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Country report Malawi

Mind the funding gap: Who is paying the health workers?

ACHIEVING AN ADEQUATE, FAIR FUNDING LEVEL FOR A STRONG HEALTH WORKFORCE IN MALAWI

This document is part of Wemos' contribution to the health systems advocacy partnership

KIT Royal Tropical Institute

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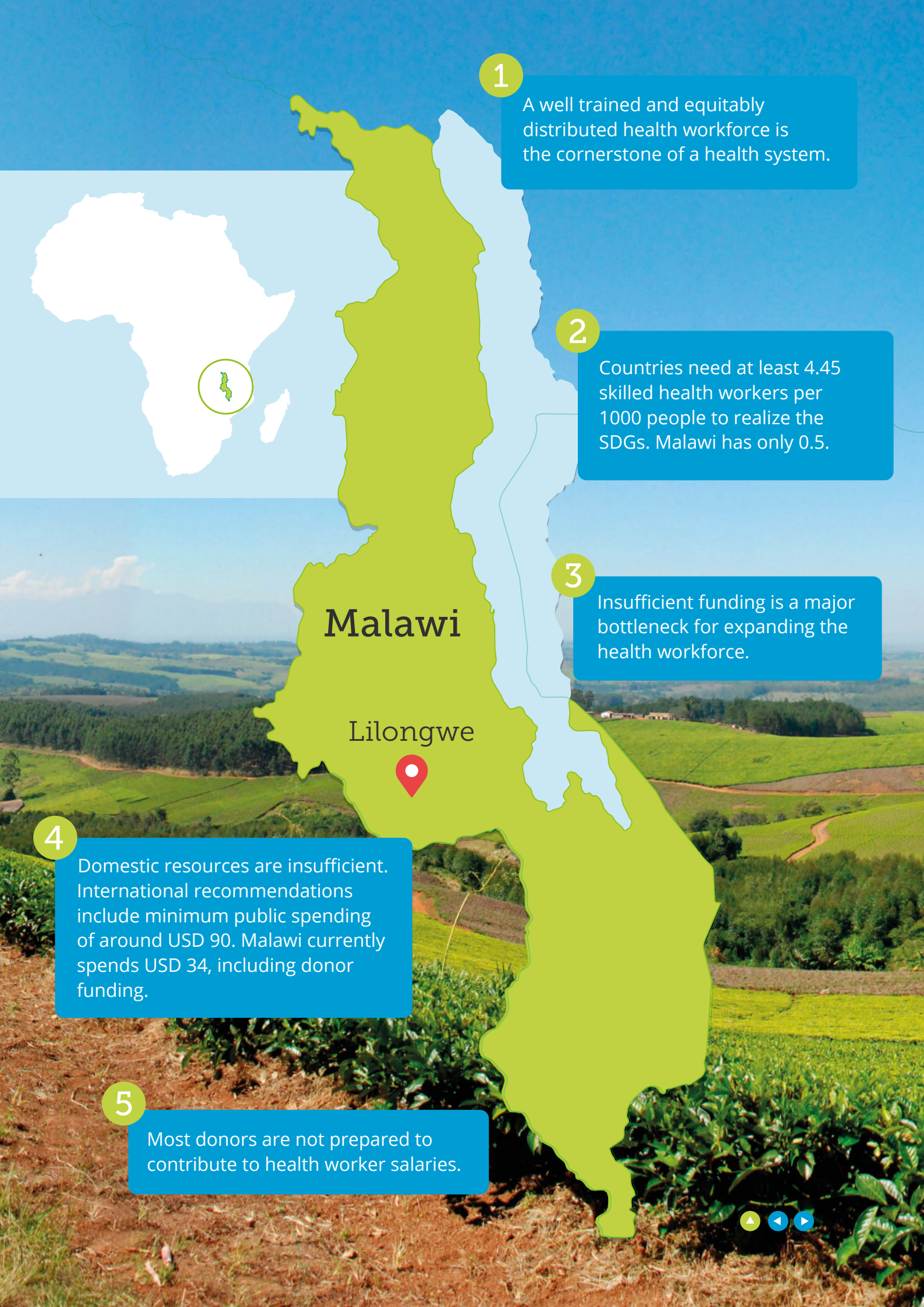
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Malawi
Lilongwe
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Executive summary

A health workforce that has enough well-trained and equitably distributed health workers is the cornerstone of any health system, and is essential to ensuring universal health coverage (UHC), improving population health and achieving the Sustainable Development Goals (SDGs). The World Health Organization (WHO) has estimated that a country needs at least 4.45 health workers per 1,000 people to realize UHC and the SDGs (see box 1). Malawi only has 0,5 health workers per 1,000 people which is far below this threshold.

The Government of Malawi and its Development Partners have made various investments and efforts to increase training and recruitment of health workers. Despite these efforts, the health sector in Malawi continues to experience a large shortage of health workers. This affects the ability of the health system to deliver essential health services, and undermines the quality of service. Inadequate training and poor retention – due to harsh working and living conditions – have contributed to the shortage of health workers in Malawi.

Insufficient funding has been identified as a major factor contributing to such inadequate training and poor retention rates and therefore this paper focuses on fiscal space for health workers, and highlights the challenges and suggests ways to tackle these challenges.

The *Global Strategy on Human Resources for Health: Workforce 2030*[i] and the recently developed *Malawi Human Resources for Health Strategic Plan (HRHSP) 2018-2022*[ii] identified low investment in the health workforce as one of the major factors contributing to the shortage of health workers in Malawi. Various stakeholder meetings and analyses of the Health Systems Advocacy Partnership identified insufficient funding as the main bottleneck for growing a strong health workforce in low- and middle-income countries. This paper presents a case for the need to increase financial resources for health workers in Malawi. It also addresses key messages to the various actors supporting human resources for health in the country.

We have conducted an extensive literature review, analyzed the core issues and consulted them with representatives from the government, the donor community and civil society in individual meetings and at a stakeholder meeting in Lilongwe on June 13, 2018.

Based on these consultations, we are calling on the government, development partners, international financial institutions and civil society to join forces and work towards the following:

1. a substantial increase in public spending for health to help finance health worker salaries, and that is made available without incurring further hardship on the poor;
2. ensuring the optimal use of existing and new resources in the health sector;
3. and creating a more conducive macroeconomic environment that prioritizes equity and recognizes the crucial importance of public investments in health and other human investments.

BOX 1

Sustainable Development Goal 3: 'Ensure healthy lives and promote wellbeing for all at all ages' is operationalized in 13 targets, including target 3.c. that calls for 'substantially increasing health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in the least developed countries'.

Introduction

A strong and effective health workforce is a critical input for achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs). The *Global Strategy on Human Resources for Health: Workforce 2030* emphasizes that health systems can only function well when they have a health workforce with sufficient numbers and that is equitably distributed - and which is competent, responsive, motivated and productive. However, the World Health Organization (WHO), together with ILO and the OECD, has calculated that by 2030, around 40 million new health and social care jobs need to be created to meet the world's health needs. A gap of 18 million health workers is expected, especially in low and middle-income countries (LMICs).[iii]

Several factors contribute to the global Human Resources for Health (HRH) shortages, including insufficient training and recruitment, increasing demands from a growing and aging world population and health workers migration. The *Global Strategy on HRH 2030* identifies **low investment in the health workforce as one of the key challenges** affecting HRH. The international community has made strong commitments (see box 2) for realizing the Global HRH 2030 strategy and the SDGs globally, including external support to those countries that cannot yet mobilize enough domestic resources.

BOX 2

International commitments to strengthen the Health Workforce

Recognizing the crucial importance of investing in the health workforce, several international commitments, action plans and strategies have been agreed over the past years. Much remains to be done, to translate these plans and commitments into action.

In 2010, the 193 members of the WHO adopted the *Global Code of Practice on International Recruitment of Health Personnel.*[v] The code is not binding and aims at raising awareness on the ethical aspects of active international recruitment. Every three years, WHO calls upon Member States to report on measures taken to implement the Code.

In 2016, WHO published the *Global Strategy on Human Resources for Health: Workforce 2030,* followed by a five-year action plan and including specific global milestones set for 2020 and 2030. The global strategy has been translated to the African context in *the African Regional Framework for the Implementation of the Global Strategy on Human Resources for Health*. This framework sets regional targets to be met by 2022.

Also in 2016, the report by the High-Level Commission on Health Employment and Economic Growth (UNHEEG) was published: Working for Health and Growth. Comprised of experts from the International Labour Organization (ILO), the Organization for Economic Cooperation and Development (OECD) and the WHO, the commission's report urges countries to invest in their health workforce. The report foresees a shortfall of 18 million health workers worldwide by 2030, primarily in LMIC. It stresses that the health sector is key to the economy.

Renewed international commitments were made at the 4th Global Forum on HRH in the 2017 *Dublin Declaration on Human Resources for Health: Building the Health Workforce of the Future.*

BOX 3

Health Systems Advocacy Partnership

The Health Systems Advocacy Partnership (HSAP) is a consortium of Wemos, African Centre of Global Health and Social Transformation (ACHEST), AMREF Health Africa, Health Action International (HAI), and the Dutch Ministry of Foreign Affairs. We work in Kenya, Uganda, Zambia, Tanzania, and Malawi on innovative practices that combine advocacy, research and civil society engagement. We want to strengthen health systems from the bottom up.

HEALTH SYSTEMS ADVOCACY PARTNERSHIP

HEALTHY SYSTEMS, HEALTHY PEOPLE

The main aim of the partnership is advocating sustainable and accessible health systems in Sub-Saharan Africa so that all people and communities can use the health services they need. We focus on essential high-quality sexual and reproductive health services. We analyze relevant (inter)national policies that affect health systems and assess the impact and implications of these policies. We translate findings from country case studies into effective evidence-based advocacy aimed at governments, international donors, relevant European and global institutions.

Malawi is one of those priority countries that need more health financing, including financing for strengthening HRH. In spite of government efforts and the involvement of numerous bilateral, multilateral and non-governmental actors, there is still a critical shortage of health workers in the public sector. **Malawi has only around 0.5[1] professional health workers per 1,000 inhabitants, approximately one ninth of what the WHO has calculated a country needs to realize Universal Health Coverage and the SDGs.**[iv] The Malawi HRH Strategic Plan 2018-2022 identifies inadequate and unsustainable funding as critical bottlenecks for HRH in the country. Domestic resources are not sufficient to provide good quality training for adequate numbers of health workers, and to recruit them. Health workers in the public sector are confronted with a lack of essential drugs, supplies, equipment and basic infrastructure. This leads to low productivity, frustration and a high number of health workers leaving the sector.

[1] Including medical officers, clinical officers, medical assistants, nursing officers and nurse midwife technicians and assistants, for comparison with the WHO threshold.

In light of the above, and following from knowledge gaps identified by the Health Systems Advocacy Partnership (see box 3), Wemos and Amami analyzed fiscal space for health workers in Malawi. We reviewed policies, plans and publications, conducted interviews and held discussions with relevant stakeholders. In this paper, we present our findings and the recommendations following from the discussions.

This paper starts with a description of the current gap between the numbers of health workers deployed and those that are needed. We compare the current number of health workers with domestic needs assessments and with international standards, and considered other critical issues around HRH as well as policy measures taken and lessons learned. The next section analyses resource availability and prospects for increasing fiscal space in the health budget for health workers. Solutions exist both inside and outside the health sector. We take some steps into the domains of taxation and macroeconomics and invite our health sector colleagues to join us in broadening our scope in searching for options to expand fiscal space for health and health workers. We conclude with key messages to various actors, indicating priority areas for action to ensure that UHC does not remain a distant dream for the people of Malawi.

NUMBERS, POLICIES AND PLANS

The health workforce gap in Malawi

Malawi has only 0.5[2] professional health workers per 1,000 inhabitants, whereas WHO has calculated that a country needs at least 4.45 professional health workers per 1,000 inhabitants to realize Universal Health Coverage and the Sustainable Development Goals.[vi]

The health workforce gap

According to the World Bank Workload Indicators of Staffing Need (WISN) study completed in 2017, there is an overall vacancy rate of 51 percent for all cadres. [vii] If Health Surveillance Assistants (HSAs), a Community Health Worker (CHW) cadre, are not considered, the overall vacancy rate is even higher, reaching 59 percent.[viii] The largest gap in absolute numbers is for nursing/midwifery officers, 'where an estimated 1,603 additional nursing/midwifery officers are required to meet current utilization of services, representing a gap of 62 percent between current staffing levels (990) and required staffing levels (2,593)'.[ii]

There has only been a minimal increase in the number of health workers over the last decade and the size of the health workforce has not been commensurate with population growth. **As a consequence, the ratio of professional health workers to the population has improved only very little or, for certain cadres, has deteriorated, as with the case for nurses and midwives (see table 1).** The 23 health professional training institutions in Malawi that offer training programmes for priority health cadres produced an average of 2,068 graduates per year from 2012 through 2017. These numbers are insufficient for meeting the demand for health workers or health care needs in Malawi. Furthermore, the recently developed HRH Strategic Plan also identified challenges with the quality of training due to the lack of infrastructure, training materials and highly-qualified lecturers and tutors, as well as with the coordination of training needs.

TABLE 1 Malawi health worker to population ratio 2009 and 2017

Cadre	2009 total	2017 total	2009 ratio* p/1000	2017 ratio* p/1000
Medical Officer	259	558	0,02	0,03
Clinical Officer	958	1306	0,07	0,08
Nurses and midwives	4,812	5437	0,37	0,31
Medical Assistant	925	1213	0,07	0,07
Health Surveillance Assistants	10,507	10,085	0,8	0,58

Population growth from 13 million (Household Census, 2008) to 17.4 million (Population Projection, NSO 2017). Source staffing numbers: EHRP Evaluation 2010 (2009 data), HRHSP 2018 – 2022.

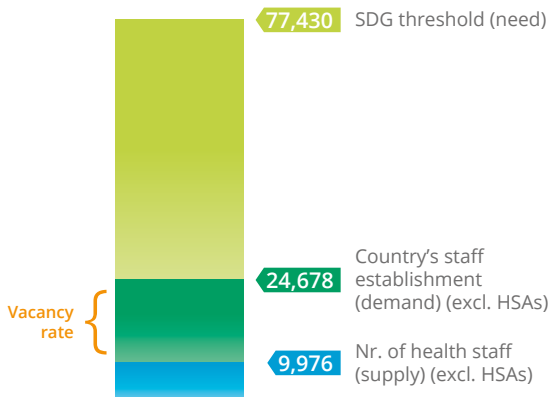
[2] Including only medical officers, clinical officers, medical assistants, nursing officers and nurse midwife technicians and assistants, for comparison with the WHO threshold.

Heavy duty

In the rural health clinic in the Mchinji district, two nurse midwife technicians, one community midwife and a medical assistant work on a heavy schedule, 24/7. Ines and Mary, the nurse midwife technicians, often work a whole week continuously, 24 hours a day with very little sleep. Their sleep deprivation is compensated by their energy and motivation. All four of them agreed on that, yet felt that they cannot do much to change the situation. 'I had a colleague, but then he left and was never replaced. That was four years ago; since then, I have not had any leave,' said Felix, the medical assistant. 'There is no improvement, there are only more people to care for now, so I guess it is actually worse than it used to be.'

It is important in this respect to make a distinction between the *demand, need* and *supply*. The *demand* for health workers refers to the number of established positions, i.e. the number of health workers that should be able to be employed with the available resources. The *need* for health workers refers to the number needed to realize UHC and the SDGs as estimated by WHO, i.e. 4.45 per 1,000 population. As figure 1 clearly shows, there is a large difference between *demand* and *need* for health workers in Malawi, indicating that resources are too scarce to create the number of positions required to fulfil health needs. Additionally, Figure 1 shows that *supply* (the number of employed health workers) is far below the number of available positions, which in turn is far below the number needed (the SDG threshold).

FIGURE 1
Health workforce numbers versus demand and needs



'Government is not keeping up with absorption of nurses and midwives, as today there are approximately 2000 trained but not working, representing three cohorts of the 14 nursing schools in Malawi and next month, another cohort is due'. **- Dorothy Ngoma, president of the National Organization of Nurses and Midwives of Malawi (interview by Wemos, October 2017)**

For several cadres, insufficient numbers of health workers are being trained. In addition, recruitment falls short. For example, several interviewees pointed to delays in the recruitment of graduated nurses and midwives, leading to large numbers of trained but unemployed health workers. The HRHSP also mentions the delays and problems in the hiring process, with absorption rates across all cadres being approximately 50 percent in 2015 and 2016.

Several stakeholders have reported that recruitment freeze "caps", created by the Ministry of Finance (MOF) in coordination with the International Monetary Fund (IMF), have halted new recruitments at several moments over the last years. Circulars ordering a freeze on all government recruitment are on record for the years 2013 and 2018. Although we could not identify a direct link between IMF programme conditions and these freezes, it should be noted that containment of the public sector wage bill is a recurring issue in IMF programme reviews in Malawi since early 2015. IMF programme documents do mention that "essential recruitments" are allowed, and an explicit exemption is made for recruiting

teachers, but they do not make explicit what is considered essential nor whether health workers are exempted as well. Nor is it clear whether the limitation on the public sector wage bill arises from concerns over fiscal sustainability only, or if concerns over inflationary pressure play a role too. To have an informed debate on the wage bill cap and its implications for health worker recruitment, and allow for meaningful civil society participation, more openness is necessary.

Looking at the vast numbers of health workers needed, government, international financial institutions and development partners should be doing everything possible to recruit more health workers, including being flexible on the wage bill ceiling.

Apart from the absolute shortages in the number of employed health workers, there are also concerns about uneven geographic distribution of health workers.[ix] [x] The current distribution of health workers is not correlated with the population size and healthcare needs in various areas throughout the country. For example, vacancy rates are up to five times higher in rural and peripheral areas than those in centrally located or urban areas. While 85 percent of the population lives in rural areas, only 29 percent of Malawi's nursing professionals deliver services there.[xi] Whereas most migration occurs from rural to urban areas, emigration of health workers outside of Malawi also plays a role. Although current numbers are not available, data from the early 2000s showed that almost 60 percent of the medical doctors born and trained in Malawi were working abroad. [xii] The risk of health workers emigrating will remain as long as working and living conditions in Malawi, particularly in rural areas, do not improve.

No ambulance

Gloria, from Mchinji district, has been trained as a community midwife, which involves a training of eighteen months in order to rapidly deploy staff for addressing the high maternal mortality and morbidity in Malawi. She explained: 'I do deliveries on my own; I do practically everything. I remember when I just worked here and one day I was alone on duty. There was a mother in labour. The umbilical cord came out first. The ambulance could not come, because there was no fuel. There was no staff around, and I simply had to wait. Finally the baby came out, dead. The family then came to take and bury the baby in their village.'

'A Mozambican mother came to deliver twins,' told Ines, the nurse midwife technician. 'She started bleeding, and the ambulance was somewhere else very far away; I was alone. Then I hired a motorcycle with my own money, which the family later paid back. The babies and the mother survived.'

Similar stories are plentiful. Her colleague, Mary, recounted her earlier experience in another district: 'Again there was no ambulance, and I was afraid the patient would die. She needed a Caesarean section, but the next hospital was 15 km away. Then we found someone who could take her on a motorbike. Finally it was fine.'

Future projections point towards a growing mismatch between supply and demand for health workers on a global scale.[xiii]

There are many factors which drive health workers in Malawi to go abroad.[3] Among the main factors are excessive workload pressure, poor remuneration, lack of promotion, lack of appreciation, lack of supplies and poor management.[xiv] [xv] Those who are employed face difficult living and working conditions. Finding adequate housing is a problem not only in rural areas but also in cities, where rents are often unaffordable. Consequently, policies addressing the health worker shortage have to go beyond increasing the numbers trained and deployed. Other investments related to these factors are also required.

Policies and interventions to address the HRH gap

The shortage of health workers is not a new problem. In 2004, the Government of Malawi raised the alarm stating that the HRH situation was in a crisis and "near collapse", and urgent action had to be taken. With a concerted effort by the Government and Development Partners, an Emergency Human Resources for Health Programme 2005-2009 was implemented, resulting in considerable improvements in numbers of health workers trained and deployed (see box 4).

Despite these efforts, opportunities were missed. The number of health workers increased, but broader management issues were not adequately addressed. These include investments needed to support the effective employment of staff, such as housing, timely and adequate drug supplies and hygiene at facilities. The evaluation of the EHRP

BOX 4

The Emergency Human Resources for Health Programme (2005 – 2009)

Between 2005 and 2009, the Government of Malawi and donors implemented the Emergency Human Resources Programme (EHRP). This programme was committed to providing adequate health workers that are properly trained and paid, well-motivated and capable of effectively delivering the Essential Health Package (EHP) to the Malawi population. Targets were set to address the critical health workforce shortage, to achieve a more equitable distribution of the workforce. Investments were made in health education institutions (i.e. training more health workers).

The main donors were DFID and the Global Fund to fight AIDS, TB and Malaria (GFATM). Further contributions came from the World Bank, NORAD, German Development Cooperation, UNFPA and UNICEF. For the GFATM, the shift towards supporting a long-term Human Resources Management programme was novel at the time.

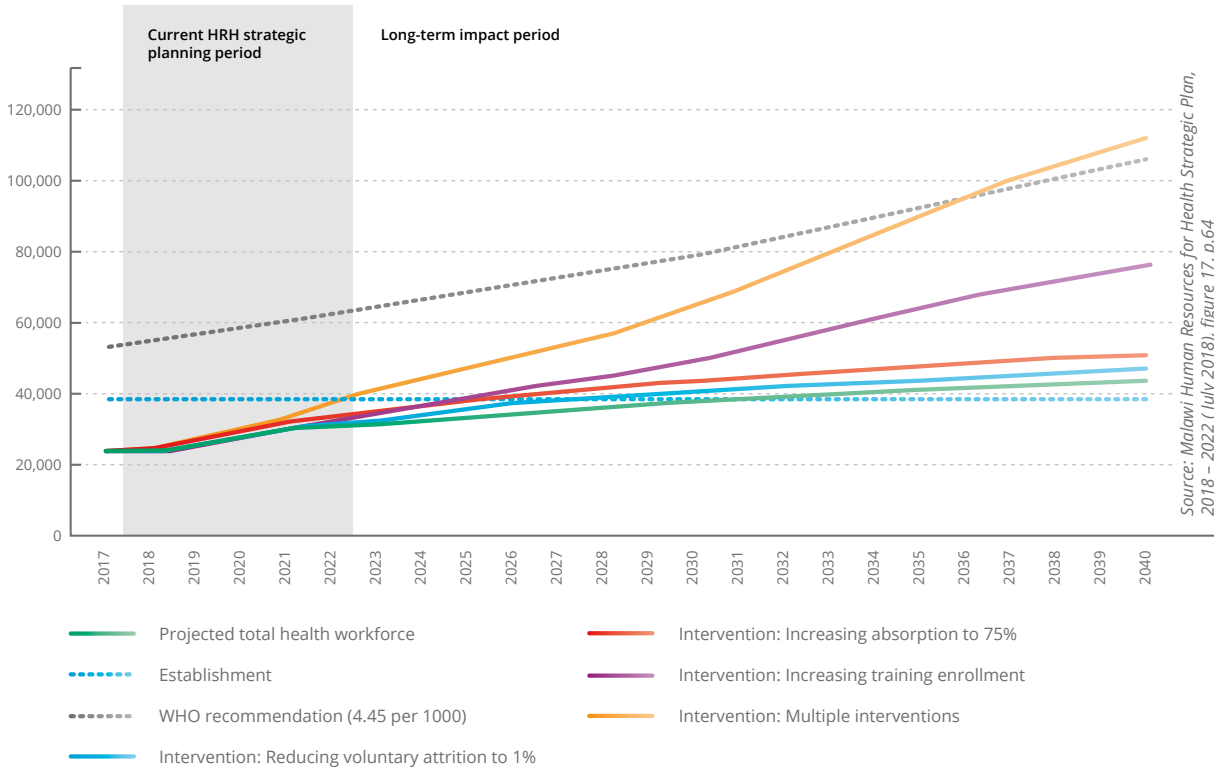
The EHRP brought about significant improvements, resulting in:

- an increase in the number of health workers for 11 priority cadres from 5,453 to 8,369 between 2004 and 2009,
- an improvement in the health worker/1,000 population ratio from 0.34 to 0.52 for core health workers,
- a doubling of training capacity,
- and a 52 percent salary top-up, providing a boost to health worker retention.

There is broad agreement among various stakeholders that the EHRP has been a positive step forward.

[3] Reliable data on attrition are not available according to the HRHSP, which estimates attrition at 7%, based on a multi-country analysis including Malawi.

FIGURE 2 Impact of intervention scenarios on size of workforce for all cadres through 2040



also noted that 'the gains are fragile due to the lack of a plan for sustainability, weak health systems, population growth and a continuing high burden of disease[xvi].' **The current situation proves that more comprehensive and sustainable actions are required to achieve lasting change.**

Malawi HRH strategic plan

The challenges facing the health sector and the HRH situation are well known in Malawi. Lessons from the past – including those from evaluating the EHRP – are duly taken into account in current health sector policies. For both the Health Sector Strategic Plan II 2017 – 2022 (HSSP II) and the Human Resources for Health Strategic Plan 2018 – 2022[xvii], extensive information collection has taken place. An HRH labour market analysis was undertaken, of which the results are forthcoming. The HSSP II and the HRHSP 2018-2022 adopt a comprehensive health systems approach, embedding strengthening of the health workforce into broader health sector strategies.

The HRHSP 2018-2022 depicts different scenarios and states that, 'holding all variables constant, Malawi will meet its current establishment levels in 2030, but is not projected to meet the WHO standards by 2040.' Without any interventions, by the end of the strategic planning period (2022), the health worker gap[xviii] would still be vast:

- a gap of 8,978 health workers between baseline projected and establishment (75 percent of positions filled);
- a gap of 33,643 health workers between baseline projected and WHO target (44 percent of the recommended workforce in place).

Daily challenges in the life of a health worker in Malawi

Imagine working at a health clinic and finding out that your only colleague has left and will not be replaced. Imagine, then, having to rely on your mobile telephone for light while attending a mother giving birth. Does this sound extreme? It is. It is also the reality of health workers in Malawi. It is the reality for health workers in public hospitals and health clinics, especially in rural areas where the situation is at its worst. Wemos visited health workers in Mchinji, a district bordering with Zambia and Mozambique, located a couple of hours to the west from the capital of Lilongwe. Their stories are disheartening.

Listen, a midwife working in the Mchinji District Hospital, oftentimes struggles with a lack of electricity for days on end. 'We are quite used to doing deliveries by candlelight', her co-workers confirm. Candles and mobile telephones are part of the essential equipment of public hospital staff in Mchinji. Surgeries and deliveries with light from the mobile telephones are not exceptional, as the hospital's only generator has limited capacity. There are frequent power cuts, and medicines and other supplies are often missing. The nurses sometimes even go to a private hospital to buy medicines with their own money, if needed.

Another challenge is the shortage of health workers. Agnes, a young nurse technician, recounted: 'One afternoon, there was no electricity at the neo-natal ward. I had to go look for the generator, and when I went back I found a completely silent baby. It took hours to stabilize the baby. In the meanwhile, nobody was taking care of the other babies. I sometimes have to leave the babies on their own with their mothers for days.' Greg, another nurse, illustrated the lack of time: 'I often only have time for admissions, not for providing care for the patients. People here are very shy in complaining. If they are in pain, they won't tell anyone. So you really need to observe them, but the time is simply not there.'

Asked what these committed health workers would change first if they could, the hospital nurses and midwives are unanimous: there should be more jobs, more trained staff put to work. 'While we are overworked, I know so many unemployed nurses who just sit at home,' sighed Agnes, the health worker in Mchinji. 'I wish they could get a job.'

Dr. Ann Phoya, President of the Association of Malawian Midwives (AMAMI), said: 'Donors have financed the education of large numbers of health workers, while at the same time international finance institutions have discouraged the government's investment in more jobs. As a result, the newly trained nurses and midwives cannot be absorbed in the health system. Our message to the government is: look at health as an investment, not as a burden.'

Four possible intervention scenarios are described and projected into the future:

1. Reducing voluntary attrition (people leaving their job) to 1 percent: the baseline scenario assumes total annual attrition of 7 percent, of which 3 percent is voluntary attrition. This intervention scenario reduces voluntary attrition – the type most likely to be influenced by policy – to 1 percent annually;
2. Increasing absorption of health workers to 75 percent: the baseline scenario assumes that 50 percent of graduates from Malawian training institutions are absorbed into the public sector or the Christian Health Association of Malawi (CHAM) facilities annually and the intervention targets an absorption of 75 percent beginning in 2018;
3. Doubling training enrolment: this intervention doubles the size of enrolling cohorts in all training programmes, except for HSAs, starting in 2020. By 2030, training enrolment would double again;
4. Multiple interventions: implementing all of the above.

As can be seen in figure 2, only in scenario 4 would Malawi approach the WHO target/SDG threshold of 4.45 health workers per 1,000 inhabitants. Exact calculations of the costs are not available yet. The HRHSP 2018-2022 includes provisional costing estimates, ranging from over USD 115 million in fiscal year 2017/18 to USD 149 million in fiscal year 2022/23. However, these are estimates and do not include detailed costing of health worker salaries and recruitment, incentive packages, salary top-ups, pre-service training, as these costs depend on decisions made on final targets. The HRHSP announces that detailed costing will be developed as part of annual operational planning and recommends that annual rigorous costing exercises should be done during the implementation of the Strategic Plan, 'to ensure that resource mobilization and advocacy are linked to clear financial gaps and targets'.[xix]

The next section will examine in greater detail levels of available resources and plans and options for increasing fiscal space for health, while paying special attention to the health workforce.

Expanding fiscal space for the health workforce...from where?

'Adjusting for population growth in 2022, Malawi will need to spend at least USD 775 million on health per year just to maintain the status quo, and about USD 2.8 billion per year to meet the SADC average, compared to the 2017 – 2018 health budget allocation of approximately USD 177 million.' **- The Malawi Growth and Development Strategy (MGDS) III (2017 – 2022)**

The above quote from the MGDS III indicates the enormous challenge Malawi faces when it comes to funding health care, to even maintain the status quo. Maintaining the status quo would leave Malawi far removed from achieving the SDGs. According to international experts and think tanks, the minimum average per capita public investment needed for providing primary health care in low- and middle income countries (LMICs) ranges between USD 86 and USD 112 per year.[xx] [xxi]

Recommendations on health spending are generally expressed in relative terms – as a percentage of the budget (e.g. the Abuja target, aiming at health expenditure of 15 percent of the budget), or of GDP – or as an absolute amount. The Chatham House Global Health Security Working Group on Health Financing proposes a combination of a relative target of 5 percent of GDP (which 'indicates a substantial yet feasible effort for LICs and MICs') with an absolute target of USD 86 per capita per year ('representing the minimum expenditure required to ensure priority services for everyone in the context of LICs. Most of these services fall in the category of comprehensive primary care services.').[xxii]

Figures 3a to 3c illustrate health spending per capita and as a percentage of the budget and GDP for Malawi and other countries in the region.[xxiii] Two things stand out from these figures: 1) Malawi is far below the level of required health spending to provide priority services for everyone; and 2)

FIGURE 3A
Total expenditure per capita per year (by source in USD)

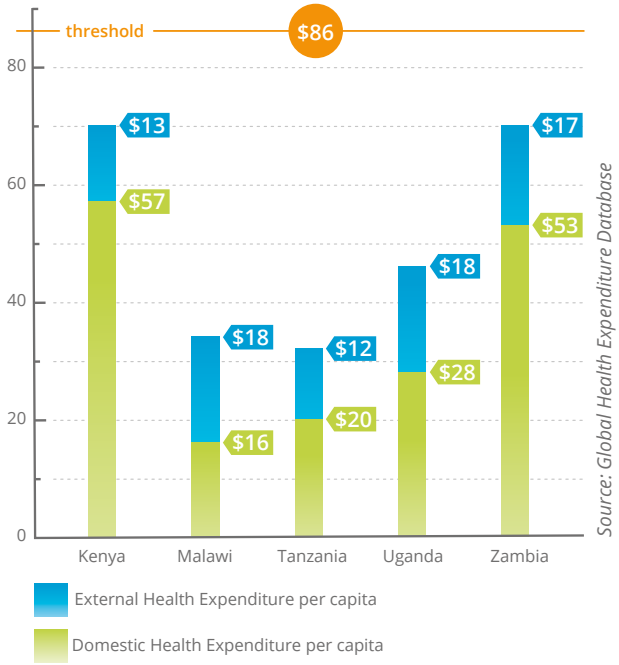


FIGURE 3B
Domestic General Government Health Expenditure as % of General Government Expenditure

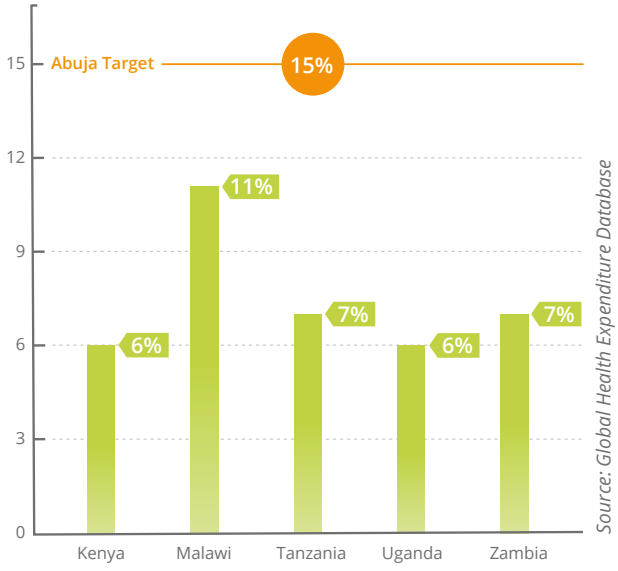
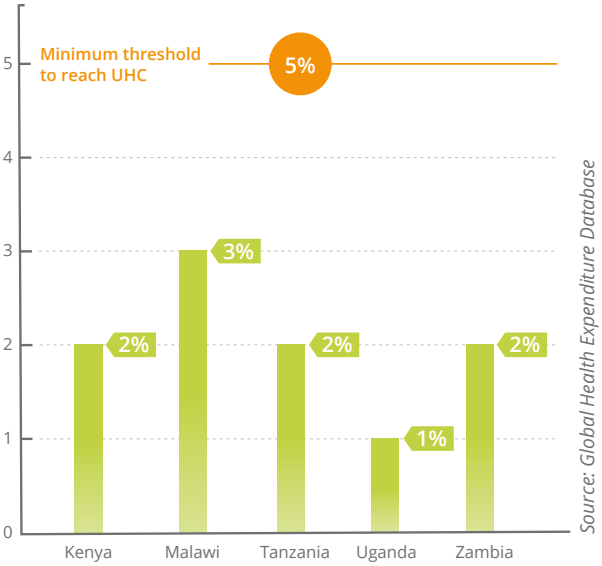


FIGURE 3C
Domestic General Government Health Expenditure as % of Gross Domestic Product



although not reaching the relative targets, Malawi does prioritize health (in relation to the budget and to GDP) more than other countries in the region.

With a population of 17.4 million (2017)[4], spending USD 86 per capita would translate into an amount of USD 1.5 billion, for primary care only. If Malawi would allocate 5 percent of its GDP to health, as is recommended internationally, that would amount to USD 315 million or approximately USD 18 per capita in 2017.

The HSSPII foresees a much smaller funding gap for the health sector, ranging from about USD 89 million in 2018/19 to USD 117 million in 2021/22, based on projections from the round 4 Resource Mapping exercise[5] and HSSP cost estimates of USD 30 per capita. This is in stark contrast with the funding gap based on the international recommendations on minimum per capita spending required to provide a basic package of health services.

With a view to improving equity as well as realistic planning within the available resource envelope, the HSSPII presents a revised Essential Health Package (EHP). As stated in the HSSP II, by being financially unaffordable, the previous EHP was in practice inequitable '...because failure to fully fund it has meant varying degrees of coverage for different interventions by level of health care system and geographic location.' In revising the EHP, the Government of Malawi acknowledges the importance of equity and prioritizing disadvantaged groups, even with limited resources.

It is crucial to move towards more equitable spending even within the limited resources available. **However, this more realistic planning should not result in lower ambition levels because there is no doubt that the realistic scenario will not bring Malawi close to achieving UHC and the SDGs.** The targets for per capita spending set in the HSSP II (being USD 43, USD 45 and USD 47 respectively, for the year 2018, 2020 and 2022, departing from a baseline of USD 39 in 2015 as per the National Health Accounts) are all very far below international recommendations.

[4] National Statistical Office in 2016 Population Projections, taken from HSSP II, p.1.

[5] The Ministry of Health undertakes an annual Resource Mapping (RM) exercise to track health sector resources and to inform planning and budgeting decisions both for the MoH and its development partners.

BOX 5

Investing in health pays off

Investing in health and in health workers is one of the best investments in human capital that a country can make. Malawi has seen considerable improvements in a number of health outcomes over the past 15 years, meeting four out of eight Millennium Development Goals. But, on the other hand, missing out on the other four, including maternal health and gender equity, and having a long way to go towards meeting Sustainable Development Goal 3 targets (see table 2).

The improvements achieved between the year 2000 and 2015, coincide with stark increases in health spending (as can be seen in figure 4), mostly from external funding but also from increased domestic budget allocations. The often-used argument against increasing foreign health financing – that it would lead to reduced domestic allocations to the health sector (also referred to as fungibility) – doesn't seem to apply in the case of Malawi.

TABLE 2 Health outcome indicators: progress and challenges

	2000	2015	HSSP II target 2022	SDG 3 targets 2030
Infant mortality rate (neonatal mortality rate)	103.5 (--)	42 (27)	- (22)	- (12)
Under 5 mortality rate	189	85		25
Maternal mortality rate	1120	439	350	70
Total fertility rate	6.3	4.4	3.0	Universal access to sexual and reproductive health-care services
Births attended by skilled staff	54.2	87.4	95	

Expanding fiscal space from domestic resources?

In recent years, the need to finance health care from domestic resources has been emphasized. This is understandable from the viewpoint of becoming independent from donor funding. This type of funding is often volatile, unpredictable and fragmented (see also below). But with a GDP per capita of USD 327 (2017 estimate) [xxiv] , even sharp prioritization of health spending relative to GDP and in the national budget does not result in an absolute amount sufficient to realize the health SDG in Malawi.

Still, some progress can be made in terms of expanding domestic resources and improving spending. The Global Strategy on HRH 2030 estimates that about 20-40 percent of health spending is wasted as a result of health workforce inefficiencies, weaknesses in governance and lack of oversight, among other factors. The extent of wastage of resources is estimated to be worse in resource poor countries such as Malawi. A fiscal space for health analysis done by the World Bank in 2017, calculated that efficiency gains can be made in the health sector, adding up to an additional USD 10 per capita. This is obviously important, and efforts must be made to spend available resources as efficiently – and equitably – as possible. The MOH affirms that efficiency will remain the hallmark in health workforce planning, management and development for the health sector in Malawi (through the HRH strategic plan, 2018-2022.) However, it is important to bear in mind that the efforts and resources required to bring down inefficiencies can be substantial.

TABLE 3 Trends in health spending from domestic and external sources

Indicators	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Domestic Government Health Expenditure as % General Government Expenditure	6	6	4	8	5	7	7	6	9	9	11
Domestic General Government Health Expenditure (GGHE-D) per Capita in USD	4	4	3	7	6	7	8	5	7	8	10
External Health Expenditure per Capita in USD	11	13	16	18	22	21	25	22	26	22	18
External Health Expenditure (EXT) as % of Current Health Expenditure (CHE)	62	63	65	57	62	63	64	71	68	63	54
External Health Expenditure Channelled through Government as % of External Health Expenditure	49	48	55	64	72	54	50	41	50	40	31

Source: global health expenditure database.

The per capita health expenditure targets in the HSSP II refer to total health expenditure, meaning that they include household out of pocket spending (OOP). **Out of pocket spending is one of the most regressive, inequitable, ways of health financing. This is recognized in the HSSP II objective to reduce the contribution of OOPs to health spending from 10.9 percent (2015) to 7 percent in 2022. This is an important objective to maintain, and for civil society to be vigilant about (see Oxfam et al[xxv]), in view of government plans** to expand the number of fee-paying wards in district hospitals and the statement in the Malawi Growth and Development Strategy aiming at expanding user fees[6].

Prospects for expanding the tax base or for establishing a national health insurance fund are limited, at least in the short to medium term, because of a large informal sector, low wages in the formal sector and limited government capacity[xxvi] . However, with a view to the future, we call on the Government of Malawi and development partners to continue paving the way towards increasing the tax base with commensurate increases for public health funding and/or setting up mandatory prepaid funding mechanisms for sustainable and equitable funding of the health sector. Voluntary prepayment mechanisms, such as community-based health insurance schemes, may provide small-scale solutions in some cases. But evidence shows that mandatory prepayment or government funding is critical for moving towards UHC[xxvii] .

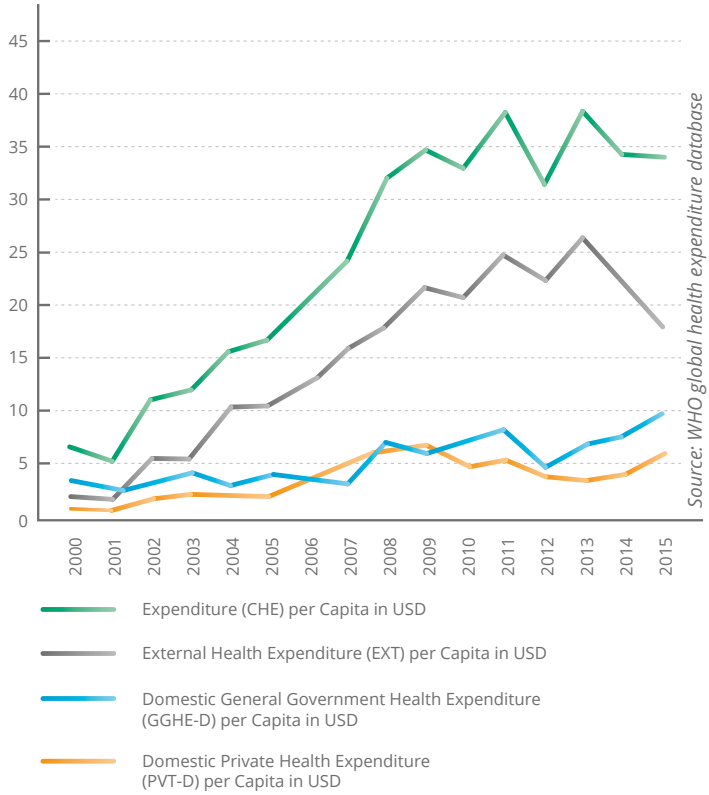
The picture that emerges from the current context is one of a gradual increase in prioritization of the health sector in the national budget. But there is a remaining gap that is too large to be filled by only domestic resources.

Increasing Development Assistance for Health (DAH)

One factor which could play an important role in addressing the budget shortfall is an increase in overseas development assistance (ODA), particularly for the health sector. External funding for health in Malawi has decreased in both absolute and relative terms, yet it still accounted for 73 percent of total resources available for health in fiscal year 2015/16. **This makes Malawi one of the**

[6] *The Malawi Growth and Development Strategy (MGDS) III (2017 – 2022), p. 49.*

FIGURE 4
Health Expenditure Over Time in US Dollars Per Capita



most aid-dependent countries in the world, and its health financing system is highly vulnerable to external decisions. The volatility and sharp cuts in external funding, as well as the decrease in the share of funding channelled through the government, are clearly shown in figure 4 and in table 3.

Challenges with regard to donor funding are well-known, and many international commitments have been made to improve aid effectiveness, including the alignment, harmonization and predictability of aid. But progress has been slow. In Malawi, most donor funding for health is earmarked and off-budget. External funding in the health sector originates from 170 different external donors or organizations, and 61 percent is for disease-specific programmes, placing a heavy burden on the planning and coordination capacity of the government.[xxviii] This presents a significant challenge when it comes to supporting the health workforce.

After the sudden donor withdrawals following "cash gate" in 2013[7], several donors resumed funding to the health sector via off-budget funding and supporting NGOs. Concerns over the accountability of government financial systems persist, along with challenges related to absorptive capacity. Two years ago, again a large cut in donor funding took place, as the GFATM, USAID and DFID reduced their combined support by USD 52.5 million from fiscal year 2014/15 to 2015/16.[xxix]

Despite efforts to expand domestic resource mobilization, DAH is essential and donor dependence will continue to be high in the short to medium term. **Therefore, initiatives to improve coordination and to provide health system support – including support for health workers salaries – should be scaled up urgently.** Recent efforts to do so, e.g. with bridge funding paying for health worker salaries from the Global Fund and PEPFAR/HRH 2030, have also revealed the limitations to effectively absorbing donor funding. There can be many reasons behind the limited absorptive capacity, and they may include capacity or procedural constraints within the government as well as on the part of development partners. A task force has been formed within the Technical Working Group (TWG) on health financing to analyze and address absorptive capacity constraints.

In December 2015, the Ministry of Health, UK DFID, Norway, Germany and Flanders set up a Health Services Joint Fund (HSJF) in order to pool and improve coordination of donor resources with the ultimate goal of moving back to on-budget funding. This fund pools donor contributions and aligns these with priority budget lines in the MOH, but funds are not channeled through government systems. Instead, they are channeled through commercial banks and a strict fiduciary and procurement oversight mechanism is put in place

[7] At the end of 2013, a large corruption scandal was uncovered, involving civil servants and senior cabinet members. More than USD 45 million had disappeared in the preceding 18 months and in subsequent audits covering the period 2009 to 2014, an amount of USD 356 million could not be accounted for. Subsequently, donor aid was suspended worth USD 150 million per year.

to prevent misuse. Despite this active oversight, the round 4 resource mapping exercise showed that only a small part of external funding for the health sector (6.6 percent) was channeled through the HSJF.

Although use of the HSJF remains limited, alignment of donors to HRH policies and plans appears to be improving with the new HRHSP. The MOH, by taking a more active role than in the past in bringing together various stakeholders in the process, has played a crucial role in facilitating donor coordination and alignment. Donors are actively involved and several provide extensive support to the process.

External support for health worker salaries

Unlike most other donors, GFATM and the US Government (via HRH 2030) support recruitment and temporary funding of health care worker salaries in Malawi. Although these initiatives are not without challenges, they provide valuable lessons and **we call upon other donors to learn from these and past initiatives and make more resources available for funding not only health worker training but health worker salaries in a sustainable manner.**

The GFATM announced support for recruiting 1,222 health care workers using grant savings of USD 8.8 million in 2016, and an additional 800 nurses in 2018. Funding for their salaries is guaranteed for three years. After that, the Government of Malawi has committed to take over the funding. However, there has been resistance from within the Ministry of Finance who is hesitant to take on the long term financial commitments, given the current levels of fiscal space available to the government. Health workers supported by GFATM are employed and deployed by the Ministry of Health through the Health Service Commission. These health workers are on government payroll and their salaries come from GFATM funds. There have been delays in the recruitment process, leading to frustrations at both the Government of Malawi and the development partners and eventually even to a loss of part of the funds.

PEPFAR recruitment is managed by HRH 2030 and its focus has mainly been to recruit health workers (including nurse midwife technicians, medical assistants, laboratory assistants, and pharmacy assistants) in high HIV burden sites. In 2017, PEPFAR recruited 462 health care workers on a three-year contract and has recruited an additional 480 health care workers in 2018 on a one-year contract with the prospect for renewal for another year. PEPFAR supported health workers are recruited as project staff. Recruitment and deployment are done following the MoH's job descriptions and salary scales, but the health workers are not on the government payroll. The government has expressed its commitment to absorb these health workers onto the MoH payroll as well after 2019, but funding to do so is not guaranteed. And unlike those recruited with GFATM funding, these health workers will have to go through the MoH recruitment process once their contracts end.

These initiatives exhibit a flexibility that should be applauded, whilst taking lessons from these experiences to ensure greater sustainability for salaries. The two cases are different in nature – in terms of recruitment and funding procedures – each carrying different risks and implications for sustainability. As illustrated in the HRHSP, donors make considerable investments in training, but many of the health workers trained could not be employed. A presentation at the HRH Technical Working Group in 2017 showed that, of the 951 health workers graduated in 2016 with donor scholarships, only 67 had been deployed.[xxx] **To ensure optimal use of resources, investments in training must go hand in hand with investments in salaries.**

All actors are responsible to see that these lessons are taken into account in existing external funding as well as in new initiatives. One of those new initiatives is the Global Financing Facility (GFF, see also box 6) which has recently started preparations in Malawi to provide support for reproductive, maternal, neonatal, adolescents and child health and nutrition (RMNACH-N). The GFF states that it is committed to mobilizing additional domestic

BOX 6

The Global Financing Facility

The Global Financing Facility (GFF) in support of Every Woman, Every Child is a health financing partnership managed by the World Bank Group, launched in 2015. GFF facilitates the mobilization of finances for countries' plans – called investment cases – for reproductive, maternal, neonatal, child & adolescent health and nutrition (RMNCAH-N), alongside general health system strengthening and health related sustainable development goals like UHC. It aims at mobilization of additional domestic and external finance and at better pooling of external financial resources: it starts from the country's own finance for the investment case for health and explicitly involves the ministers of finance and health, in order to prevent fungibility.

The external financing consists of an International Development Association (IDA) loan, supplemented by a grant from the GFF multi-donor trust fund and other funds. The GFF has emphasized that countries are in the lead and that the investment cases should be country-led and aligned with the country's health plans.

Malawi joined the GFF in November 2017 and the Government of Malawi, through the MOH, is currently leading the GFF process. The official launch was done and a Multi-Stakeholder Country Platform has been convened, bringing together a range of stakeholders in RMNCAH-N, to develop the investment case.

and external finance, achieving better pooling of resources, and making investments in priority needs of the health system and doing these things in line with country plans and priorities. However, there are some concerns because the GFF funding model is partly built on loans, hence could possibly jeopardize future sustainability. Additionally, case studies in other countries (Uganda, Tanzania and Kenya) have demonstrated limited flexibility towards funding salary costs.

Exploring a more conducive macroeconomic environment

In the search for more fiscal space for health and health workers, it is essential to look beyond the boundaries of the health sector and beyond national boundaries. Because, in the end, it is often the Ministry of Finance – in a context of national and international economic and financial developments – that decides on the resource envelope for public expenditure.

Overall, Malawi's economic situation is not favourable for substantially increasing public spending, including for health. Heavy dependence on agriculture, several years of drought and continuing high population growth, make it impossible to substantially increase domestic resource mobilization in the short to medium term. Development strategies take time to implement and even more so to show results. In the meantime, external support will remain essential to meeting health sector financing needs.

That does not make it any less relevant to start working on more sustainable and equitable sources for public spending, including on health. Whereas Malawi's tax base is very small, with a large informal sector and low wages in the formal sector, gains can be made in taxing transnational corporations. Estimates from the United Nations University and the IMF indicate that Malawi may lose as much as USD 100 million each year from legal tax avoidance by multinational companies.[xxxi] In the case of the Palladium mining company – uncovered by ActionAid in 2015 – the

losses amounted to USD 43 million over a six-year period.[xxxii] There is also the problem of illegal tax evasion. Steps to tackle both problems could help to build the domestic tax base.

A potentially positive development in this regard is the tax reform foreseen in the most recent Extended Credit Facility (ECF)[xxxiii] signed with the IMF, for the period 2018 – 2021, including repealing the industrial rebate scheme and discontinuing the granting of tax holidays. However, the programme with the IMF may also have negative consequences for poorer households, as it plans to shift taxation to consumption and to undo the tax exemption on cooking oil. The government – with support of the IMF – might better focus attention on tackling tax avoidance and tax evasion. **The gains that could be made by strengthening government capacity to tax, and by improving international collaboration to properly address tax avoidance and evasion, could result in significant additional resources.**

In its programme with the IMF, Malawi furthermore commits to further reducing the budget deficit, including through limiting 'non-essential recruitments'. Whereas explicit exemption is mentioned to hire teachers and of the need to strengthen access to and quality of education and health services, hiring additional health workers was not mentioned. **There is no transparency around the issue of wage-bill caps, recruitment freezes and their implications for the health workforce. Unless civil society is better informed on the exact limitations and the underlying reasoning for limiting the wage bill, an informed debate on the issue is not possible.**

Spending on health and education is projected to increase very little under the new ECF: 0.4 percent of GDP over the programme period. With current GDP[8], that would amount to USD 25.2 million over the three-year period, or USD 8.4 million on an annual basis. Compared to the funding gap described above, such an amount will do very little in bringing Malawi closer to achieving the SDGs. Recognizing the importance of macroeconomic stability, in light of the enormous resource constraints, we call on the government and the IMF to explore options that allow for higher public spending on health and education, as these constitute crucial investments in future growth and well-being.

[8] Estimated at USD 6.3 billion in 2017 https://data.worldbank.org/country/malawi accessed on July 5th, 2018.

Key Messages

The magnitude of the challenges faced by Malawi to realize UHC and get sufficient numbers of health workers in place to do the job is enormous. The main issues are recruiting and retaining health workers, as identified by many stakeholders. These challenges must be addressed urgently, and substantive new investments in salaries will be needed.

Based on our analysis and debates with representatives from civil society, the donor community and government, we as CSOs, call on all actors to join forces and work towards:

- achieving an **increase in public spending for health** that is sufficient to realize UHC and the SDGs, including a health care package consistent with international recommendations, and to reach the WHO threshold of 4.45 health workers per 1,000 population. And to raise these resources in an equitable, pro-poor manner;

- ensuring **optimal use of available and new resources** in the health sector;

- creating **a more conducive macroeconomic environment** that prioritizes equity, places due emphasis on taxation and tax justice and recognizes the crucial importance of public investments in health and other human investments.

Government, CSOs and the international community can each make important contributions to these objectives and will need to identify new synergies for making progress. We call upon:

The **Government of Malawi (GoM)**, to

- increase its allocation to health to 15 percent of the national budget by 2022 at the latest, as is also indicated in the HSSP II, and to maintain the 52 percent salary top-up for health workers, making it an integral part of salaries;
- raise these funds in an equitable manner, reducing out-of-pocket payments, abolishing user fees – including fee paying wards in public hospitals – and avoid regressive forms of taxation such as consumption taxes that disproportionately impact the poorest;
- strengthen and institutionalize sound financial management systems to instill donor confidence and avoid the repeat of cash gate;
- improve spending efficiency, avoid duplication of procedures and make it possible to fast-track recruitment in view of the urgency of the need to strengthen the health workforce;
- analyze and properly address issues that hinder effective and timely absorption of funds;
- demand support from the international community and the IMF to increase tax justice (including progressive taxation, repealing industrial rebates and ending tax holidays), collaborate with progressive international actors (including governments, multilateral organizations and civil society) to put an end to tax avoidance and evasion;
- ensure that the GFF investment case is aligned with the HSSP II and the HRHSP, is properly informed on the resource gap and that the opportunity is used to improve coordination and mobilize additional resources (not loans impairing future sustainability) for health systems strengthening, including for health worker salaries.

The International Development Partners to

- increase their contribution to the health sector in Malawi to ensure a minimum per capita spending that is needed to provide basic primary care to all Malawians (with estimates varying between USD 86 – USD 112 per capita per year) in a sustainable manner until a point when Malawi is capable of mobilizing sufficient resources domestically;
- continue and expand support for health worker recruitment and salaries, including learning lessons from the EHRP, taking a comprehensive approach and investing in improving work and living conditions (such as availability of essential drugs and equipment, accommodation);

- following the model used by GFATM with recruitment taking place through the Ministry of Health and staff becoming public servants on the government payroll;
- return to pooling of resources following a Sector Wide Approach in the health sector – increasing use of the Health Services Joint Fund – and implement aid effectiveness commitments, by aligning support to the HSSP II and the HRHSP and harmonizing procedures;
- analyze and properly address issues that hinder effective and timely absorption of funds.

The **International Monetary Fund** to

- acknowledge the fact that the increase in health and education spending as foreseen in the Extended Credit Facility 2018 – 2022 is far below what Malawi needs to realize the SDGs, and support the government in exploring options to increase public spending on health (from donor funding, progressive taxation, easing targets on monetary and/or fiscal policy), without jeopardizing macroeconomic stability.

Civil Society to

- advocate for prompt implementation of the Human Resources for Health Strategic Plan and the elaboration of annual costed implementation plans so that the financial gaps become clearer, and resource mobilization can take place;
- advocate for resources to be made available to fully implement the HRHSP, including its scenario for reaching the WHO SDG target for health worker to population ratio of no less than 4.45 per 1,000;
- strengthen, coordinate and collaborate on the analysis and expenditure tracking of external grants and public health budgets at the central and district levels, through the costed district implementation plans;
- increase economic literacy and collaborate with organizations and networks working on economic policies and tax justice.

List of Acronyms

ACHEST	African Centre for Global Health and Social Transformation
AMREF	African Medical and Research Foundation
CHAI	Clinton Health Access Initiative
CHAM	Christian Health Association of Malawi
CSO	Civil Society Organization
DAH	Development Assistance for Health
DFID	Department for International Development
DHRMD	Directorate of Human Resources Management and Development
EHP	Essential Health Package
EHRP	Emergency Human Resource Programme
HRHSP	Human Resources for Health Strategic Plan
HAI	Health Action International
HRH	Human Resources for Health
HSAs	Health Surveillance Assistants
HSAP	Health Systems Advocacy Partnership
HSJF	Health Services Joint Fund
HSSP	Health Sector Strategic Plan
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, TB and Malaria
GFF	Global Financing Facility
IDA	International Development Association
ILO	International Labour Organization
IMF	International Monetary Fund
MDGs	Millennium Development Goals
MEHN	Malawi Health Equity Network
MEJN	Malawi Economic Justice Network
MGDS	Malawi Growth and Development Strategy
MK	Malawi Kwacha
MOH	Ministry of Health and Population
MOF	Ministry of Finance
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organization
NOMN	National Organization of Nurses and Midwives of Malawi
NORAD	Norwegian Agency for Development Cooperation
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
OPC	Office of the President and Cabinet
PEPFAR	President's Emergency Plan for AIDS Relief
RMNACH-N	Reproductive, Maternal, Neonatal, Adolescents and Child Health and Nutrition
SDG	Sustainable Development Goal
TWG	Technical Working Group
USD	United States Dollar
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNHEEG	United Nations High-Level Commission on Health Employment and Economic Growth
WISN	Workload Indicators of Staffing Need
WHO	World Health Organization

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Colophon

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