous hospitals to deliver; (c) to determine hospital investments and capital works based on national priorities to be developed; (d) to establish hospital standards and to monitor compliance and performance; and (e) to provide incentives for quality and efficiency improvements. A key theme of the proposed reforms is the conversion of existing MOHP-hospital relationships into “contracts” that make a clear distinction between MOHP as purchaser/regulator of services and the autonomous hospitals as providers of services.

4. Improving the governance of autonomous hospitals. Hospitals granted autonomy will be managed by individual boards, each of which is envisioned to be a legal corporate body. The Act of Parliament will have to define the roles, composition and appointment, powers and authorities, accountabilities, and specific duties and responsibilities of these boards, as well as their relationship with the hospital management, with the communities they serve, and with MOHP. The Working Group also proposes the establishment of a Council of Hospital Boards consisting of representatives from the individual hospital boards. The Council is envisioned as a “trade organiza-
tion" acting in the interests of the autonomous hospitals vis-à-vis the MOHP in such aspects as staff salaries, pensions, and benefits; hospital fee schedules; staff training; bulk procurement and equipment sharing; and coordination of management systems and procedures.

Hospital financing must also be reformed. This is the weakest aspect of the proposed hospital restructuring in Malawi. While the Working Group recognizes the need to reform hospital financing, it provides little guidance on how to do it. There is no discussion on reducing government subsidies going to these facilities or the need to broaden their revenue base. The proposal implies that the same scope and level of services will be provided and that the quality of services will be improved. This is more optimistic than realistic, given constraints in the GOM budget. A more thorough hospital restructuring is necessary, based on (a) a realistic assessment of the budget and available extra-budgetary resources, (b) the most essential and cost-effective clinical services that these hospitals should be providing, and (c) the most cost-effective way to provide ancillary services.

MOHP and hospital directors should explore opportunities for broadening the revenue base of these hospitals. As GOM reduces its subsidy to the three hospitals, they should be made more financially viable through other financing mechanisms such as (a) cost recovery programs; (b) health insurance reimbursements (an immediate activity should be the review and updating of reimbursement schedules for health insurance firms and medical aid schemes); (c) corporate contracts to provide care, including private amenity wings; (d) nonmedical revenue programs (parking fees, cafeteria, training fees, research, etc.); and (e) direct grants from external sources.

MOHP and hospital directors should also consider the feasibility of privatizing or contracting out hospital ancillary services (such as preventive maintenance and repairs).

Finally, hospital statistical databases should be strengthened. There is a serious lack of information on the status and performance of these hospitals (bed capacity, other assets, personnel, budget allocations and spending, catchment area and origin of patients, inpatient census, case-mix, average length of confinement, outpatient attendance, other service delivery statistics, patients' ability and willingness to pay, and so on). While hospital autonomy is almost universally prescribed in the existing documents on health reform, no in-depth study can be done unless these data are generated. From these data, rational decisions can be made.

To provide a more rational basis for developing a strategy of hospital reform, a study should be commissioned to analyze the feasibility of extending greater autonomy to the tertiary hospitals (and possibly the seven largest district hospitals). The scope of the study should include analysis of (a) the degree of autonomy these three Malawian hospitals currently have with respect to management, staffing and personnel; budgeting and financial resource base; procurement; and quality improvement; (b) legal, policy, organizational, management, and financial requirements for increasing/improving their autonomy; (c) quantitative targets for reducing government subsidy and for increasing alternative revenue sources such as fees, insurance reimbursement, grants, nonmedical revenues, and so on; and (d) service delivery targets.

Improving pharmaceutical financing, distribution, and use

Financing and distribution

The Central Medical Stores (CMS) is set up as a Treasury Fund to procure, store, and supply pharmaceuticals and medical supplies and equipment to MOHP and CHAM health facilities. It has an annual budget set in conjunction with the Treasury, and it uses these funds to tender for goods that are requisitioned by approved hospitals and clinics. Theoretically, CMS is zero-budgeted and is expected to cover its operating costs by appropriately charging
its users (Norman and Dawbarn 1999). However, because of overall budget difficulties, poor dialogue between MOHP and MOF regarding the release of funds for drugs, and the absence of a sustainable financing mechanism (including fees), MOHP hospitals are substantially behind in reimbursing CMS for approved purchases. In effect, CMS is treated by MOHP health facilities as a “bursary.” As a result, CMS is frequently in arrears. Delays in the release of funds, if not the general intermittent unavailability of funds, negate all potential benefits of bulk procurement. Aside from the core financing problem, CMS also suffers from mismanagement due to weak leadership, lack of qualified staff, poor logistics, and weak support systems. Poor MOHP staff morale has also led to reported theft of drugs, either from CMS warehouses or within the health facilities themselves. These factors lead to chronic shortages of drugs all over the country.

Organizationally, CMS is part of the MOHP and therefore lacks autonomy to make critical decisions. Absence of such autonomy has been seen to constrain CMS’ ability to operate as a commercial enterprise. On the basis of this diagnosis, a series of DFID-funded consultancies (first in 1995-96 by Deloitte and Touche, and later in 2000 by another set of independent experts) have proposed the restructuring or “transformation” of CMS, with concomitant reforms in pharmaceutical financing, and multi-donor commitment to its recapitalization. Towards this end, MOHP submitted to Parliament a draft CMS reform bill in 1996-97, but later withdrew it pending the resolution of certain legal technicalities raised at the Cabinet level. This reform program was not implemented, and lack of progress in this policy area has certainly contributed to drug shortages nationwide. A number of donors who are keen on providing drug financing have deliberately stayed away due to the absence of an enabling environment and political commitment to CMS reforms.

Pharmaceutical sector reforms are being revived with more modest expectations, with DFID again providing critical support. Cabinet endorsement to restructure and improve the governance and management of the CMS is critical, and the consultants have proposed the following principles for reform: (a) need-based and resource-based drug procure-ment, which may require revision of the current Essential Drug List; (b) cash-limited system which ensures that drug supplies can be paid for, that is, “cash and carry” system; (c) government commitment not to divert drugs to non-priority locations for any reason; (d) political acceptance of some form of fees (cost sharing) for drugs; and (e) a coherent information strategy for pharmaceutical planning, procurement, and distribution. In addition to these steps, the government must address all forms of pilferage and commit to a transparent external reporting of the CMS reform process, especially to donors who are financing drugs or providing them in-kind.

In FY2000, the government raised the spending on drugs from the estimated FY98 level of US$0.80 per capita to US$1.00, to be further increased in FY01. (The WHO/World Bank estimated requirement is US$1.00 for district health services in Sub-Saharan Africa; US$1.60 inclusive of STD drugs; and US$2.00 if tertiary-level needs are included.) Though this increase in drug financing is admirable, it should be underpinned by radically improved management of CMS to ensure greater availability of these inputs at the patient level.

Provider and consumer behavior

Compared to the drug supply problem, this demand problem is not as well recognized. However, without corresponding reforms in the way providers and consumers behave, improvements in the supply situation may not result in overall health sector efficiency. In fact, readily available drugs may just lead to over-consumption. The issues in this area involve: (a) the manner of dispensing drugs as most private doctors prefer to fill their own prescriptions; (b) prescription drugs being made available in the open market and dispensed illegally; and (c) tendency of government physicians, especially at central hospitals, to aggressively prescribe medicines even when cheaper therapeutic alternatives are available. (“Over-prescription” of antibiotics has been observed and reported anecdotally.) Given these problems, investigations are needed on drug consumption and prescription behavior. Specific interventions can include the formation of hospital therapeutic committees, the development or update of drug formularies, the
requirement for hospitals to have drug and revenue registers, and necessary training for hospital and clinic staff on the use of these registers and on better prescription.

**Health service decentralization**

The government sees decentralization as bringing health resources and services closer to the periphery. However, the problem of pursuing decentralization of government and government-funded health services in Malawi is that there are three structures, not exactly parallel but often duplicative and uncoordinated. These are MOHP’s health system, MOLG-supported local authority health services focusing on preventive care, and CHAM subvented health services. MOHP, the largest provider, itself consists of the national office, four central tertiary hospitals, and district health authorities. In the late 1990s, the Ministry of Local Government (MOLG) also funded health services through 22 local authorities (LA), 19 dispensaries, 26 maternity units, and nine health centers in 22 districts, although most of these now seem to have been turned over to the MOHP. In addition, the cities of Blantyre, Lilongwe, Mzuzu, and Zomba provide preventive services. Finally, CHAM operates its own network of independently-managed health facilities, though these often receive government subvention. The relationship of these various players under a decentralized arrangement remains to be clarified.

**Legal and administrative framework**

The Local Government Act No. 42 was passed by Parliament in December 1998. The demarcation of wards has been completed, although these boundaries do not always match those of the catchment areas of health facilities. “Cross-jurisdictional” flows of patients will be a real issue in this regard.

Local elections were held in 2000, paving the way for the creation of 39 local assemblies, consisting of an elected mayor and elected ward representatives. Ex-officio nonvoting members include the traditional authorities, five persons to be appointed from special interest groups (gender, minorities, and technical expertise), and the M.Ps from constituencies in the local government area. It is expected that local assemblies will take over the District Development Committees (DDCs), which were primarily responsible for social services at the local level prior to decentralization.

**Fiscal framework**

The main revenues for the local assemblies are to be traditional, locally generated revenues, central government transfers, ceded nontax revenues, sector grants, and donor financing.

a. *Traditional, locally generated revenues* include property rates, ground rent, fees and licenses, commercial undertakings, and service charges including user fees for health services. The issue of user fees in health is particularly relevant in discussions on locally generated revenues. There is no formal MOHP user fee policy for health services in Malawi. However, according to the Decentralization Secretariat, with devolution, the local assemblies can impose user charges, even without a national policy on this issue.

b. Under the decentralization law, the national government is mandated to make available to district assemblies at least 3-5 percent of national revenues, excluding grants, as central government transfers. In FY00/01, the government will not effect the transfer of the whole 5 percent, due to capacity constraints in local assemblies. However, MK 1 million for each assembly will be included in the budget. By the third year of the decentralization process, it is anticipated that the national government will make the 5 percent transfer. It is not clear how much of these resources will be devoted to health services. A DANIDA-funded study on inter-governmental transfer systems will assist in determining an effective mechanism for the allocation of these revenue to local assemblies.

c. The formula for the distribution of *ceded (nontax) revenues* will be formulated by Parliament.

d. Due to capacity constraints at local assemblies, *sector grants (budgets)* from FY00/01 to FY03/04
for the assemblies will still be incorporated into the line ministries’ budget. However, Treasury would disburse funds directly to the assemblies without passing through the line ministries. The key issues that remain to be resolved include the mechanisms for channeling these sector grants, management of sector grants, basic performance indicators for these sector grants, and preparation of sector standards.

e. **Donor financing** can be channeled through the District Development Fund (DDF), which gives unconditional block grants for development purposes. The DDF is used by the U.N. Country Development Fund and UNDP and the government’s development budget. Individual donor funds are accounted for separately through individual receipting accounts. Despite this convenience, other donors have been less enthusiastic in channeling resources through DDF (or similar “uniform” channel). This is clearly an issue that needs to be resolved as there is a plethora of donors providing or planning to provide resources to districts including:

- The African Development Bank, which plans
to focus on five districts;

- The Dutch: Lilongwe;

- The European Union, which provides or plans
to provide resources to four districts: Blantyre, Mulanje, Thyolo, and Chiradzulu;

- GTZ: Machinga;

- JICA rehabilitation of district hospitals: Dowa, Kasungu, and Dedza;

- UNDP, which has been supporting six “local
impact area” districts since 1994: Nkhata Bay, Mangochi, Nsanje, Dedza, Thyolo, and Salima;

- UNFPA training of family planning and repro-
ductive health coordinators at the districts;

- USAID, whose CHAPS Project\(^1\) partners
NGOs with four districts and eventually to 10 districts: Mangochi, Mzimba, Salima, Mulanje, Chikwawa, Folambe, Blantyre, Lilongwe, Thyolo, Chiradzulu, and Machinga;

- WHO/UNICEF, which provide resources for
IMCI in four “early use” districts: Kasungu, Mzimba, Mwanza, and Blantyre;

- WHO support to reproductive health in eight
districts:\(^2\) Chitipa, Karonga, Rumphi, Nkhotakhota, Nchisi, Salima, Dowa, and Ntcheu; and

- The World Bank’s Population and Family
Planning Project operating in three districts:
Chitipa, Nchisi, and Chiradzulu.

f. **Equalization grants** are envisioned to correct disparities in districts, with the formula to be determined by the central government.

In advance of actual devolution, the MOHP has
established each district as a “cost center” under the
MTEF exercise. Thus, the recurrent budget is now reflected for each district. However, the develop-
ment budget remains outside the district “cost center”; thus, the process of disentangling the dis-
trict development budget from the MOHP develop-
ment budget will be challenging.

**Extent and pace of decentralization**

The devolution of health assets and functions is cur-
rently in Phase 1. As planned, in FY01, the “basic
peripheral services” will be devolved, including:

- Hospital services (that is, rural hospitals) other
than hospitals providing referral and medical
training – Under Phase 1, district hospitals will
continue to be under the MOHP; thus, all doc-
tors, dentists, most nurses, and most other tech-
nical staff (lab technicians, and so on) would
remain under MOHP in Phase 1. Under Phase 2,
district hospitals and relevant staff will be
devolved to the local assemblies.

- Health centers, dispensaries, sub-dispensaries,
and first-aid posts.
• Maternity and child welfare services.

• The control of communicable diseases including HIV/AIDS, leprosy, and tuberculosis; the control of the spread of diseases in the local government area.

• Ambulance services.

• Primary health care services, vector control, environmental sanitation, and health education.

For its part, the MOHP is expected to dispense functions related to health policy formulation and enforcement, standard setting, quality control and quality assurance, supervision and monitoring, training and curriculum development, international and regional representation in health fora, and formulation of the national health plan.

To carry out the devolved functions, the local assemblies will be responsible for hiring and firing health staff, planning for health programs at their jurisdictions, and managing and inspecting health facilities within their purview. Toward this end, the following administrative actions are being initiated:

• A District Local Development Planning System is being introduced to enable local people to plan, prioritize, and implement their own plans at the district level.

• The District Development Plan is a constitutional requirement; it consolidates all sector initiatives in the district. According to the MLG, two districts (Nchinji and Dedza) have completed their district development plans while another district (Thyolo) is about to complete its plan.

• At varying rates, all districts are in the process of formulating their respective socioeconomic profiles, which are the basis for their district plans.

• No health planning officers have been established at the district level. The understanding is that the District Health Officer (DHO) will be the de facto health planner. Since the district hospitals will not be devolved in Phase 1, the DHO will still be under the Ministry, but coordination will be maintained between the DHO and the local assembly. In Phase 2, the district hospitals will be devolved.

• MOHP is also working to strengthen financial management systems at the district level. Bank accounts have been opened for most districts.

Other overarching issues

How does decentralization affect MOHP's plan to have a National Health Service Commission (NHSC), as articulated in the Human Resource Development Plan? It appears that, since all district hospitals and all central hospitals will continue to be under the MOHP, a considerable number of health staff will continue to be central government employees under the civil service. It is possible that these "retained" civil servants can be organized as the NHSC.

Devolved health staff are expected to become employees of the local assemblies and cease to be members of the civil service. It is also expected that district assemblies would be required to pay a minimum salary equivalent to the existing civil service rate for the particular level of the devolved staff, and that devolved staff will convert from the existing civil service pension program (noncontributory) to a contributory pension scheme under the local government assemblies. How this can be brought about, given the limited revenues of districts, is a serious issue.

The role of CHAM facilities in decentralization is unclear, and this issue has not been properly taken into account. CHAM's 153 health units (21 of which are hospitals) account for 30 to 35 percent of health services delivered in Malawi. In many districts, the CHAM facility is the only hospital, though such facilities have not been formally designated as "district hospital." In the past, the government contributed as much as 30 percent of the CHAM budget through subvention grants (now managed by the Ministry of Finance), though the size of the grants decreased in the 1990s. The lack of a formal agreement between the government and CHAM has caused confusion, especially in years when the subvention grant was not forthcoming. Nevertheless, by tradition, the District Health Officer has been expected to supervise CHAM facilities.
Contracting of health services

The government views contracting of health services, provision of autonomy to selected health facilities, and "privatization" of specified functions as inherent parts of the overall decentralization program. Under the World Bank's Second Fiscal Restructuring and Deregulation Program, the government committed to contract out several health functions, as laid out in Table 30. According to MOHP, contracting out these services will focus on central hospitals during the first phase of implementation.

Responsibility for contracting out is handled by the OPC with technical support provided by the Public Sector Change Management Agency (PSCMA). According to PSCMA consultants, the contracting out process has gone on for three years, the prolonged process due to Malawi's lack of experience in this new area. There were no government rules or procedures dealing specifically with health services or ancillary health services. Appropriate procedures had to be developed; the relevant directive from the OPC Secretary has been forwarded to the Implementation Committee on Civil Service Reform for implementation.

A national competitive procurement process was used. The Terms of References (TORs) and Requests for Proposals (RFPs) were prepared with MOHP support, especially on matters of standard requirements. The short-list of firms (all Malawi firms) has been developed and are as follows: (a) Catering services in the three central hospitals - three firms; (b) Laundry services - two firms; (c) Cleaning services - four firms; and (d) Ambulance services (only in Zomba Central Hospital) - one firm. Negotiations are ongoing, but the tendering committee needs to speed up the process. Contracts have been drafted for each type of service.

Affected hospital staff will be handled by the OPC's Rationalization Unit, which has the mandate to retrench staff, retrain and/or redeploy staff, or

<table>
<thead>
<tr>
<th>Name of function</th>
<th>Current number of civil servants affected</th>
<th>Type of rationalization</th>
<th>Expected date of rationalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional health offices*</td>
<td>70</td>
<td>Abolition of offices</td>
<td>Dec. 31, 1998</td>
</tr>
<tr>
<td>Cleaning services</td>
<td>2,645</td>
<td>Contracting out</td>
<td>Apr. 1, 1999</td>
</tr>
<tr>
<td>Transport services</td>
<td>415</td>
<td>Contracting out</td>
<td>Apr. 1, 1999</td>
</tr>
<tr>
<td>Building and ground maintenance</td>
<td>1,132</td>
<td>Contracting out</td>
<td>Dec. 31, 1998</td>
</tr>
<tr>
<td>Laundry services</td>
<td>159</td>
<td>Contracting out</td>
<td>Apr. 1, 1999</td>
</tr>
<tr>
<td>Security services</td>
<td>740</td>
<td>Contracting out</td>
<td>Dec. 31, 1998</td>
</tr>
<tr>
<td>Catering services</td>
<td>46</td>
<td>Contracting out</td>
<td>Apr. 1, 1999</td>
</tr>
<tr>
<td>Audit services</td>
<td>5</td>
<td>Contracting out</td>
<td>Apr. 1, 1999</td>
</tr>
<tr>
<td>Drama, band graphics</td>
<td>25</td>
<td>Contracting out and redeployment</td>
<td>Dec. 31, 1998</td>
</tr>
<tr>
<td>Mortuary services</td>
<td>29</td>
<td>Contracting out</td>
<td>July 1, 1999</td>
</tr>
<tr>
<td>All establishment changes</td>
<td>5,097</td>
<td>Creations, upgrading of posts especially field staff, e.g., nurses and doctors</td>
<td>Apr. 1, 1999</td>
</tr>
</tbody>
</table>

Total 5,237

*This has been accomplished: All three regional health offices have been abolished and the functions transferred to the relevant district hospitals.

have contractor(s) absorb affected staff. In the evaluation of proposals, it is estimated that 25 percent of affected staff can potentially be absorbed by the contractors. PSCMA has requested the OPC to make adequate budgetary provision for the initial (upfront) payment to contractors as well as the full cost of the contract.

The issue of “appropriate cost” of contracted services is rather complicated, especially in a setting where these services are being poorly provided by the central hospitals due to budgetary constraints of the government. As a result, current services and current costs cannot be compared directly with contracted services (with standard specified requirements) and their attendant costs.

The OPC’s Government Contracting Unit (GCU) will manage the contracts, but the MOHP and individual hospital management are expected to monitor the services provided. All of the contracts have a time-frame of one year, renewable for another year, based on acceptable performance. In the case of contracts with “asset specific” elements, the one-year timeframe may be a problem. The mission was informed that, in the case of the ambulance contract for Zomba Hospital, the single contractor promised to provide as many as five ambulances, in addition to the existing two ambulances of the hospital; the contractor will then manage the entire fleet of seven ambulances. In the case of the catering and laundry contracts, the central hospitals retain ownership of the relevant equipment. Repairs will be made by the hospital (government) or, if the repairs are made by the contractor, the hospital (government) will reimburse the contractor for expenses incurred.

The role of nongovernmental organizations in health

Subvention program

The Christian Hospital Association of Malawi (CHAM) operates 148 health units, mainly in rural areas. Though primarily curative in orientation, 52 percent or 77 of the health units provide primary health care services (Gondwe: 1996). CHAM facilities get an estimated 30 percent of their operating funds from GOM subvention. This is used mainly for salaries of local staff. The fiscal crisis is drying up the subvention program, so some CHAM facilities are reportedly closing down. In general, the MOHP-CHAM subvention program is drying up. GOM has to make a fiscal commitment to support this program, especially in areas where government health services are unavailable and CHAM is left to provide them.

While MOHP services are free, CHAM services are chargeable, leading to an anomaly that has led to persistent calls for the establishment of free-service MOHP units in CHAM areas. In spite of CHAM’s fees, it continues to draw patronage. In general, CHAM facilities are reputed to be better run than MOHP facilities, and the quality of services are perceived to be better. The modest fees support quality improvements.

As has been suggested, it would be wasteful for GOM to build hospitals in areas where CHAM is already established. There is a clear need to synchronize fee policies of MOHP and CHAM, and to work towards a uniform fee policy.

Overall private sector policy environment

GOM’s policy is characterized as flexible; it allows participation by different NGOs (CHAM, estates, industries, licensed practitioners, and for-profit providers), and includes traditional health practitioners (Ngalande, and others 1994). Religious missions preceded the government in health service delivery and remain a significant part of Malawi’s health care system. Despite the flexible environment, the private sector seems to have very little input in overall decisionmaking in the health sector. NGOs complain that the “government makes policies and decisions on health issues with little or no involvement of other health providers,” and that health service goals are being made “the sole responsibility and prerogative of small select groups” (Gondwe 1996).

NGO representatives recommend that (a) every service provider should play a role in policy formulation and decisionmaking; (b) MOHP should be more consultative, for example, by inviting the private sector to technical committee sessions, discussions on health policies, and coordination meetings; and (c) district hospitals and the private sector in each district should be organized as teams (Gondwe 1996).
In view of the scanty management expertise in the public sector, CHAM has suggested sharing its management expertise with the government. Specifically, it has recommended that the country be divided into 39 health delivery areas (HDAs) to be headed by 15 CHAM hospitals, 24 government district hospitals, and the three district health offices in Blantyre, Zomba, and Lilongwe, where the three tertiary central hospitals are located. These HDA hospitals would then be responsible for the administration of health services in their areas (MOH: 1992). The Health Policy Framework (MOHP 1995) recognizes the need to define the concept of HDAs in light of the review of the role of regional health offices and the delay in introducing user fees at government facilities.

1. USAID support to the first set of CHAPS districts ended in FY01, and an evaluation is being planned. Meanwhile, CHAPS II is being envisioned; new NGO proposals will be sought. It is likely that CHAPS II will cover six districts – including, but not necessarily, the four original districts. If more funds are available, as many as 10 districts will be covered.

2. Support focuses on TBA (traditional birth attendant) shelters, provision of seeds, water, and sanitation.

3. However, PSCMA informed the mission that the affected staff have not been informed, because, if the contracts do not materialize, the central hospitals would have to operate the services “as usual” with the affected employees.
Appendix

Unit cost of providing health services to the top five disease conditions in Malawi

his appendix provides information on the unit cost of providing health services to the top 5 disease conditions for adults and children in Malawi, namely, malaria, diarrhea, pneumonia/respiratory conditions, tuberculosis, and HIV/AIDS. The study was conducted by KPMG/Blantyre for the MOHP’s PHN Project. It relied on 1998 data from 15 sample health facilities:

- Private Hospitals (2) – Blantyre Adventist Hosp., Chitawira Private Hospital
- CHAM Mission Hospitals (3) – Madisi MH, Ekwendedni MH, St. John MH
- Government Central Hospitals (2) – Queen Elizabeth CH, Lilongwe CH
- Government District Hospitals (2) – Salima DH, Kasungu DH
- Government Rural Hospitals and Health Centers (6) – Mponela RH, Mzuzu HC, Mitundu HC, Chileka HC, Mpemba HC, Kasiya HC operated by the local authority

From these facilities, a purposive sample of 3,909 patients suffering from one of the top five diseases was selected (excluding those with co-morbidities). Of these, 2,183 were inpatients and 1,726 were outpatients. The following costs were taken into account: staff time, accommodation and food, x-ray and lab, and other supplies. The study is an attempt to generate actual resource costs; hence they reflect scarcities experienced by government facilities as well as wastage often reported in both government and private hospitals and clinics. No attempt was made to adjust for severity of illness.

The following observations can be gleaned from the results: First, private for-profit hospital costs exceed central government hospital costs by a substantial factor: as much as 120 times for inpatient malaria, 38 times for inpatient diarrhea, 30 times for inpatient palliative HIV/AIDS care, 14 times for inpatient pneumonia, and eight times for inpatient tuberculosis. To be sure, these cost differences can very well reflect quality differences, but the orders of magnitude are such that they call attention to either or both of the following:

- Government facilities are severely underfunded. A detailed analysis of the cost structure of these facilities would indicate what specific items are scarcely being provided (drugs, lab tests, x-rays, other supplies, food), thus driving down their cost structures.
- Private for-profit facilities may very well be creaming off those with ability to pay. The KPMG study suggests that some private facilities may be unduly prolonging length of stay to maximize on patients’ accommodation fees. Insurance coverage worsens these moral hazard problems and they need to be addressed.
Second, while outpatient care is in general less costly than inpatient care, the cost difference in private facilities between these two types of care is so large that it raises questions about the type of inpatient services being given there. In other developing countries, the cost of inpatient care is usually four to five times that of outpatient care. In this study, the private-facility cost of inpatient care exceeds outpatient care by as much as 26 times for diarrhea, nine times for HIV/AIDS, and seven times for pneumonia. (See Table 30.) Such inflated inpatient costs can tempt private facilities to admit and confine patients that can otherwise be treated on an outpatient setting. This conjecture needs to be looked into.

Third, among government health facilities, there are few marked differences between the costs incurred by central tertiary hospitals, district hospitals, and rural hospitals and health centers. Cost being a measure of quality, this finding raises the issue of the quality of health services being provided at central hospitals, as well as the types/severity of patients these apex hospitals treat. In the case of inpatient malaria and inpatient tuberculosis, district hospitals had costs exceeding those of central hospitals.

1. The cost levels between CHAM and government facilities, by disease and by type of care, are not too different. If CHAM facilities indeed provide better services, as is frequently claimed, and if indeed these cost patterns reflect efficient resource use, then government facility managers need to learn more from their CHAM counterparts on how to deliver services more cost-effectively.

### Table A-1

Average cost of care per patient, by type of care, by type of disease, and by type of facility: 1998 (in Malawi Kwacha)

<table>
<thead>
<tr>
<th>Disease type, by type of care provided</th>
<th>Patient sample size</th>
<th>Private hospitals (MK)</th>
<th>CHAM hospitals (MK)</th>
<th>Central government hospitals (MK)</th>
<th>District hospitals (MK)</th>
<th>Rural hospitals and health centers (MK)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient care</td>
<td>595</td>
<td>3,012</td>
<td>61</td>
<td>25</td>
<td>56</td>
<td>26</td>
</tr>
<tr>
<td>Outpatient care</td>
<td>1,004</td>
<td>623</td>
<td>30</td>
<td>80</td>
<td>31</td>
<td>15</td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient care</td>
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<td>4,290</td>
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<td>112</td>
<td>66</td>
<td>47</td>
</tr>
<tr>
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<td>167</td>
<td>18</td>
<td>n.d.</td>
<td>24</td>
<td>n.d.</td>
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<td>Pneumonia</td>
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<td></td>
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<tr>
<td>Inpatient care</td>
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<td>2,723</td>
<td>167</td>
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<td>126</td>
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<tr>
<td>Outpatient care</td>
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<td>403</td>
<td>32</td>
<td>40</td>
<td>24</td>
<td>n.d.</td>
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<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient care</td>
<td>123</td>
<td>5,931</td>
<td>246</td>
<td>197</td>
<td>111</td>
<td>74</td>
</tr>
<tr>
<td>Outpatient care</td>
<td>17</td>
<td>634</td>
<td>29</td>
<td>80</td>
<td>10</td>
<td>n.d.</td>
</tr>
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</table>

### Table A-2
Average cost of care per inpatient and per OPD visit by disease: 1998
(in Malawi Kwacha)

<table>
<thead>
<tr>
<th>Disease type, by type of care</th>
<th>Patient sample size</th>
<th>Private hospitals</th>
<th>CHAM hospitals</th>
<th>Central government hospitals</th>
<th>District hospitals</th>
<th>Rural hospitals and health centers</th>
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</thead>
<tbody>
<tr>
<td>Cost per inpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria, adult</td>
<td>356</td>
<td>3,137</td>
<td>73</td>
<td>33</td>
<td>65</td>
<td>32</td>
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<tr>
<td>Malaria, child</td>
<td>239</td>
<td>2,887</td>
<td>48</td>
<td>16</td>
<td>47</td>
<td>19</td>
</tr>
<tr>
<td>Diarrhea, adult</td>
<td>295</td>
<td>4,076</td>
<td>191</td>
<td>132</td>
<td>85</td>
<td>33</td>
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<tr>
<td>Diarrhea, child</td>
<td>180</td>
<td>4,503</td>
<td>95</td>
<td>92</td>
<td>47</td>
<td>61</td>
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<td>Pneumonia, adult</td>
<td>405</td>
<td>2,957</td>
<td>178</td>
<td>207</td>
<td>166</td>
<td>173</td>
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<tr>
<td>Pneumonia, child</td>
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<td>2,489</td>
<td>156</td>
<td>190</td>
<td>110</td>
<td>78</td>
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<tr>
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<td>3,432</td>
<td>-</td>
<td>621</td>
<td>545</td>
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<tr>
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<td>11</td>
<td>-</td>
<td>-</td>
<td>193</td>
<td>762</td>
<td>-</td>
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<tr>
<td>HIV/AIDS, adult</td>
<td>117</td>
<td>7,481</td>
<td>246</td>
<td>237</td>
<td>111</td>
<td>74</td>
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<td>HIV/AIDS, child</td>
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<td>4,381</td>
<td>-</td>
<td>156</td>
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<tr>
<td>Cost Per OPD Visit</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria, adult</td>
<td>616</td>
<td>601</td>
<td>33</td>
<td>80</td>
<td>35</td>
<td>15</td>
</tr>
<tr>
<td>Malaria, child</td>
<td>388</td>
<td>644</td>
<td>26</td>
<td>80</td>
<td>26</td>
<td>15</td>
</tr>
<tr>
<td>Diarrhea, adult</td>
<td>116</td>
<td>159</td>
<td>21</td>
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<tr>
<td>Diarrhea, child</td>
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<tr>
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<tr>
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<td>143</td>
<td>566</td>
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<td>HIV/AIDS, child</td>
<td>7</td>
<td>634</td>
<td>-</td>
<td>80</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source of basic data: KPMG/Blantyre (1999).

2. Cost analysis is in its infancy in Malawi and should be made a regular analytical activity for program managers in both government and private facilities. This type of analysis is critical for (a) program costing required by the annual MTEF budget exercise; (b) the development of fee schedules for cost recovery or cost sharing programs envisioned for government hospitals; (c) the development of reimbursement schedules for patients with health insurance coverage; and (d) the identification of problems associated with resource use of specific inputs, such as food and drug supplies.
References


Malawi Institute of Management (MIM). March 14, 1991. “A Study to Identify Options for Reducing the Vacancy Rate of the Malawi Civil Service.”


Malawi's public spending on health has historically been high relative to other Sub-Saharan countries and developing nations with similar GNP per capita, but the country's living conditions are among the poorest in the world. Although physical access to a health facility has improved over the years, access to functional health services continues to be limited. Major public health issues include a high HIV/AIDS prevalence rate, poor reproductive health and severe constraints in the availability of health personnel and drugs and other supplies.

_Better Health Outcomes from Limited Resources: Focusing on Priority Services in Malawi_ takes stock of Malawi's performance in the health sector. It reviews the status of the country's health expenditures, identifies issues surrounding the level and quality of these expenditures, and provides recommendations to improve resource mobilization, resource allocation and organization efficiency.

The publication of this health expenditure review for Malawi is intended to contribute to our collective knowledge about the country's health sector and the nature of the policy challenges, and to share that knowledge where possible. It is our hope that as new knowledge emerges in the course of implementing the country's poverty reduction strategy, this knowledge will be instrumental in overcoming health sector constraints that currently impede poverty reduction in Malawi.