Quest for equity in resource allocation in the health sector

Budget Analysis of the 2007/8 Health Sector Budget Estimates

Commissioned by Malawi Health Equity (MHEN)

July 2007

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CONTENTS

List of abbreviations

ADB	African Development Bank
CHAM	Christian Hospital Association of Malawi
CMS	Central Medical Stores
EHP	Essential Health Package
EHRP	Emergency Human Resource Programme
GDP	Gross Domestic Product
GOM	Government of Malawi
KCH	Kamuzu Central Hospital
MDGs	Millennium Development Goals
MFA	Ministry of Foreign Affairs
MGDS	Malawi Growth and Development Strategy
MHEN	Malawi Health Equity Network
MLGRD	Ministry of Local Government and Rural Development
MoF	Ministry of Finance
MOH	Ministry of Health
MOU	Memorandum of Understanding
MPs	Members of Parliament
NAC	National AIDS Commission
NGO	Non-Governmental Organisation
OPC	Office of the President and Cabinet
OPEC	Oil Producing and Exporting Countries
ORT	Other Recurrent Transactions
PMCT	Prevention of Mother to Child Transmission
QECH	Queen Elizabeth Central Hospital
SWAp	Sector Wide Approach
TBAs	Traditional Birth Attendants
UNDP	United Nations Development Programme

Executive Summary

MHEN commissioned this analysis to assist it in its mandate of lobbying for health equity in the provision of health services. The purpose of the analysis is to highlight issues from the 2007/8 health budget that needs to be looked at during the current June-August 2007) parliamentary seating. The findings of the analysis will also be shared with the Ministry of Health and Population; and other relevant stakeholders that are involved in the budget implementation.

The analysis covers financial years 2004/5 to 2007/8 although some earlier financial years are analysed in some instances. It concentrates on budget estimates for the Ministry of Health. By focussing on Ministry of Health, the analysis has taken the view that it that Ministry that is given the responsibility of providing health services to the Malawi Population. That focus leaves out budgets for public sector health facilities in some institutions like the Malawi Defence Force and Malawi Police Service, just to mention the major ones, which also offer health services for free to the population surrounding them. The analysis also looks at budget estimates for HIV and activities in Government ministries and departments.

The analysis recognises the fact that public expenditure in health is determined, among others, by priority accorded to it in relation to the global and country visions, health indicators as well as the size of the public purse in relation to the size of the economy and donor support to the sector. The analysis considers the Malawi Vision 2020, Millennium Development Goals on health, Malawi Growth and Development Strategy and Health

SWAp as the critical determinants of the Malawi's Health Budget.

Key findings of the report

The analysis has highlighted a number of issues that are important for health equity. The key findings include the following:

1 The vacancy rates of health workers in Government health facilities are too high. It seems the impact of the EHRP, which has a top up salary element, has not been very effective considering the small improvement from 58% at the start of the programme to 55% in January 2007.
2 The EHRP needs to be replaced by a holistic incentive package because it is not addressing the motivation problem holistically. The incentive package should also look at other aspects like working and living environments. It is stated that an incentive package has been developed but the current budget is silent on the nature and when the new package will come into force.
3 There has been no serious in-service training conducted in the recent past and the current budget is not explicit on this yet in-service training is a crucial element of quality service delivery.
4 Construction of houses for health workers has been mooted in the recent past as one way of retaining health workers in remote areas. The Current budget has provided for the construction of 250 houses. This is commendable. What needs to be done is to monitor its implementation. For effective monitoring, the executive needs to provide its house construction programme.

5 The progress in reaching the EHP is slow. For example, immunisation coverage is 37% against a target of 74% and a historical immunisation coverage of over 90%. This is a serious problem which needs urgent answers. Further, only 19% of deliveries were handled by skilled health personnel. The Multiple Cluster Indicator Survey found that 54% of deliveries were handled by health personnel (most of which were nurses that are not midwives).

6 Health indicators are still poor. Life expectancy at birth has been declining over the years, possibly under the weight of the high HIV prevalence and AIDS, and has been below 40 years since 1997. Child mortality rates have steadily been declining since 1996 but this trend can be reversed with the declining immunisation rates. Maternal mortality rates are very high and not improving reflecting the poor maternal health services offered in public health facilities.

7 It will be difficult to achieve the Malawi Vision 2020 related to health, MDGs in health, and the MGDS health targets if the Government budgets fail to prioritise the health sector and improve the delivery of health services.

8 Health expenditures have not been constrained in the recent past. At the least, all the resources that are approved by the National Assembly for the health sector especially under the recurrent budget are spent.

9 Public resources allocated to the health sector have been increasing since 2004/5 both in nominal and real terms even when the growth in the total budget has been very slow.

10 On average, in terms of fiscal priority, the health sector has been second only to agriculture and natural resources over the years. In the current (2007/8) recurrent budget, the Ministry of Health is the highest with a share of 17% as opposed to Ministry of Agriculture and Food Security whose share is 14%.

11 There have been radical shifts in intra-sectoral allocation since 2004/5. The share of district hospitals in the total health budget has drastically declined from close to 60% in 2004/5 to less than 15% in the current budget as headquarters allocation jumped from 20% to close to 60% and central hospitals from 20% to close to 30%. Yet there have been no radical shift in the spatial distribution of the population. Over 80% the population still rely on the district health system.

12 Health expenditures are dominated by administration and support services. There is little left for preventive services, asset maintenance and manpower development. Administration and support services took over 50% of the entire health budget in the period since 2004/5. The share has come down to 39% in the current budget. Hopefully this trend will be maintained.

13 Personal emoluments have always been the major cost item in the years 2004/5 to 2006/7. However, in the current budget, medical supplies and expenses have the highest share at 32%. This is the same as that which was obtained in 2004/5. This implies that there has been no improvement in drug availability since then.

14 As much as 58% of the 2007/8 budget has been allocated to the headquarters vote. A further 23% has been allocated to the five

central hospital votes. This leaves only 19% for 26 district hospital votes to share.

15 The distribution of the resources amongst the 26 district hospital votes is difficult to understand. Some districts with poor health indicators are allocated meagre resources while some with relative good indicators are loaded with resources.

16 HIV and AIDS activities are basically donor funded. There are mainly four sources of funding namely NORAD, CIDA, CDC and Global Fund. NORAD is by far the largest source, contributing 84%, followed by CIDA with 15%, CDC 1% and the Global Fund 0.5%.

17 Government funding of HIV and activities amounts to 0.2% of the 2007/8 health recurrent budget. Further, some ministries and departments do not have meaningful HIV and AIDS programmes judging from the amount of resources allocated to such activities. Some have not even budgeted for any activity.

18 The cost of drugs for ART in the HIV and AIDS budget under NAC is 26%. The approved estimates for 2006/7 showed that as much as 41% was allocated to drug procurement but this was revised to 28% over the year.

19 The ART drug cost per beneficiary stands at MK22,797 in the current budget estimate. The cost was 49,112 in 2006/7 approved estimates and 30,256 in the 2006/7 revised estimates. The number of beneficiaries of the ART was 81,821 by December 2006 and the current budget has 120,000 as the potential beneficiaries.

20 The health development budget is almost exclusively funded by donors. Government contribution has been meagre. In the 2006/7 approved estimates the Government share was 6%. This was 5% in the revised

estimates. In the current budget, the share is has come down to 4%. This is not good enough.

Critical issues for consideration

- Government has been increasing public resources allocated to the health sector. However, it has been silent on why it has taken this route. It is not clear whether this is an accident or comes from donor pressure or is based on some clear policy. The budget statement is not clear on this big shift.
- If the current trend is maintained the health status of the population is likely to improve. It will, however, take sustained prioritisation of the sector if Malawi is to achieve the global and national health aspirations. The high levels of public resource allocations should be complemented by health systems restructuring as well as intra-sectoral re-allocation of resources from central level to lower levels.
- The Government should join and take the lead in the fight against HIV and AIDS. Government should systematically budget for HIV and AIDS activities under the revenue budget. As a first step, NAC should assist public sector entities develop realistic HIV and AIDS programmes.

- MHEN is lobbying for continued prioritisation of the health sector in the foreseeable future along with other important health issues.
- Regarding the budget, the following are issues raised by MHEN :

  - MHEN is commending the Government for prioritising the health sector.

- Commends the Government for addressing critical issues affecting the health sector by putting in place the Health SWAp, introducing the EHRP as well as the increased allocations to preventive health services and infrastructure development.
- The incentive package for health workers must be holistic and its implementation should be accelerated.
- GoM through MoH should reverse the trend where district hospitals get the least resources considering that these serve the population more than the central hospitals and headquarters
- The formula used to allocate resources to district should be made available to MHEN so that it can be scrutinized. MHEN is lobbying for an improved, equitable and transparent system for resource allocation
- There has to be for immediate improvement of immunisation coverage.
- GoM should improve maternal health services through increased numbers of motivated midwives, well equipped and trained TBAs
- There is need for an improved system of drug availability at health facility and community levels
- Government ministries and departments should develop HIV and AIDS prevention and mitigation programs
- ART funding must be reasonable and equitable with an ultimate aim of increasing beneficiaries in the program

1. Introduction

The Malawi Health Equity Network carried out an independent analysis of the health sector national budget following the delivery of the 2007/8 Budget Statement in the National Assembly by the Minister Finance on 29th June, 2007. The ministry of Health and Population is amongst the top three funded ministries for the past ten years. In the 2007/08 fiscal year, it has been allocated K25.1billion including the amounts administered by the Local Assembly. This represents 14.5% of the national budget. The development budget is at K5.1billion. The next top funded ministries are agriculture and education at K21billion and K17billion respectively.
The analysis is meant to bring out salient issues that need to be considered by Members of Parliament as they deliberate on the presented budget. The report will also be circulated to the Ministry of Health and other relevant stakeholders involved in the budget implementation with an aim of influencing the 2008/09 budget formulation. This is the report of the budget analysis focussing on the health sector.

Scope of the analysis

1.2 The analysis is on public resource allocation on health and HIV and AIDS. It is, however, concentrated on public resource allocation to Ministry of Health, NAC and HIV and AIDS programmes in Government Ministries and Departments dubbed 'HIV and AIDS in the workplace'. It excludes other public resource allocation to other public health service providers under other public entities like the Malawi Defence Force, Malawi Police Service, City Assemblies and other Government funded public companies and agencies. The analysis also excludes purchases of drug and medical supplies by other Ministries and Departments.

1.3 Detailed analysis is done on the 2007/8 estimates for recurrent health expenditures. However, most of the analysis starts from the financial year 2005/6 to provide some background to the current budget estimates. The analysis has also provided some context by presenting some health-related indicators. It has also related the public resource allocation to a number of issues that are known to have an influence on inter-sectoral and intra-sectoral resource allocation by using a basic conceptual framework.

1.4 The analysis has not gone as far as relating budget estimates to approved expenditures to actual expenditure in all the three years within the health sector because of lack of data. The Accountant General, which is responsible for producing actual expenditures, does not have data for public consumption for financial years later than 2004/5. Again, the analysis has not related the previous health public resource allocation to outputs because the information is scanty. Some attempt has been made to follow up on the health projects under the health capital expenditure.

1.5 The analysis was meant to look at discretionary expenditure (Government expenditure excluding statutory expenditure like public debt and pension and gratuities) as opposed to total expenditure because this is the expenditure that the executive has control over. The analysis has not been done after considering that resources available, after

deducting statutory expenditure from total resources, does not affect the health sector uniquely. Such an analysis is appropriate for a comprehensive inter-sectoral budget allocation because it requires the determination of the actual 'size of the cake'.

Outline of the report

1.6 The report has five sections. Following the introduction is a section that presents a conceptual framework from which come key issues guiding the budget analysis. This is followed by Section 3 which analyses the budget allocation to the Ministry of Health while Section 4 follows allocations for HIV and AIDS related activities in Nutrition, HIV and Aids and the National Aids Commission under the Office of the President and Cabinet as well as all ministries and departments. Section 5 presents critical issues meant from MHEN's Malawi Health Equity Network in its lobbying and advocacy campaigns.

2 Key issues guiding the analysis

2.1 Conceptual framework

2.1.1 The allocation of public funds to the health sector is determined by factors which are outlined by the conceptual framework in Figure 1 which is explained below.

Malawi Health Vision

2.1.2 Malawi as a country has its expectations regarding the health status of its people. These aspirations are captured in Malawi Vision 2020[1]. It is expected that successive Governments would endeavour to translate these aspirations into reality by putting in place their visions which would be translated into reality through various means including policy changes and national budgets. The current Government has Malawi Growth and Development Strategy (MGDS) which has a health vision. It is hoped that its national budgets are based on this strategy.

Health-Related International Commitments

2.1.3 Malawi is a state party to various international conventions and commitments. One of the most recent commitments is on achieving the Millennium Development Goals (MDGs) by the year 2015. Some of the MDGs relate to the health sector. Again, it is important to check whether the current budget estimates are contributing towards the achievement of the goals. Malawi also signed the Abuja declaration in 2001 where African heads of state committed themselves to be allocation 15% of their national budgets to the health sector to fight TB, malaria and HIV and AIDS. The analysis also tries to check how far the budget contributes to these commitments.

Health-Related Indicators

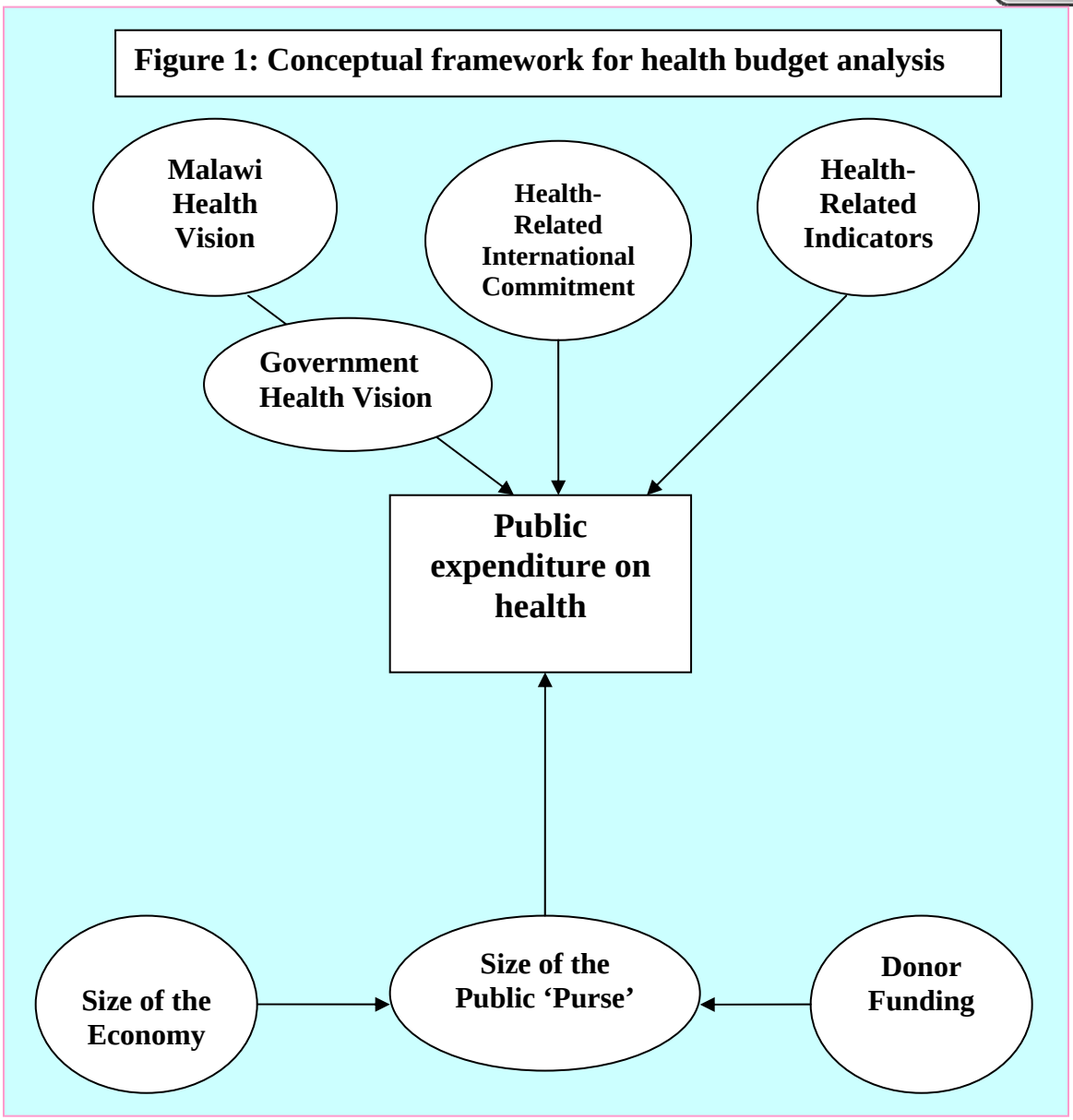
2.1.4 The public health budget is supposed to reflect the level of health problems in the country. Inter-sectoral allocation should be related to the gravity of the health problems

[1] GOM. 1998. Malawi Vision 2020. Ministry of Economic Planning and Development

vis-à-vis other socio-economic problems confronting the country. Likewise, intra-sectoral allocation in the health sector should be related to where the health problems are in terms of geographical areas as well as the type of problems. Type of problems in this case includes the leading causes of morbidity and mortality and health services delivery system problems as identified by experts including MHEN.

Size of the Government budget

2.1.5 Public services depend on amount of money government has both from domestically generated revenue and donors. The size of the economy and its related fiscal policy determines the level of government revenue. Government budget is not supposed to be too large for fear of choking the economy since too high taxes generally act as disincentives to tax payers to generate taxable income. The size of the Government budget is also determined by donor support. There is also a limit as to how much donors can support a country for fear of overheating the economy. This means that the size of the economy limits the size of the national budget. By extension, the size of the national budget limits the size of the public expenditure on health. In Malawi, some donors have clearly indicated their interest in funding the health sector. This interest has culminated in the development and funding of a health SWAp.



2.1.6 In this analysis, the size of the total Government budget is taken as given. What is important is the share of the national budget by various services in the public sector. In particular, the budget analysis will look at how the health services compare with other services. The idea in this case is to establish the fiscal priority the health sector receives vis-à-vis others. The analysis also attempts to assess whether the national budget is responding to the lessons learnt as well issues highlighted from the implementation of the health SWAp by all the stakeholders. In particular, the analysis follows on what the findings of the mid-term report of the implementation of the health SWAp.

2.2 Key issues critical for health budget analysis

2.2.1 The conceptual framework provides a basis for generating issues that need to be followed up in health budget analysis. This analysis has taken two issues namely Malawi

Health Vision (as found in the Malawi Vision 2020, Malawi Growth and Development Strategy and the Malawi Health SWAp) and health-related indicators. This sub-section presents these issues as they relate to the health budget.

Malawi Health Vision

2.2.2 The Malawi Vision 2020 statement does not specifically mention the quality of health Malawians should have by 2020. It only mentions that Malawi will have social services by the year 2020. It reads:

> *By the year 2020, Malawi, as God-fearing nation, will be secure, democratically mature, environmentally sustainable, self-reliant with equal opportunities for all and active participation by all, **having social services**, vibrant cultural and religious values and a technologically driven middle-income economy.*

2.2.3 However, the Malawi Vision 2020 document states that Malawians **aspire** to have adequate and good quality social services – especially in the fields of education and health. The Malawi Vision 2020 health **goal** is to have health services that are available, accessible and of good quality. It notes that to realise this goal there will be need to have preventive health programmes, essential clinical services, stronger technical health support services and improved human resource management.

Text Box1: Malawi Vision 2020 Key Strategic Ingredients

- Availability of pharmaceuticals and drugs
- Appropriately designed and equipped health facilities
- Trained and better paid personnel deployed in those facilities
- Improved supervision and decentralised health services
- Community participation in delivery and coordination
- Increased number of private and NGO players in the provision of health services
- Improved customer-oriented services
- Protection of patients and health workers rights
- Increased number of private wards in state health facilities
- Increased use of drug revolving funds

2.2.4 Malawi is also a state party to the Millennium Development Goals (MGDs). By being party, it is committed to achieving the eight MDGs. Of these, three are expected to be achieved partly through the provision of health services. The three MDGs are

- Reduce maternal mortality by half by the year 2015
- Reduce child mortality by three-quarters by the year 2015
- Halt and reverse HIV and AIDS pandemic by the year 2015

2.2.5 The Malawi Growth and Development Strategy (MGDS) 2006-2011 is the current Government's medium-term translation of the Malawi Vision 2020. The MGDS does not specifically include the delivery of health services as one of the key focus areas. According to some observers, the importance of the health sector in the MGDS is implied because an economy cannot grow with a sick people. Suffice to mention that the MGDS has prevention and management of HIV and AIDS as one of the key focus areas. Of course, this does imply not neglect of health services. Its Theme Three is devoted to social development under which health and population falls. In fact, to quote the MGDS itself, "*MGDS recognises that a healthy and educated population is necessary if Malawi is to achieve sustainable economic growth*" and "*Malawi seeks to achieve and sustain Millennium Development Goals (MDGs).*" (Page xvi).

Text Box 2: MGDS Focus, Goals, Expected Outcomes and Strategies

Focus:
- Provision of EHP
- Development of health infrastructure
- Prevention and mitigation of the negative consequences of HIV and AIDS

Goals:
- Increase life expectancy
- Decrease maternal mortality rate by 50% from 1120 per 100,000 live births
- Decrease diarrhoea-related child morbidity and mortality

Expected medium term outcomes:
- Decreased cases of preventable diseases
- Improved use of ORT for diarrhoea control
- Increased use of modern contraceptives
- Increased access to ARV treatment
- Increased vaccination rates
- Increased life expectancy at birth to 45 years
- Reduced malaria cases by 50%
- Increased TB cure rate to 70%

Key strategies:
- Retention of qualified health personnel
  - ✓ using a special program (EHRP)
  - ✓ improved working environment for health personnel
- Elimination of drug theft
- Improvement of health facility and infrastructure and equipment

2.2.6 The budget analysis is meant to assess whether the current budget, taken together with previous ones, is contributing towards meeting the Malawi Health goals and achieving the expected outcomes.

The Health Sector Wide Approach and Stakeholder views

2.2.7 Government as well as other stakeholders are keenly aware of the problems besetting health services in the country. To accelerate the improvements in the sector, stakeholders in the sector developed a health sector financing and monitoring system known as the Health Sector Wide Approach (SWAp). According to the progress report on the Health SWAp[2], there are some areas that still need to be addressed in the sector. These include current levels of human resource and retention of existing human resources and their related impact on the provision of the Essential Health Package (EHP); inadequate drugs, pharmaceuticals and equipment; and poor maternal health services, among others. Key issues under human resource include:

- Provision of pre-service training in increased numbers
- Provision of monetary and non-monetary incentives to existing health personnel
- Provision of housing at district and health centre levels in hard-to-reach areas

[2] MoH. 2007. Mid-Year Report for the Work of the Health Sector, June – December 2006.

2.2.8 It is reported that there have been improvements in the filling of positions at various levels in the health service delivery system. Expansions of training colleges and increases in enrolments have been reported. Further, the number of filled positions of critical health personnel has also increased. This human resource improvement is attributed to the EHRP implemented since 2004. See Table 1.

Table 1: Vacancy Rates; before and after the EHRP

Cadre	2004 vacancy rate (%)	January 2007 (%)
Doctors	68	45
Clinicians	32	11
Nurses	58	55
Others	64	30

2.2.9 Of course, it is not clear whether the improvement is indeed due to the EHRP or an increase in the training and recruitment of health personnel. What is clear from the table is that there is shortage of all cadres, especially nurses and doctors. In fact, the exodus of nurses has continued even after the EHRP; possibly implying that net pay, despite being the most important, is not the only factor. According to a study conducted by Lindsay Mangham[3], factors that would motivate public sector registered nurses to remain in the public sector include, in descending order, net pay, opportunities for further education and free provision of housing. The Health SWAp addresses some of these issues and reported their status in the referred to report.

2.2.10 On in-service training, the report provides a list of in-service training undertaken in the reference period. A cursory look at the list reveals the inadequacies in the training provided. The numbers trained is very small. Further, most of the training is geared towards orienting staff to new types of services. Routine in-service training is conspicuously missing. **There is a lot of scope for increasing the in-service training if the quality of service is to improve.** The cost of the health personnel absence during training far outweighs the benefits of the in-service training in terms of motivation and acquired knowledge.

2.2.11 On housing, it is reported that housing needs at district and health centre level especially for hard to reach areas have been evaluated, and a consultant identified to prepare designs. To ensure that the issue of housing problems for health staff in these areas is quickly dealt with, the National Assembly should follow up on the issue. **The executive should provide a programme including which health facilities will be covered and when. This should be presented to the national Assembly for MPs to appreciate how long the programme will take and why.**

[3] Mangham, L. 2007. Addressing the Human Resource Crisis in Malawi's Health Sector: Employment preferences of public sector registered nurses. ESAU Working Paper 18. ODI. London.

2.2.12 The report also mentions non-monetary incentive package for health personnel designed, finalised and approved with the objective of retaining them. The package was scheduled to be implemented starting from 2007/8. This is very welcome. The question, nonetheless, is whether or not the current budget has factored this in. The 2007/08 budget estimates are however silent on this issue. **It is therefore imperative that the national assembly demand a report from the executive on the structure of the incentive package as well as how the current budget factored that in.**

2.2.13 Other factors that de-motivate public sector nurses include the lack of adequate supplies of drugs and supplies at their workplaces. According to the mid-year report, the progress on the availability of drugs and pharmaceuticals was slow. In fact, the report discusses the need to recapitalise the Central Medical Stores as if the problem is its financial incapacity. Stakeholders question this alleged capitalisation problem given the existence of the Health SWAp. The question is: why operate a Health SWAp if this important link in the chain can still be that weak even in its presence? If indeed CMS has a capitalisation problem, does the current budget take this into consideration? **It is proper that this issue be raised and responses given in the National Assembly for the sake of improving the drug availability in the health facilities.** Drug availability, apart from improving the health status of the population, motivates health personnel. **In the same vein, the encouragement and facilitation of the setting up of drug revolving funds could also be raised.** This is in line with the Malawi Vision 2020.

2.2.14 Rural health centre staffing problems are reported to be acute. It is reported that an incentive package for rural staff was finalised and adopted to deal with the problem. Again, just like the general non-monetary incentive package, **the national assembly should be furnished with the structure of the package and should insist on having this implemented in this financial year.** It is also reported that health centres lack essential equipment for the provision of the EHP. Likewise, the general progress on the provision of EHP is far from the agreed targets. So far, no target has been reached. For example, the proportion of children fully immunised is reported to be 37% and this is very far from the targeted 74%. See Table 2. Considering the importance of prevention, **the National Assembly should demand an explanation on the underlining causes of the slow progress.**

2.2.15 Another area that keeps coming up relates to maternal health. The Health SWAp also takes this issue up by reporting on deliveries handled by skilled personnel. It has also reported that the Reproductive Health Unit finalised its strategy and prepared a proposal that could be used by MOH for accessing the ADB Grant for the improvement of maternal and neonatal services in the country. This is encouraging and needs to be followed up. Considering the importance of this issue, **the National Assembly should be appraised on the progress on this proposal and should find out whether the executive has also considered putting aside resources to deal with the problems in maternal health services.**

Table 2: Progress in the provision of EHP

Indicator	Baseline	Target	Progress
Health centres supervised at least quarterly	43%	97%	83%
Proportion of children fully immunised		74%	37%
Health facilities carrying out TB microscopy	17%	46%	16%
Deliveries by skilled personnel	33%	49%	19%
Facilities offering integrated services	22%	47%	29%
Facilities offering PMCT services	24%	57%	31%
Facilities providing integrated routine HIV testing	47%	80%	50%
Facilities with IP certificates	0	79	5
Health centres with functioning health committees	95%	110%	93%
Facilities with procurement plan	18	28	18
Facilities with procurement coordinator	20	28	20

Source: GoM. Mid-Year Report for the Work of the Health Sector July-December 2006, MOH

Certainly it is disheartening to learn that less than one in five (19%) of the deliveries were handled by skilled personnel. There is an urgent need to address the quality of maternal health services in order to increase the number of births attended by skilled personnel. In the mean time it is crucial that **TBAs, which handle a substantial proportion of deliveries, should be trained to improve their skills and the proportion handled by 'friends and relatives' should drastically be reduced in the interest of improving maternal health. It is recommended that the National Assembly take this issue as a crisis.**

2.2.16 The Malawi Health Equity Network (MHEN), a network of civil society organisations interested in equality in health services, produced a position paper on the Mid-term report on the Health SWAp. The paper raised two critical issues, among others. The first is the unavailability of drugs in government health facilities. The second is lack of transparency in human resource management. MHEN believes that the drug and human resource crises are beyond what is generally given in reports. For example, the failure to rectify the drug shortages in the face of available resources is suspect. Again, the high vacancy rates experienced in the face of the EHRP shows that there is much more that is required to retain health personnel in the public sector.

2.2.17 MHEN also produced a Position Statement regarding the 2007/8 budget estimates. In that statement, apart from stressing the issue of shortage of drugs and health personnel, MHEN also focuses on HIV and AIDS and Preventive Health. The statement also seeks the assistance of the legislature to check and balance the executive arm of Government. Probably what can be taken from this is **the need for the executive to deal with the issue of health personnel retention holistically.** Clearly the EHRP was a very good idea. Likewise, the various 'independent' incentive packages developed are also required including in-service training and orientation courses. However, **all these have to be worked out as one package to ensure that all key factors contributing to their motivation are dealt with**. Piecemeal answers will not stem the exodus as rapidly as the system requires.

2.2.18 This section has highlighted critical issues that will inform the subsequent analysis but has also provided issues that MHEN can take to MPs. MHEN will use these to lobby MPs. The subsequent health budget analysis will also provide some issues for lobbying the MPs.

Health-related indicators

2.2.19 Malawi has one of the worst health indicators. The budget can be used to improve some of these. The Multiple Indicators Cluster Survey conducted by the National Statistical Office provides the latest health profile of the country which is presented in Table 3.

Table 3: Malawi Health Profile, 2006

Reproductive health	Institutional deliveries	53.8	Per cent
	Skilled attendance at delivery	53.6	Per cent
	Antenatal care	91.8	Per cent
	Contraceptive prevalence	41.7	Per cent
	Marriage before 15 years	10.6	Per cent
	Marriage before 18 years	50.2	Per cent
	Girls 15-19 years in marriage or union	32.1	Per cent
Fertility	Total Fertility Rate	6.3	Per woman
	Crude Birth Rate	43.6	Per 1,000 population
Child Health	TB Immunization Coverage	95.5	Per cent
	DPT 3 Immunization Coverage	86.2	Per cent
	Polio 3 Immunisation Coverage	81.3	Per cent
	Measles Immunization Coverage	85.2	Per cent
	Full Immunization Coverage	71.4	Per cent
	Under-5 sleeping under bed nets	29	Per cent
	Under-5 sleeping under ITNs	23	Per cent
Nutrition	Stunting prevalence	45.9	Per cent
	Wasting prevalence	3.3	Per cent
	Underweight prevalence	19.4	Per cent
Child care and Orphanhood	Children living with biological parent	17.4	Per cent
	Prevalence of orphans	12.6	Per cent
	Ratio of orphans to non-orphans in school	97	Per cent
Child Mortality	Neonatal Mortality Rate	31	Per 1,000 live births
	Infant Mortality Rate	69	Per 1,000 live births
	Under-five Mortality Rate	118	Per 1,000 live births

Source: NSO. 2007. MICS Preliminary Report, www.nso.malawi.net

Without dwelling too much on the details of the table, it is clear that there is a problem in the maternal health as only 54% of deliveries are dealt with by skilled health personnel. This indicator, which is a determinant of maternal mortality, is picked up as we present trends in some of these indicators. Likewise the low immunisation rates are of great concern considering that very recently Malawi had one of the highest immunisation rates. The child mortality rates are impressive considering how high they were in the 1990s.

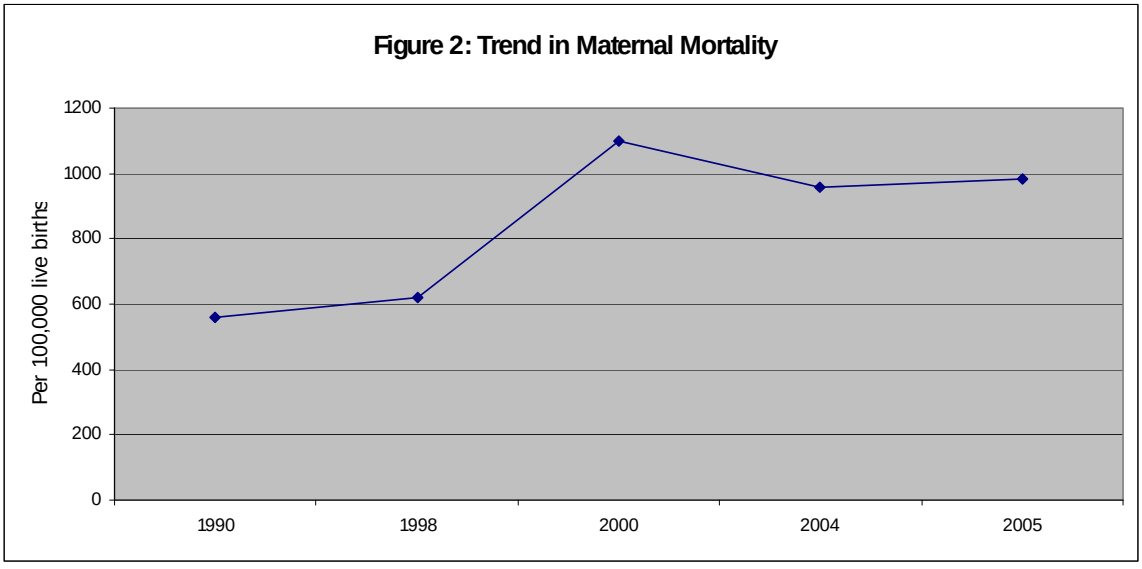
However, the rates are still high and need to be reduced further. The gains can easily be wiped out, what with the declining immunisation rates.

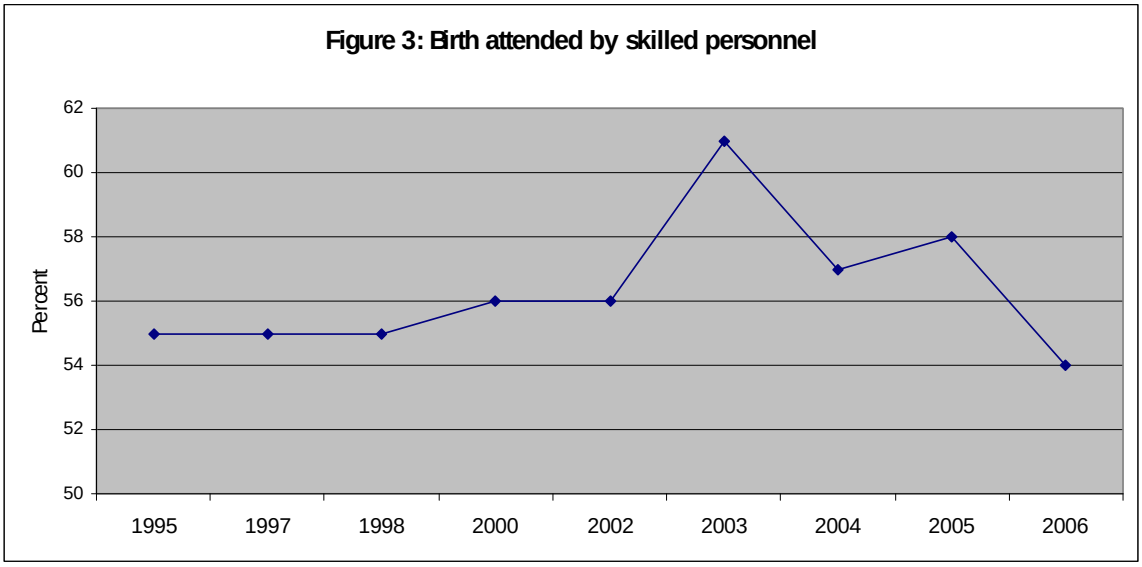
2.2.20 Trends in some of the key indicators show that there have been gains in child health indicators but losses in maternal health. The high HIV and AIDS prevalence has not helped matters as life expectancy has declined in recent years. On the maternal health front, the maternal mortality which used to be 560 per 100,000 live births in the 1980s, declined to 1120 in 2000 and moderately improved to 984 in 2005. See Figure 2.

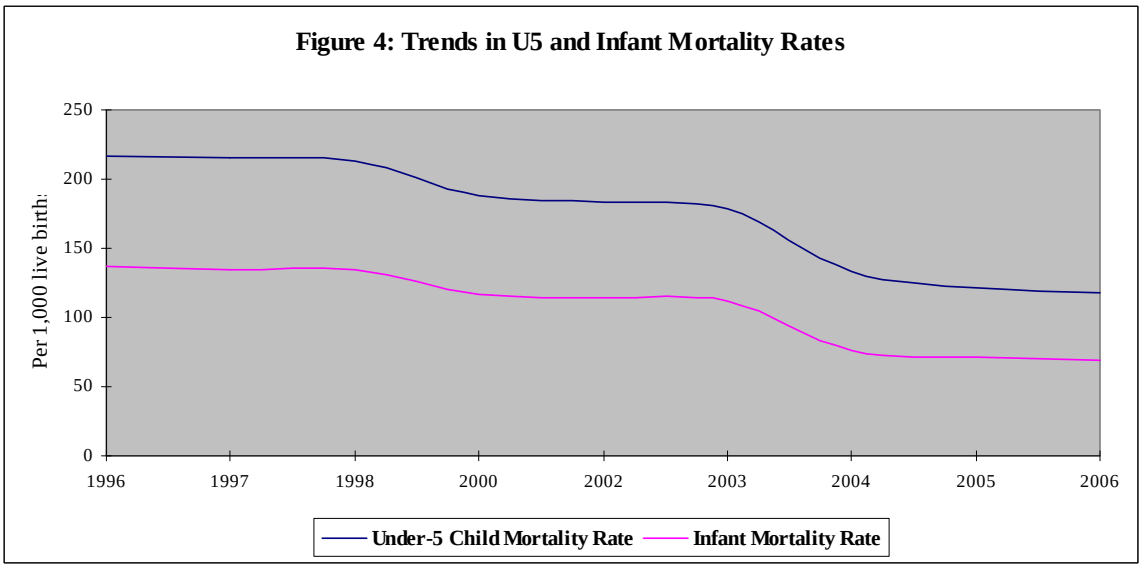
2.2.21 As already said, one of the causes of this high maternal mortality rate is the delivery care received by pregnant women. Figure 3 presents this grave picture. In fact, as will be seen when presenting district indicators, as much as 21% of deliveries were attended by 'friends and relatives' and another 21% by TBAs in 2005.

2.2.22 There have been some improvements in child mortality rates. There have been steady declines in all the early childhood mortality rates. See Figure 4. Although there have been improvements in these rates the rates are still high. **The need to maintain the trend cannot be overemphasised considering that the health sector has ever seen reversal in so many areas including maternal mortality and immunisation coverage, possibly due to laxity following some euphoria.**

Figure 2: Trend in Maternal Mortality







2.2.23 One indicator that sums up the health status in the life expectancy. Malawi had ever had 57 years as its life expectancy at birth. However, this is long time ago. Of late Malawi's life expectancy has hovered below 40 years. According to UNDP's Human Development Reports, the life expectancy has declined from 41 years in 1995 to 37 years in 2005 as depicted in Figure 5. While the high HIV prevalence rate (Figure 6) is blamed for the decline, health services have been under general strain even before HIV and AIDS turned into a pandemic.

Figure 5: Trend in life expectancy at birth

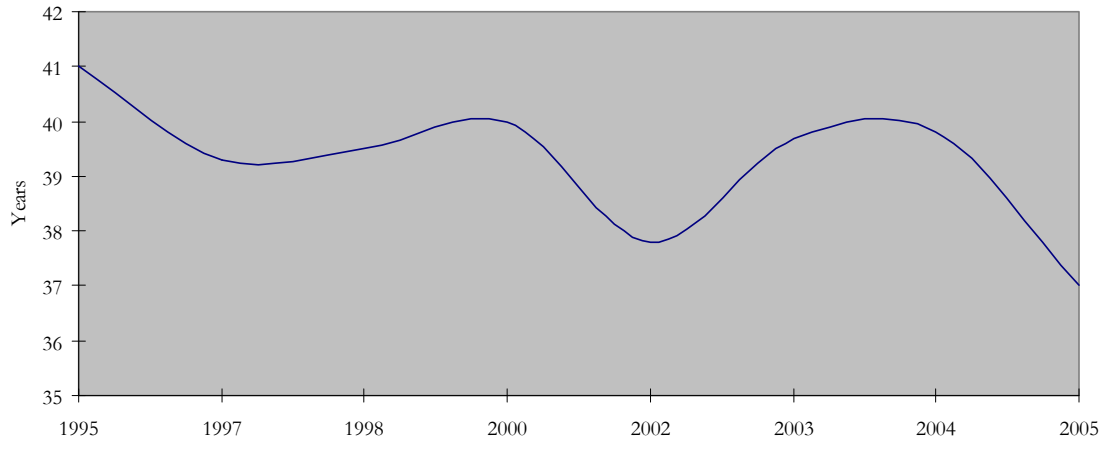
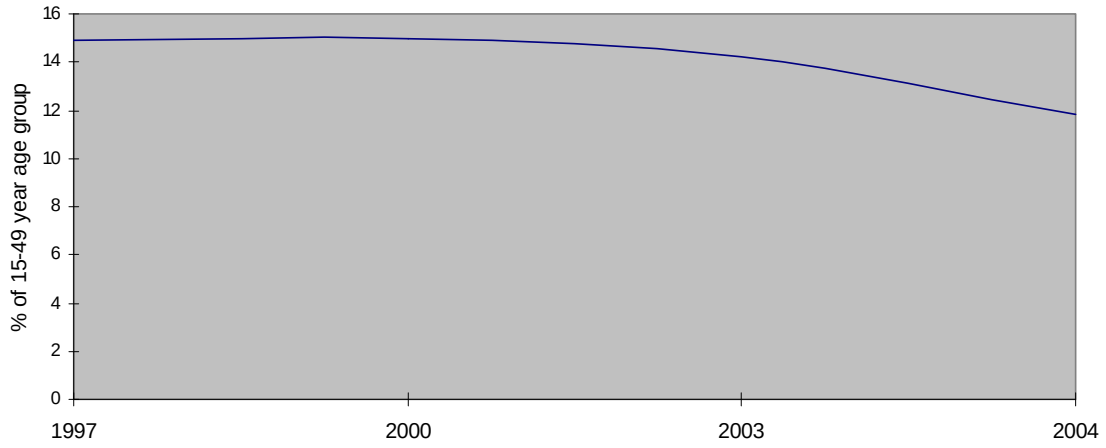


Figure :6 Trend in adult HIV prevalance rate



2.2.24 The above indicators clearly show that there is a lot the health sector budget can do to improve Malawi's health status. Unless some radical moves are made, the aspirations given by Malawians in the Malawi Vision 2020, the commitment to achieve the MGDS will not be met. Key is the need to address the HIV and AIDS pandemic, human resource crisis in the health sector and provision of high quality preventive and curative health services. Further, civic education and immunisation campaigns should still be considered as a priority. **MHEN is calling upon MoH to revive immunization campaigns.**

3 Health Budget Analysis

3.1 The budget statements, delivered by the Minister of Finance, provide another glimpse of executive's thinking of the health sector. The four budget statements since June 2004 have not always been explicit on the Government's basis for fiscal position of the health sector. The 2004/2005 Budget Statement states that the resources to the health sector was on the basis of the need to provide resources to pro-poor expenditures agreed in the MPRSP and the need to address HIV/AIDS activities (page 24). The 2005/2006 Budget Statement states that the allocations to the health sector was on the basis of Government's concern on health matters as well as the donor community's determination to contribute towards the attainment of the Millennium Development Goals of the United Nations in the field of health (page 24). This was in reference to the introduction of the health SWAp. The subsequent statements did not provide any basis for the allocations to the health sector.

3.2 The point, nonetheless, is to determine whether in reality the executive allocated the requisite resources to the sector to do that. The budget analysis will be done at two levels. We will start with inter-sectoral analysis where the health budget will be related to the macro-economy and total expenditure vis-à-vis other sectors. Then we will move to intra-sectoral analysis where there will be comparisons of allocation to programmes and levels. Apart from comparing the allocations between tertiary, secondary and primary health services, we will also compare hospital allocations in light of critical health-related indicators.

3.3 Before this analysis, it is important to discuss the relationship between what is presented to the National Assembly as estimates and what is approved by the National Assembly and how much is actually spent. It is also worthwhile to discuss whether the budget has been in tandem with trends in inflation. We start with the relationship between original estimates, revised estimates and actual expenditure. Table 4 presents the relationship between what is presented to the national Assembly as estimates and what is actually approved by the National Assembly and finally what is actually spent on health services.

Table 4: Original Estimates versus revised estimates and actual expenditure

Recurrent	**2003/4**	**2004/5**	**2005/6**	**2006/7**
Approved as % of estimate	101	100	101	107
Revised as % of estimate	98	109	118	115
Actual as % of estimate	101	109	118	-
Development				
Approved as % of estimate	100	20	102	100
Revised as % of estimate	286	20	96	402
Actual as % of estimate	100	20	96	
Total expenditure				
Approved as % of estimate	100	57	101	105
Revised as % of estimate	163	60	115	199
Actual as % of estimate	101	60	115	-

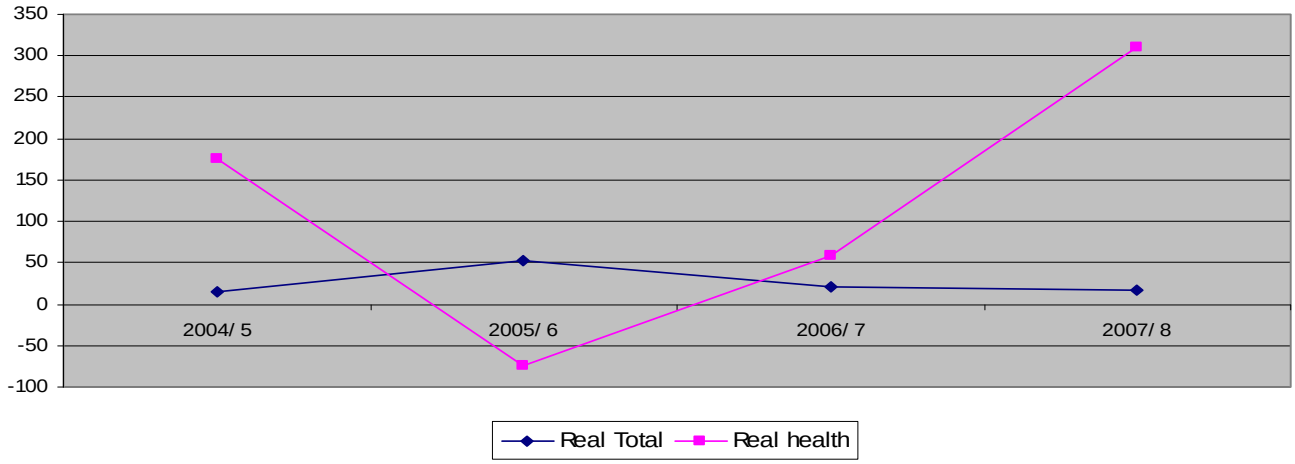
Source: Economic Reports (2003-2007)

3.4 On the basis of the above table, it is can be concluded that what is approved is generally above what is estimated. This could imply that the lobby for the health sector in the National Assembly is strong[4]. Further, the actual expenditure under recurrent budget has generally been above the estimate. Again, this is an encouraging outturn as far as lobbying is concerned. It implies that Government does not constrain health expenditure as the financial year progresses. **MHEN is lobbying for the continuation of this trend.** Further, this could also be an indication that with more lobbying more resources could be re-allocated to the health sector.

3.5 Probably a general issue worthy exploring is the integrity of the data provided in the Economic Reports regarding revised estimates and actual expenditure. The fact that most of the revised estimates are equal to actual expenditure gives the impression that what are referred to actual expenditures are in fact revised estimates. It is important that what is reported should be accurate to avoid misunderstandings.

3.6 One other area that also needs further discussion before the intra-sectoral or intra-sectoral budget analysis is whether the budgeted expenditures are indeed in step with cost escalations. Our analysis shows that real health expenditure has been on the increase since 2005/6 while real total expenditure declined during the same period. This is encouraging because it means that the increases in the health expenditure have been over and above cost escalations experienced in the economy as a whole. See Figure 8.

Figure 8: Growth in real expenditure

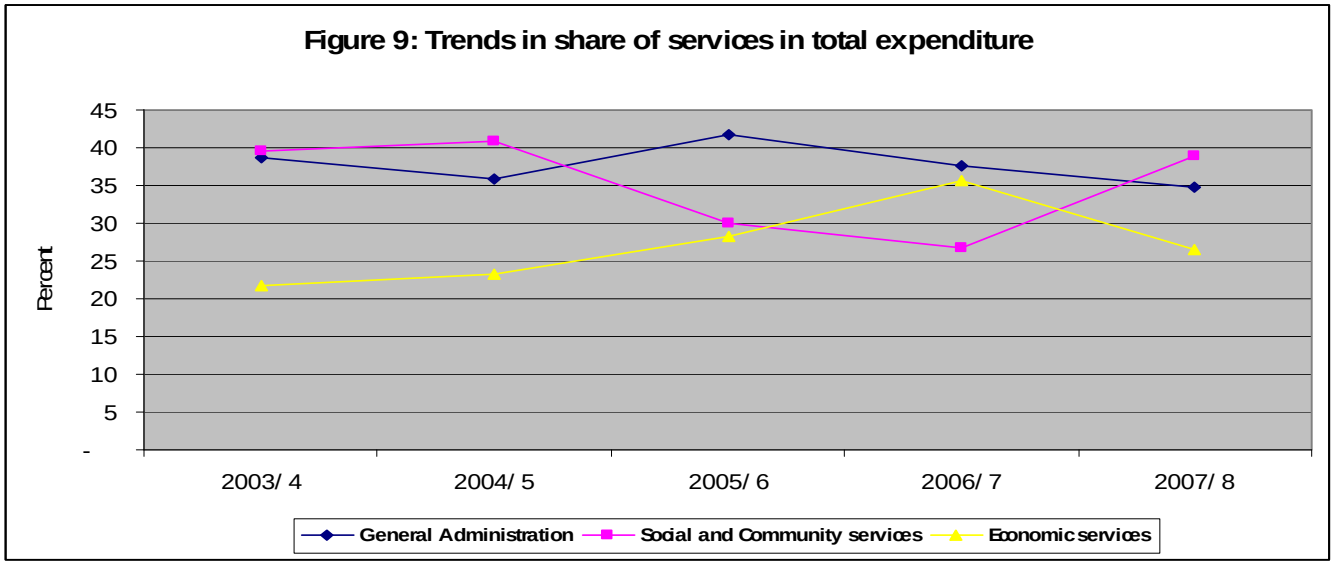


Inter-sectoral analysis

3.7 Fiscal priority of the social sectors, under which health falls, is still high despite the clear favour for economic services given in the MGDS. The share of social sectors in total budget has almost always been high. In the current budget estimates, the share of social

[4] This argument could be better be made if the analysis covered all sectors and it was demonstrated that the health sector's ratio is higher than any other sector. This high proportion could be common to all sectors.

sectors in total expenditure is the highest at 39%. This is the same share social services had before the current government took over. See Figure 9.



3.8 The situation is rarely different even when one considers approved estimates, revised estimates and actual expenditure. Of course in some years, actual expenditure turned out to be lower for the social services than what was approved or estimated or higher as were the cases in 2003/4 and 2004/5. Yet in others the actual outturn was higher than what was estimated as was the case in 2006/7. See Table 5.

Table 5: Shares in total expenditure

Original estimates	**2001/2**	**2002/03**	**2003/4**	**2004/5**	**2005/6**	**2006/7**	**2007/8**
General Administration			38.7	35.9	41.7	37.6	34.7
Social and Community services			39.5	40.8	30.0	26.8	38.8
Economic services			21.8	23.2	28.3	35.6	26.5
Approved estimates							
General Administration		36.1	37.2	34.3	41.7	37.3	
Social and Community services		35.0	41.8	30.1	29.9	27.0	
Economic services		12.4	21.0	35.7	28.4	35.8	
Revised estimates							
General Administration		39.4	39.5	37.4	42.5	35.4	
Social and Community services		44.2	43.6	29.6	31.4	37.8	
Economic services		13.7	16.8	32.1	26.1	26.8	
Actual expenditure							
General Administration	33.3	29.5	28.3	44.7	37.4	43.3	
Social and Community services	30.6	40.4	31.7	28.0	29.6	30.9	
Health affairs and services	*6.5*	*11.6*	*8.7*	*9.1*	*8.8*	*13.2*	
Economic services	17.6	15.1	9.8	15.8	32.1	25.8	

Source: Economic Report (2003-2007)

3.9 Perhaps what needs to be noted is that health expenditures have not been steady in terms of their proportion to GDP and share in expenditures (recurrent, development or total). In other words, the position of health expenditures is unpredictable. There seems to be no proper basis. **This unpredictability is not good for planning.** See Table 6.

Table 6: Health expenditure in recurrent, development, total expenditure and GDP

	2003/4	2004/5	2005/6	2006/7	2007/8
% of total recurrent expenditure	12.6	10.3	16.6	10.1	13.6
% of total development expenditure	12.3	29.7	5.0	6.4	22.5
% of total social services	31.6	39.4	42.0	32.4	43.9
% of total expenditure	12.5	16.1	12.6	8.7	17.1
% of GDP	3.2	4.7	4.9	3.3	5.2

Source: Economic Reports (2003-2007)

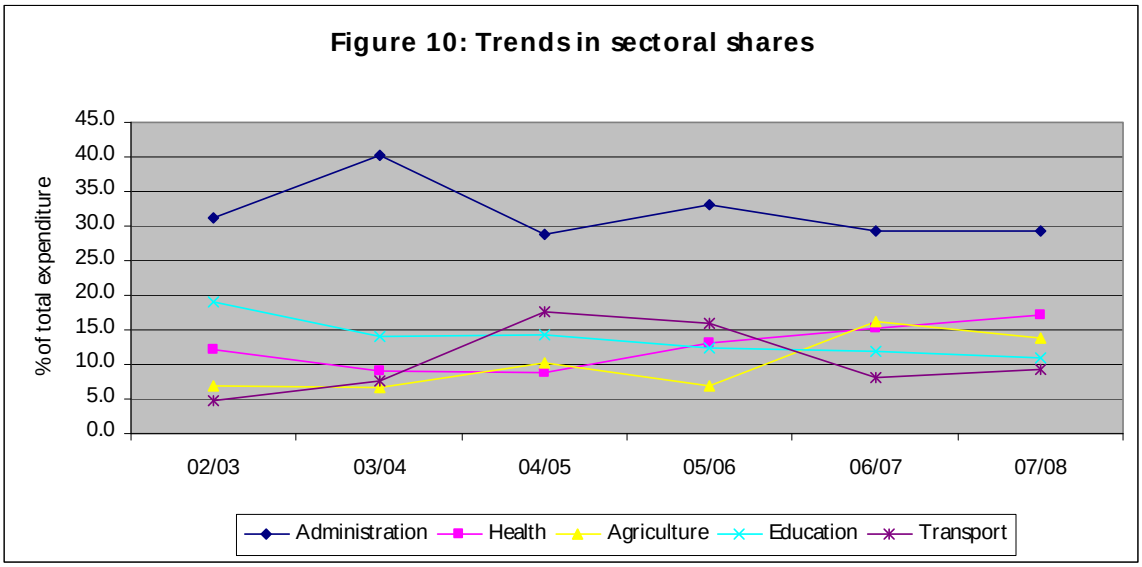
3.10 In relation to other sectors, the health sector has received the second highest share after agriculture and natural resources in the recurrent budget. It is again the second highest sector in the development budget. Overall, the health sector was second to general administration (OPC, MoF, MFA and MLGRD). Thus as a line ministry, the Ministry of Heath received the highest share in the current budget estimates. This has not always been the case, though. See Table 7.

Table 7: Sectoral shares in total expenditure

Sector	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
	Actual	Actual	Actual	Actual	Revised	Estimate
General administration	31.3	40.3	28.9	33.0	29.2	29.3
Health Affairs and Services	12.1	9.1	8.8	13.2	15.3	17.1
Agriculture and Natural Resources	7.0	6.8	10.3	7.0	16.3	13.9
Education Affairs and Services	19.0	13.9	14.2	12.3	11.9	10.9
Transport and Communication Services	4.8	7.6	17.7	16.0	8.2	9.2
Social Security and Welfare Affairs and Services	3.9	3.4	4.4	3.0	6.1	6.4
Housing and Community Amenity Services	8.8	1.3	1.1	1.9	3.7	3.4
Public Order and Safety Affairs	6.3	2.4	4.7	5.7	3.4	2.7
Defence Affairs	3.2	2.1	3.8	4.6	2.9	2.6
Physical Planning and Development	0.3	0.3	2.4	1.3	1.7	1.6
Industry and Commerce	0.3	0.3	0.6	0.7	0.2	1.1
Broadcasting and Publishing Affairs and Services	0.3	0.2	0.7	0.3	0.4	0.6
Recreational, Cultural and Other Social Services	0.2	0.1	0.2	0.2	0.4	0.4
Tourism Affairs and Services	0.4	0.2	0.0	0.0	0.0	0.3
Labour Relations and Employment Services	0.6	0.4	0.5	0.4	0.2	0.2
Energy and Mining Services	0.1	0.2	0.1	0.1	0.1	0.1
Total (recurrent and development expenditure)	100	100	100	100	100	100

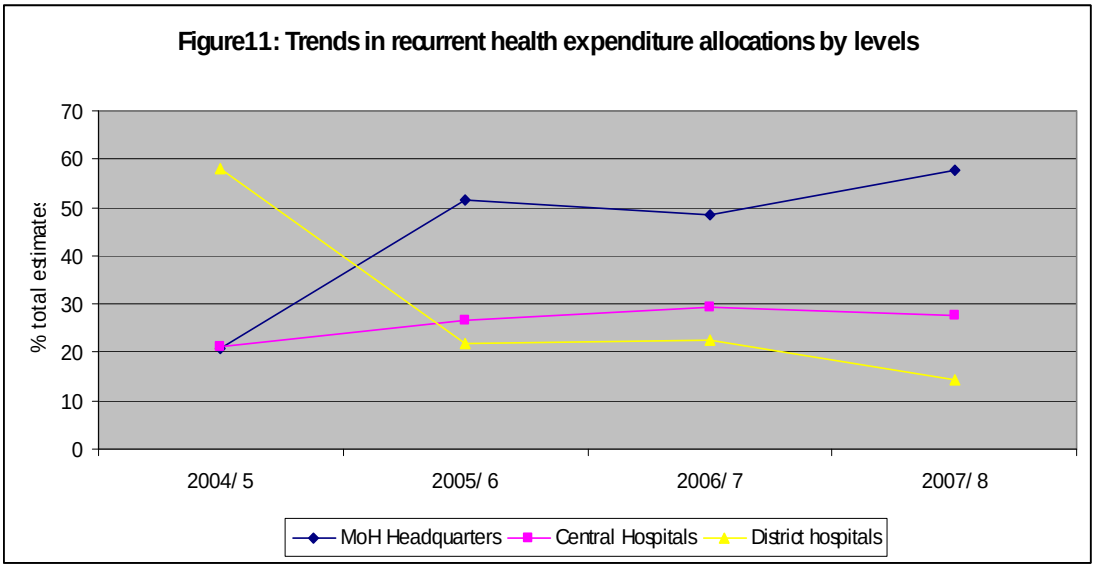
Source: Economic Report 2003-2007

3.11 As can be seen the health sector was not as well funded until 2005/6 and the growth in its share has been at the expense of general administration as well as transport and communication, among others (Figure 10). The high proportion of the health budget does not give scope for inter-sectoral allocation. **MHEN is requesting MoH to continue with this trend.**



Intra-sectoral allocation in the health budget

3.12 Ever since 2005/6, public resources have been shifted from district hospitals to Ministry of Health headquarters. The relative share of district hospitals has gradually declined from 58% in 2004/5 to 14% in the 2007/8 budget. If anything, it has only been central hospitals that have marginally benefited from the marked increases in the health expenditure. See Figure 11.



3.13 The shift was very radical and can only be explained by some policy shift. However, there was no policy shift announced by government in 2004 or 2005. Thus the lauded increased allocation for health services has not been pro-service after all. Contrary to the statements that the increases were for the benefit of pro-poor health services or MDGs or concern for health services, the increases have been for the benefit of what can crudely be termed as non-life saving services at headquarters. No wonder immunisation coverage is declining. No wonder fewer and fewer deliveries are handled by skilled personnel. **MHEN is seriously lobbying against this trend because it is not in line with any health vision or strategy and will certainly fail to change the health status of the population which relies upon health services at area and not headquarters level.** This begs the question: where do the increased resources to health services go to then? Which programmes benefited from the increases or which cost items benefited from the increases?

3.14 Health expenditures have been dominated by administration and support services. In the 2007/8 budget estimates, the share is 39% from 55% in 2004/5. In fact, the share has been declining since 2005/6 after it peaked at 64%. The share of curative services has slightly declined from 26% in 2004/5 to 21% currently. However, the trend is that the share of curative services has been increasing since 2005/6. Probably, the most encouragingly trend is that of the share of preventive health services. Its share has steadily increased from 2% in 2004/5 to 15% in the 2007/8 budget. The trends in infrastructure development and manpower development have not been as encouraging. However, judging from the 2007/8 budget allocations, it can be deduced that the executive intends to address the long standing issues in these two areas. The current budget has allocated 12% for infrastructure development from roughly 3% in the previous three years. It has also allocated 8% of the total budget to manpower development. **Given the shortage of staff, it is hoped that there will be some acceleration in the pre-service and in-service training for health personnel. In fact, MHEN is calling upon government through to allocate more resources for in-service training.** However, it is not clear how the training is to be done given the capacity constraints in training institutions. **There is need for the executive to provide some indication as to how it plans to spend the manpower development resources given the capacity constraints.**

3.15 The above discussion is based on combined total expenditure of both recurrent and capital budgets. The situation is a little different in the two budgets. See Table 8. For example, the capital budget was dominated by administration and support services up until this budget when there has been serious infrastructure development. Likewise, the steady increase in preventive health services emanated from the recurrent budget. The share of administration and support services jumped from 19% in 2004/5 to 44% in 2005/6 but has steadily declined to 30% in the current budget. **As indicated above, the health sector is better off with increased preventive and curative health services and reduced administration and support services. Further, the recurrent budget should be tuned to resonate with high morbidity and mortality rates and working realities of operative staff at health delivery service levels.** It is still a mystery why the 'supporters' (administration and support services) gets much more than the 'players' (preventive and curative services).

Table 8: Shares of health programmes in total health expenditure

	2004/5	2005/6	2006/7	2007/8
Total expenditure				
Administration and Support Services	54.7	63.6	56.7	38.7
Curative Health Services	26.2	16.3	19.2	20.5
Preventive Health Services	1.6	2.3	5.6	15.2
Infrastructure Development and Rehabilitation	3.3	3.5	3.0	11.7
Manpower Development	3.0	7.0	6.8	8.1
Information and Communication Technology	0.2	0.2	0.2	2.0
Technical Support	6.7	2.8	3.9	1.5
Nutrition and Food Security	0.7	1.4	1.2	0.8
Environmental Management	3.2	2.4	2.2	0.7
Planning Services	0.2	0.3	1.0	0.5
Media and Information	0.1	0.3	0.2	0.2
Research, Technology Generation and Development	0.0	0.0	0.1	0.1
Total	100	100	100	100
Recurrent expenditure				
Administration and Support Services	19.2	43.9	35.3	30.2
Curative Health Services	49.3	26.3	29.6	28.3
Preventive Health Services	2.5	3.4	8.4	21.0
Manpower Development	5.3	10.9	10.2	11.2
Information and Communication Technology	0.3	0.3	0.3	2.8
Technical Support	12.6	4.5	6.0	2.1
Infrastructure Development and Rehabilitation	2.6	3.6	3.1	1.1
Nutrition and Food Security	1.4	2.3	1.9	1.1
Environmental Management	6.1	3.8	3.4	1.0
Planning Services	0.5	0.5	1.5	0.8
Media and Information	0.2	0.4	0.3	0.2
Research, Technology Generation and Development	0.0	0.0	0.1	0.2
Total	100	100	100	100
Development expenditure				
Administration and Support Services	94.9	95.5	96.1	60.8
Infrastructure Development, Rehabilitation & Maintenance	4.2	3.4	2.7	39.2
Manpower Development	0.4	0.5	0.5	0.0
Preventive Health Services	0.6	0.6	0.6	0.0
Technical Services	0.0	0.0	0.0	0.0
Total	100	100	100	100

Source: Ministry of Finance

3.16 Another question worthy pursuing is which cost items take up most of the expenditures. For that analysis we again take a global view as opposed to analysis by either cost centre or level of service)[5]. Table 9 presents the budgeted cost items since 2004/5. Medical supplies and pharmaceuticals have the highest share. This is seconded

[5] Aanalyzing by cost centre would have been ideal because it would provide more insights on show how variable costing is. Given the short period allocated to this exercise that could not be done.

by personal emoluments and benefits. Training expenses come third in this current budget. The training expenses have almost stabilised after an initial jump from 6% to 11% between 2004/5 and 2005/6. **As already indicated, there is scope for some increase in this area by reducing some cost items like office supplies and expenses and non-service-delivery internal travel.**

Table 9: Cost items in the recurrent health budget

Cost items	2004/5	2005/6	2006/7	2007/8
Medical supplies and expenses	31.6	8.1	14.6	31.7
Personal emoluments & benefits	40.8	9.2	25.3	16.3
Training expenses	5.7	11.0	10.2	12.0
Grants and subventions	0.2	13.7	6.4	9.7
Internal Travel	6.6	2.6	7.3	6.6
Office supplies and expenses	5.1	5.7	4.4	3.1
Capital formation & maintenance	2.6	3.4	4.2	2.9
Public utilities	2.7	1.8	2.3	1.7
Food and rations	3.0	1.8	1.4	0.6
Foreign travel	0.2	0.2	0.3	0.4
Other goods and services	0.6	0.1	0.1	0.1
Consultancy	0.1	1.1	0.4	0.1
Rent expenses	0.0	0.0	0.0	0.0
Insurance expenses	0.2	0.0	0.1	0.0
Total MOH Recurrent budget	100	100	100	100

Source: Ministry of Finance

3.17 **The fact that the medical supplies and expenses share is the same as that of 2004/5 clearly shows how this cost item has lagged behind given the natural population growth since then.** Given that there has been little improvement in the health indicators, the allocation for medical supplies and expenses was supposed to be increasing overtime, what with inflation over the period as well.

3.18 It is also a mystery that the share of personal emoluments and benefits tend to be unstable. Of course, it is expected that the share of personal emoluments and benefits would decline with increases in total budget allocation unless there were salary and benefit adjustments in line with budget increases. According to the output based budget documents, the total budget for salaries has increased from MK2.6 billion to MK2.9 billion from 2006/7 to 2007/8, an increase of 11%. This is despite having a 41% increase in the number of filled posts. Note that substantial increases are expected for two grades namely Grade H and Grade M. Also note that the estimated cost of Grade K is estimated to be 17.1% lower than in 2006/7 when the estimated number of filled posts is expected to increase by 15.3%. This is also true of Grade M where the cost is to decline by 28% in the presence of an increase in the number of positions filled from 2,014 to 2,849. **These are clear anomalies and need some explanation.** See Table 10 for details. From Table 10, it can be deduced that Government intends to recruit health workers of grades H, K, M and O. However, there is no statement to that effect in either output based budget documents or budget statement. Likewise, there is a budget of MK1.5billion for training but there is no

clear training plan in the documents in order to allow meaningful analysis of the types of training (pre-service or in-service) as well as the training capacities.

Table 10: Personal emoluments budget for MOH and CHAM staff

Grade	Authorised Establishment	Filled July 2006	Provision in 2006/7 budget (MK '000)	Estimated filled posts for 2007/8 budget	Cost of estimated posts 2007/8 (MK '000)
C	1	1	4,225	1	4,141
D	20	11	34,078	11	26,769
E	95	39	95,166	39	106,910
F	126	74	86,589	74	97,030
G	263	118	64,701	118	133,257
H	432	137	64,709	207	147,166
I	1,114	251	143,748	251	236,905
J	1,658	277	124,982	277	154,895
K	3,260	2,422	801,377	2,792	664,509
L	555	386	80,569	386	89,733
M	3,497	2,014	332,497	2,849	187,377
N	1,616	1,766	129,441	1,766	165,827
O	6,238	7,237	502,831	12,819	638,093
P	1,956	1,025	68,819	1,025	117,237
Q/R	1,803	814	62,625	814	99,479
Total	**22,634**	**16,572**	**2,596,356**	**23,429**	**2,869,328**
CHAM				7,312	1,149,044
Total	**22,634**	**16,572**	**2,596,356**	**30,741**	**4,028,373**

Source: Ministry of Finance

3.19 As far as health services are concerned, impact can mostly be achieved if more activities are done by the district hospitals and health centres. This is true even for preventive health services. It would work to the benefit of the population if more resources, including human, were allocated to the district. **It is unrealistic to expect any meaningful impact on the health status of the population when 58% of the health budget is spent through the headquarters and 23% through Central hospitals.** Refer to Table 11.

Table 11: Share of cost centres in the 2007/8 health budget (%)

Ministry Headquarters	57.8	Kasungu District Health Office	0.5
Queen Elizabeth Central Hospital	9.1	Salima District Health Office	0.5
Lilongwe Central Hospital	6.9	Dowa District Health Office	0.5

Mzuzu Central Hospital	5.3	Chiradzulu District Health Office	0.5
Zomba Central Hospital	4.6	Zomba District Health Office	0.5
Zomba Mental Hospital	1.9	Chikwawa District Health Office	0.5
Lilongwe District Health Office	1.2	Karonga District Health Office	0.5
Blantyre District Health Office	0.7	Rumphi District Health Office	0.4
Mzimba District Health Office	0.7	Nsanje District Health Office	0.4
Thyolo District Health Office	0.7	Nkhata-Bay District Health Office	0.4
Mchinji District Health Office	0.7	Mwanza District Health Office	0.4
Mangochi District Health Office	0.6	Balaka District Health Office	0.4
Machinga District Health Office	0.6	Nkhotakota District Health Office	0.4
Mulanje District Health Office	0.6	Ntchisi District Health Office	0.4
Ntcheu District Health Office	0.6	Chitipa District Health Office	0.3
Dedza District Health Office	0.6	Phalombe District Health Office	0.3
Source: Ministry of Finance			

3.20 Further, it is not clear how district hospital health budgets are determined. One would expect that they are based on population. Table 12 does not support that expectation. Note that the headquarters budget is far above any cost centre even when the entire population is factored in. Ideally, if the allocations to cost centres were based on population alone, the per capita allocations would have been equal. Of course it is not expected that the budget would only be based on population although population ought to be a major determining factor.

3.21 Ideally the estimates ought to be based on some objective measure. Using a composite of health indicators at the district level, one sees some pattern which barely supports the hypothesis that the budget is based on health indicators[6]. See Figure 12. The poorest district in terms of health indicators is Mangochi and its allocation, though not highest is not the lowest. However, some district like Phalombe, Balaka and Nsanje and Ntchisi are apparently under-funded on the basis of this composite index. On the other hand, Lilongwe is apparently getting more than its fair share. Note that this is a crude way of relating the two but gives an idea of ways of getting the budgeting aligned to health-related indicators

Table 12: Per capita allocation of health budget by cost centre

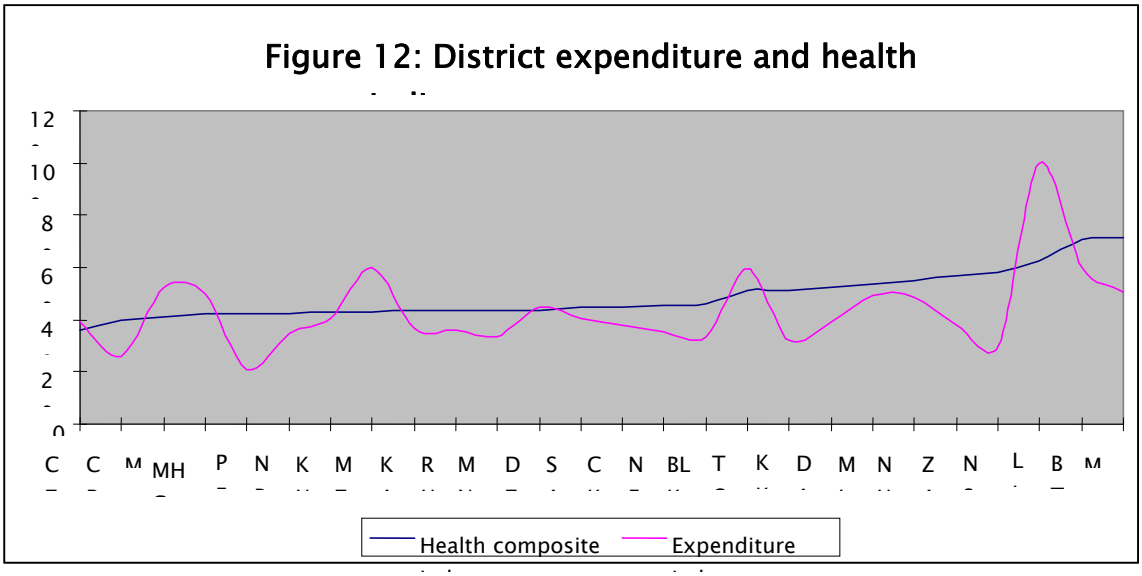
Cost centre	Per capita Allocation (Kwacha)	Cost centre	Per capita Allocation (Kwacha)
Ministry Headquarters 1/	579.55	Nkhotakota District Health Office	176.59
Mzuzu Central Hospital 2/	454.36	Balaka District Health Office	168.57

[6] The indices were constructed that the poorest district got the lowest index for each indicator. Table A1 at the end of the paper provides the raw indicators from which the indices were constructed. The composite index was a simple average of the six indices. This implies that each index was given an equal weight. This means that the lower or poorer the district the lower the index. Since the highest was used as the base, the maximum index was 100 for each indicator. The expenditure index has the lowest allocation is the lowest. This implies that the district with the lowest allocation had the lowest index. However, if allocation is based on indices then the higher the higher the district health indices the lower the allocation would have been.

Rumphi District Health Office	377.73	Thyolo District Health Office	164.65
Queen Elizabeth Central Hospital 3/	318.41	Lilongwe Central Hospital 5/	164.02
Mwanza District Health Office	306.59	Ntcheu District Health Office	161.61
Nkhata-Bay District Health Office	284.70	Mzimba District Health Office	160.30
Zomba Central Hospital 4/	265.72	Mulanje District Health Office	144.63
Blantyre District Health Office	259.75	Lilongwe District Health Office	136.31
Chitipa District Health Office	254.53	Chikwawa District Health Office	134.24
Nsanje District Health Office	240.97	Dowa District Health Office	126.92
Karonga District Health Office	238.26	Dedza District Health Office	113.71
Chiradzulu District Health Office	216.20	Phalombe District Health Office	109.19
Ntchisi District Health Office	210.86	Mangochi District Health Office	107.23
Mchinji District Health Office	195.87	Zomba District Health Office	102.72
Salima District Health Office	192.89	Kasungu District Health Office	102.27
Machinga District Health Office	186.68	Likoma District Hospital Office	-

Source: Ministry of Finance

1/ Catering for the entire 2007 population; 2/ Catering for the entire 2007 Northern Region population; 3/ Catering for the 2007 Shire Highlands population including Phalombe; 4/ Catering for the 2007 Eastern Region population excluding Phalombe; 5/ Catering for the entire 2007 Central Region population



3.22 The pattern in this figure shows that the poorer the district in terms of health indicators the lower the allocation. That seems not to make sense. The allocation ought to be done on some health-related bases. **MHEN is lobbying for an objective basis for the allocation of resources to district hospitals. It is imperative that a formula be devised that would reflect reality on the ground.**

Relationship between MOH and CHAM

3.23 CHAM health facilities play a major role in providing health services to Malawians. In some communities, these CHAM facilities are the only available health providers. Those communities are forced to get health services from those CHAM facilities. Recognising the role CHAM health facilities play in the country, a Memorandum of Understanding between MOH and CHAM was developed. The MOU is aimed at increasing access to the EHP to

the poor. Among others, the MOU provides for Government subvention for salary support of health workers in CHAM facilities in order for CHAM to charge less than commercial fees. Thus the MOU constitutes a basis for objective resource allocation to CHAM. The salary support to CHAM is recorded under MOH headquarters grants and subsidies. In the 2007/8 budget estimate, the salary subsidy to CHAM is 29% of the total personal emoluments budget for the Ministry of health.

3.24 Apart from the subsidised services, it has been recognised that some essential services in CHAM facilities are inaccessible to some poor people. To provide for their access, service level agreements (SLAs) between Government and CHAM have been introduced. In essence these are agreements between contiguous districts and CHAM institutions within those districts for the provision of EHP services to underserved communities. Under these SLAs, women are supposed to access life-saving services like neonatal and antenatal services from CHAM facilities free of charge. This is meant to reduced child and maternal mortality. DHOs in such districts allocate resources to the CHAM districts every month once it is funded. In 2006/7 a total of 50 SLAs were implemented and the target for 2007/8 is 75. Currently, CHAM facilities under SLAs and amounts transferred are not indicated in the budget documents. **It would help if this was made public for the purposes of monitoring as well as advocacy. Community beneficiaries ought to be informed of this opportunity in order for them to take advantage.**

Development budget

3.25 The development budget has seen some increase over the years as already seen. There are few players in health projects funding. If anything, it is SWAp pool funding that is likely to be used to fund some of the proposed projects. According to the 2007/8 budget, four of the seventeen projects will be funded from the pool while four are funded directly by donors. The rest are Government-funded. However, in terms resources, Government funding is meagre. For example, the approved estimates for the development budget for the 2006/7 shows that government contributed only 6.3%. This was revised to 4.6% by the end of 2006. In the current budget, the contribution is 3.5%. This is low and not sustainable. Table 13 presents the projects that are given in the output based budget documents. However, two of the projects have been on the list of potential projects for sometime and **there needs to be some explanation as to why there has been no progress. These include the New Blantyre District Hospital and Improvement of Health Infrastructure.** In terms of the actual

Table 13: Government Budget Projects for 2006/7 and 2007/8

Project	Status 2006/7	2007/8
Rehabilitation of Zomba Central Hospital	Tendering in progress	Norway to fund - contract awarded
Construction of New Blantyre District Hospital	Not started	
Construction of new Nkhata Bay District Hospital	Not started	OPEC Fund - preparatory work done works to start
Re-electrification of MoH Headquarters	Initial installations complete	GOM funding - to be completed by December 2007
Construction of Phalombe District Hospital	Not started	Pool funding - preparatory work
Improvement of health infrastructure	No progress	
Rehabilitation of Mzuzu Central Hospital sewerage	No progress	GOM funding - works to be completed by December 2007
Construction of New Dowa District Hospital	Not started	Pool funding - preparatory work
Rural health care project	Completed - equipment procured	
Construction of Nkhotakota Hospital	Completed	Budgeted for but no indicator
Support to National TB programme	Completed - routine operations maintained	
Construction of Orthopaedic Centre at QECH	Completed	
Rehabilitation of laundry at Ntchisi hospital	Not started	Budgeted for but no target - GOM funding
Rehabilitation of BEmOC sites (ADB)		Funded by ADB
Rehabilitation of Balaka District Hospital		GOM funding - preparatory work – no target given
Rehabilitation of Mulanje District Hospital kitchen		ADB funding - to be rehabilitated by December 2007
Construction of Orthopaedic Centre at KCH		GOM funding - Not budgeted for – needs assessment
Rehabilitation of Chintheche Hospital		GOM funding - Not budgeted for – needs assessment
Construction of staff housing		Pool - 250 houses planned and budgeted for
Construction of laboratories		Pool - seven labs - preparatory work

4 Public expenditure on HIV and AIDS

4.1 HIV and AIDS in Malawi are serious problems. Although the HIV prevalence rate has declined in recent years, it is still one of the highest in the world. The problems are slowly being recognised as evidenced by various programmes initiated or sanctioned by the Government. At the centre of the efforts by Government is the National AIDS Commission (NAC). Apart from NAC, Government has encouraged all ministries and Departments to run staff-related HIV and AIDS preventive and mitigation programmes. The campaign, under the common name of HIV in workplace, requires ministries and departments to fund activities using government funding. This section follows on the resources channelled to NAC, Ministry of Health and other Government ministries and departments in the name of combating the HIV and AIDS pandemic. The resources channelled to NAC are then related to the number of patients on ART. The analysis will start with the development funding of HIV and AIDS activities through the NAC.

Donor funding of activities through NAC

4.2 The total approved estimated budget for 2006/7 was MK5.7 billion. This was revised to MK8.7 billion on account of NORAD's increased allocation. The estimate for 2007/8 is put at MK10.2 billion, again on account of increased allocation to the campaign by NORAD. CIDA, CDC and the Global Fund have not changed their allocations to the HIV and AIDS activities since 2006/7. The approved estimates for 2006/7 provided for substantial procurement of ARVs. The proportion of drug budget was 41%. However, this was revised to 28% as the year progressed. For 2007/8 financial year the estimates put the drug procurement proportion at 26%. See Table 14.

Table 14: Donor resources for HIV and AIDS activities

	2006/7	**2006/7**	**2007/8**
	Approved	**Revised**	**Estimate**
Total allocation		*(MK million)*	
NORAD	4,075	7,047	8,555
CIDA	1,500	1,500	1,500
CDC	128	128	128
Global fund	52	52	52
Total resources	5,754	8,726	10,234
Drug allocation			
NORAD	1,322	1,322	1,602
CIDA	917	917	917
CDC	174	194	174
Global fund	43	43	43
Total drug cost	2,456	2,476	2,736
Persons on ARTs	50,000	81,821	120,000
Drug to total HIV Funds (%)	*41.0*	*27.8*	*26.1*
Drug cost per beneficiary (MK)	*49,112*	*30,256*	*22,797*

Ministry of Finance

4.3 Note that the number of beneficiaries in the period is small. For example, the MK2.5 billion for drugs (ART) in 2006/7 targeted 50,000 HIV positive people. The number went up to 81,821 over the year on the same budget. The target for 2007/8 is 120,000 for a budget of MK2.7 billion. This implies that drug cost per beneficiary was MK49,112 for the 2006/7 approved estimates, MK30,556 for the 2006/7 revised estimates and MK22,797 for the 2007/8 budget estimates. **The differences in cost per beneficiary point to some problems, either in the budgeting or drug procurement or drug distribution or administration. This needs to be followed up.** There are two issues here. The first is whether the cost per beneficiary is realistic and the second is whether the variations in the cost per beneficiary have plausible explanation.

Government budget allocation for HIV and AIDS activities

4.4 An analysis of budget allocations to HIV and AIDS activities varies widely from ministry to ministry. In some cases the variations can be explained by number of staff under a ministry. However, in many cases, it is a matter of differences in prioritisation. All HIV and AIDS activities totalled 0.2% of the total recurrent budget in both 2006/7 and 2007/8. When donor funding is considered, HIV and AIDS activities were 4% of 2006/7 approved estimates, 7% of the 2006/7 revised estimates and 6% of the 2007/8 estimates under the recurrent expenditure budget. **What this means is Malawi as a country is not prioritising the fight against the HIV and AIDS pandemic because if donors pulled out there would be no effective national AIDS response.**

4.5 Probably more serious are the differences in resource allocation for HIV and AIDS activities. It is sad that some ministries do not consider budgeting for HIV and AIDS activities knowing that such activities could go along way in preventing HIV infection among staff or mitigating the effects of HIV and AIDS. Some ministries did not even budget for such activities in 2007/8. These include Department of Poverty and Disaster preparedness; Department of Science and Technology; Ministry of Economic planning and Development; Chikwawa Police Station; Department of Fisheries; Mpemba Staff Development Institute; Mzuzu Prison; Kasungu Teachers Training College; Lilongwe Teachers Training College; Blantyre Teachers Training College; St Joseph Teachers Training College; Montfort College; Mzimba Prison; Mzuzu Technical college; Livingstonia Technical College; Namitete Technical College; Chichiri Prison; Northern Region Prison Headquarters; Karonga Police Station; Human Rights Commission; Forestry Department; Prison Farms; Housing Department; Mines Department; and the office of the Ombudsman.

4.6 Some of these without HIV and AIDS activities planned are training institutions yet the activities could be used to turn some of the learners into peer educators or even prevent some of them from getting infected with HIV. Some like Forestry and Fisheries Departments have a large number of staff and some of them are stationed in areas where HIV prevalence is very high. Further, some prisons do not have any HIV and AIDS activities yet they keep inmates which could benefit from some HIV and AIDS education. Apart from these, there are many more others than have budgets of less than MK100,000 and many others less than MK500,000. The lack of meaningful HIV and AIDS prevention programmes in these government institutions is not helpful for the fight against HIV and AIDS.

4.7 It is encouraging that some ministries and departments have budgeted for over MK3 million, even up to MK15m. These include Malawi Defence Force, Ministry of Education headquarters, Police headquarters, Central West Division of the Ministry of Education, Ministry of Foreign Affairs, National Assembly, Agriculture and Food Security, Shire Highlands Division of Ministry of Education, Lands and Environmental Affairs. See Table 15.

Table 15: Top Government institutions in HIV and AIDS budgeting

	2006/7	2006/7	2007/8
	Approved	**Revised**	**Estimate**
Health	41,470,623	33,999,999	44,003,532
National Roads Authority	-	-	20,072,703
Malawi Defence Force	22,800,000	22,800,000	15,769,232
Malawi Defence Force HIV drugs	12,000,000	12,000,000	12,562,419
Education headquarters	13,204,462	13,204,462	11,197,552
Police headquarters	3,010,098	2,826,492	10,431,125
Division Office - Central West	4,065,894	4,065,894	9,058,060
Foreign Affairs	15,000,000	800,000	6,500,000
National Assembly	9,269,900	543,900	6,000,000
Nutrition, HIV/AIDS & NAC	3,717,300	2,119,800	5,371,398
Agriculture and food security	4,837,440	3,950,680	5,000,000
Division Office - Shire Highlands	2,868,077	2,868,077	3,887,758
Division Office - South East	-	-	3,339,302
Lands & Natural Resources	2,500,000	2,505,000	3,302,000
Environmental Affairs	3,267,845	3,264,982	3,231,899
Industry and Trade	3,084,000	1,591,500	2,936,943
Division Office - South West	2,048,707	2,048,707	2,842,258
Justice	2,550,000	2,510,000	2,680,638
State residences	721,888	100,000	2,520,000
Labour	2,143,968	2,143,968	2,500,000
Anti-Corruption Bureau	1,900,000	1,900,000	2,500,000

Source: Ministry of Finance

4.8 There is need therefore to bring all ministries and departments to an understanding that HIV and AIDS activities are essential and needs to institutionalised. The wide differences should be reduced and should only be related to the number of staff a ministry or department has. **Probably, NAC in collaboration with the Department responsible for HIV and AIDS in the Office of President and Cabinet should take the lead in developing relevant activities of ministries and departments in relation to their various needs given that there are differences in appreciation of the problem in the public service.**

5

Critical issues

5.1 This year's budget estimates for the health sector are more improved than any other in the recent past. The current year budget marks a very good beginning that, if followed, will lead to meaningful allocation of resources in the health sector. However, it does not help Government to be silent about its good intentions in the health sector as has been the case in the recent budget statements. The budget statements should be clear of the intentions laudable allocations are just an accident or due to donor pressure.

5.2 Although the budget estimates are clearly pro-poor and meant to improve the health status of the population, there is a long way before we achieve the aspirations of the people and global MGDs. However, if the current share of health allocation is maintained or increased, Malawi is likely to move forward, especially if there is serious intra-sectoral re-allocation of resources from central level to lower levels.

5.3 There are some problems though with health 'hardware'. Some commentators are of the view the health system is weak such that allocation more resources may not give the intended outcomes. They argue that that the first step is to revamp the entire system from community to national level; including addressing capacity problems at the technical level and poverty at community level. Along the same vein, it is argued that there is need for more health research and increased Government investment funding in health infrastructure as opposed to relying heavily on donor funding. Needless to say that the MGDS addresses the socio-economic status of the poor and that Government has been increasing the share of its funding of development projects. Probably what remains is to increase Government funding to of health investments and research activities to levels that will indicate ownership. What seems to be issues under weak health system include health system planning; investment development, deployment and motivation; drug procurement and distribution; and limited involvement of district assemblies and communities in health service delivery.

5.4 The fight against HIV and AIDS is heavily donor-driven. As long as there is donor support this is not a problem. However, it is important to start strategising on how Government can take on this fight under the revenue budget considering that donors can decide to pull out for various reasons. The country will not afford to do without resources for HIV and AIDS activities, especially ARTs. Thus although the number of HIV positive people on ARTs is low, its growth should go hand in hand with the growth in the support services like number of health workers and the possibility of donor withdrawal and therefore the need for Government to take over. Along the same lines, all ministries and departments should take HIV and AIDS activities as part and parcel of their annual activities in order to reduce the HIV prevalence, among others. They should seriously budget for HIV and AIDS activities under the revenue budget. NAC should take a leading role in orienting the public sector on the activities they can embark on to prevent HIV infection and mitigate the effects of HIV and AIDS among their staff. There should be some mandatory level of funding allocated to HIV and AIDS activities but for that to be effective, the implementation should be preceded by the orientation.

5.5 MHEN has a critical role to play to ensure that the current priority accorded to the health sector continues in the foreseeable future and that non-budget issues are also concurrently addressed to optimise the benefits from the increased budget allocation. Regarding the budget, MHEN should take the following as issues for itself and the National Assembly to discuss and deliberate.

(i) The executive has clearly prioritised the health sector. This is very laudable and it should clearly be applauded. MHEN should be in the forefront congratulating the Government on this.

(ii) The executive has shown signs of moving towards the right direction in terms addressing critical issues. The introduction of the Health SWAp and EHRP as well as the increased allocations to preventive health and infrastructure development are evidence of that. It should also be commended for this.

(iii) The allocation of the health budget still needs some re-alignment. The issue of retaining health personnel is being dealt in piecemeal. The EHRP was introduced in 2004 but other related issues like housing, training and other non-monetary incentives are yet to be introduced. Rather than this approach, it will help if the issue of the incentives for the health personnel was dealt with holistically.

(iv) The allocation of the budget within the health sector clearly ignores the fact that most of the health services required by the population are at area and district levels. The allocation to district hospitals is very far from ideal. It is important that allocation of resources be in tandem with health-related indicators including population.

(v) Although the allocation to preventive health services is increasing, this is at central level. The evidence shows declining immunisation rates. There is an urgent need to have this reversed because the gains achieved in child mortality rates could easily be reversed if immunisation is not stepped up. District hospitals should be given the necessary resources to step up the campaigns.

(vi) The high maternal mortality should drastically be reduced. Evidence shows that the number of deliveries attended to by skilled by increasing that number and improving health workers morale, which is currently because of heavy workloads and lack of materials, poor incentive system. Further, the short and medium term require the use of skilled and well equipped TBAs. TBAs should be given basic training and equipment like radios for referral cases. This should be done along side increased pre-service and in-service training of health workers and implementation of a holistic incentive package for health workers.

(vii) Drug availability at community level is critical for survival for the most dangerous diseases like malaria and diarrhoea. While pressing hard for drug availability at health centre and district hospital levels, it is important to step up the establishing of functioning drug revolving funds. These act as a first line of defence for the communities and can serve lives.

Table A1: Health Indicators used for constructing health indices									
	Proportion with	Proportion of birth assisted by			Poverty	HIV	OPD	Population	Pop
	Chronically ill	Professional *1/*	TBA 2/	others *3/*	Incidence	Prevalence	Utilisation	Per nurse	
Malawi	**8.9**	**58.0**	**20.7**	**21.3**	52.4	**14.4**	**99.0**	**3,240**	12,7
Chitipa	4.2	63.1	15.5	21.4	67.2	10.8	103.0	4,628	1
Nkhata Bay	0.8	83.7	16.3	0.0	63.0	10.8	106.0	4,005	1
Rumphi	2.3	76.3	4.8	18.9	61.6	10.8	127.0	2,796	1
Mzimba	3.8	62.8	19.0	18.2	50.6	5.2	78.0	5,387	6
Kasungu	8.8	39.3	31.0	29.7	44.9	4.1	72.0	9,252	6
Nkhotakota	5.4	74.1	12.1	13.8	48.0	10.8	140.0	3,624	2
Ntchisi	22.2	43.9	49.0	7.1	47.3	10.8	154.0	6,278	2
Dowa	12.4	44.4	33.2	22.4	36.6	10.8	87.0	5,107	4
Salima	7.6	52.0	11.7	36.3	57.3	8.9	119.0	4,959	3
Lilongwe Rural	11.9	50.5	34.7	14.8	37.5	11.5	79.0	15,532	1,1
Mchinji	6.0	42.3	33.0	24.7	59.6	10.8	80.0	5,460	4
Dedza	6.8	52.4	26.6	21.0	54.6	10.8	39.0	9,062	6
Ntcheu	18.0	55.4	10.2	34.4	51.6	10.8	94.0	5,227	4
Mangochi	15.8	50.1	13.3	36.6	60.7	20.8	209.0	5,626	7
Machinga	8.2	51.3	16.9	31.8	73.7	11.8	84.0	6,625	4
Zomba Rural	13.1	70.1	9.8	20.1	70.0	17.8	90.0	4,206	5
Zomba Municipality	15.2	93.5	2.2	4.3	28.7			200	1
Chiradzulu	3.0	62.6	16.9	20.5	63.5	10.8	36.0	3,140	2
Blantyre Rural	23.5	73.1	11.5	15.4	46.5	22.3	97.0	5,461	3
Mwanza	4.5	57.4	28.7	13.9	55.6	10.8	132.0	3,471	1
Thyolo	3.6	71.5	20.5	8.0	64.9	21	58.0	4,420	5
Mulanje	9.5	61.3	20.7	18.0	68.6	19.8	89.0	6,902	5
Phalombe	9.3	45.4	33.0	21.6	61.9	10.8	90.0	5,628	3

Chikwawa	3.2	56.5	15.1	28.4	65.8	10.8	137.0	4,045	4
Nsanje	8.8	62.0	6.0	32.0	76.0	10.8	149.0	2,691	2
Balaka	8.9	48.4	28.1	23.5	66.8	10.8	143.0	5,170	3
Sources:	IHS2	IHS2	IHS2	IHS2	MPVA	2004 MDHS	MHMIB 2002/2003	MHMIB 2002/2003	www.nso.ma