GOVERNMENT
OF MALAWI
MINISTRY OF
HEALTH

MALAWI NATIONAL HEALTH ACCOUNTS (NHA) 2002-2004 WITH SUB-ACCOUNTS FOR HIV AND AIDS, REPRODUCTIVE AND CHILD HEALTH

World Health
Organization

Recommended Citation: Ministry of Health. March 2007 Malawi National Health Accounts (NHA) 2002-2004 with Subaccounts for HIV and AIDS, Reproductive and Child Health, Department of Health Planning & Policy Development, Lilongwe, Malawi.

Abt Associates Inc. | 4800 Montgomery Lane, Suite 600 |
Bethesda, Maryland 20814 | Tel: 301/347-5000 | Fax: 301/652-3916
| www.phrplus.org | www.abtassoc.com

In collaboration with:
Development Associates, Inc. ■ Emory University Rollins School of Public Health ■ Philoxenia International Travel, Inc. ■ PATH ■ Social Sectors Development Strategies, Inc. ■ Training Resources Group ■ Tulane University School of Public Health and Tropical Medicine ■ University Research Co., LLC.

CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

National Health Accounts (NHA) is an internationally accepted framework designed to give a comprehensive description of resource flows in a health system, showing where funds come from and how they are used. The Malawi Government and its partners have recognized the importance of documenting the overall flow of health funds as well as those associated with HIV and AIDS, reproductive health and child health. This NHA report aims to document the magnitude, flows and uses of public, private and donor funds in Malawi for overall health care and, specifically, for HIV and AIDS, reproductive health and child health services for financial years 2002/03, 2003/04 and 2004/05. The key findings show that total expenditure on health rose from MK14.61 billion (US$164.4 million) in 2002/03 to MK26.21 billion (US$240.6 million) in 2004/05 representing per capita health expenditures of US$15 and US$20 per annum respectively – far less than the US$34 per capita per annum that the World Health Organization's Commission on Macroeconomics and Health recommended in 2001 for delivering basic essential health care interventions in developing countries but close to the estimated cost of the Malawi Essential Health Package of US$22 per capita per annum.

Total health expenditure a as percentage of gross domestic product increased from 9% in 2002/03 to 12.8% in 2004/05 – the highest in the Southern Africa Development Community. Government expenditure on health as a percentage of total government expenditure was 9.1% in 2002/03, fell to 7.1% in 2003/04 and rose again to 9.3% in 2004/05, well below the Abuja Target of 15%. Donors were the major source of financing for health care services and goods, contributing an average of 56%; second was the public sector, at 28%, and third the private sector, at 16%. HIV/AIDS, reproductive health and child health sub-accounts found the same pattern of financing percentages (donor, followed by public sector and private sector).

Curative health care services and goods consumed the largest amount (an average of 50% during the three financial years studied) of total spending on health, followed by prevention and public health care services and goods at an average of 27%. These overall amounts mask the distribution of expenditure by sub-sector such as the Ministry of Health, which made on average 78% of its total health expenditures on curative health care services and only 6% on prevention and public health. The same breakdown – donors funding prevention and public health programmes and the government funding curative health care services – was also seen for HIV and AIDS (except antiretroviral drugs), and reproductive and child health services and goods.

ACRONYMS

ARV	Antiretroviral
BCC	Behaviour Change and Communication
CBO	Community-based Organization
CH	Child Health
CHAM	Christian Health Association of Malawi
CIDA	Canadian International Development Agency
CMH	Commission for Macroeconomics and Health
DfID	Department for International Development
DHS	Demographic and Health Survey
DIP	District Implementation Plan
EHP	Essential Health Package
EPI	Expanded Programme on Immunization
GDP	Gross Domestic Product
HIV	Human immunodeficiency virus
HMIS	Health Management Information System
IDASA	International and Institute for Democracy in South Africa
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
MASM	Medical Aid Society of Malawi
MDG	Millennium Development Goal
MEJN	Malawi Economic Justice Network
MK	Malawi Kwacha
MoH	Ministry of Health and Population
NAC	National AIDS Commission
NGO	Nongovernmental Organization
NHA	National Health Accounts
NHE	National Health Expenditure
OI	Opportunistic Infection
OPC	Office of the President and Cabinet
PHR*plus*	Partners for Health Reform*plus*

PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
POW	Programme of Work
PxQ	Price x Quantity
RH	Reproductive Health
SADC	Southern Africa Development Community
SP	Sulfadoxine-Pyrimethamine
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
THE	Total Health Expenditure
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Funds
US$	United States Dollar
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

ACKNOWLEDGMENTS

This Malawi National Health Accounts (NHA) study, with sub-account studies of HIV and AIDS, reproductive health and child health, is the result of enormous contributions from many individuals and institutions. The data presented in this report were collected, cleaned and analyzed by a NHA Technical Team from various institutions – government, donor and civil society – in Malawi.

The study was financed mainly by the Ministry of Health, U.S. Agency for International Development (USAID)/Malawi, World Health Organization/Malawi, Action Aid International Malawi, Institute for Democracy in South Africa, United Nations Development Programme (UNDP)/Malawi, UNAIDS/Malawi, National AIDS Commission, Malawi Economic Justice Network and USAID through the Partners for Health Reform*plus* (PHR*plus)* Project based in Bethesda, Maryland, USA. On behalf of partners undertaking this study, the Ministry of Health would like to thank these organizations for their timely financial support.

Special thanks for excellent technical support provided to this study, from study design to data collection, entry, cleaning, processing, analysis and report writing, go to the following: PHR*plus* staff, in particular, Takondwa Mwase, Susna De, Stephanie Boulenger, Maria Merino, Manjiri Bhawalkar, Tania Dmytraczenko and Steve Musau; two PHR*plus* consultants, Brian Mtonya and Spy Munthali; and WHO/Malawi, in particular Eyob Zere.

Great appreciation should also go to the dedicated NHA Technical Team, composed of the following members: Edward Kataika and Paul Revill, Ministry of Health; Davie Kalomba, John Chipeta and Chimwemwe Mabulekesi, National AIDS Commission; David Chitate and Patrick Makono, UNAIDS/Malawi; Thandiwe Chirwa and McBride Nkhalamba, Action Aid International Malawi; Fred Mwathengere, UNDP/Malawi; Dalitso Kubalasa and Ephraim Nzengo, Malawi Economic Justice Network; and Flanneys Nkhata, WHO/Malawi.

EXECUTIVE SUMMARY

BACKGROUND

This National Health Accounts (NHA) study, which includes sub-accounts on HIV and AIDS, reproductive health (RH) and child health (CH), was undertaken in 2005 using data for financial years 2002/03, 2003/04 and 2004/05. Malawi produced its first NHA in 2001 (for 1998/99). A number of developments have taken place since then, among them development and implementation of the Malawi Programme of Work 2004-10 (POW) through the Sector-Wide Approach (SWAp) to health financing and management; design of the Essential Health Care Package (or EHP, which provides certain basic health care services free of charge); and increased donor support through the Global Fund to Fight AIDS, Tuberculosis and Malaria, World Health Organization (WHO) 3x5 Initiative, U.K. Department for International Development, U.S. Agency for International Development and Canadian International Development Agency, among others. Currently in Malawi, information on health (i.e. general health, HIV and AIDS, and reproductive and child health) financing and expenditures is fragmented and imprecise, and, in some cases, nonexistent. It was felt that only with a clearer picture of the sources of financing and the distribution and extent of expenditures on health and HIV and AIDS financing will the Government of Malawi and its development partners be able to make informed decisions that will ultimately benefit the population.

The major objectives of the NHA and sub-accounts study therefore were to:

- Quantify total expenditure on general health, HIV and AIDS, RH and CH;
- Document the flow of funds within the health system for general health, HIV and AIDS, RH and CH by source of financing and financing agents;
- Describe the distribution of total expenditure on general health, HIV and AIDS, RH and CH by use: providers, functions, levels of care;
- Evaluate the efficiency and equity in the allocation of resources among various functions and levels of care;
- Evaluate the sustainability of the health and HIV and AIDS systems; and
- Draw policy implications arising from the overall analysis.

NATIONAL HEALTH ACCOUNTS

NHA is an internationally approved framework for gathering actual expenditures on health from all sources: public, private (including households) and donors. It traces the flow of funds from sources to ultimate uses such as providers, line items, functions and beneficiary groups. NHA can also be extended to capture expenditures on targeted diseases such as HIV and AIDS and malaria, and specific health interventions such as RH and CH.

Countries worldwide have used NHA to inform policy decisions such as projections of resource needs and to monitor and evaluate the effects of those decisions on health systems goals such as equity, efficiency and sustainability. In Malawi, NHA has been used to advocate for policies regarding resource mobilization and resource reallocation between levels of care (from central hospitals to district health services) and among regions, and to compare Malawi with other countries.

METHODS AND DATA SOURCES

The general NHA and sub-accounts for HIV and AIDS, RH and CH was conducted in 2005 using data for financial years 2002/03, 2003/04 and 2004/05. Data were collected from all sources of health and HIV and AIDS financing, such as the Ministry of Finance, city and district assemblies, employers (private firms and parastatals), households and donors. Data also were collected from all financing agents for health and HIV and AIDS such as the Ministries of Health, Defence, Home Affairs and Internal Security, Foreign Affairs and International Cooperation, and Education; regulatory bodies such as the Nurses Council and Medical Council; and nongovernmental organizations (NGOs) including the Christian Health Association of Malawi (CHAM). Finally, data were collected from people living with HIV and AIDS (PLWHA) in order to estimate their contributions to health and non-health expenditures.

FINDINGS

TRENDS IN HEALTH EXPENDITURES

GENERAL HEALTH EXPENDITURES

Total expenditure on health (THE) rose from MK14.61 billion (US$164.4 million) in 2002/03 to MK26.21 billion (US$240.6 million) in 2004/05. This represented a per capita expenditure on health of US$15 in 2002/03 and US$20 in 2004/05. This is an increase from the 1998/99 THE of US$ 12 per capita, but it falls critically short of the US$34 that the WHO Commission on Macroeconomics and Health recommends for a package of basic, cost-effective health care interventions in developing countries. In 2004/05 government and donor contributions alone came to US$16.9 per capita, less than the conservative estimate of US$22 required to deliver Malawi's EHP. Changes in treatment regimens for malaria, from sulfadoxine-pyrimethamine to the more costly artemisinin-based combination therapy, widened the financing gap. In addition, the government funded non-EHP services, including treatment abroad; this implies that there is huge resource gap in the health system.

Health expenditure as a percentage of gross domestic product (GDP) increased from 9.9% in 2002/03 to 12.8% in 2004/05 – the highest in the Southern Africa Development Community. Despite increasing in absolute terms, the government's contribution to THE fell from 35% in 2002/03 to 25% in 2004/05. In the same period, the donor contribution increased from 45% in 2002/03 to 60% in 2004/05, making Malawi one of the most donor-dependent countries. The average household contribution was US$1.78 per capita, 10.3% of THE.

The Ministry of Health (MoH) is the major financing agent (programmer/manager/controller of funds). Its share of control of total health funds increased from 49.5% in 2002/03 to 60% in 2004/05. The National AIDS Commission's (NAC's) share also increased significantly during the period, from 1.8% in 2002/03 to 11.9% in 2004/05, reflecting the increasing importance of HIV and AIDS in Malawi.

The major providers of health services were hospitals (general secondary and tertiary hospitals, and mental hospital), consuming 31% of THE in 2002/03 and 30.3% and 2003/04. In 2004/05, health centres/dispensaries/maternity units were the major providers, consuming 24.7% of THE. This shift towards primary care is a move towards *efficiency* in that most diseases are amenable to interventions delivered at the primary level, as included in the EHP. It is also a move towards *equity,* because most people in Malawi live in rural areas where health centres/dispensaries/maternity units are situated.

The distribution of expenditures by function shows that curative care consumed around 50% of THE during the years under review. Prevention and public health services rose from 27% to 31.4% of THE in the period. This increased spending on prevention and public health services reflects a more efficient allocation of resources, because benefits accrue not only to the individual but also to the population.

A sub-sector analysis shows that the MoH funds a hospital-based health care system. About 64% of all MoH expenditures occurred at hospitals, including central, district and rural hospitals. An additional 2% was spent at Zomba Mental Hospital. This is contrary to the vision of the PoW 2004-10, which attaches priority to primary health care and in particular to prevention and public health. MoH spending on curative health care increased substantially from the 1998/99 level of 47% of total MoH recurrent expenditures (MoH 2001); by 2004/05, it had grown by 31 percentage points, to 78% of total MoH expenditures on health. This increase in funding is understandable in that curative care is more expensive than prevention and public health interventions, but it does not reflect MoH policy, which voices priority for prevention and public health services. Furthermore, the benefits of curative care accrue only to an individual whereas prevention and public health interventions benefit both the individual and the population at large and, in the long run, reduce curative care expenditures by preventing illness. For these reasons, the MoH should invest more resources in prevention and public health services.

The Malawi NHA 1998/99 study (carried out in 2001) revealed that MoH per capita recurrent expenditures by geographic region were highest in the North, followed by the South, and lowest in the Centre. This trend has continued through 2004/05, even with the introduction of a resource allocation formula in 2001/02, and it suggests that more resources need to be allocated to the Southern and Central regions, especially as these two regions had worse socio-economic indicators than the North. Further analysis indicates that there is a high level of correlation between expenditure on health and the number of MoH facilities in each of the three regions. This shows resource allocation follows infrastructure and not health *needs*[1] of the population.

TRENDS IN HIV AND AIDS EXPENDITURES

Total HIV and AIDS expenditures rose dramatically in the three years examined by this study, from MK2.54 billion (US$29.1 million) in 2002/03 to MK7.53 billion (US$ 69.1 million) in 2004/05. This is the result of a steep increase in donor support for HIV and AIDS, from MK1.17 billion in 2002/03 to MK5.5 billion in 2004/05.

The analysis indicates a donor bias for HIV and AIDS over other health services. Donors account for 73% of HIV and AIDS expenditures, compared to only 54% of general health expenditures. Employers contributed only 2% of total HIV and AIDS expenditures in 2004/05. An interesting funding duality is revealed whereby:

[1] *Needs* refers to capacity to benefit from health care resources and to the severity of illness.

Donors, through NAC, are the major contributors to prevention and mitigation services for HIV and AIDS (information, education and communication [IEC]; prevention of mother-to-child transmission [PMTCT]; distribution of contraceptives; support to orphans and vulnerable children).

The Treasury, (through the MoH) is the major financier of treatment and care for HIV and AIDS and related opportunistic infections (apart from antiretroviral drugs, which are funded by donors); this care is delivered at hospitals and health centres.

In spite of the increase in donor contributions, PLWHA expenditures rose from MK169 million in 2002/03 to MK334 million in 2004/05; or from MK190 per PLWHA in 2002/03 to MK379 in 2004/05.

In 2002/03, the public sector excluding NAC was the largest financing agent, controlling about 41% of the total HIV and AIDS expenditures; this was followed by donors and international NGOs at 24.3%. The private sector and NAC controlled 16.8% and 11.2% respectively. However, by 2004/05, NAC was the largest financing agent, controlling about 56.9% of total HIV and AIDS funds, followed by the public sector at 18.4%. This shows how important the NAC has become in terms of programmatic responsibilities for the national response to HIV and AIDS.

The major recipients of HIV and AIDS funds were hospitals and health centres, which received about 59% and 57% of total HIV and AIDS funds in 2002/03 and 2003/04 respectively. By 2004/05, providers of prevention and public health programmes (including IEC, PMTCT, voluntary counselling and testing [VCT] and prevention of sexually transmitted infections) rose from MK702 million in 2002/03 to MK1.18 billion in 2003/04 and a massive MK2.91 billion in 2004/05, accounting for 39 percent of all HIV and AIDS expenditures in that year.

A reversal of the relative funding of HIV and AIDS functions took place during the period under review. In 2002/03, the bulk (57%) of total HIV and AIDS funds were spent on treatment and care for opportunistic infections. This remained constant in 2003/04, and then fell drastically to 34% in 2004/05. The extent of spending on prevention and public health, health-related and non-health functions rose to 65% of total HIV and AIDS expenditures by 2004/05, an increase from 37% in 2003/04 and only 23 % in 2002/03.

TRENDS IN REPRODUCTIVE HEALTH EXPENDITURES

The RH sub-accounts revealed that total RH expenditures rose from MK2.8 billion (US$32.1 million) in 2002/03 to MK3.6 billion (US$33.0 million) by 2004/05, an average of about 2% of GDP during the period under review. Per capita expenditures (per woman of reproductive age) remained constant at US$11, despite an increase in absolute terms in Malawi kwacha (due to a sharp decrease in the exchange rate between 2002/03 and 2003/04). RH expenditures accounted for 19% of THE in 2002/03, then only 14% in 2004/05.

The major source of funds for RH services in 2002/03 was the public sector, in particular the Ministry of Finance at 42%, followed by donors at 39%, and private sources (principally households) at 18%. Households continued to be the third major source of RH financing, their percentage rising to 21% of THE for RH in 2003/04, then falling to 20% in 2004/05 (though still more than 2002/03). Public funding for RH declined by almost half from 2002/03 to 2003/04, while donor contributions rose 17% during the same period.

On average, donors were the major source of RH funding in Malawi (contributing about 49% of the health expenditure for RH during the period under review) as the sub-accounts have found in other

countries[2]; however, their contribution was found to be less than had been claimed before this study. Government also contributes substantially to RH services and goods (an average of 31% of total RH expenditures during the period), through its funding of MoH recurrent expenditures – salaries, drugs, equipment etc. – and development budget and the recurrent budget (in particular, salaries for all local staff) of the Christian Health Association of Malawi (CHAM).

The public sector, in particular the MoH, was the major financing agent during the period under review. The public sector averaged 61% of THE for RH, followed by private sector at 33% (of which household out-of-pocket expenditures/control averaged 14% of THE for RH). The Rest of the World (donors and international NGOs) controlled an average 5% of RH funds.

Most RH resources are spent in public sector facilities (hospitals and health centres): 55%, 47% and 49% of THE for RH in 2002/03, 2003/04 and 2004/05 respectively. Provision of prevention and public health programmes accounted for 18%, 20% and 22% of THE for RH in those years. Private not-for-profit facilities consumed an average of 18%, and private for-profit facilities consumed around 7% of the total RH expenditures.

In terms of functions, most RH resources are spent on curative care (mostly maternal health services such as deliveries, and pre- and post-natal care but excluding family planning consultations and commodities) accounting for 55% of the THE for RH in 2002/03, 44% in 2003/04 and 45% in 2004/05. Family planning consultations and issuance of modern family planning methods consumed 24%, 26% and 26% in 2002/03, 2003/04 and 2004/05 respectively.

Donors largely finance prevention and public health programmes, including family planning commodities. The government through its funding to the MoH and CHAM (including contributions for salaries of health personnel, drugs and medical supplies) provides the bulk of all inpatient and outpatient RH services. This government expenditure on RH has often been overlooked in the past.

TRENDS IN CHILD HEALTH EXPENDITURES

The CH sub-accounts shows that total CH expenditures in Malawi were MK2.42 billion (US$27.7 million), MK2.86 billion (US$26.4 million) and MK3.91 billion (US$35.9 million) in 2002/03, 2003/04 and 2004/05 respectively. These amounts represent 17%, 14% and 15% of THE in the respective three years. In per capita terms, this amounted to US$12 per child in 2002/03, US$11 per child in 2003/04 and US$15 per child in the 2004/05. Using these figures to compare Malawi to other countries that also have undertaken the CH sub-accounts (Table 1), Malawi's total and per child health expenditure is relatively high – particularly given the constrained size of the Malawian economy. However, CH indicators in Malawi are worse (child mortality of 133 per 1,000 in Malawi, compared to 69 in Bangladesh and 15 in Sri Lanka). This might indicate that (1) Malawi is spending its CH resources less effectively than it could, and (2) many factors other than services provided, such as household income and its distribution, nutrition levels and the education of the mother, have a serious impact on CH.

[2] Other countries that have undertaken RH sub-accounts are Rwanda, Ethiopia and Jordan.

TABLE 1: COMPARISON OF CHILD HEALTH EXPENDITURES AND CHILD HEALTH INDICATORS BETWEEN COUNTRIES*, 2002/03

Country	CH expenditure as % of THE	CH expenditures per child, in US$	THE per capita, in US$	Infant mortality rate (per 1000 live births)	Child mortality rate (per 1000)
Malawi (2002)	17	12	15	76	133
Ethiopia (2004)	19	7.8	7.1	110	166
Bangladesh (2002)	12.2	10.7	11.4	46	69
Sri Lanka (2002)	4	14.6	30.9	13	15

Sources: National Statistics Office and Measure/DHS (Demographic and Health Surveys) 2000, 2004; Institute for Health Policy Studies Sri Lanka 2006, Data International Bangladesh 2006, Federal Ministry of Health Ethiopia 2006.

In 2002/03 alone, the major financing sources for CH were public, in particular the Ministry of Finance through its funding to the annual health budget managed by the MoH. This reached a high of 41% of total CH expenditures in 2002/03, but it subsequently fell to a low of 30% of total CH expenditures by 2004/05. From 2003/04 to 2004/05 donors were the major sources of CH activities contributing 49% of total CH expenditures in both years. Private sources of funds also made a significant contribution to CH expenditures, ranging from 20% to 23% of the total in during the three years under review. Among private sources, households were the major financiers, accounting for 14%, 18% and 15% in the three years respectively.

The major financing agent for CH funds is the public health sector, mainly the MoH, accounting for a high of 63% of the total CH expenditures in 2002/03 and falling to a low of 54% of total CH expenditures by 2004/05. The private health sector is the second major financing agent, controlling on average 30% of total CH expenditures during the period under review.

The major recipients of CH expenditures were public health sector providers, which received a high of 53% of CH funding in 2002/03; this fell to 46% in 2003/04 and rose to 49% in 2004/05. Private providers received about 17% of total CH funds in 2002/03, rising to 27% of total CH funds in both 2003/04 and 2004/05.

The majority of funds for CH (an average 66%) were spent on inpatient and outpatient curative care. Spending on prevention and public health programmes for children increased only marginally in MK terms, despite increased resources flowing into the health sector as a whole. In fact, in US dollar terms the spending fell, from US$7.56 million in 2002/03 to US$7.10 million in 2004/05 (or from US$3.21 per child in 2002/03 to only US$2.87 per child in 2004/05). This is worrisome as most childhood illnesses could be prevented through effective prevention and public health programmes including immunization, breastfeeding counselling and promotion of complementary feeding, micronutrient supplementation and fortification of food, e.g. Vitamin A and iodised salt.

However, within total prevention and public health programmes, there was a steady increase in expenditures for immunization activities for children under five, in both relative and absolute terms. This included procurement of vaccines, materials and cold chain equipment. Immunization expenditures were

US$2.90 million (10% of total CH expenditure) in 2002/03, fell slightly to US$2.80 million (13%) in 2003/04[3], but then increased substantially to US$3.52 million (16%) in 2004/05.

POLICY IMPLICATIONS OF FINDINGS OF THE NHA AND SUB-ACCOUNTS STUDY

GENERAL NATIONAL HEALTH ACCOUNTS

1. Health financing

- Decrease in real terms of government contributions for health: Government need to increase in real terms its contribution to health as agreed in the SWAp Memorandum of Understanding between the Government of Malawi (MoH) and pool donors signed in October 2004.

- Inadequacy of resources to fund the Malawi EHP estimated at US$22 per capita per annum in 2004 and meeting the Abuja Declaration target of allocating 15% of national budget to health: Need for sustained and increased actual spending on health by all funding sources in particular government and donors.

- Low contribution by employers (private firms and parastatals) to THE: Need to increase employers contribution to health care by investigating the feasibility and viability of establishing mandatory health insurance for the formal sector, and installing onsite health facilities for employees and dependents.

- Huge annual increases in household spending in the face of free public health care services and increased donor expenditures for health: (1) Need to reduce out-of-pocket spending through risk pooling mechanisms such as health insurance plans for the formal sector and community financing schemes for the informal sector and (2) government need to evaluate the impact of free public health care services policy (where government funds inputs such as salaries, drugs, equipment etc.) on quality of care and access to and utilization of health care services by different socio-economic groups and investigate the feasibility and viability of alternative financing mechanisms for paying its providers such as performance-based financing or conditional cash transfers to beneficiaries for specific outputs.

- Continuous provision of free health services and goods outside the EHP including treatment abroad: Government need to identify viable and feasible alternative financing mechanisms for funding services outside the EHP such as establishment of mandatory insurance for the formal sector employees.

- MoH resource allocation appears to follow infrastructure rather than health needs of the population despite design of an allocation formula in 2001/02: Need to revise the current resource allocation formula such that it takes into account the health needs of the population as defined in the EHP and thereafter uses this as the basis for MoH resource allocation decisions.

- At the district level, more MoH resources spent at the district hospital itself, mainly on curative health care services: Need to split the budget for the district into two parts, (1) the hospital and (2)

[3] This decrease was largely due to an exchange rate devaluation of the Malawi kwacha from 87.28 to the U.S. dollar in 2002/03/03, to 108.57 to the dollar in 2004/05/05. The rate held at 108.94 to the dollar in 2004/05.

peripheral facilities and prevention and public health programmes as proposed in the Fourth National Health Plan of 1999-2004.

2. Institutional and human resource capacity

- Inadequate capacity to manage increased donor health expenditure through the SWAp: Need to strengthen national institutional and human capacity to plan, manage and distribute the inflow of funds, human resources for health and material resources (drugs and medical supplies, equipment etc.) in a coordinated manner. In particular, strengthen MoH capacity in planning, resource allocation, budgeting, procurement and monitoring and evaluation.

3. Public/private partnership

- Inequity in access to health care and in particular in certain catchment areas where there are paying facilities: Government need to strengthen public-private partnerships through establishment of new service agreements and strengthening the existing ones with CHAM and other NGOs so as to deliver health services free to the population where the public sector has limited capacity as indicated in the POW 2004-10.

HIV AND AIDS SUB-ACCOUNTS

- Inadequate funding for HIV and AIDS services by employers: Need for NAC and other key stakeholders (MoH in particular) to initiate campaigns for employers to spend more on HIV and AIDS in the workplace. Evidence indicates such programmes (including condom distribution, VCT, provision of antiretroviral drugs, treatment of opportunistic infections) are a cost-effective way for firms to improve productivity through reduced staff illness and lower absenteeism.

- Increased flow of HIV and AIDS resources in the face of limited capacity: Need for NAC to build national capacity to effectively handle and allocate increased resources for HIV and AIDS through training to develop skills in procurement, planning and budgeting and distribution, and offering remuneration packages to attract highly skilled workers.

- Existence of biased funding priorities: Need for NAC to reconsider funding priorities to ensure that a fairer proportion of HIV and AIDS funds are directed to health systems strengthening in particular treatment and care of patients with opportunistic infections, which currently is funded primarily from Treasury resources, in addition to prevention and public health and mitigation of the disease.

- Huge expenditures on administration of HIV and AIDS activities: Need to reduce the administrative channels for disbursement and management of HIV and AIDS funds so as to reduce administrative costs and hence more funds reach the target beneficiaries.

- Increase in out-of-pocket expenditure by PLWHA in the face of increased donor funding for HIV and AIDS. Government need to investigate (1) alternative ways of funding services targeting PLWHA such as direct cash transfers and (2) feasibility and viability of developing risk pooling mechanisms such as mandatory health insurance for the formal sector employees and their dependents, and community prepaid financing schemes for the informal sector.

- Inequities in access to care for PLWHA suffering from opportunistic infections: Need for the MoH to continue negotiating for a comprehensive contract between government as financier and CHAM as service provider to cover staff salaries, provision of drugs and service agreements whereby

CHAM reduces or abolishes user fees for PLWHA who are in need of health care services for opportunistic infections.

REPRODUCTIVE HEALTH SUB-ACCOUNTS

- Inadequate funding for maternal health: As Malawi continues to face challenges in regard to RH services, the government need to increase funding for training and paying salaries for nurses and enrolled midwives who are critical to maternal health service delivery.

- Inequities in access for RH services: Need for the MoH to continue strengthening its service contracts for provision of most of its RH services to NGOs in particular CHAM and Banja La Mtsogolo and in the medium term enter into service agreements with private for-profit providers.

- Huge donor financing for RH prevention and public health programmes including procurement of contraceptives and commodities: Need for donors to examine their funding priorities and consider funding for maternal health services such as purchase of more drugs and medical supplies, medical equipment and ambulances needed for emergency obstetric care, and prenatal, labour, delivery and postnatal care.

- Huge expenditures on RH contraceptives and commodities while contraceptive prevalence rates are low and fertility rate is high: Government need to investigate the effectiveness of RH spending on contraceptives and commodities, i.e. investigate whether the RH contraceptives and commodities are indeed used by the clients once they are obtained.

- High household direct out-of-pocket spending for RH services in particular maternal health services: Because Malawi has some of the worst maternal health indicators, there is need to reduce out-of-pocket financing for RH. One way to do this is to expand the benefit packages of prepaid health insurance schemes such as the Medical Aid Society of Malawi to include RH services. Another strategy could be to investigate the feasibility of conditional cash transfers to pregnant women to deliver in formal health facilities, and ensure supervision from appropriately trained health personnel. Furthermore, the government could consider investigating the feasibility of performance-based financing whereby providers could be given incentives for reaching an agreed target such as number of deliveries in formal health facilities assisted by trained health personnel.

CHILD HEALTH SUB-ACCOUNTS

- Steady increase in CH spending while childhood illnesses and mortality are high: In addition to increasing the amounts of resources for CH, there is great need to improve efficiency and equity in resource allocation and utilization for CH interventions. There is also need to investigate patterns of CH care seeking behaviour, and factors which negatively affect utilization of CH services among different socio-economic groups.

- The public health sector is the major financing agent of CH services and goods: Need for a two-stage approach to improve the poor CH situation. In the short term, the major responsibility lies with public providers, and in particular public hospitals and providers of preventive and public health services, to ensure that the resources they continue to receive for CH are utilized efficiently and equitably. In the longer term, the MoH and key partners need to ensure improvements in the capabilities of health centres and peripheral facilities to meet patient demands with regard to CH, addressing factors that impede utilization of health facilities for CH health services. This could be

done through improved human resources, infrastructure improvements and, in particular, ensuring effective supply and delivery of essential drugs and medical supplies.

- Increased household direct out-pocket spending for CH: Need to reduce household direct out-of-pocket spending for CH through (1) expansion of a health insurance scheme to cover all formal sector employees and their dependants and assessing the feasibility of introducing community prepaid financing mechanisms and (2) conditional cash transfers to mothers as an incentive for using agreed upon CH services such as immunization and Vitamin A supplementation.

CONCLUSIONS

This second-round NHA exercise in Malawi has four components: the general NHA and sub-accounts for HIV and AIDS, RH and CH. The sub-accounts were done in Malawi for the first time and are among only a few such exercises conducted in Africa and the developing world.

This study has clearly shown that the THE per capita falls critically short of the minimum amount (US$34 per capital per annum) required to provide essential health services in developing countries and Malawi EHP targets (US$22 per capita per annum). Furthermore, it observed that the donor component of health financing has been increasing while that of government has been declining. This has serious implications for sustainability of the health care system, unless there is a reliable and predictable flow of donor funds.

Allocation of public sector health care resources was observed to follow health facilities rather than health needs of the population. This calls for a move towards the revision of the resource allocation formula developed in 2001/02 and strictly adhering to it in future resource allocation decisions. Furthermore, in line with regional initiatives and commitments, there is a need for the government to increase its allocation of resources to the health sector, and explore the feasibility of prepaid health financing mechanisms so as to increase its resource base and avoid possible financial burden for households. There is also a crucial need to introduce measures that enhance allocative efficiency so as to purchase (produce) the right mix of inputs and outputs to address the health problems of the majority of the population – the current analysis indicates that the health care system is biased in favour of hospital-based curative services.

The sub-accounts also demonstrate critical shortages of resources relative to the burden of morbidity and mortality in the three major programme areas investigated. This is not surprising as these are a reflection of the overall health system resource constraints. It is thus necessary to solicit more funds and utilize these in an equitable and efficient manner in order to achieve the Millennium Development Goals by all segments of the Malawian population.

In the final analysis, it is essential for government and development partners to utilize the information generated by this NHA study for evidence-based decision making as it relates to all aspects of the health financing function. The MoH has to play its stewardship role, so that the recommendations are implemented as deemed appropriate. Health financing is one the core functions of a health system; it is therefore necessary to have it institutionalized and integrated with the routine health information system. To this end there is a need to build more capacity in health financing and NHA.

1. BACKGROUND

The health system in Malawi faces serious challenges to improving health care financing and delivery and ultimately enhancing the health status of the population. While the population's health needs are escalating, the resources (human, financial and material) needed to meet these growing needs are declining as a result of various factors such as emerging and re-emerging diseases, concomitants of the demographic and epidemiological transition and poor macro-economic performance.

In order to address the problems, the Government of Malawi, together with development partners, have adopted a health Sector-wide Approach (SWAp) as a way of mobilizing resources and co-coordinating activity within the health system in line with one of the strategies contained in the fourth Malawi National Health Plan 1999-2004. To this effect, the Ministry of Health (MoH) has through a consultative process developed a Joint Programme of Work (PoW) for the period 2004-2010. This PoW focuses on six components, namely: human resources, pharmaceuticals and medical supplies, essential basic equipment, infrastructure, routine operations at the service delivery level and central operations, and policy and systems development. It has identified an Essential Health Package (EHP) of core health care interventions to be delivered free at the point of service to all Malawians. This EHP will be funded through a SWAp to health financing and management.

While the HIV prevalence rate in Malawi has been stable, the estimated rate of around 12% of the adult population is quite high (National Statistics Office and Measure/Demographic and Health Survey 2004, henceforth referred to as DHS). In order to respond to this serious HIV and AIDS situation, the Government of Malawi has put in place a number of policies and structures. A National AIDS Commission (NAC) was formed in 2001 to coordinate HIV and AIDS activities in the country. More recently, a HIV and AIDS and Nutrition Department has been established in the Office of the President and Cabinet. A National HIV and AIDS Strategic Framework for 2000-2004 was launched in 2000, and this was followed by the launch of the National HIV and AIDS Policy in February 2003 by the State President. After the expiry of the National HIV and AIDS Strategic Framework 2000-2004, a National HIV and AIDS Action Framework for 2005-2009 was developed and is now being implemented.

Malawi is a signatory to a number of regional and international declarations, committing the country to the achievement of time-bound goals such as the Abuja Declaration and the Millennium Development Goals. To achieve these goals, the government has been the recipient of continuous bilateral and multilateral support in the fight against HIV and AIDS, poor maternal and child health and other problems. The bulk of this support is from the Global Fund to Fight AIDS, Tuberculosis and Malaria. There is also World Bank support for HIV and AIDS through the Multi-Country HIV and AIDS Programme, the World Health Organization's (WHO's) 3x5 Initiative and the SWAp, among others. This has been supplemented by aid from large bilateral donors, such as the U.K. Department for International Development (DfID), U.S. Agency for International Development (USAID), Canadian International Development Agency (CIDA), German GTZ and Japanese International Cooperation Agency (JICA), among others. International nongovernmental organizations (NGOs) have also contributed funding.

Malawi produced its first National Health Accounts (NHA) report in 2001 (for financial year[4] 1998/99). As noted above, a number of developments have taken place in the health and HIV and AIDS sectors since then. It is therefore against this backdrop that the need for an accurate, up-to-date and comprehensive picture of the health and HIV and AIDS financing systems in the country has become urgent. Currently information on health and HIV and AIDS finance and expenditures in Malawi is very fragmented and imprecise, or nonexistent. Only with a clearer picture of what is being financed within the health and HIV and AIDS sectors, to what extent, from which source, and to the benefit of whom, will the government and partners be informed about the distribution and extent of health and HIV and AIDS expenditures so as to make informed decisions that will ultimately benefit the population.

1.1 AIM AND OBJECTIVES OF THE NATIONAL HEALTH ACCOUNTS STUDY IN MALAWI

The aim of this NHA study is to generate important information on health financing in Malawi that will enable policymakers assess the financial functioning of the health system at large and design appropriate interventions to promote equity and efficiency and ultimately contribute to the improvement of the health status of individuals and the general population.

Furthermore, the sub-accounts for HIV and AIDS, reproductive health (RH) and child health (CH) will provide a fairly detailed picture of the financing for these health care programmes and hence contribute to the identifying appropriate financing options/strategies that will facilitate the achievement of the relevant Millennium Development Goals.

1.2 SPECIFIC OBJECTIVES

Specifically this study aimed to:

1. Quantify total expenditure on general health, HIV and AIDS, RH and CH;
2. Document the flow of funds within the health system for general health, HIV and AIDS, RH and CH by financing source and financing agent;
3. Describe the distribution of total expenditure on general health, HIV and AIDS, RH and CH by use: providers, functions, levels of care;
4. Evaluate the efficiency and equity in the allocation of resources among various functions and levels of care;
5. Evaluate the sustainability of the health and HIV and AIDS systems; and
6. Draw policy implications arising from the overall analysis.

[4] The financial year in Malawi is from July 1 through June 30.

1.3 STRUCTURE OF THE REPORT

This report is structured as follows:

Chapter 2 presents an overview of Malawi's social structure: general social, economic and health system. This includes a review of the macro-economic environment and consideration of key socio-economic indicators. It also reviews the health system in Malawi, the health status of people and the providers of health services.

Chapter 3 presents an overview health financing and NHA. Their importance is documented and the economic objectives of health care (equity and efficiency) are reviewed.

Chapter 4 examines the methodology used in quantifying current health care expenditure and financing for general health, HIV and AIDS, RH, and CH.

Chapter 5 presents results and discussion on total health expenditures (THE). It also documents the distribution of MoH recurrent expenditures by level of care, type of service, and geographic area. In addition, it presents the summary and implications of the financing and expenditure patterns in Malawi.

Chapter 6 presents results, methods and data sources and discussion on total HIV and AIDS financing and spending for both health and non-health expenditures. It also presents findings about expenditures by people living with HIV and AIDS (PLWHA), and this is followed by a summary and implications of HIV and AIDS financing and expenditure patterns in Malawi.

Chapter 7 presents results, methods and data sources and discussion on RH financing and expenditure. This is followed by a summary and implications of the health financing and expenditure patterns for RH in Malawi.

Chapter 8 presents results of the CH financing and expenditures. It has also a summary and implications of CH financing and expenditure in Malawi.

Chapter 9 presents conclusions of the entire study and next steps.

2. MALAWI'S SOCIAL STRUCTURE, ECONOMY AND HEALTH SYSTEM

It is important to evaluate the current status of a country's health system within the context of the overall policy, political and socio-economic environment. This chapter therefore provides an overview of the administrative, political and social system, and macro-economic and socio-economic indicators in Malawi. It highlights the country's economic growth prospects, which have an impact on the health system. The organization of the health system and access to health services is also reviewed.

2.1 SOCIO-DEMOGRAPHIC PROFILE

Malawi is a land-locked country located in Southern Africa. It is bordered to the north and northeast by the United Republic of Tanzania; to the east, south and southwest by the Republic of Mozambique; and to the west and northwest by the Republic of Zambia. A quarter of the surface area is covered by Lake Malawi.

The country is 901 kilometers long and ranges in width from 80 to 161 kilometers. It has a total area of 118,484 square kilometers of which 94,276 square kilometers is land area. The remaining area is mostly composed of Lake Malawi, which is about 475 kilometers long and runs down Malawi's eastern boundary with Mozambique. Malawi is divided into 28 administrative districts, which vary in population size, and geographical and socio-economic factors.

The population of Malawi was projected at 12,757,883 in 2006, with an annual growth rate of 2.0%. Thus the population density is 108 persons per square kilometer. The overall sex ratio is 96 males per 100 females, while the average household size is 4.3.

2.2 MACROECONOMIC ENVIRONMENT

With a per capita gross domestic product (GDP) of US$157 in 2005 (U.N. Development Programme [UNDP] 2005), Malawi is classified as a low-income country. The UNDP's Human Development Index ranked Malawi 165th of 177 countries in 2005. Coupled with the low GDP is high income inequality, which favours the rich and produces a high level of poverty. About 52% percent of the population lives below the national poverty line[5].

The economy is characterized by large fiscal deficits and relatively high inflation, which ranged between 29 percent in 2002/03 and 17 percent in 2004/05. The economy is dominated by the agriculture sector, which accounts for 30% of GDP, 80% of exports and 85% of employment. This sector is highly vulnerable to adverse climatic conditions and deteriorating terms of trade, particularly for tobacco, the major foreign exchange earner.

[5] The National Poverty Line is defined as households living with less than MK16,000 per annum, (US$146.83 per annum in 2004).

Malawi has a very small formal sector. In 1998 only 9% of individuals of working age and about 21% of household heads were employed in the formal sector. About 80% of the labour force is engaged in the non-formal sector, which includes self-employment in small-scale agriculture, casual labour and vending. These are the major sources of income for the rural and urban poor.

2.3 EPIDEMIOLOGICAL PROFILE

Malawi's health indicators are among the worst in the world. Communicable diseases make up a large proportion of the disease burden. The most common cause of morbidity in both adults and children is malaria, whose incidence and case fatality has remained high for a long time. Resistance to commonly used anti-malarials has also been increasing over time.

DHS statistics indicate that childhood mortality rates are steadily declining. The infant mortality rate declined from 104 per 1,000 live births in 1992 to 76 per 1,000 births in 2004. A downward trend in under-five mortality is likewise observed, from 190 per 1,000 births in 1992 to 133 per 1,000 in 2004. Maternal mortality initially increased sharply in this period, from 620 per 100,000 live births in 1992 to 1,120 per 100,000 per live births in 2000, but the trend has reversed to a rate of 984 per 100,000 births in 2004.

Despite the major gains in reducing childhood mortality, life expectancy has worsened in the other age groups, due in great part to the HIV and AIDS pandemic. Overall life expectancy has declined from 44 years in early 1990s to 38 years by 2004.

In recent years, HIV and AIDS has become the other major public health problem in Malawi. In 2004, its prevalence in adults was estimated at 12% (DHS 2004). Tuberculosis is likewise on the increase, from 5,300 cases in 1985 to 24,000 in 2002, due in great part to the disease's association with HIV and AIDS. The HIV and AIDS prevalence rate is 77 percent among tuberculosis patients.

Table 2 provides a summary of Malawi's social, health and economic situation relative to other countries in the region. Such comparison will provide a good basis for analyzing the health and HIV and AIDS expenditures in Malawi.

TABLE 2: DATA ON SELECTED HEALTH, SOCIAL AND ECONOMIC INDICATORS OF VARIOUS AFRICAN COUNTRIES

Indicator	Malawi	Rwanda	Zimbabwe	Kenya	Uganda	Tanzania	Zambia	Ethiopia
Population (in millions) (2002)	11.6	8.1	12.8	31.2	24.2	35.6	10.6	67.3
GDP (in US$ billions) (2001)	1.7	1.7	9.1	11.2	5.7	9.3	3.6	6.2
GDP per capita (in US$) (2001)	166	211	706	362	249	271	354	95
Percent population below income poverty line (1 US$ per day)	41.7	60	36	23	82.2	19.9	63.7	81.9
Infant mortality rate per 1000 births (2001)	114	96	76	74	79	104	112	116
Under five mortality rate per 1000 births (2001)	133	183	123	112	124	165	202	172
Maternal mortality rate per 100,000 live births (1998)	1100	1071	700	590	510	530	650	870
Total fertility rate (2000)	6.1	5.8**	3.9	4.7	7.1	5.1	5.6	6.1
Literacy rate (2001)	61	68	89.3	74	68	76	79	40.3
Life expectancy (years) (1999)	38	39	35.4	56	44.7	44	39	45.7
Percent contraceptive use (2004)	28	13	54	39	23	25	25	8

Sources: DHS 2004, UNDP 2003 and 2005

2.4 HEALTH POLICY AND ORGANIZATION OF HEALTH SERVICES

2.4.1 HEALTH GOAL AND POLICY

The goal of Malawi's government is "To raise the level of health status of all Malawians by reducing the incidence of illness and occurrence of premature deaths in the population" (Ministry of Economic Planning and Development 2002).

MoH policy is "To raise the level of health status of all Malawians through the development of health delivery system capable of promoting health, preventing, reducing and curing disease, protecting life and fostering the general well-being and increased productivity and reducing the occurrence of premature deaths" (MoH 1999). The vision of the MoH is " To improve the health status of all Malawians through the provision of effective, efficient and safe health care" (Vision 2020 1999). Finally, its Mission is " To stabilize and improve the health status of Malawians by improving access, quantity, cost-effectiveness and quality of EHP and related services so as to alleviate the suffering caused by illness, and promoting good health, thereby contributing to poverty reduction (MoH 2004).

The statements above entail economic objectives for health care, which are also the centrepiece of health sector reforms:

- Equity in delivery and financing of health services;
- Efficiency in resource allocation and utilization;
- Quality of health care goods and services; and
- Effectiveness of health care services and goods provided.

Some of these economic objectives, in particular equity and efficiency, will be evaluated in the later chapters of this report. (For more details on the definitions of these concepts see Annex 1).

2.4.2 HEALTH DELIVERY SYSTEM AND STRUCTURES

OVERALL STRUCTURE

Nearly all formal health care services in Malawi are provided by three agencies: The MoH provides about 60%; the Christian Health Association of Malawi (CHAM) provides 37%; and the Ministry of Local Government provides 1%. Other providers, namely private practitioners, commercial companies, the Army and Police, provide the remaining 2%.

CHAM is made up of independent church-related health facilities. The government assists CHAM by providing it with an annual grant that covers local staff salaries. CHAM facilities charge user fees for treatment, with the exception of growth monitoring, immunization and community-based preventive health care services including treatment of specific communicable diseases such as tuberculosis, sexually transmitted infections (STIs) and leprosy. Although CHAM provides services at a fee, it is generally perceived that the quality of care in these facilities is relatively better than that of public facilities.

In the recent past, government has extended its support to CHAM through the introduction of service-level agreements. This arrangement aims to improve poor peoples' access to health services by removing financial barriers, and to strengthen government's partnership with nongovernmental partners. Under this arrangement, district health officers contract CHAM health facilities to provide an agreed range of EHP services to the catchment population at no fee. The costs of providing the services are met by the District Health Office.

Health services are provided at three levels: primary, secondary and tertiary. Primary-level services are delivered by rural hospitals, health centres, health posts and outreach clinics. The secondary level, consisting of district hospitals[6] and CHAM hospitals, mainly supports the primary level by providing surgical backup services, mostly for obstetric emergencies, and general medical and paediatric inpatient care for common acute conditions. Some of these hospitals also provide some specialized health care. Tertiary hospitals provide services similar to those at the secondary level, along with a small range of specialist surgical and medical interventions.

The MoH adopted the concept of the EHP in the mid 1990s and defined the package in 2001. The package covers cost-effective interventions that address the major causes of morbidity and mortality in

[6] 'District hospital' refers to secondary-level health care facilities at the district level and owned by government.

the general population, and focus on medical conditions and service gaps that disproportionately affect the rural poor. Components of the EHP are presented in Table 3.

TABLE 3: THE MALAWI ESSENTIAL HEALTH PACKAGE

	EHP Components
1	Prevention and treatment of vaccine preventable diseases
2	Malaria prevention and treatment
3	Reproductive and neonatal health interventions (including RH, family planning, safe motherhood and prevention of mother-to-child transmission [PMTCT])
4	Prevention, control and treatment of tuberculosis
5	Management of acute respiratory infections (ARIs)
6	Prevention, treatment and care for acute diarrhoeal diseases (including cholera)
7	Prevention and treatment of STIs (HIV and AIDS, antiretroviral therapy [ART] and voluntary counselling and testing [VCT])
8	Prevention and treatment of schistosomiasis and related complications
9	Prevention and management of malnutrition, nutrition deficiencies, and related complications
10	Management of eye, ear and skin infections
11	Treatment for common injuries
	Support services
	Essential laboratory services
	Drug procurement, distribution and management
	Information, education and communication (IEC)
	Pre- and in-service training
	Planning, budgeting and management systems
	Monitoring and evaluation

ACCESS TO HEALTH CARE FACILITIES

Malawi has a good network of health facilities belonging to different ministries and agencies. About 85% of the population live within 10 km of a health facility. The facilities range from small dispensaries on estates to large hospitals in cities. Between these agencies, there were 843 health facilities in the country in 2002, more than 50% of them health centres (dispensary/maternity unit) (see Table 4).

TABLE 4: DISTRIBUTION OF HEALTH FACILITIES IN MALAWI, BY OWNERSHIP, 2002

Type	Government		Nongovernment			Private for-profit		Total
	MoH	LG	CHAM	BLM	NGO	Firms	Private facilities	
Central hospital	4	-	-	-	-	-	-	4
Mental hospital	1	-	1	-	-	-	-	2
District hospital	22	-	-	-	-	-	-	22
Hospital	19	-	27	-	-	7	3	56
Health centre	288	12	115	1	-	-	-	416
Maternity centre	2	12	1	-	-	-	-	15
Rehabilitation centre	-	-	1	-	-	-	-	1
Clinic	2	4	8	27	1	-	-	42
Voluntary counselling clinic	-	-	-	-	3	-	-	3
Dispensary	54	4	8	-	-	119	97	282
Total	392	32	161	28	4	126	100	843
%	46.5	3.9	19.2	3.3	0.5	14.9	11.7	100

Source PER 2005, Health Information System Data Base and Manpower Development Unit Survey (1996, 1997)

As can be seen from the table above, the MoH has the largest number of facilities (46.5% of the total health facilities in Malawi), followed by CHAM (19.2% of the total). Firms are the third largest providers with 14.9% of the total health facilities while the private-for-profit is the fourth largest provider of health services with 11.7% of the total health facilities. Last but one is the Ministry of Local Government with 3.9% of the health facilities in Malawi and finally, other government agencies.

Although Malawi has this good network of health facilities, a JICA/MoH inventory in 2002 found that only about 9% of government and mission health facilities were capable of providing the EHP onsite (Calcon 2003). In each district, only one or two facilities had adequate EHP capacity[7]. These service deficits arise from lack of health workers, supply stock-outs, and lack of basic utilities (water, electricity, phone or radio communication) (Calcon 2003).

2.5 SUMMARY

Malawi faces major economic, demographic or epidemiological problems. Given this scenario it is doubtful whether the improvements in the health system alone could improve the health status of the majority of Malawians, as health care is just one determinant of health. Health is influenced by several factors, such as income levels and distribution, adequate sanitation, nutrition, accessibility to safe drinking water, housing conditions, education (in particular that of women) and life style (Wagstaff 1986). In Malawi, all these factors are in short supply and underdeveloped. Nevertheless health indicators will not improve if the health system remains in its current state of disrepair.

Malawi has a good organizational structure of health service delivery, even though the lower levels have little decision-making powers. There is a good supply of health facilities, but only a few are capable of

[7] The JICA study applied the following criteria in determining whether a facility had the capacity to deliver EHP services: (1) it must be able to deliver outpatient care, family planning services, maternity services, and immunization; and (2) it must have the following staff complement – medical assistant or clinical officer (one per facility), and nurse/midwife (two per facility).

providing EHP. Also, as we shall see in more detail below, there is inequity in geographical and financial access to these services.

3. HEALTH FINANCING AND NATIONAL HEALTH ACCOUNTS

This chapter introduces the basics of NHA, the general issues that it addresses, how it has helped in shaping policy decisions in some countries where it has been undertaken and major policy issues impacting on health and HIV and AIDS financing and expenditure in Malawi.

3.1 HEALTH FINANCING SYSTEM

The main purpose of health financing is to pay for health care, but it also can be used to set financial incentives that will motivate providers to increase the supply of health care goods and services, to ensure that all individuals have access to effective public health and personal health care services and goods (WHO 2000) and ultimately to improve the health of individuals and the general population. Health system financing comprises three interrelated functions, namely: revenue collection, risk pooling (leading to resource allocation), and purchasing of interventions. The challenge is to design and implement technical, organizational and institutional mechanisms that are able to carry out these functions and protect people from catastrophic expenditures[8]. The NHA framework is designed to capture health finance and expenditure information along dimensions that inform the three financing functions.

3.2 DEFINITION OF NATIONAL HEALTH ACCOUNTS

NHA is a framework that has been used internationally to diagnose the financial functioning of health systems and design sound health financing policies, which can lead to improvement in the performance of health systems (for more details on the NHA concepts and definitions see Annex 2).

NHA provides a framework for measuring THE, i.e. both public and private including donors. It tracks the flow of funds through the health system from sources (e.g. Ministry of Finance, donors, households), through financing agents (entities which pool and manage the funds received from financing sources to pay for or purchase health care goods and services (e.g. MoH, NGOs), to providers (e.g. hospitals, clinics, dispensaries, pharmacies, traditional healers), functions (e.g. curative, preventive, rehabilitative, administration), health stratification (type of diseases or interventions funded e.g. HIV and AIDS, RH, child health, malaria) and beneficiaries (e.g. by location of residence, age, gender, socio-economic status).

[8] Catastrophic health expenditure occurs when financial contributions to the health system are equal to or exceed 40% of income remaining after subsistence needs have been met. Studies have indicated that when the out-of-pocket health spending is less than 15% of the total health spending, few households are affected by catastrophic payments (WHO 2005)[8].

In summary, NHA addresses and answers four key policy questions:

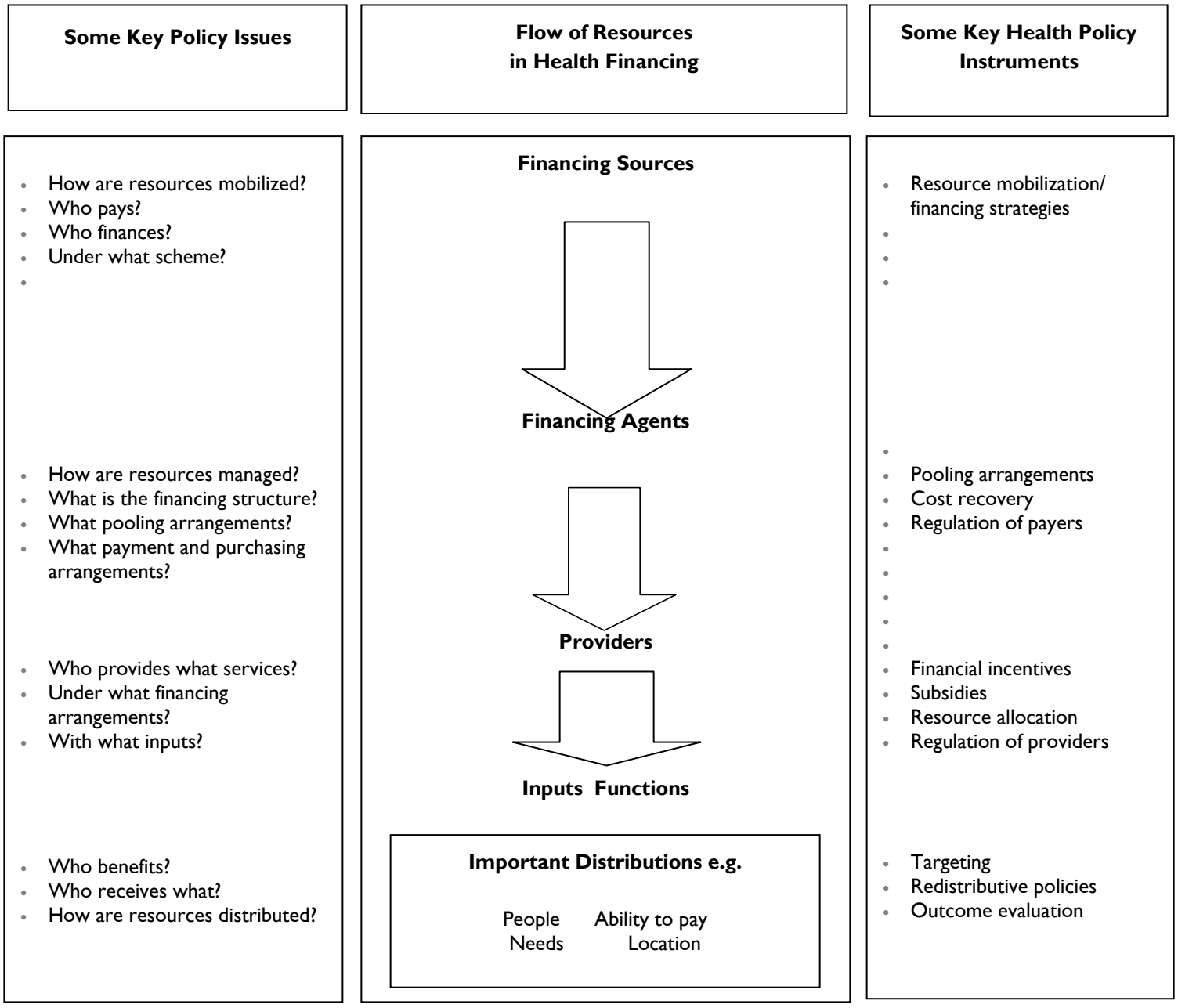
- Who pays and how much do they pay for health?
- Who are the important actors in health financing and health services delivery and how significant are they in total health expenditure?
- How are health funds distributed across the different services, interventions and activities that the health system produces?
- Who benefits from health expenditure?

This information is critical to understanding the functioning of any health system and to make sound health financing policy decisions.

3.3 USES OF NATIONAL HEALTH ACCOUNTS

NHA provides important prerequisite data for monitoring health system functions (stewardship, service provision, resource generation, and financing). It is useful in identifying and tracking shifts in resource allocation (e.g. from curative to preventive or from private to public health sector), making comparisons of one country with other countries and/or over time, making comparisons of health system sectors, and evaluating instrumental goals of the health system: equity (between regions, income groups, and age/sex), efficiency and sustainability of financing. Figure 1 summarizes the policy uses of NHA.

FIGURE 1: POLICY USE OF NHA



Note: Key to the figure

Basic source: National Health Accounts Unit, WHO/Geneva, 2001

Additional sources: Partners for Health Reform*plus* 2003 (www.phrplus.org)

Notes:

The panel on the right shows some of the main policy instruments or decision areas that health care policymakers must address to improve health system performance through financing reforms.

It is possible to link the panels of the figure. NHA reports health expenditures as they flow through the health system. The reporting is structured in ways that help policymakers answer a wide range of crucial questions that should improve their capacity to provide good stewardship and hence improve health system performance.

3.4 MAJOR ISSUES/POLICIES THAT IMPACT ON HEALTH SERVICE DELIVERY AND HEALTH FINANCING AND EXPENDITURE IN MALAWI

The following text box enumerates major health care delivery, financing and expenditure issues in Malawi.

1. Provision of free health care services in all MoH facilities, apart from private wings that exist in a small number of district hospitals and all central hospitals and outpatient departments 1, and the presence of user fees in all CHAM facilities, which are heavily subsidized by government and donors
2. Provision of EHP free of charge in MoH facilities and its impact on quality of health care services and utilization of health care services
3. Development and implementation of the SWAp and its impact on availability, utilization and management of financial, human and material resources for efficient and equitable delivery of health services
4. Financing by donors (outside the government budget) of vertical programmes for preventive and public health, e.g. Integrated Management of Childhood Illness (IMCI), Expanded Programme on Immunization (EPI) and RH, and its impact on organization and delivery of health care services
5. The relationship between the MoH, the HIV and AIDS Unit of the MoH, NAC and the HIV and AIDS Unit of the Office of the President and Cabinet (OPC) and its impact on organization, financing and service delivery
6. The relationship between public, private not-for-profit (i.e. NGO) and private for-profit providers and its impact on organization, financing and delivery of health care services
7. Financing of HIV and AIDS activities through various mechanisms (Global Fund to Fight AIDS, Tuberculosis and Malaria, pool funding, bilateral donors, multi-lateral organizations etc.) and its impact on the delivery of HIV and AIDS services

3.5 SUMMARY

This chapter has clearly defined NHA, its links with health system policy instruments and how NHA has been used in countries where it has been implemented. It has also provided definitions of important NHA terms with their reference to the Malawi situation. Furthermore, the chapter has outlined policies which have a significant impact on the health financing and expenditure patterns in Malawi.

4. METHODS AND DATA SOURCES

The Malawi NHA study used the internationally endorsed framework for undertaking NHA contained in *the Guide to producing national health accounts with special application for low-income and middle income countries* (WHO, World Bank and USAID 2003). It collected both primary and secondary data for financial years 2002/03-2004/05 from institutions, and 2005 data from households, including a specialist survey of PLWHA.

4.1 HEALTH CARE EXPENDITURE BOUNDARIES

The guiding principles for data collection were:

- Definitions of health expenditures: Institutions and individuals which were undertaking activities whose primary purpose was to *improve, restore or maintain* health, regardless of effects or institution. The comprehensive list of such activities is included in Table 5 and the comprehensive list of institutions and their adaptation to Malawi using the International Classification of Health Accounts (ICHA) is found in Annexes 3 and 4.
- Geographic boundary: regardless of location where the expenditures took place, as long as they were incurred by Malawian citizens and residents in 2002/03, 2003/04 and 2004/05. Attempts were made to collect expenditures on treatment abroad incurred by residents and citizens of Malawi.
- Time boundary: Institutions and individuals who financed or incurred health expenditures in 2002/03, 2003/04 and 2004/05, even if goods were consumed in later years, eg antiretroviral drugs (ARVs) procured in 2003/04, and consumed in 2003/04 and 2004/05.

TABLE 5: ACTIVITIES INCLUDED IN HEALTH EXPENDITURE

ICHA Code	Function
HC.1-HC.5	Personal health services and goods
HC.1	Services of curative care
HC.2	Services of rehabilitative care
HC.3	Services of long-term nursing care
HC.4	Ancillary services to health
HC.5	Medical goods dispensed to outpatients
HC.6-7	Collective health services
HC.6	Prevention and public health services
HC.7	Health administration and health insurance
HCR.1-HCR.5	Health-related functions
HCR.1	Capital formation of health care provider institutions
HCR.2	Education and training of health personnel
HCR.3	Research and development in health
HCR.4	Food, hygiene and drinking water control
HCR.5	Environmental health
HC.1-7	Total current expenditure on health (TCEH): H0
HC.1-7+HCR.1	Total expenditure on health (THE): H1
HC.1-7+HCR1-5	National health expenditure (NHE): H2

Source: WHO, World Bank and USAID 2003

4.2 DATA SOURCES

Data were collected from the following institutions:

- Public sector institutions: these are institutions providing and receiving health funds, and providing health care goods and services, including: Ministries of Health, Finance, Foreign Affairs and International Cooperation, Local Government, Defense, Home Affairs and Internal Security, and Education, Women and Child Welfare and Agriculture; municipalities/local authorities; NAC; Nurses and Midwives Council, Medical Council; Pharmacy, Medicines and Poisons Board; School of Health Sciences;
- Donors (both bilateral and multilateral);
- NGOs involved in health;
- Health Insurance Organization-Medical Aid Society of Malawi (MASM);
- Employers/firms;
- Health care providers (for-profit health facilities, not-for-profit health facilities, public health facilities);
- Households; and
- PLWHA, identified from health facilities where they receive HIV and AIDS services.

4.2.1 PUBLIC INSTITUTIONS

All public institutions financing and providing health care services were included using key informant interviews. It is common knowledge that most stakeholders in Malawi regard health expenditures as expenditures incurred on health by the MoH, whose sources of funding are Ministry of Finance through the annual government approved budgets and donors through vertical programmes and budget support. However, this is only part of the picture. Several public institutions in Malawi which incur health expenditures from various sources. As such, in order to have a comprehensive list of all institutions involved in financing and delivery of health care and related services, key informant interviews were held. A questionnaire was developed and thereafter research assistants were assigned to work with the selected institutions in collecting the required data.

The following sources were consulted: government budget books, Consolidated Annual Appropriation Accounts, audited accounts, expenditure print-outs and ledgers. The response rate was excellent.

4.2.2 DONORS

Donors[9] play a major role in financing health care goods and services in Malawi. However, there is no existing database for all donor expenditures on health in Malawi, unlike the MoH's Consolidated Annual Appropriation Accounts. Thus, in order to capture donor contributions for health, a special donor

[9] The NHA term 'Rest of World' refers to donor organizations and all foreign NGOs and foundations.

survey targeting all 19 donors involved in health was undertaken. A special questionnaire was developed and research assistants collected the required information from donor institutions. However, the response rate was poor – only about 40% responded despite several follow-ups by the research assistants and the NHA Technical Team. To augment this information other data sources were also consulted, including:

- Donor mapping study, conducted by a DfID consultant in early 2005;
- MoH study on all donor support in the health sector updated in March 2005 from one originally undertaken in readiness for the SWAp;
- NHA Team survey of NGOs in late 2005, used to triangulate donor contributions to NGOs; and
- Documents related to the government development budget, which is funded by donors, and all vertical programme expenditures, also funded by donors.

4.2.3 NONGOVERNMENTAL ORGANIZATIONS AND COMMUNITY-BASED ORGANIZATIONS

There are no records or database of NGO and implementing agency expenditure on health in Malawi, despite the heavy presence of such organizations in the country. As such, in order to estimate NGO spending on health, a list of all NGOs and implementing agencies working in the health sector and HIV and AIDS sub-sector was obtained from Action Aid International Malawi. The list was reviewed to identify NGOs which were still functional during the time of the survey (late 2005), in order to avoid sampling non-functional NGOs and community-based organizations (CBOs). Key informant interviews were used to select the institutions to survey. In total 120 NGOs/CBOs were identified and all were selected for the survey. Questionnaires were designed and research assistants visited the institutions to collect the required information. The response rate was 60%, but this was after several follow-ups by both the research assistants and the NHA Team. This information was complemented by donor survey information.

4.2.4 HEALTH INSURERS

Malawi has only one well-known health insurance non-profit organization: MASM. In order to estimate part of employer and employees contribution for health, a questionnaire was designed and a research assistant visited the institution. The quantity and quality of the data provided by MASM were excellent and the institution was exceptionally cooperative and transparent in providing the expenditure figures.

4.2.5 EMPLOYERS

Some firms and corporations in Malawi finance and provide health care and HIV and AIDS services and goods to their employees, dependents and the communities in their catchment areas. Employers and employees contribute to health expenditures in Malawi in the following ways:

- Provision of onsite health facilities;
- Reimbursements to employees;

- Employer/employee contribution to an outside health insurance scheme, in particular MASM; and

- In-house health insurance scheme.

In order to estimate the employer and employee contribution, a list of all firms and corporations registered in Malawi was obtained from the Malawi Chamber of Commerce. The list noted firms and corporations which had HIV and AIDS workplace programmes, in essence, almost all the large and well-known firms and corporations in different sectors: agriculture, manufacturing, service etc. Only a few were missing. In order to obtain a comprehensive list, key informant interviews were held and a comprehensive list of all firms involved in health and HIV and AIDS financing and delivery was prepared. Research assistants with a questionnaire were sent to all the selected firms. The response was about 65%. The information collected was supplemented by that collected from MASM.

4.2.6 PROVIDERS

Surveys of purposely selected providers by different levels of care, ownership and region were carried out by research assistants and the NHA Team. Forms/questionnaires were used to collect the relevant information on utilization of various services, in particular for HIV and AIDS, RH and CH (children age 0-5 years) and expenditure figures by source of finance/financing agent and function. The quantity and quality obtained were, however, very poor, as most providers did not have accurate expenditure and utilization figures for different services.

Lack of accurate expenditure figures arises from the fact that, in Malawi, budgeting, funding and service delivery are integrated at the provider level, making it extremely difficult to tease out expenditures by function or disease/intervention.

As for utilization figures, it appears that a lot of information is collected and recorded in patient registers but these data are not entered and analyzed in the agreed upon health management information systems (HMIS) for use by the facility itself or management at the central level.

4.2.7 HOUSEHOLDS

In order to estimate household out-of-pocket spending, Integrated Household Survey results for 2004/05 were used. This estimated that health care consumes 1.3% of total private consumption. The figures were then distributed to various providers and functions using the household health expenditure and utilization survey of 2000.

4.2.8 PEOPLE LIVING WITH HIV AND AIDS

The PLWHA survey targeted confirmed HIV-positive persons in Malawi age 15 years and older at the time of the survey (for more details see Annex 5). The major types of information obtained included utilization of health care services, household assets and expenditures for inpatient and outpatient care. Location sampling was used to identify the target population. The locations identified for the survey were:

1. PLWHA receiving ARVs in health centres and hospitals in 2005

2. PLWHA receiving PMTCT in 2005

A sample of 900 individuals through the country was selected. The response rate was 93%.

Table 6 summarizes data sources, types of data collected and collection methods.

TABLE 6: SUMMARY OF INSTITUTIONS/ENTITIES, TYPE OF DATA COLLECTED, METHODS AND DATA SOURCES

Entity	Type of data collected	Methods and data sources
MoH	• Actual expenditures • Audited expenditures • Utilization figures • Inpatient days	• Budget and expenditure review of budget books, Consolidated Appropriation Accounts, audited accounts • HMIS review • Survey of selected providers by level of care and region
Other government departments including NAC	• Actual expenditures	• Survey of all institutions involved in financing health and HIV and AIDS services • Audited reports review, in particular NAC • Survey of selected providers by level of care and region
Donor	• Budgets • Disbursements • Actual expenditures	• National survey of all donors involved in funding health and HIV and AIDS services • Public Expenditure Review reports • Consultant's reports
NGOs	• Budgets • Actual expenditures	• National survey of all NGOs involved in financing and delivery of health and HIV and AIDS services
Firms and corporations	• Actual expenditures	• National survey of all firms and corporations involved in health and HIV and AIDS financing and delivery
Providers	• Actual expenditures • Utilization figures • Inpatient days	• National sample survey of selected facilities by ownership: MoH, private not-for-profit, private for-profit by level of care (health centre, district hospital, central hospital) and region (North, Centre and South)
Households	• Actual expenditures • Utilization	• Integrated Household Survey Report of 2004/05 • Household Health Expenditure and Utilization Survey Report 2000
PLWHA	• Actual expenditures • Utilization figures	• Special survey targeting PLWHA who have been confirmed HIV positive age 15 and above

Annex 6 contains a detailed methodology for estimating sub-accounts for HIV/AIDS, RH and CH.

4.3 PREPARING FOR DATA COLLECTION

4.3.1 The NHA Technical Team

Because the Malawi NHA study had four components (general, HIV and AIDS, RH and CH), the composition of its Technical Team was multi-sectoral, drawing from government, donors and civil society including the MoH, NAC, Malawi Economic Justice Network (MEJN), Action Aid International Malawi, UNAIDS/Malawi, WHO/Malawi, UNDP/Malawi, OPC HIV and AIDS Unit and the USAID-funded Partners for Health Reform*plus* Project (PHR*plus*). Overall technical support was provided by PHR*plus* and WHO/Malawi.

4.3.2 Survey Questionnaires

With technical assistance from PHR*plus,* the Malawi NHA Technical Team developed data collection instruments for various groups, notably: employers, NGOs, donors, health insurers, households, PLWHA, providers, other ministries/government institutions, among others. The questionnaires were thoroughly reviewed by all members of the NHA Team and adapted to the Malawi situation.

4.3.3 Training

The NHA Team was first exposed to NHA and HIV and AIDS sub-accounts training in September 2005. This training attracted all stakeholders interested in sub-accounts in Malawi as follows: the MoH was interested in the general NHA and RH and CH sub-accounts; NAC, with support from UNAIDS/Malawi and UNDP/Malawi, was interested in HIV and AIDS sub-accounts; and Action Aid International Malawi and MEJN, with support from the regional office for Action Aid International and Institute for Democracy in South Africa (IDASA) respectively, was interested in HIV and AIDS budget tracking. Because of this wide interest, PHR*plus* suggested that all stakeholders first undergo training on various types of methodologies used in resource tracking for both health and HIV and AIDS and thereafter decide the most efficient and cost-effective approach. After the training, all stakeholders agreed to undertake one study using the NHA framework including the HIV and AIDS (both health and non-health expenditures), RH and CH sub-accounts.

Several meetings were held to review and adapt data collection instruments for the study. Training sessions for data collectors for the Household Health Expenditure and Utilization Survey, PLWHA survey and institutional surveys were also conducted, in November 2005.

Due to the large quantity of data collected and entered, two data analysis workshops were held in May 2006.

4.4 DATA COLLECTION AND PROCESSING

Data collection was carried out by research assistants who visited all the selected institutions. Once questionnaires were filled out, they were submitted to the NHA Technical Team for initial checking for completeness and subsequent follow-up.

All the data were processed using micro computers. The data processing consisted of office editing of questionnaires, and data entry using Micro Soft Excel. The NHA Team also did data cleaning, which involved validation and consistency checks. NHA tables in Micro Soft Excel were used to analyze financial data.

4.5 FUNDING OF THE STUDY

The study design, training of NHA team members, enumerators, research assistants, data collection, entry, cleaning and analysis were funded by Action Aid International Malawi, IDASA through the MEJN, USAID/Malawi and WHO/Malawi through the MoH, UNDP/Malawi through NAC, UNAIDS/Malawi and MoH. All technical support was funded by USAID through PHR*plus* implemented by Abt Associates Inc. and partners.

4.6 LIMITATIONS OF THE STUDY

Five years after the first NHA was published in 2001, most of the limitations highlighted in that report were still encountered during this study. They included:

1. Reliability of estimates

   Data sources often provided conflicting data; therefore appreciable time had to be spent on cross-checking and in some cases making value judgments of the data.

2. Incompleteness of data

   Despite the research assistants' and NHA Team's repeated attempts at data collection, the response rate from donors and NGOs was poor and other sources had to be used to estimate their spending.

3. Unavailability of essential data in HMIS reports

   Desired information which was not available included utilization by type of reported cause of morbidity, facility type, age and ownership. Patient records at MoH facilities contain a lot of valuable information such as age, name of facility, cause of illness and discharges; however; these data are not reported in the HMIS bulletins. The indicators produced by the HMIS are not suitable for management performance improvement at facility and central levels as they are so aggregated and essential indicators such as bed occupancy rates, average length of stay, bed turnover rates, utilization by age, gender, type of facility-central hospital, district hospital, health centres are not reported.

4. Serious problems encountered with provider surveys

   Problems in quantity and quality of data were found in data collection from almost all providers (except MoH facilities at central and district hospitals) in terms of actual expenditures. This is because funding and health services delivery are integrated at the health facility level. As such, it was extremely difficult for providers to isolate expenditures by source, function (curative, rehabilitative, ancillary services etc.) and disease type such as HIV and AIDS. Furthermore, most private for-profit facilities were unwilling to provide their expenditures and revenue data, perhaps fearing that the data would be used for taxation purposes. Data on reported cause of morbidity or care seeking, number of bed days, discharge etc. were available in patient registers, but also were in a very poor state.

5. GENERAL NATIONAL HEALTH ACCOUNTS RESULTS

5.1 INTRODUCTION

This section presents the findings of the general NHA and discusses their policy implications. In addition to the presentation of the basic NHA tables, an attempt is made to undertake an analysis of equity, technical and allocative efficiency with the available data.

Major Policy Issues Addressed by the General National Health Accounts in Malawi

- Who are the major sources of financing health care services and goods in Malawi?
- Are actual expenditures on health increasing over time?
- Who are the major managers of health funds and how are their roles changing over time?
- On what are health funds spent?
- Which health providers receive the large share of health funds and is the situation changing over time?
- Are the resources efficiently and or equitably allocated and utilized?
- How sustainable is the Malawi health system?

5.2 TOTAL HEALTH EXPENDITURE

For the three years of this study, Malawi's THE increased from MK14.6 million to MK26.2 million (Table 7). Per capita THE grew from $15 to $20. This is an increase from the per capita estimate of $12 in 1998/99 (Malawi NHA Report 2001), but still one of the lowest amongst Southern Africa Development Community (SADC) countries and the sub-Saharan Africa region.

It also falls critically short of the $34 per capita THE that the WHO Commission on Macroeconomics and Health recommends is necessary to deliver a basic health care package in developing countries. For example, had Malawi tried to reach this $34 target with government resources alone, the expenditure would have equated to 18.5% of GDP in 2004/05, and total government general revenue in that year was approximately 20%. In other words, almost all government general revenue in 2004/05 would have been spent on health in order to reach the $34 per capita mark. This of course, would not have been feasible. Even combining government and donor resources, the gap would have represented about 11% of GDP. These scenarios, both unfeasible, show the serious inadequacy of financial resources in the Malawian health system and the economy as a whole. The country's economy needs to improve greatly so that it can make a meaningful contribution to health funding.

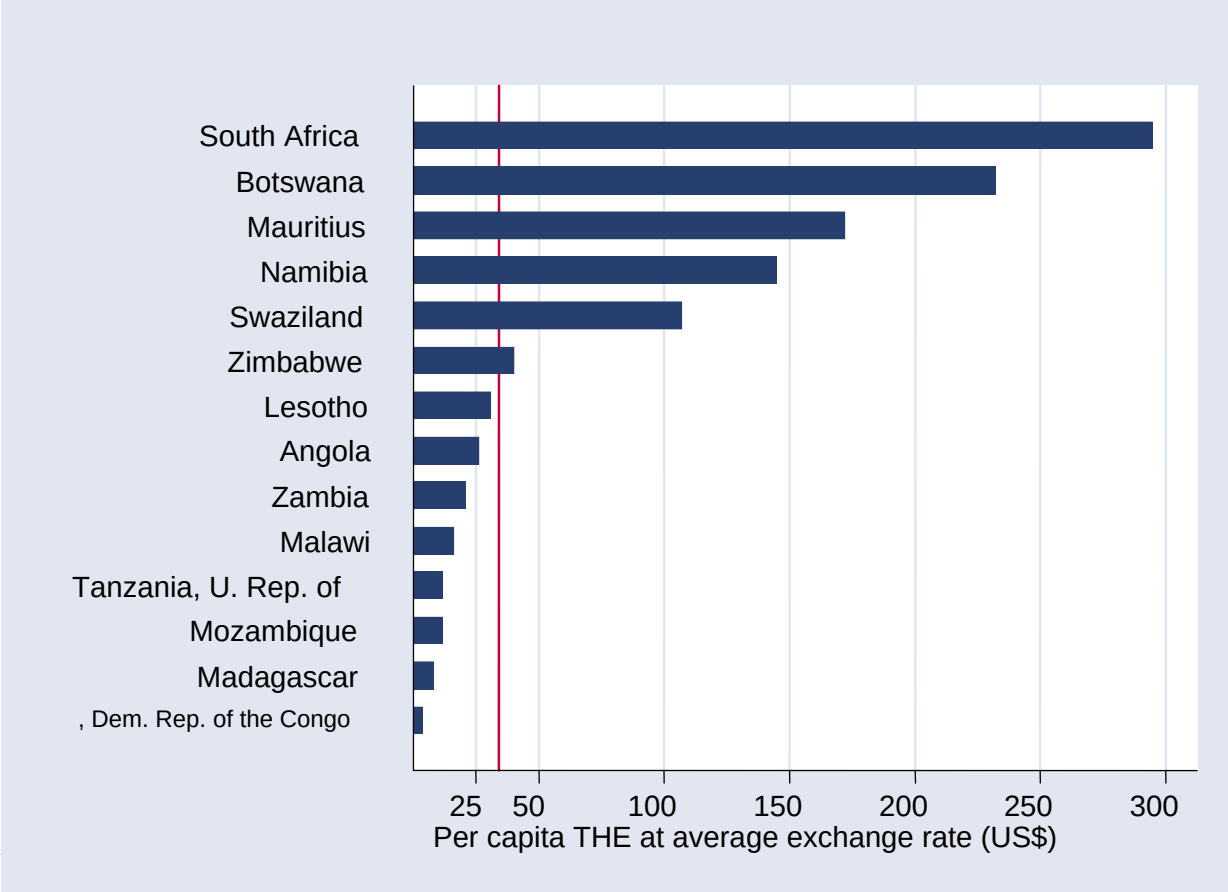
TABLE 7: MAIN NHA FINDINGS, MALAWI 2002/03-2004/05

Variable	Financial Year		
	2002/03	2003/04	2004/05
Total population	11,174,648	11,548,841	11,937,934
Average exchange rate US$1=MK	87.2818	108.5667	108.9432
Nominal GDP (millions MK)	148,356	171,917.8	204,640
Total government expenditure (millions MK)	56,583.261	64,787.000	68,769.835
Total expenditure on health (MK)	14,617,138,793	21,704,326,182	26,213,605,313
Total government expenditure on health (MK)	5,173,536,686	4,571,812,042	6,417,187,218
Per capita total expenditure on health (at average US$ exchange rate)	15	17	20
Per capita total expenditure on health (at international dollar rate)	50	66	70
Total expenditure on health as a % of GDP	9.9	12.6	12.8
Government expenditure on health as a % of total expenditure on health	35.4	21	24
Government per capita total health expenditure (at average US$ exchange rate)	5.3	3.6	4.9
Government total expenditure on health as a % of total government expenditure	9.1	7.1	9.3
National expenditure on health (MK)	15,492,798,289	23,129,120,331	28,347,302,608
Per capita national expenditure on health (at average US$ exchange rate)	16	18	22
Distribution of THE by financing source (%):			
• Public	35.4	22.5	25.4
• Donor	45.9	62.3	60.0
• Private	18.7	15.2	14.6
Households:			
• Household expenditure on health as a % of THE	12.2	9.7	9.1
• Out-of-pocket expenditure on health as a % of THE	12.1	9.6	9.0
• Out-of-pocket expenditure on health as a % of private expenditure on health	64.5	67.9	63.8
• Out-of-pocket per capita expenditure on health (at average US$ exchange rate)	1.8	1.7	1.8
Distribution of THE by financing agents (%):			
• Public	63.4	55.3	64.6
• Donor	10.7	20.0	10.9
• Private	25.9	24.7	24.5
Distribution of THE by provider type (%)			
• General hospitals	30.9	30.0	24.4
• Specialised hospital (mental hospital)	0.2	0.3	0.3
• Ambulatory health care	25.3	28.8	28.8
• Retail sale of medical goods	2.0	1.6	1.5
• Prevention and public health programmes	27.2	25.2	31.4
• General health administration	13.8	13.0	12.8
• Other	0.6	1.1	0.8

Source: General NHA Tables 2006 in Annex 7-A

As Figure 2 shows, for 2003/04, Malawi ranked fifth from last of the 14 SADC countries in terms of THE per capita. Most of the countries that have met the WHO-recommended $34 are in the middle-income category, with the exception of Zimbabwe.

FIGURE 2: TOTAL HEALTH EXPENDITURE PER CAPITA IN SADC COUNTRIES, 2003

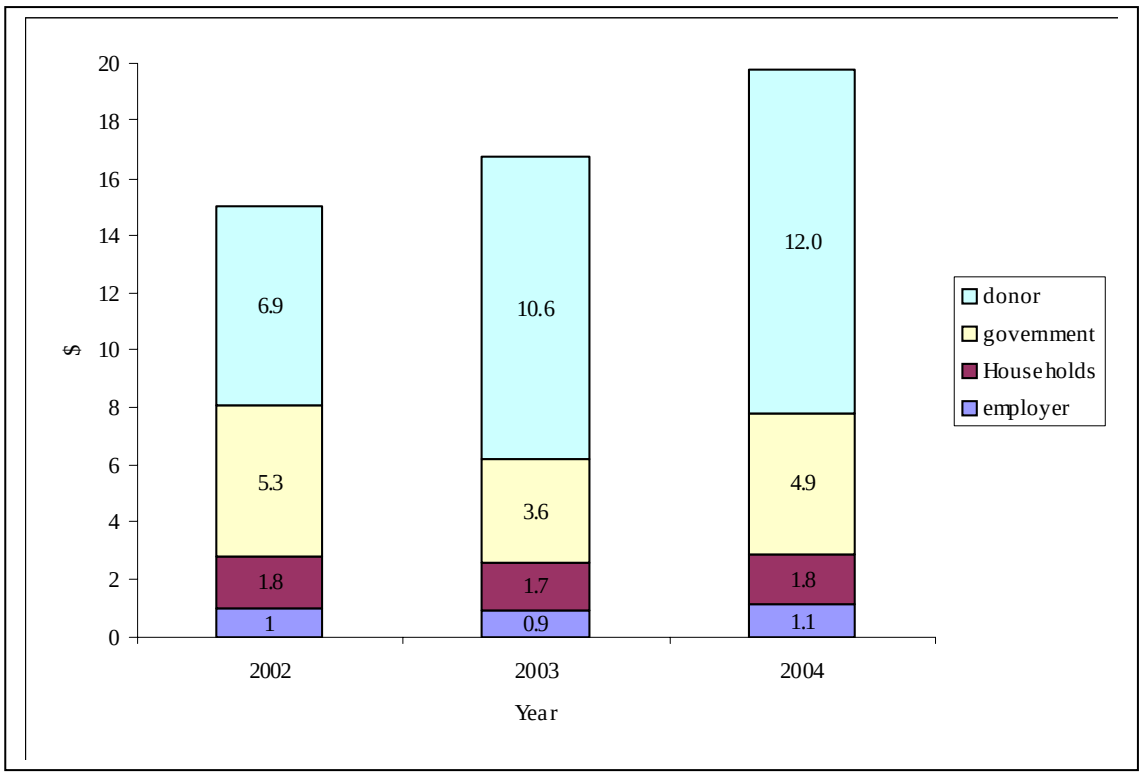


Despite a 44% increase in THE per capita in terms of Malawian kwacha between 2002/03 and 2004/05, the increase in U.S. dollar terms was only about 13%. This is due to the significant depreciation of the kwacha against the U.S. dollar in 2002/03-2003/04. Thus, although government contributed more to health care, depreciation eroded the value of its contribution, implying serious constraints in importing essential health technologies including pharmaceutical products.

The government's contribution to THE per capita fluctuated, from $5.3 in 2002/03 to $3.6 in 2003/04 to $4.9 in 2004/05. That is, government expenditure on health as percentage of THE decreased substantially in the three years, from about 35% in 2002/03 to 24% in 2004/05.

In the same period, donor contributions almost doubled, as shown in Figure 3. In fact, the greatest increase in contributions to per capita THE has been in donor funding, due to growth in HIV and AIDS funding from the Global Fund to Fight AIDS, Tuberculosis and Malawi and other donor initiatives such as the WHO 3x5 Initiative and the SWAp. The others have remained relatively constant.

FIGURE 3: CONTRIBUTION OF VARIOUS FINANCING SOURCES TO PER CAPITA TOTAL EXPENDITURE ON HEALTH



Source: General NHA Tables 2006 in Annex 7-A

Despite this increase, the combined contribution of government and donors, for a 2004/05 per capita THE of US$16.9, still falls short (by US$5.1) of the US$22 per capita estimated in 2004 to be required to deliver the Malawi EHP.[10] Furthermore, this gap (between the actual per capita THE and EHP need) was even wider than US$5.1 per capita because (1) there are several other health services which are outside the defined EHP which are treated in MoH and CHAM health facilities, (2) there are several non-EHP services which are treated in private for-profit hospitals and abroad in particular South Africa but financed by the MoH health budget[11] and (3) the estimated US$22 per capita per annum did not take into account changes in technology that could have significant impact on the overall cost of health care, notably introduction in 2003/04 of artemisinin-based combination therapies for malaria treatment, which are more expensive than the sulfadoxine-pyrimethamine (SP) which the government used to use as the frontline drug. This therefore implies that resources available in the health sector in order to meet the basic health needs of the population were seriously inadequate during the period under review.

However, it is heartening to note the increase in donor contributions from 2003/04 to 2004/05 (the commencement of the implementation of the POW 2004-10 through the SWAp arrangement to health financing and management). It is hoped that this situation will continue throughout the POW 2004-10

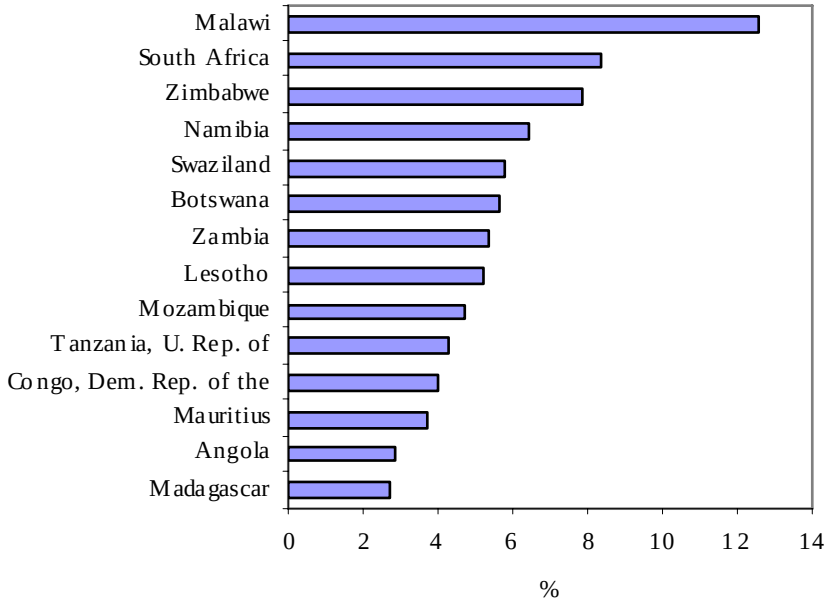
[10] In 2002 the full cost of EHP implementation was calculated to be about US$17.5 per capita per annum. This figure was revised upwards in 2004 to US$22 per capita per annum during development of the PoW 2004-2010 to include new activities such as ARV drugs, District Health Management Team supervision costs, operational costs for Zonal Health Support Offices and the Health Services Commission.

[11] In 2004/5, about MK128 million was spent on treatment abroad for 15 patients.

implementation period. Even though this is the case, currently, there is need for (1) re-estimating the cost of implementing EHP so that it reflects changes in new technologies, such as the aforementioned introduction of artemisinin-based combination therapies for malaria treatment, (2) much more rigorous and explicit prioritization of EHP services such that only EHP services are funded and provided free as described in the POW 2004-10 and (3) finding feasible alternative ways of funding non-EHP services including treatment abroad.

The THE as a percentage of the GDP increased from 9.9% in 2002/03 to 12.8% in 2004/05. This figure is one of the highest in sub-Saharan Africa, and the sub-region (Figure 4). However, as discussed earlier, it should be noted that because of the country's low GDP, this translates to a low level of per capita THE. So, until the GDP demonstrates a remarkable growth rate, significant improvement in the per capita health spending is unlikely to be realized. Malawi is therefore expected to rely on continued donor contributions to health for the medium to long term.

FIGURE 4: TOTAL HEALTH EXPENDITURE AS % OF GDP, SADC COUNTRIES, 2003



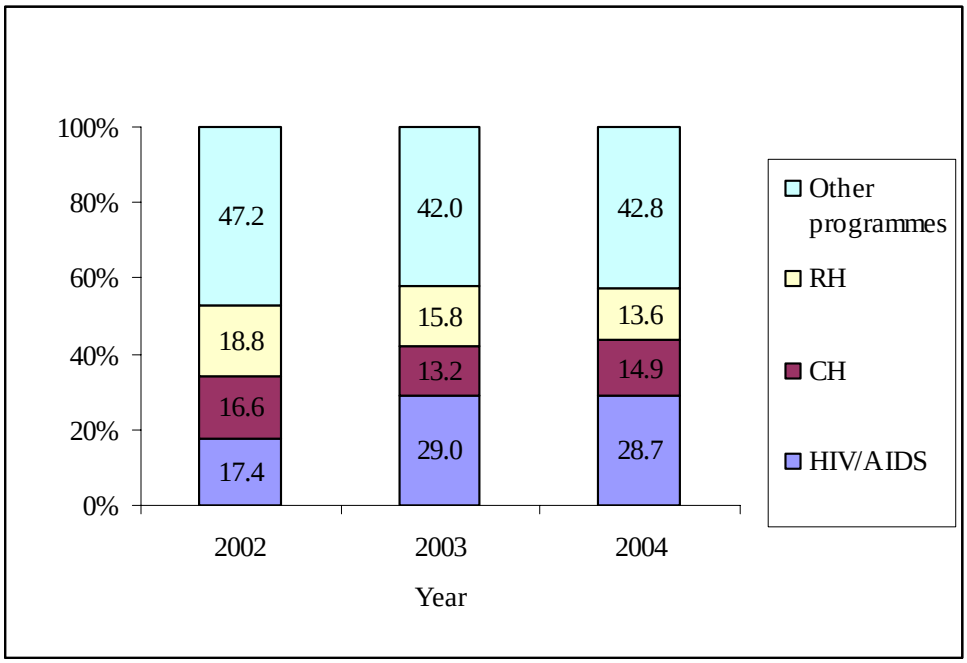
Source of data for Malawi is current NHA; for others: WHO (2006)

THE accounts for about 9% of total government expenditure. This percentage is much less than the Abuja Declaration target, which asks governments to allocate at least 15% of the government budget to health, but typical – in 2003/04, African governments allocated on average about 9% of their total expenditure to health (WHO 2006).

Out-of-pocket health spending as a percentage of THE decreased from about 12% in 2002/03 to about 9% in 2004/05. Out-of-pocket health spending accounted for about two thirds of the private component of THE. This implies that the share of private insurance or any other prepaid system is relatively small.

Figure 5 summarizes the relative proportion to THE that each of the four components of this NHA study (general NHA, HIV and AIDS, RH and CH) constitutes. It is clear that HIV and AIDS share of THE rose substantially during the period under review.

FIGURE 5: DISTRIBUTION OF TOTAL HEALTH EXPENDITURE BY PROGRAMME AREA: 2002-2004



Source: General NHA, HIV and AIDS, RH and CH tables in Annexes A, B, C and D.

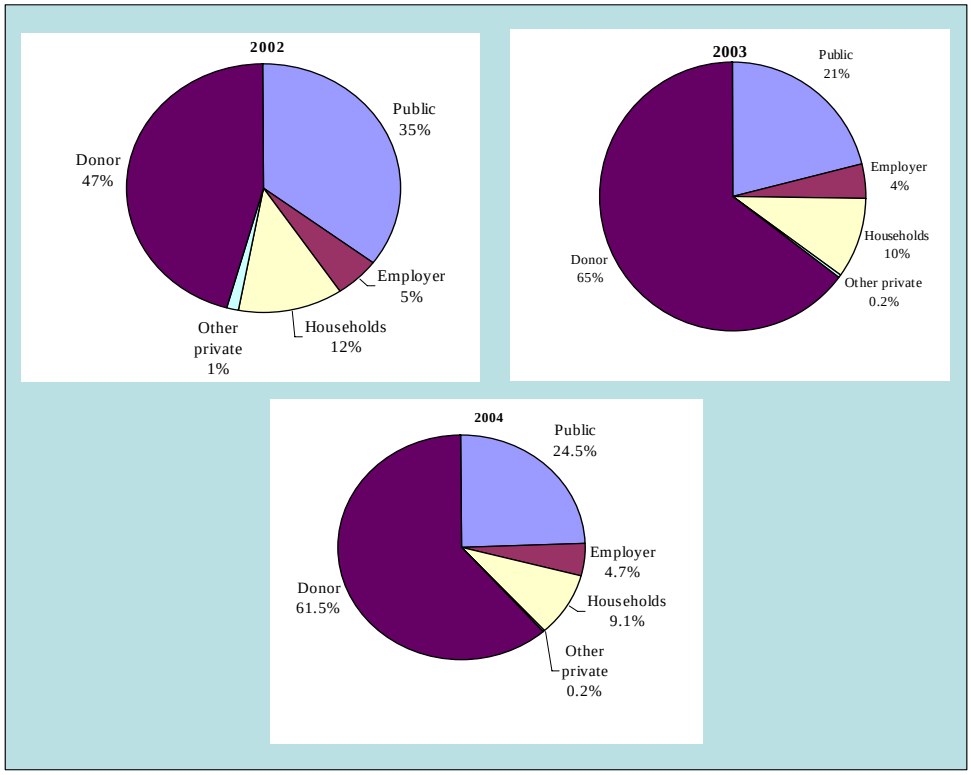
5.3 FINANCING SOURCES: WHERE DO HEALTH FUNDS COME FROM?

Financing sources generate health funds. In the three years covered by this NHA study, donor funds accounted for the bulk of THE, ranging between 45 and 65% (see Figure 6). This donor funding increased as the share of public sources declined, from about 35% to 25%. The increase is due mainly to (1) the commencement of financing for HIV and AIDS by the Global Fund in 2003/04 and (2) the commencement of implementation of the PoW 2004-10 through the SWAp in 2004/05. This has made the health system increasingly donor dependent, which poses a major challenge for the sustainability of provision of health care in the event of the country disagreeing with donors over political and management issues. Furthermore, some donor funds come with 'complex conditionalities' which delay implementation of the planned activities (WHO 1994). Government contributions must keep pace with (or at least not fall too far behind) donor financing if the tenet of sustainability is to retain meaning in the health sector. Furthermore, it is clearly stated in the SWAp Memorandum of Understanding signed in 2004 between the Government of Malawi (MoH) and donors that the Treasury contribution to the pool fund must be maintained or increased in absolute terms. As such, the decline in the government's contribution until 2004/05, when the SWAp partially commenced, is an issue which needs urgent attention12.

[12] The SWAp Memorandum of Understanding between the Government of Malawi (MoH) and donors (DfID, Nowergian Government and the World Bank) was signed on 29 October 2004. Commencement is called partial because only a few activities as agreed in the PoW 2004-10 were implemented in the first year.

FIGURE 6: HEALTH FINANCING SOURCES, 2002/03-2004/05

Source: General NHA tables 2006 in Annex 7-A



Furthermore, it should be noted that these high donor expenditures went mainly to many 'projects and programmes' which were outside the government budget and over which the government had no direct control. As such, their effectiveness in addressing the health system priorities identified in the PoW 2004-10 (development and retention of human resources, pharmaceuticals and medical supplies, essential basic equipment, infrastructure-facilities development, routine operations at service delivery level and central institutions and policy and systems development) was questionable.

It is hoped that the commencement of the SWAp planning, financing, management and monitoring arrangement will address most of these problems. As for the donors who are not yet part of the SWAp pool arrangement, it is hoped that they will buy into the PoW 2004-10 and start implementing the Malawi health systems priorities as outlined above.

Figure 6 also shows that employer contributions to THE remained essentially the same (4-5%) throughout the study period. Household contributions, predominantly direct out-of-pocket payments, declined slightly (from 12% to 9%). This decrease is desirable as it lessens the risk of catastrophic health expenditure for a population of which more than 52% lives below the national poverty level. However, it should also be noted that this decline in household contribution is a result of the increase in donor contributions. In absolute terms, household's contributions rose by 35% from 2002/03 to 2004/05 (see Annex 7-A for more details).

5.4 FINANCING AGENTS: WHO MANAGES/CONTROLS HEALTH FUNDS?

Financing agents are institutions or entities that have programmatic control on how and where the funds are spent. They undertake the financing function of pooling and purchasing, pooling resources from different financing sources and purchasing health care/paying health providers through a variety of mechanisms such as budgets and contracts.

The major financing agent in Malawi is the MoH, which controlled about half of total health expenditures in 2004/05 (see Table 8). However, it is clear that its role as a financing agent has declined over the three years of this study. In contrast, the NAC's role as a financing agent increased significantly. This may be explained by the fact that the bulk of financing for HIV and AIDS providers and health functions that were previously undertaken by the MoH were transferred to the NAC and, again, the NAC manages almost all Global Fund resources to fight HIV and AIDS.

TABLE 8: PERCENTAGE DISTRIBUTION OF TOTAL HEALTH EXPENDITURE BY FINANCING AGENTS, 2002/03-2004/05

ICHA Code	Financing agent	Year		
		2002/03	2003/04	2004/05
		%	%	%
HF.1.1.1.1	MoH	60.2	49.5	51.6
HF.1.1.1.2	NAC	1.8	3.5	11.9
HF.1.1.1.3	Other ministries and government agencies	0.7	0.8	0.7
HF.1.1.3	Local authorities	0.7	1.5	0.4
HF.2.2	Private insurance scheme	2.3	2.0	2.7
HF.2.3	Households (out-of-pocket payments)	12.1	9.6	9.0
HF.2.4.1	CHAM	4.2	2.9	4.2
HF.2.4.2	Local NGOs	4.4	7.9	6.4
HF.2.5	Private firms/employers	3.0	2.3	2.2
HF.3	Rest of the world	10.6	20.0	10.9
		100	100	100

Source: General NHA Tables 2006 in Annex 7-A

Even though the public sector is the primary financing agent and provider of health care services in Malawi, and its services are free of charge at the point of use thus encouraging utilization, there are indications that there are serious inequities in access to health care services and goods in Malawi. A trend analysis of selected DHS indicators of health service utilization (see Table 9) shows that the richest 20% of the population utilize more health services than the poorest 20%.

TABLE 9: SELECTED INDICATORS OF HEALTH SERVICE USE

Indicator	1992		2000		2004	
	Population average	Quintile ratio (poor/rich)*	Population average	Quintile ratio (poor/rich)	Population average**2	Quintile ratio (poor/rich)***
Immunization coverage (%)	81.8	0.82	70.1	0.80	64.4	0.67
ARI*: % medically seen if ill	53.7	0.76	26.7	0.39	19.6	0.67
ARI: treatment in public facility	36.5	0.73	18	0.58	NA	NA
Diarrhoea: oral rehydration therapy	73.3	0.75	62.1	0.85	61.1	0.84
Diarrhoea: % seen if medically ill	49	0.76	28.3	0.79	36.4	0.85
Diarrhoea: % seen in public facility if ill	34.7	0.87	20.7	1.08	NA	NA
Antenatal visits to a medically trained person (doctor, nurse or nurse-midwife)	90.1	0.87	92.5	0.91	92.1	0.91
Delivery attended by a medically trained person	54.9	0.57	55.6	0.52	56.1	0.55
Delivery: % of births at a public facility	41.2	0.58	40.2	0.56	41.9	0.61
Delivery: % of births at home	42.7	2.6	43.6	3.39	29.4	4.0

Note: NA=Data not available

* A ratio of 1 indicates equity between the richest and poorest quintiles; greater than 1 indicates inequity in favour of the poorest quintile; less than 1 indicates inequity in favour of the richest quintile.

** Source: Malawi DHS 1992, 2000 and 2004

*** Own calculation

In almost all the service use indicators, the richest quintile utilized more health services than did the poorest quintile. The degree of inequity manifested a substantial increase in the two ARI service indicators in favour of the rich. Inequity in the proportion of births taking place at home favours the poorest quintile. This implies that home delivery is mainly practiced by the poor compared to the non-poor. Furthermore, the magnitude of the pro-poor inequity in home delivery has widened during the period, implying that the poor increasingly resort to home delivery. A decline in inequality was seen only in oral rehydration therapy use and the proportion treated for diarrhoea in public facility.

The public sector, in particular the MoH, also funds the cost of overseas referrals. For example in 2004/05, approximately MK128,858,651 was spent on treatment abroad for about 15 patients; this equates to MK8,590,576 (US$78,812) per patient, an amount equivalent to the annual recurrent cost of one district health services-hospital, health centres/dispensaries and prevention and public health

services[13]. While many of these referrals are a necessity for lack of specialized medical personnel and equipment in Malawi, their cost effectiveness appears to be very low.

A thorough evaluation of the free public health service provision policy, whereby public resources fund inputs[14] such as salaries, drugs and equipment, and its overall impact on quality of health care services and access to and utilization of health care services should be undertaken. However, to ensure that that the poor benefit most from the available resources, the public sector should fund only EHP services from public funds. Alternative mechanisms for financing non-EHP services, such as the introduction of compulsory health insurance for all formal sector employees and their dependents, could be investigated. This could free up resources currently used by this group, whose utilization of health care services is often higher than that of the poor as noted in Table 9. However, the major challenges facing the development of such a scheme include the small size of the formal sector, low salaries and wages which are already over taxed and inequities in the distribution of health care facilities and human resources for health between rural and urban areas.

It is also interesting to note that on average donors managed about 13% of THE; this was highest (20%) in 2003/04. One explanation for this peak in 2003/04 is the procurement of ARV drugs with funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria and managed by donors (UNICEF) themselves. This situation, as has been noted previously and will be pointed out in other contexts below, whereby donors provide and manage funds, has implications for the sustainability of Malawi's health system. As long as there is a clear understanding between donors and the MoH (which has stewardship responsibility for health) that this is a short-term solution, while in-country human and institutional capacity is being built in the health system, this is acceptable. However, if capacity is not being built in national institutions such as Central Medical Stores, which has responsibility for planning, procurement and distribution of drugs including ARVs, then sustainability is jeopardized, and this calls for immediate attention.

Households through direct out-of-pocket spending are the third largest financing agent, averaging about 10% of THE, a dramatic decline from 26% in 1998/99. Nevertheless, in absolute terms, direct out-of-pocket spending has been increasing substantially, rising by 41% between 1998/99 and 2002/03, by 12% between 2002/03 and 2003/04 and by 21% between 2003/04 and 2004/05. This rise in out-of-pocket spending could be due to the fact that, while donor contributions for health increased[15], it appears these resources were not used to address the long-standing issues of poor quality health care services in MoH facilities (Ministry of Economic Planning and Development 2002, and MOH 2004), thus forcing households to continue seeking health care in paying facilities (see Annex 7-A for more details). By 2004/05, household direct out-of-pocket spending for health stood at MK2.3 billion, almost half of the MoH recurrent health budget actual expenditure of MK5.3 billion (see Annex 7-A). It was much greater than the amount of funds passing through health insurance schemes, in particular MASM, about MK0.7 million in 2004/05. The size of these expenditures is huge considering the poverty of the population and the negative effects of the direct out-of pocket spending on access to and utilization of health care

[13] For example, in 2004/05, Salima district, which had an estimated population of 331,308 and 11 facilities (one district hospital of 240 beds, eight health centres, two dispensaries) and also provided prevention and public health services had recurrent expenditures of MK122, 358,873, an amount was less than that spent on treatment abroad for 15 patients.

[14] Alternative financing mechanisms such as Conditional Cash Transfers to the beneficiaries of a specific service such as delivery, immunization and VCT or Performance-Based Financing can be examined. Performance-Based Financing is an approach to health financing that shifts attention from inputs to outputs in health services, such as number of patients seen and number of deliveries, linking incentives to performance. Rwanda is currently replicating the results of the pilot performance based/incentive financing system nationally (Eichler, Feb 2007).

[15] Donors mainly funded prevention and public health vertical programmes while households through direct out-of-pocket spending financed mostly curative health care services during the period under review.

services and goods. This level of household contributions in an almost-free public health care system raises serious issues of equity in access to health care and health outcomes, especially in light of the goals of the Malawian health system.

The MoH, as the largest pooling and purchasing agent for health care services and goods in Malawi, needs to serious examine how the limited resources under its control can be efficiently allocated so as to improve the quality of care delivered in its health facilities and hence encourage utilization of its services which would ultimately improve the health of individuals and the population. One way is to investigate the feasibility and viability of performance-based financing where focus would be on providing incentives to providers for achieving agreed targets rather than funding inputs as was done during the period under review or investigate the feasibility of Conditional Cash Transfers to would-be beneficiaries for utilizing agreed services.

While households by virtue of their direct payments for health are only the third largest financing agent in the Malawian health system, they are the largest financing agent in the private sector, controlling an average of 40% of total private health expenditures (see Table 10). Furthermore, the household direct out-of-pocket contribution exceeds that of health insurance schemes/MASM and is almost half of the government recurrent health budget. This suggests that there is potential to pool a large part of these household expenditures by expanding membership of MASM or introducing an insurance scheme for the formal sector[16].

Local NGOs which are funded mainly by donors are the second largest financing agent in the private health sector, controlling an average of 25% of private financing health spending. Private insurance (MASM) handles only 9% of total private financing agents health funds and only 2% of THE (as seen in Table 10 below and Table 7 above). This is a very small percentage compared to the number of formal sector companies and their employees.

TABLE 10: PERCENTAGE DISTRIBUTION OF HEALTH EXPENDITURES BY PRIVATE FINANCING AGENTS, 2002/03-2004/05

Financing agent	2002	2003	2004	Average: 2002/03-2004/05
Private insurance	8	8	11	9
Household out-of-pocket spending	44	39	37	40
CHAM	15	12	17	15
Local NGOs	16	32	26	25
Private firms and parastatals	17	9	9	11
	100	100	100	100

Source: NHA Tables 2006 in Annex 7-A

[16] Because prepaid funds are not paid at the point of use of health services, they may encourage overutilization of health care services and goods; this moral hazard could be minimized through effective monitoring systems.

Health Care Providers: Where do health funds go in Malawi?

Providers are the entities that deliver health service. They answer to the question "where does the money go?" These include entities such as public and private hospitals, health centres, dispensaries, clinics and pharmacies.

Overall, hospitals as providers accounted for the greatest proportion of THE in 2002/03 and 2003/04 (see Table 11). This may be due to the fact that the public health sector budgeting system, in particular the MoH, follows infrastructure rather than health needs of the population despite the development of a resource allocation formula[17]. However, their share declined significantly, from 31% in 2002/03 to about 25% in 2004/05, and the shares of public health programmes and ambulatory health care increased slightly. Given the disease profile in the country, which consists predominantly of diseases amenable to interventions at the health centre/dispensary level, this move is likely to augment the allocative efficiency of the system. It is also an equitable allocation as the majority of the population in Malawi (about 85%) live in rural areas where most of the health centres, dispensaries and maternity units are located. The details are depicted in Table 11.

However, much as the expenditures at health centres, dispensaries and maternity units increased during the period under review, these facilities most often suffer from lack of drugs and medical supplies and trained health personnel[18]. This therefore implies that there is need for a review of systems for drugs and medical supplies distribution, prescription, storage and use in these facilities and training of health personnel and review their deployment.

TABLE 11: PERCENTAGE DISTRIBUTION OF TOTAL HEALTH EXPENDITURE BY PROVIDER TYPE, 2002/03-2004/05

Provider type	Year		
	2002/03	2003/04	2004/05
Hospitals	31.0	30.3	24.7
Health centres, dispensaries, maternity, clinics, traditional healers,	25.3	28.8	28.8
Pharmacies/shops/groceries	2.0	1.6	1.6
Public health	27.2	25.2	31.4
General health administration and insurance	13.8	13.0	12.8
Rest of the world	0.3	0.2	0.4
Provider not specified	0.4	0.9	0.3
	100	100	100

Source: NHA Tables 2006 in Annex 7-A

[17] The current MoH Resource Allocation Formula takes into account poverty levels, population and infrastructure. However, it is not strictly followed and is in need of revision.

[18] Data demonstrating poor quality abound. The IMCI Baseline Survey shows that not all therapies provided for child fever were appropriate and that inappropriate use of malaria drugs is common, both instances showing the scant training of the caregiver. DHS data show that although use of antenatal care is high, services received by mothers are highly variable, based on advice provided to mothers, drugs and supplies given, and procedures performed. The poor quality of health facilities is starkly shown in the high fatality rate of mothers reaching health centres and hospitals to deliver. Data on a small-scale community audit of all maternal deaths in Nankumba (population of 63,000) show that as many as 44 percent of all maternal deaths occur in hospitals and 12 percent in health centres (McCoy et al., 2004), proving that although patients had physical access to facilities, these facilities are ill-equipped or ill-staffed to deal with emergency obstetric cases.

The part of THE spent on general health administration and insurance has remained relatively stable over the period considered.

Public sector hospitals account for about 23% of THE, whereas those of CHAM and other private not-for-profit hospitals account for about 6% (see Annex 7-A). The share of private for-profit hospitals is very low (see Tables in Annex 7-A). It therefore cannot be overemphasized that overall, the public sector is the main provider of health services in the country and therefore has the major responsibility to improve the quality of health care services and goods to benefit the majority of the population.

5.5 HEALTH CARE FUNCTIONS: ON WHAT WHERE HEALTH FUNDS SPENT?

Health care functions are services or activities delivered by providers. These include curative care, rehabilitative care and prevention.

The greatest proportion of THE is spent on outpatient and inpatient curative care (see Table 12 and Annex 7-A for more details). A breakdown by financing agents, however, shows great variability. For example, in 2002/03, while curative care consumed about 41% of THE, the corresponding figure for CHAM was about 68%. (See FA X HC Tables in Annex 7-A.) This implies that the private health sector purchases more curative care, relatively less prevention and public health. Past studies have shown[19] that in the catchment areas of some CHAM health facilities, immunization rates were found to be below the national average, despite being free.

Thus even though a large amount of resources are spent on CHAM facilities, it appears the majority of the population within CHAM catchment areas are denied access to its health care services and goods due to the need to pay user fees in its facilities. Thus the MoH strategy to enter into service contracts with CHAM, such that CHAM will provide EHP services free of charge on behalf of the government, is a move in the right direction.

TABLE 12: PERCENTAGE DISTRIBUTION OF TOTAL HEALTH EXPENDITURE BY HEALTH CARE FUNCTION, 2002/03-2004/05

Health care function	Year		
	2002/03	2003/04	2004/05
Curative	48.9	54.3	48.3
Rehabilitative	0.8	0.9	1.4
Prevention & public health	27.3	25.2	31.4
Health administration & insurance	13.8	13.0	12.4
Capital formation	0.4	0.9	0.3
Not specified by kind	8.8	5.7	6.2
Total	100.0	100.0	100.0

As also can be seen from the Table 12, capital formation accounted for less than 1% of THE in each of the three years studied. Health administration and insurance fluctuated at around 13%.

[19] A cost sharing study undertaken in 1992 by CHAM and MoH to provide information on the feasibility of introducing cost sharing in MoH hospitals.

5.6 NATIONAL EXPENDITURE ON HEALTH

National expenditure on health (NHE) includes the THE (expenditure with the primary objective to enhance, maintain and restore the health of individuals and population groups) and expenditure on health-related functions, which in the context of this study include education and training of health personnel; research and development in health; food hygiene and drinking water control; and environmental health[20].

Over the three years studied, expenditure on health-related functions was US$1-2 per capita, and per capita NHE was between US$16 and US$22 (see Table 4). Thus, the NHE was not significantly different from THE.

Expenditure on research and development in health constituted less than 1% of NHE. This is less than the 1990 recommendation of the Commission on Health Research for Development that governments in low- and middle-income countries allocate at least 2% of the national health budget to essential national health research. This is likely to adversely affect evidence-based policy making and practice.

Distribution of Sources of Finance by Function

Table 13 shows that nearly three quarters of Ministry of Finance funds were used for curative care services in hospitals, health centres and dispensaries, as well as treatment abroad. Only 9% of Ministry of Finance funds were used for prevention and public health activities. In contrast, about 25% and 43% of total donor funds were used for curative care and prevention and public health care services respectively in 2004/05.

This high level of funding of curative care by the Ministry of Finance is of great concern for many reasons, one of them being the fact that curative interventions benefit only the treated individual while prevention and public health interventions benefit other members of the community as well as the individual. In addition, as was seen in Table 3 (EHP interventions), it is clear that most of the major causes of Malawi's burden of the disease could be prevented through simple, inexpensive technologies and preventive public health care interventions at community and health centre and dispensary level.

[20] Capital formation of health care provider institutions is included in THE.

TABLE 13: DISTRIBUTION OF MINISTRY OF FINANCE FUNDS BY USE (%), 2004/05

Function	Ministry of Finance	Donor	Local government	Employers	Households	Other private sources
	%	%	%	%	%	%
Services of curative care	73	25	8	84	83	0
HC.1.1 Inpatient curative care	47	8	2	24	47	
HC.1.1.1 Treatment abroad	2			1		
H.C.1.3 Outpatient curative care	24	17	6	59	36	
HC.2 Services of rehabilitative care	1	2				
HC.4 Medical goods dispensed to outpatients				5	14	
HC.6 Prevention and public health services	9	43	60	2		
HC.7 General health administration	8	16		9		70
HC.R.1 Capital formation	5	7				
HC.R.2 Education and training	2	7				
HC.R.4 Food, hygiene and drinking water control	2	1	32			30
HC. Nsk		0			3	

Source: NHA Tables in Annex 7-A

5.7 SUB-HEALTH SECTOR ANALYSIS: MINISTRY OF HEALTH

5.7.1 DISTRIBUTION OF MOH RECURRENT EXPENDITURE BY LEVEL OF CARE

Table 14 shows the distribution of MoH recurrent expenditure by provider type. It can be clearly seen that the MoH funds a hospital-based health care system. About 64% of all MoH expenditures occurred at hospitals, including central district and rural hospitals. An additional 2% was spent at Zomba Mental Hospital. This runs contrary to the vision of the POW 2004-10.

As noted above, the major causes of morbidity and mortality in Malawi can be prevented and treated at health centres and dispensaries through the provision of the EHP (MoH 1995, 1999, 2004). Thus the current consumption of resources by hospital-level care is inefficient. Underfunding and lack of prioritization of the health centre level means that services (drugs, supplies, equipment and personnel) are not available there; as a result patients bypass these facilities to seek higher quality care in hospitals (MoH 2005a, MEJN 2005). Current MoH financing, by which resources have tended to follow infrastructure rather than health needs, exacerbates this problem. A hospital-based system is also an equity concern in that the majority of the Malawian population, and particularly those most poor, live in rural areas, away from district and central hospitals.

TABLE 14: DISTRIBUTION OF MINISTRY OF HEALTH RECURRENT EXPENDITURE BY PROVIDER TYPE, 2004/05

Provider type	%
HP.1 Hospitals	66
HP.1.1 General hospitals	64
HP.1.1.1.1 Central hospitals	19
HP.1.1.1.2 District and rural hospitals	45
HP.1.2 Mental hospital	2
HP.1.3.9.1 Health centres/dispensaries	21
HP.5 Providers of prevention and public health programmes	6
HP.6 General health administration-headquarters	7
	100

Source: General NHA Tables in Annex 7-A

A further cause of excessive expenditures on district hospitals is likely the structural organization of health services at the district level. Each district is served by a District Health Management Team (DHMT), headed by the District Health Officer and responsible for the planning and allocation of resources among all the functions and facilities within the district. In practice, however, the DHMT almost without exception is based at the district hospital and, in effect, also operates as a District *Hospital* Management Team. It is hardly surprising, therefore, that given the interests at play and that the needs of the district hospital and surrounding facilities are most evident to the DHMTs, a centralization of resources within districts has occurred. This implies the need to split the functions of the District *Health* and District *Hospital* Management Teams, to ensure adequate focus on peripheral facilities and prevention *and* public health programmes in District Implementation Plans.

5.7.2 DISTRIBUTION OF MOH EXPENDITURE BY FUNCTION

MoH spending on curative health care has increased substantially from the 1998/99 levels (MoH 2001). In 1998/99 MoH spending on curative health care services was around 47% of total MoH recurrent expenditures; by 2004/05 it had grown by 31 percentage points to 78% of the total (see Table 15). This is due mostly to the increased burden of HIV and AIDS and opportunistic infections, and increases in the salaries of health workers (although expenditure on personal emoluments still remains far lower than desired).

TABLE 15: DISTRIBUTION OF MINISTRY OF HEALTH RECURRENT EXPENDITURE BY FUNCTION, 2004/05

ICHA	Function	%
HC.1	Curative care	78
HC.1.1	Inpatient curative care	50
HC.1.1.1	Treatment abroad	2
HC.1.3	Outpatient curative services	25
HC.1.2	Rehabilitative care	1
HC.R.1	Capital formation	5
HC.6	Prevention and public health	6
HC.7	General health administration-headquarters	7
HC.R.4	Nutrition	3
		100%

Source: General NHA Tables in Annex 7-A

Because, as previously noted, the benefits of curative care accrue to the individual and not to the general population (i.e. curative care is less of a public good than prevention or public health), it is therefore reasonable, depending on the economic situation of users, that curative care, in particular non-EHP services, be financed from private sources. Given the current high levels of MoH spending on curative services, and that the EHP is free to all, it is possible that richer sections of the population are being highly subsidized. Even in district and central hospital private wings, and paying outpatient departments, it is likely that fees charged do not match costs of treatment – resulting in a further subsidy to richer patients (MoH 2005a).

Cooperation between the MoH and private sector in areas of joint interest holds potential for exploiting efficiency gains in this regard. The introduction of mandatory health insurance for instance, most likely initiated in the formal public sector, is just one such move. The MoH recently appointed a desk officer to develop a public-private partnership policy for the health sector. This is a welcome move. Service agreements need not be restricted to CHAM, but rather can also encompass other not-for-profit and for-profit private providers. The recent passage of the NGO Law and Procurement Law should provide the legal basis for such contracts.

Distribution of Ministry of Health Recurrent Expenditure by Geographic Region

The Malawi 1998/99 NHA (MoH 2001) revealed that MoH per capita recurrent expenditures by region were highest in the North, followed by the South, and lowest in the Centre. This trend has continued through 2004/05 (see Table 16), even with the introduction of a resource allocation formula in FY 2001/02. One probable factor is the lower population density in the North, and the lower resultant economies of scale in health service delivery. However, scrutinizing per capita expenditures by regions alone does not provide a clear enough picture; we must also look within regions and consider health care *needs*.

TABLE 16: DISTRIBUTION OF MINISTRY OF HEALTH RECURRENT EXPENDITURE PER CAPITA BY REGION

	1998/99	2004/05
	Per capita (MWK)	Per capita MWK
North	46.87	558.73
Centre	23.58	340.03
South	33.45	405.69

Source: Malawi NHA Report 2001 and General NHA Tables in Annex 7-A

Ministry of Health Regional Recurrent Expenditures Compared to Need

Table 17 shows per capita allocations for health by region, against a selection of indicators to measure health care need. As noted above, per capita expenditures are highest in the North (MK559 per capita), second highest in the South (MK406) and lowest in the Centre (MK340). Population density is much lower in the North than the rest of the country – less than half of the density in the Centre, and a third of that in the South. This suggests that the North requires larger per capita expenditure to allow for such factors as higher transport and referral costs. However, other indicators of need in the North do not appear to be particularly severe. Under-five mortality and the percentage of children with stunted growth (low height for age) are actually lower in the North than in the other regions. We can therefore conclude that health care resources are not following health *needs.*

TABLE 17: DISTRIBUTION OF MINISTRY OF HEALTH RECURRENT EXPENDITURE PER CAPITA IN RELATION TO PROXY INDICATORS OF HEALTH NEEDS, 2004

Region	Per capita allocations (MK)	Population density*	% classified poor**	% stunted growth***	Under-5 mortality (per 1,000)***
North	558.73	46	56.3	42.4	120
Centre	340.03	114	46.7	52.7	162
South	405.69	146	64.4	45.3	164

Sources: General NHA Tables in Annex 7-A, *NSO 1998; **NSO 2005 (living on less than $1 per day [excludes urban areas]); ***DHS 2004

Further analysis indicates a high level of correlation between expenditure on health and the number of MoH facilities in each of the three regions. Table 18 shows the proportion of total MoH health expenditure incurred by region in 2004/05, and the distribution of MoH health facilities[21]. It clearly shows that number of facilities is a very good proxy of actual expenditures. The fact that facilities are not distributed evenly in the country means that there is an inequitable allocation of spending when analyzed on a per capita basis. Although the MoH has had a district resource allocation formula since 2001, this has not been strictly operationalized. In light of current information, the MoH should promptly update the allocation formula and ensure its implementation by elected representatives and civil society.

TABLE 18: COMPARISON OF MINISTRY OF HEALTH RECURRENT EXPENDITURE AND FACILITIES BY REGION, 2004/05

Region	MoH Health Expenditures	Facilities
North	17%	20%
Centre	36%	35%
South	47%	45%
	100%	100

Source: General NHA Tables in Annex 7-A and HMIS 2005

5.8 SUMMARY, POLICY IMPLICATIONS AND CONCLUSIONS

5.8.1 SUMMARY

The results of the general NHA reveal very interesting major findings. In summary, these include:

THE in Malawi was MK14.61 billion in 2002/03, MK21.70 billion in 2003/04 and MK26.21 billion in 2004/05.This represented a per capita dollar expenditure on health ranging from US$15 to US$20. Per capita spending on health in Malawi therefore falls critically short of the US$34 recommended by the WHO Commission on Macroeconomics and Health for an essential package of cost-effective interventions in developing countries. Malawi ranks fifth from last (tenth of 14 countries) in the SADC region for per capita expenditure on health. In 2004/05 government and donor contributions to health care financing totaled US$16.9 per capita. This is less than the conservative estimate of US$17.5 required to deliver the EHP estimated in 2002 and still less than the 2004 re-estimation of US$22 per

[21] Information on health facilities is taken from the HMIS database for 2005.

capita per annum, and shows that there is serious shortage of financial resources in the health system. Furthermore, there have been changes in treatment regiments for malaria from SP to the more costly atermisinin-based combination therapy and the government continues to fund non-EHP services including treatment abroad further "taxing" the limited health funding.

Health expenditure as a percentage of GDP increased from 9.9% in 2002/03 to 12.8% in 2004/05 – the highest in the SADC region. Despite increasing in absolute terms, government contributions to THE fell from 35% in 2002/03 to 24% in 2004/05. In the same period, donor contribution to health increased from 45% in 2002/03 to 60% in 2004/05. This makes Malawi's health system one of the most donor dependent in the world. The average household contribution was US$1.78 per capita, representing 10.3% of total health spending.

The MoH is the major financing agent. Its share of the control of THE increased from 49.5% in 2002/03 to 60% in 2004/05. NAC's role as a financing agent increased significantly during the period under review, from 1.8% control of THE in 2002/03 to 11.9% in 2004/05. This illustrates the increasing share of HIV and AIDS financing in health system financing.

The major providers of health services in 2002/03 and 2003/04 were hospitals (general secondary and tertiary hospitals, and mental hospital), consuming 31% and 30.3% of total expenditures in the two years respectively. In 2004/05, health centres/dispensaries/maternity units were the major providers, consuming 24.7% of total spending. This shift towards primary care represents a move towards *efficiency* in that most diseases are amenable to interventions delivered at the primary level, as included in the EHP. It is also *equitable* because most people in Malawi live in rural areas where health centres/dispensaries/maternity units are situated.

Data for 2002/03 show that the MoH spent 43% of its expenditures on curative health care, compared to 68% for CHAM. This indicates CHAM is under-prioritizing expenditure on prevention and public health, as witnessed by lower EPI coverage in some CHAM catchment areas. Evidence shows that the MoH is operating a hospital-based health care delivery system, with more than 60% of recurrent expenditures at the hospital level in 2004/05. Furthermore, MoH has seen massive increases in spending on curative care, from 47% in 1998/99 to 78% in 2004/05 – due largely to the increased prevalence of HIV and AIDS and opportunistic infections.

5.8.2 POLICY IMPLICATIONS

Study findings have the following policy implications:

1. Health financing

- Decline in real terms of government contributions for health: Government need to increase in real terms its contribution to health as agreed in the SWAp Memorandum of Understanding between the Government of Malawi (MoH) and donors, signed in October 2004.

- Inadequacy of resources to fund the EHP cost estimated in 2004 to be US$22 per capita per annum and the Abuja Declaration target of a 15% allocation of national budget to health: Need for sustained and increased actual spending on health by all funding sources in particular government and donors.

- Low contribution to THE by employers: Need to increase employers' contribution to health through establishment of mandatory health insurance for the formal sector and of onsite health facilities for employees and dependents benefits.

- Huge annual increases in household spending despite free public health care services and increased donor expenditures for health: (1) Need to reduce out-of-pocket spending through risk pooling mechanisms such as health insurance plans and (2) government need to evaluate the impact of free public health care services policy on quality of care and access to and utilization of health care services by different socio-economic groups and investigate alternative financing mechanisms for its providers such as performance-based financing and conditional cash transfers.

- Continuing provision of free health services and goods outside the EHP including treatment abroad: Government need to identify viable and feasible alternative financing mechanisms for funding services outside the EHP.

- MoH resource allocation appears to follow infrastructure rather than health needs of the population: Need to revise the current resource allocation formula so that it takes into account the health needs of the population as defined in the EHP and thereafter forms the basis for resource allocation decisions in MoH.

- At the district level, more MoH resources spent at the district hospital, mainly on curative health care: Need to split the budget for the district between the hospital and peripheral facilities and prevention and public health as it was proposed in the Fourth National Health Plan of 1999-2004.

2. Institutional and human resource capacity

- Managing increased donor health expenditure through the SWAp arrangement: Need to strengthen national institutional and human capacity to plan, manage and distribute the inflow of funds, human resources for health, and material resources (drugs and medical supplies, equipment etc.) in a coordinated manner. In particular, strengthen MoH capacity in planning, resource allocation, budgeting, procurement and monitoring and evaluation.

3. Public/private partnership

- Inequity in access to health care in particular in certain catchment areas where there are paying facilities: Government need to strengthen public/private partnerships through establishment of new service agreements and strengthening the existing ones with CHAM and other NGOs so as to deliver health services free to the population where the public sector has limited capacity as indicated in the PoW 2004-10.

5.8.3 CONCLUSION

The general NHA results show that donors are the major source of health financing in Malawi and their role in health financing increased substantially during the period under review. The public sector, in particular the Ministry of Finance, is the second largest source of health financing followed by private sources, mainly households. The high donor contribution for health is greatly appreciated as long as it finances the key priorities of the Malawian health system as contained in PoW 2004-10 and there are mechanisms for monitoring and evaluating its impact.

However, if this is not the case, there is an urgent need to reverse this situation. One way is for donors and government to work out appropriate and feasible modalities for implementing the PoW 2004-2010 which clearly identified the priorities of the health system, including the already commenced SWAp to health planning, financing, management and monitoring and evaluation. Even though some donors have not yet joined the SWAp pool fund arrangement, there are strong indications that they agree in principle with the SWAp and PoW 2004-10 priorities. The key issue is to demonstrate the value of predictable financing and get more donors in the pooled budget. Furthermore, with such huge amount of resources being funded by donors, it implies that the MoH needs to strengthen its stewardship and leadership in health planning, financing, procurement, service delivery and monitoring and evaluation.

As the country is experiencing economic problems, the Ministry of Finance should continue increasing its funding for health. However, it has been noted in this study that actual spending per annum is always lower than these budgeted amounts due to several factors: (1) low amounts of actual funding released per month, (2) high inflation rates and (3) currency depreciation. Thus it is important that government ensures that the health budget is actually realized and is allocated and utilized according to the agreed upon health priorities.

6. HIV AND AIDS SUB-ACCOUNTS RESULTS

6.1 INTRODUCTION

The HIV and AIDS pandemic is one of the critical health and development challenges facing Malawi. According to the 2004 DHS, the adult prevalence rate was estimated at 12%. Although this is slightly less than previous estimates, it is still one of the highest rates in the world. HIV prevalence is greater in urban areas than in rural areas (17.1% vs. 10.8%); in women than in men (13.3% vs. 10.2%) and in the southern part of the country than in the central and northern parts (22.3% vs. 4.1%) (DHS 2004).

In 2005, the total number of people infected with HIV was estimated to be 930,000, including 140,000 children under the age of 15. An estimated 170,000 people are eligible for ART. Up to March 2006, only 46,702 patients who had ever started ART.

It is estimated that a fifth of women attending antenatal clinics are HIV positive. Every year up to 40,000 babies could have been infected if PMTCT had not been initiated. By the end of 2005, 86 of the country's 524 hospitals and health centres were offering PMTCT services.

VCT services are available to pregnant women attending antenatal care clinics using the routine offer of testing and counselling (opt out strategy). According to DHS 2004, while about 52.5% of pregnant women were counselled, only 3.7% were tested for HIV and received the results.

Condom use is very low. Only 15% of women and 26% of men in the 15-24 age group used a condom at first sex.

NAC leads Malawi's national response to HIV and AIDS. In consultation with partners, NAC has developed a National Action Framework for 2005-2009.

The HIV and AIDS sub-accounts exercise was conducted in tandem with the general NHA. Data were collected for financial years 2002/03, 2003/04 and 2004/05. This covers the introduction in 2003/04 of support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as increased donor and national government attention to the HIV and AIDS pandemic. The NHA sub-accounts is the first comprehensive analysis of HIV and AIDS expenditures ever undertaken in Malawi.

As with the general NHA, the HIV and AIDS sub-accounts includes four core tables (shown in Annex 7-B); these illustrate the flow of funds between the principal dimensions of financing sources, financing agents, providers and functions relating to HIV and AIDS services. Table 19 in section 6.3 below summarizes key findings from the HIV and AIDS sub-accounts.

6.2 POLICY QUESTIONS ADDRESSED BY THE HIV AND AIDS SUB-ACCOUNTS

Malawi is one of the countries in Africa with a comprehensive and an up-to-date HIV and AIDS Action Framework for 2005-2009. It has clearly identified the following priority areas: prevention and behaviour change; treatment, care and support; socio-economic and psychological mitigation; mainstreaming, partnerships and capacity building; research and development; monitoring and evaluation; resource mobilization, tracking and utilization; and national policy coordination and programme planning. However, no comprehensive data existed on financial resources available in Malawi per annum for HIV and AIDS and the use of the funds by different stakeholders. Thus the HIV and AIDS sub-accounts exercise was undertaken specifically in order to answer the following key policy questions, which have bearing on the above priority areas:

Key Policy Questions Addressed by the HIV and AIDS Sub-Accounts in Malawi

- Who pays for HIV and AIDS goods and services (public, private, donors) and how much do they pay?
- Who controls the allocation (i.e. who are the managers) of HIV and AIDS funds?
- How are HIV and AIDS funds distributed across providers?
- How are HIV and AIDS funds distributed across different services: treatment and care, prevention and public health, mitigation etc.?

6.3 DEFINITION AND CONCEPT OF HIV AND AIDS SUB-ACCOUNTS

6.3.1 WHAT ARE HIV AND AIDS EXPENDITURES?

In this study, HIV and AIDS expenditures were defined as expenditures incurred on activities that are:

- Primarily intended to have an impact on the health status of PLWHA in a given period of time;
- Intended to prevent the spread of HIV and AIDS in the population at large; and
- Intended to mitigate the impact of HIV and AIDS.

The expenditures included the following:

- Direct health expenditures: those primarily and entirely associated with health care such as curative care (treatment and care), rehabilitative health care, pharmaceuticals and non-durables, prevention and public health services, ancillary services such as laboratory and general health administration;
- Health-related expenditures: related to an HIV and AIDS activity though overlapping with other fields of study such as education, overall "social" expenditure, and research and development. These include education and training (workshops), nutrition support, research and development and capital formation; and

- Non-health expenditures: activities aimed at mitigating the impact of HIV and AIDS on individuals and the population such as care for orphans and vulnerable children and policy advocacy.

Following from this definition of HIV and AIDS activities, expenditure on the following were captured:

- Case management of treatment services:
    - ARV treatment and monitoring
    - Opportunistic infections treatment and monitoring
- Administration of HIV and AIDS services
- Care and support activities
- Mitigation activities
- Training and support services
- Operational research and development
- Capital formation
- Policy advocacy

6.3.2 METHODS AND DATA SOURCES

The data sources and methods listed in Table 19 were used to estimate HIV and AIDS expenditures and their uses.

TABLE 19: DATA SOURCES FOR HIV AND AIDS RESOURCE TRACKING STUDY

Entity	Type of data collected	Methods and data sources
MoH	• Actual expenditures • Audited expenditures • Utilization figures • Inpatient days	• Budget and expenditure review of budget books, Consolidated Appropriation Accounts, audited accounts • HMIS review to identify utilization data on opportunistic infections • Survey of selected providers by level of care and region
Other government departments including NAC	• Actual expenditures	• Survey of all institutions involved in financing HIV and AIDS services • Audited reports review, in particular NAC • Survey of selected providers by level of care and region
Donor	• Budgets • Disbursements • Actual expenditures	• National survey of all donors involved in funding HIV and AIDS services • Public Expenditure Review reports • Consultant's reports
NGOs	• Budgets • Actual expenditures	• National survey of all NGOs involved in financing and delivery of HIV and AIDS services
Firms and corporations	• Actual expenditures	• National survey of all firms and corporations involved HIV and AIDS financing and delivery
Providers	• Actual expenditures • Utilization figures • Inpatient days	• National sample survey of selected facilities by ownership (MoH, private not-for-profit, private for-profit by level of care-health centre, district hospital, central hospital) and region (North, Centre and South)
PLWHA	• Actual expenditures • Utilization figures	• Special survey targeting PLWHA age 15 and above who have been confirmed HIV positive

6.4 RESULTS OF THE HIV AND AIDS SUB-ACCOUNTS STUDY

Total HIV and AIDS expenditures have risen dramatically in the three-year period of this study, from MK2.54 billion (US$29 million) in 2002/03 to MK7.53 billion (US$69 million) in 2004/05 (see Table 20). The rise has largely been due to a steep increase in donor HIV and AIDS support through the Global Fund to Fight AIDS, Tuberculosis and Malaria. Donor spending as a proportion of the total HIV and AIDS contribution was particularly high at 76 percent in 2003/04, due to a MK1.97 billion donor purchase of ARV drugs which were utilized in both 2003/04 and 2004/05. This donor role is expected to increase until 2011 due to commitments from the Global Fund. The Fifth Round of the Global Fund for Malawi was recently agreed upon, as follows: Phase 1 US$ 7,708,331 for orphans and vulnerable children, with a total (for the period 2006-11) for this group of US$19,104,775 as well as US$65,419,162 for health systems strengthening. Round 1 phase 2 for HIV and AIDS will consume US$137,169,342 for the period 2006-2008. Furthermore, other bilateral donors such as DfID and CIDA have also increased their expenditures and commitments.

Donor financing for HIV and AIDS is therefore likely to continue to increase in both relative and absolute terms for the short to medium term. Such a large increase in financial resources brings into question four key issues: (1) absorptive capacity and efficient use of the resources, (2) the sustainability of financing for HIV and AIDS goods and services should there be a turnaround in donor support, (3)

whether government is really directing the national response to the crisis and (4) the extent that the resources are used to strengthen the health delivery system overall rather than only for HIV and AIDS.

TABLE 20: SUMMARY INDICATORS FOR HIV AND AIDS EXPENDITURES AND FINANCING

General Indicators	2002/03	2003/04	2004/05
Total HIV and AIDS expenditure (MK)	2,536,868,803	6,296,486,291	7,527,323,449
Total HIV and AIDS health expenditure	2,343,307,389	5,113,782,256	6,254,069,140
Total HIV and AIDS expenditure (at average US$ exchange rate)	29,065,267	57,996,484	69,094,018
Total HIV and AIDS expenditure per adult population age 15 and above (MK)	2,782.11	7,046.96	8,383.69
Total HIV and AIDS expenditure per adult population age 15 and above (average US$ exchange rate)	31.97	65.25	76.73
Total HIV and AIDS expenditures as a % of GDP	1.7	3.7	3.7
Total HIV and AIDS health expenditures as a % of overall health spending	16.0	23.6	23.9
HIV and AIDS expenditures as a % of total of overall health spending	17.5	31.	29.8
Financing Sources of HIV and AIDS Funds			
Public as a % of total HIV and AIDS expenditures	40	18	20
Private as a % of total HIV and AIDS expenditures	14	6	7
Donor as a % of total HIV and AIDS expenditures	46	76	73
Household Spending			
Total household spending as a % of total HIV and AIDS expenditures	7	3	5
Out-of-pocket spending as a % of total HIV and AIDS expenditures	7	3	4
Out-of-pocket spending per PLWHA (MK)	189.72	232.79	378.89
Out-of-pocket spending (at average US$ exchange rate)	2.18	2.14	3.48
Financing Agents			
Public sector as a % of total HIV and AIDS expenditures	41%	42%	75%
NAC as a % of total HIV and AIDS expenditures	11%	25%	57%
Private sector as a % of total HIV and AIDS expenditures	24%	11%	13%
Rest of the world as a % of total HIV and AIDS expenditures	24%	47%	12%
Providers			
Public provider spending as a % of total HIV and AIDS expenditures	37%	38%	23%
Public hospital spending as a % of total HIV and AIDS expenditures	30%	36%	21%
Public health centre spending as a % of total HIV and AIDS expenditures	7%	2%	2%
Private provider spending as a % of total HIV and AIDS expenditures	22%	19%	12%
Private hospital spending as a % of total HIV and AIDS expenditures	8%	8%	5%
Private health centres/dispensaries/clinic spending as a % of total HIV and AIDS expenditures	14%	11%	6%

Providers	2002/03	2003/04	2004/05
Provision of prevention and public health programmes as a % of total HIV and AIDS expenditures	28%	19%	39%
Other providers of HIV and AIDS services as a % of total HIV and AIDS expenditures	13%	24%	26%
Functions			
Curative care as a % of total HIV and AIDS expenditures	57%	57%	34%
Inpatient curative (treatment of opportunistic infections)	44%	17%	24%
Outpatient curative (treatment of opportunistic infections)	12%	9%	11%
ARV treatment*	2%	31%	0%
Prevention and public health programmes as a % of total HIV and AIDS expenditures (PMTCT, VCT, IEC, STI prevention)	28%	19%	39%
Health administration and insurance as a % of total HIV and AIDS expenditures	5%	3%	9%
Other health functions as a % of total HIV and AIDS expenditures	1%	3%	1%
Health-related functions as a % of total HIV and AIDS expenditures (education and training, and R&D)	2%	1%	8%
Non-health expenditures as a % of total HIV and AIDS expenditures (orphans and vulnerable children, PLWHA support, advocacy, income generating activities)	5%	17%	9%

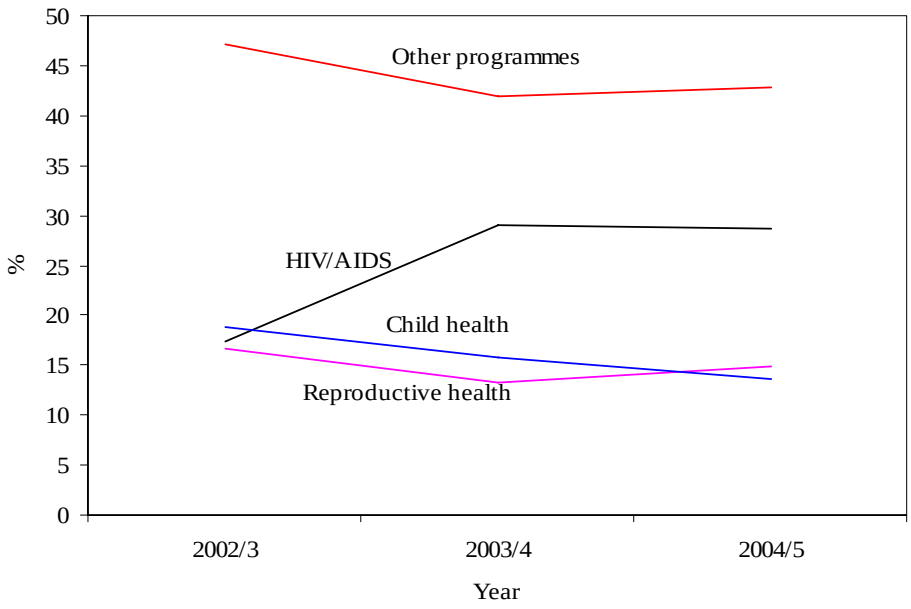
Source: HIV and AIDS Tables in Annex 7-B

* Expenditure on ARVs for 2004/05 was zero because all ARVs were bought and paid for in 2003/04 financial year, even though part of the consignment was used in 2004/05. NHA uses the accrual method; hence the zero in 2004/05.

6.5 HIV AND AIDS RESOURCES IN THE CONTEXT OF THE HEALTH SYSTEM

As Figure 7 shows, HIV and AIDS health expenditures (i.e. excluding non-health expenditures) as a percentage of THE rose from 16% in 2002/03 to 23.9% in 2004/05. While an increase in HIV and AIDS funding is good in and of itself, it increases demand for treatment, care and support, which strains the ability of the health system to respond to the existing disease burden from malaria, ARI, and diarrhoea, as well as from opportunistic infections. This occurs through reduced availability and quality of health workers, and through channels such as staff deaths from the disease, absenteeism and a shift in working patterns from general duties to the provision of ARVs.

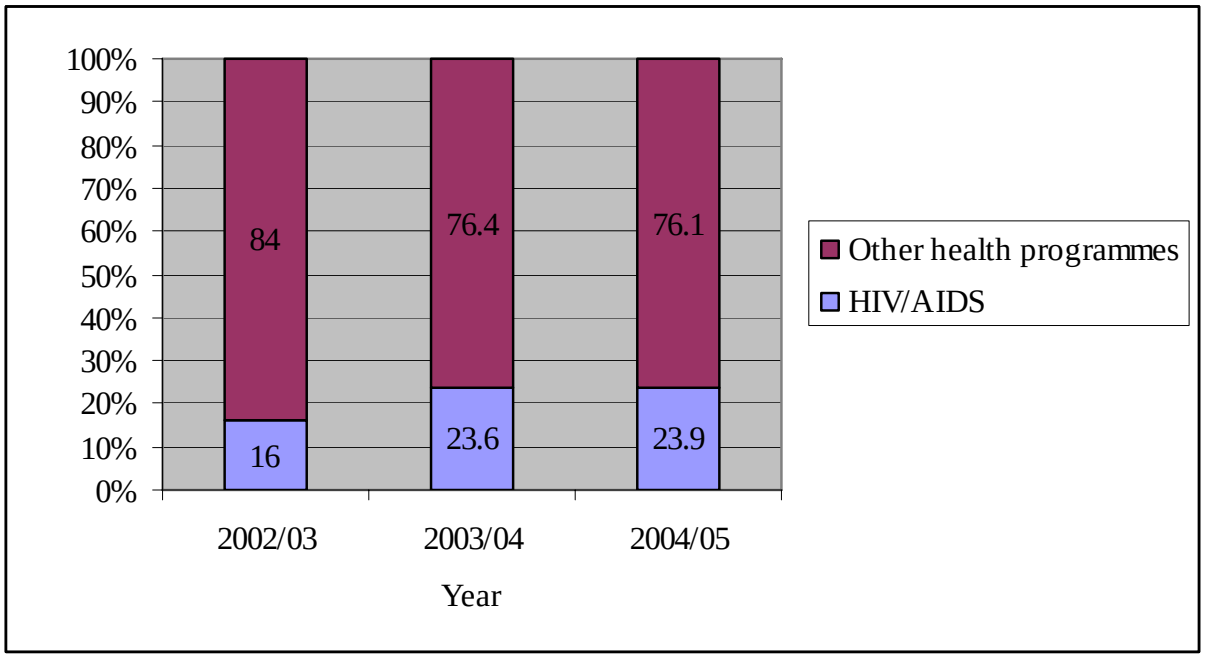
FIGURE 7: TRENDS IN HIV AND AIDS, RH, CH AND OTHER HEALTH PROGRAMMES, 2002/03-2004/05



Note: The Y- Axis represents percentage of the total health expenditures
Source: General NHA Tables in Annex 7-A, RH and CH Tables in Annexes C and D and HIV and AIDS Tables in Annex 7-B

Figures 7 and 8 both show how HIV and AIDS funding has distorted health sector financing and allocation during the period under review. While HIV and AIDS expenditures were increasing, RH, CH and other health programme expenditures were falling.

FIGURE 8: HIV AND AIDS AS A PROPORTION OF TOTAL HEALTH EXPENDITURE, 2002/03-2004/05



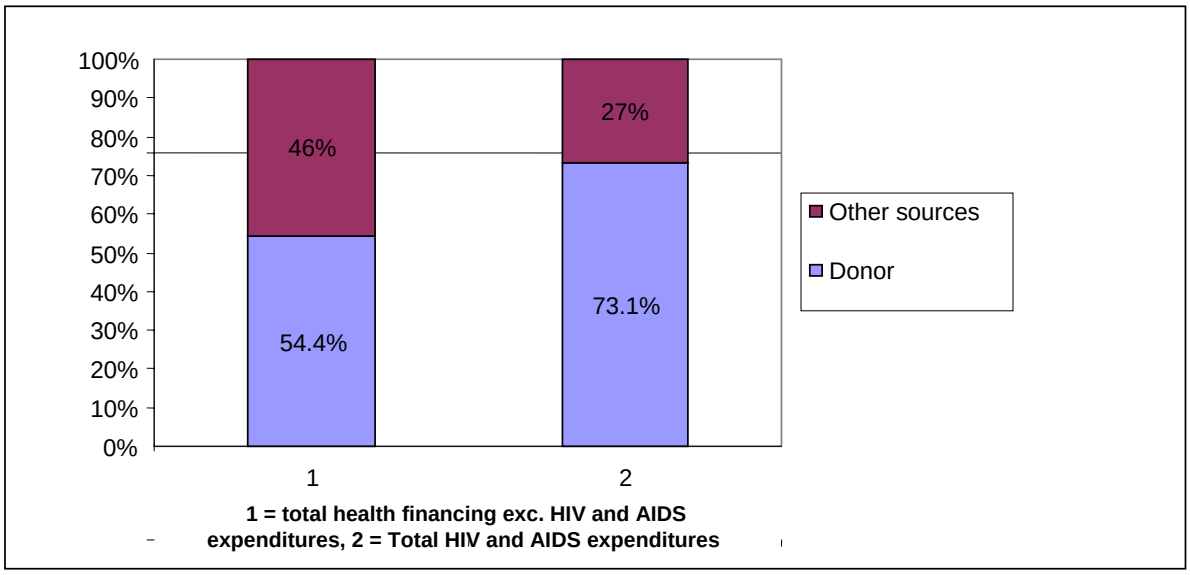
Source: General NHA Tables in Annex 7-A, RH and CH Tables in Annexes C and D and HIV and AIDS Tables in Annex 7-B

We must therefore question whether expenditures on HIV and AIDS correspond to the disease's relative call on health resources, such that HIV and AIDS expenditures are cost effective in the context of the overall health system. In 2003, the International Monetary Fund estimated that by 2010, Malawi could be devoting up to 6.5 percent of GDP to HIV and AIDS-related health services, an increase from 4.3 percent in 2000. This estimate is based on a very modest coverage assumption of 10 percent of PLWHA provided with highly active ART (HAART), and cost per patient per year of US$28.50 for palliative care, US$36.00 for the prevention of opportunistic infections, US$359.00 for the clinical treatment of opportunistic infections, US$1,400 for HAART drugs, and US$600.00 for HAART supporting inputs (International Monetary Fund 2003). The small size of the Malawian economy, and the modest growth expected for the rest of the decade, means that the financing of HIV and AIDS services could severely limit provision of other health care services. A clear understanding of health sector financing must be maintained to ensure HIV and AIDS expenditures do not come at the expense of other health functions.

A comparison of the proportion of general health and HIV and AIDS expenditure which is donor funded shows that there is a 'donor bias' for HIV and AIDS over general health financing (see Figure 9). If donor funding for HIV and AIDS increases as is projected in the coming years, without a corresponding strengthening of the existing health system, this bias will grow. Stabilizing the spread of HIV and AIDS will ease the burden on the health system, and also have multiple macroeconomic and sociological benefits. However, a focus on HIV and AIDS alone without addressing the underlying fragilities of health service delivery may represent an excess of expenditures on HIV and AIDS mitigation activities, without a corresponding strengthening of the system which must effectively manage both HIV and AIDS and the range of many related conditions.

FIGURE 9: DONOR FINANCING FOR GENERAL HEALTH (EXCLUDING HIV AND AIDS EXPENDITURES) AND FOR HIV AND AIDS EXPENDITURES, 2004/05

Source: General NHA Tables in Annex 7-A and HIV and AIDS Tables in Annex 7-B

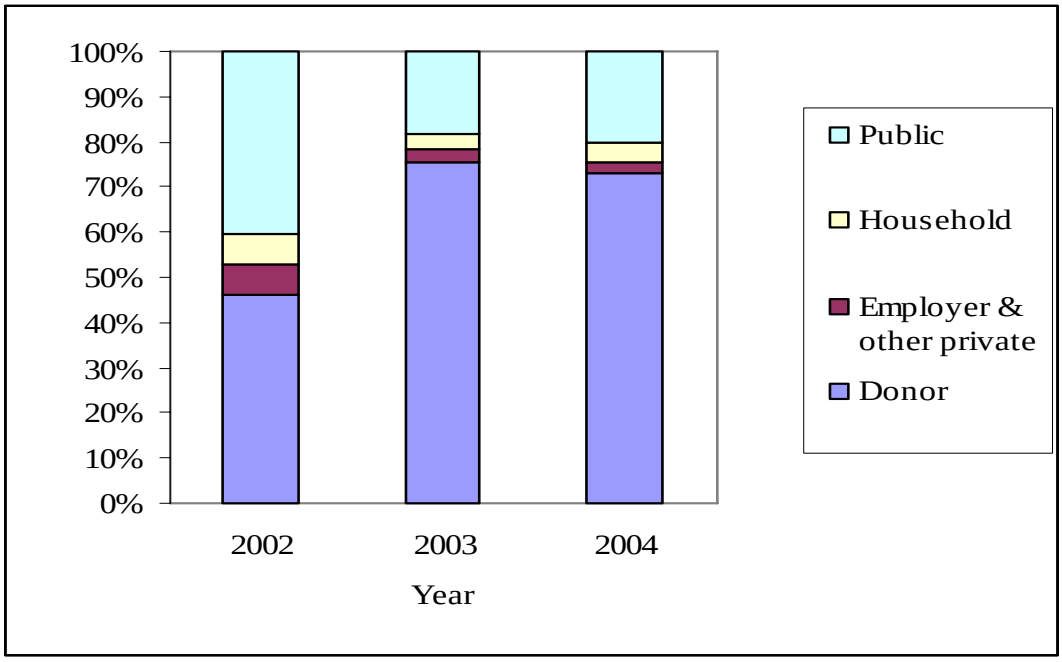


6.6 FLOW OF FUNDS FOR HIV AND AIDS: FUNDING SOURCES TO FINANCING AGENTS (FS X HF)

Financing Sources: Who pays for HIV and AIDS goods and services in Malawi?

The greatest proportion of total HIV and AIDS expenditures during the period under review were borne by donors: 46%, 76% and 73% in 2002/03, 2003/04 and 2004/05 respectively. The public sector, in particular the Ministry of Finance, is the second largest source of financing, contributing on average 26% during the three-year period. The household contribution was 7 percent in 2002/03, fell to 3 percent in 2003/04 and then increased to 5% in 2004/05 (see Figure 10). This household contribution to total HIV and AIDS spending is lower than in other countries that have conducted similar studies. For example in Rwanda, it was 15 percent and in Kenya 26% in 2002/03. The most likely explanation for this minimal household contribution in Malawi is the absence of user fees at point of service in public health facilities, in particular MoH facilities, and the existence of highly subsided fees in government-assisted (CHAM) facilities. (As has been noted elsewhere, the MoH and CHAM are the two major providers of health care in Malawi, owning 47% and 19% of the country's health care facilities respectively.) This low household contribution means that has greatly helped PLWHA to access health care and has acted as a safety net against them incurring the extent of catastrophic health expenditures they otherwise would have faced.

FIGURE 10: FINANCING SOURCES – HIV AND AIDS, MALAWI, 2002/03-2004/05



Source: HIV and AIDS Tables in Annex 7-B

The other most striking finding of this study is that before Global Fund resources were disbursed, the government contribution in 2002/03 of 41% of total HIV and AIDS spending approached the donor contribution of 46%. Soon after Global Fund resources started flowing, this picture changed. While there was a marginal increase in the government contribution in absolute terms, the government proportion decreased by 22 percentage points in 2003/04. The reason is that government resources did not rise proportionally to donor resources so as to maintain or increase its share of total HIV and AIDS funding. There also are indications that, possibly due to the arrival of the Global Fund money, the government shifted some resources originally intended for HIV and AIDS to other priorities, leaving Global Fund resources to fund most of HIV and AIDS activities. If this was the case then, it represents fungibility of resources which conflicts with the Global Fund condition of "additionality"[22].

Employers, through their various initiatives (such as HIV and AIDS workplace programmes, contributions to insurance for their employees and dependents, provision of health care services and goods to HIV and AIDS patients in onsite facilities and reimbursements to employees who have incurred health care costs), contributed 7%, 3% and 2% of total HIV and AIDS spending in 2002/03, 2003/04 and 2004/05 respectively, percentages comparable to those of households. This contribution is seriously low, bearing in mind that employers are hardest hit by HIV and AIDS as the epidemic disrupts their productivity and hence the productivity of the overall economy. A study in Cote d'Ivoire (Eholie et al. 2003) found that a private electricity company which offered ARV drugs to employees saved 4-5 times the cost of the programme due to a decrease in HIV and AIDS-related absenteeism, fewer

[22] According to the Global Fund, its resources should only be additional to government financing and not used to replace government resources – hence "additionality".

hospitalizations, a decline in new AIDS cases, and reduced mortality. Employers therefore need to increase their spending on HIV and AIDS treatment, care and prevention so that absenteeism at the workplace is reduced and productivity is improved.

Distribution of HIV and AIDS Resources to Financing Agents: Who controls HIV and AIDS funds in Malawi?

Transfers of funds are made initially from funding sources to financing agents, which allocate the funds to providers. In this way, financing agents manage and control the use of HIV and AIDS funds.

In the three financial years studied, the major controller/manager of HIV and AIDS was the public sector (in particular the MoH and NAC) at 52.2%, 42% and 75%. NAC alone accounted for 11%, 25% and 57% of total HIV and AIDS funds (for more details see Table 21 above, Table 20 below and Annex 7-B).

TABLE 21: PERCENTAGE CONTRIBUTION OF FINANCING AGENTS TO EXPENDITURE ON HIV AND AIDS, 2002/03-2004/05

Financing agent	Year		
	2002/03	2003/04	2004/05
NAC	11.2	24.6	56.9
Public (excluding NAC)	41.0	17.6	18.4
Private	16.8	8.1	8.5
Household – out-of-pocket	6.7	3.2	4.4
Donor	24.3	46.5	11.8
	100	100	100

Source: HIV and AIDS Tables in Annex 7-B

MoH and NAC funds were received from the Ministry of Finance and donors. Ministry of Finance funding to the MoH for HIV and AIDS flows through its annual allocation to the approved health budget; donor financing to the MoH flows through their funding of HIV and AIDS vertical programmes and the HIV and AIDS Unit at the MoH. Donors transfer almost all the HIV and AIDS resources through NAC; for this reason, the role of NAC as a financing agent (controlling institution) for HIV and AIDS funds has increased dramatically.

The private sector (composed of firms, CHAM, local NGOs and household direct out-of-pocket spending) and the Rest of the World (donors and international NGOs) alternate as second largest managers of HIV and AIDS funds during the period under review. In 2002/03, donors managed slightly more than the private sector; in 2004/05, the reverse was true. Financial year 2003/04 was an aberration, whereby donors were the major financing agent at 47% of total HIV and AIDS expenditures. This is because donors (Global Fund) funded the procurement of ARV drugs through UNICEF, which then distributed the drugs to various health care providers during both 2003/04 and 2004/05.

This donor and international NGOs financing and control of extensive expenditures for HIV and AIDS raises serious issues of sustainability unless in-country capacity (in particular, in the Central Medical Stores) for planning, budgeting and procurement of ARV drugs, and drug distribution is being built simultaneously. That is, the direct handling of large HIV and AIDS resources by funding agencies is commendable for the short term, but national human and institutional capacity to gradually assume ARV management responsibilities are needed in the long term.

Although not so high as in some other countries, household direct out-of-pocket spending by PLWHA is still the major private sector financing agent of HIV and AIDS resources in Malawi. This spending accounted for 28%, 29% and 35% of total private sector spending in 2002/03, 2003/04 and 2004/05 respectively (for more details see Table 22). These high percentages are disturbing – despite the cost of ART being highly subsidized in 2002/03 (MK2,500 per month) and free since then at a multitude of donor-funded NGOs/CBOs which aim to alleviate the financial plight of PLWHA, PLWHA continue to pay for their health care, accessing private facilities, private wings of public hospitals and outpatient departments that charge fees.

TABLE 22: PERCENTAGE CONTRIBUTION OF VARIOUS PRIVATE ENTITIES TO HIV AND AIDS EXPENDITURES 2002/03-2004/05

	2002/03	2003/04	2004/05	Average 2002/03-2004/05/05
Local NGOs	18	29	24	24
CHAM	24	19	22	22
Household out-of-pocket	28	29	35	31
Health insurance schemes	10	9	11	10
Employers	20	14	8	13
	100	100	100	100

Source: HIV and AIDS Tables in Annex 7-B and PLWHA Survey 2005

This may be due to the fact that NAC funding for NGOs/CBOs is mainly for prevention and public health and mitigation interventions such as VCT, IEC, STI prevention, and orphan and vulnerable children care. The funding does not cover personal needs such as treatment of opportunistic infections and other health care services such as laboratory, X-rays and admissions to the private wings of public facilities. It could also be that PLWHA view public services to be of lesser quality than private services, and thus they rely on private for-profit and CHAM facilities, which charge fees. Whatever the reason for these large out-of-pocket expenditures, this spending dissuades the very poor and vulnerable from utilizing needed health care and/or pushes them further into poverty. It also suggests that there is need to broaden support for PLWHA needs such as transport to health care, and ensure that they get free ART and subsidized treatment of opportunistic infections from designated centres. Furthermore, employers, whose workforce is seriously affected by HIV and AIDS, need to increase funding for their workplace programmes so that PLWHA can obtain health care services without paying out-of-pocket.

6.7 HIV AND AIDS SERVICE PROVIDERS: WHERE DO HIV AND AIDS FUNDS GO?

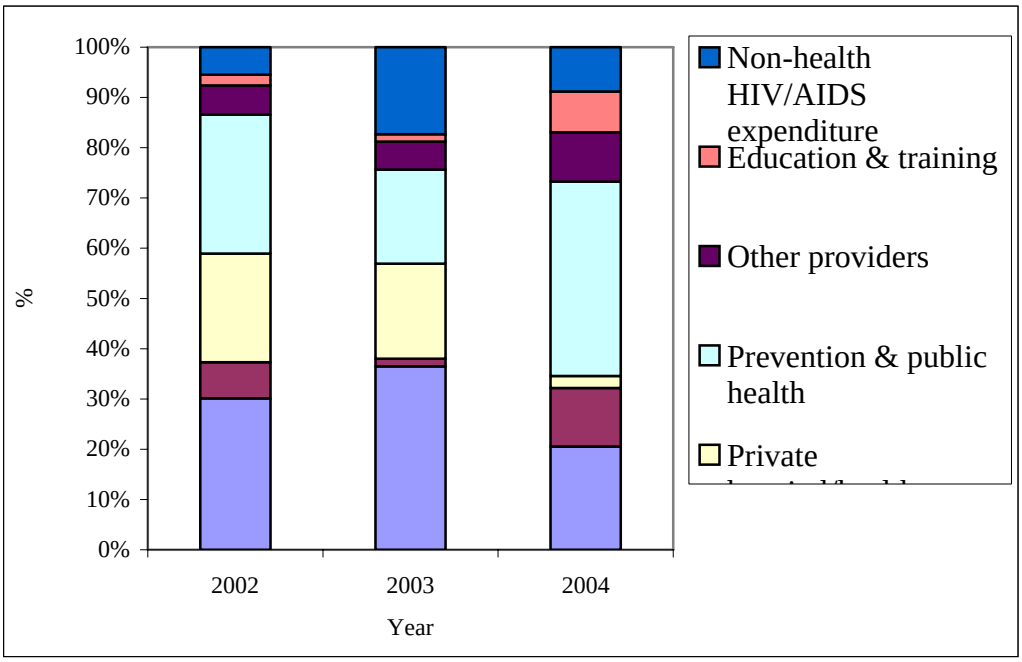
Provider Expenditures

Providers use HIV and AIDS funds to deliver goods and services to the population. They include hospitals and health centres, public health providers such as VCT, IEC and STI prevention services, and providers of non-health HIV and AIDS services, including PLWHA support, orphan and vulnerable children care, and policy advocacy expenditures.

Figure 11 shows the breakdown by provider of HIV and AIDS expenditures from 2002/03 to 2004/05. About 59 percent of HIV and AIDS funds were used by hospitals and health centres (both public and private) in 2002/03; this fell to 57 percent in 2003/04 and only 35 percent in 2004/05. The largest increase by type of provider was in the provision of prevention and public health programmes (including

PMTCT, VCT, IEC and STI prevention, and condom distribution), from MK702 million in 2002/03 to MK1.18 billion in 2003/04, and a massive MK2.91 billion in 2004/05, accounting for 39 percent of all HIV and AIDS expenditures in that year.

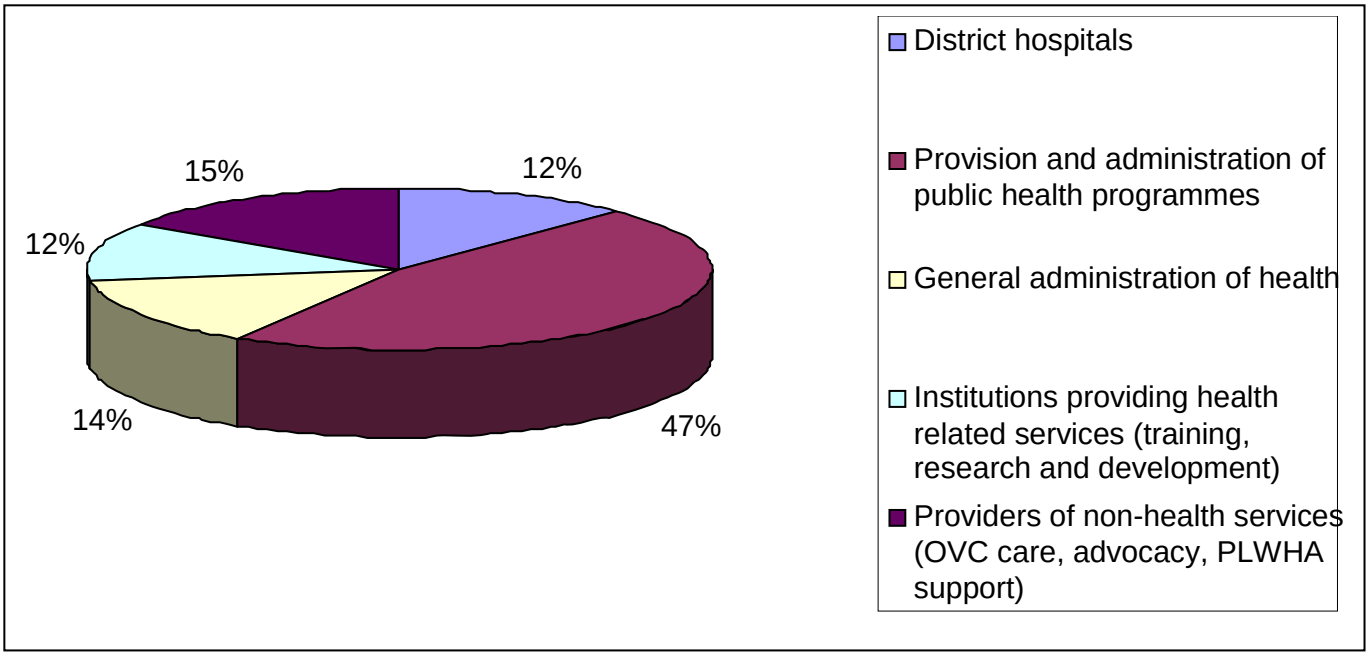
FIGURE 11: DISTRIBUTION OF HIV AND AIDS FUNDS BY PROVIDER TYPE, 2002/03-2004/05



Source: HIV and AIDS Tables in Annex 7-B

Most of these increased HIV and AIDS resources (MK4.28 billion in 2004/05) have flowed through NAC, to public health and prevention services (47 percent), health-related activities such as education and training (12 percent) and non-health activities (advocacy, care for orphans and vulnerable children) (15 percent). Only 12 percent has gone to treatment and care at district hospitals, and nothing at all to central hospitals.

FIGURE 12: DISTRIBUTION OF HIV AND AIDS FUNDS BY NAC TO PROVIDERS, 2004/05/05



Source: HIV and AIDS Tables in Annex 7-B

NAC has the responsibility to monitor and record the impact of its expenditures, and ensure that they target priority areas which will improve the lives of the most vulnerable affected by the HIV and AIDS pandemic. As noted above, despite NAC distributing huge amounts of funds to various NGOs/CBOs, PLWHA continue to pay high out-of-pocket expenditures for health care needs, thus bringing into question the effectiveness of funding modalities and priorities. While NAC has a fundamental role in preventing the spread of HIV and AIDS – today's investment in prevention is essential to reverse the course of HIV infection and the long-term demand on resources for treatment, care and support – this focus should not undermine strengthening of the underlying health system that also must provide treatment and care to PLWHA and the general population.

Attention to treatment and care is particularly important given the burden that HIV and AIDS-related opportunistic infections place on the system. It is estimated that more than 40% of beds in Malawian health facilities are occupied by PLWHA suffering from opportunistic infections (MoH 2004). If the trend of increased donor resources rushing into the HIV and AIDS sector continues, with a sole focus on mitigation and prevention of the disease, this risks serious allocative inefficiencies due breakdown in the functioning of core health facilities. Thus, the US$ 65,419162 approved by the Global Fund for Malawi's Round 5 Proposal in 2006 for health systems strengthening for the period 2006-11 is a move in the right direction as it will assist in more effective delivery of overall health services, including non-focal services such as maternal and child health services – immunizations, and treatment of ARI and diarrhoeal diseases.

That said, the Global Fund has recently revisited its proposal and funding strategies, and determined that it would not include health systems strengthening as a specific component in Round 6. The Global Fund will consider proposals for funding health systems strengthening activities but they must be integrated into disease-specific components and clearly linked to the achievement of disease-specific objectives. It is

therefore incumbent upon the Government of Malawi to ensure that any Round 6 and subsequent proposals clearly consider health systems constraints and opportunities, and identify health systems strengthening activities to ensure the effective delivery of services and goods. This will increase the prospects of success not only for the focal disease programmes, but also improve the likelihood of positive spin-off effects for other areas of Malawi's health system and the delivery of non-focal diseases services.

Another prominent feature of NAC's expenditure as a financing agent was its large amount of expenditure for overall administration of HIV and AIDS activities, MK606 million in 2004/05[23]. This means that a large amount of funds is held up in the system. There is need to streamline administration so that these activities consume fewer resources – and more resources reach intended beneficiaries.

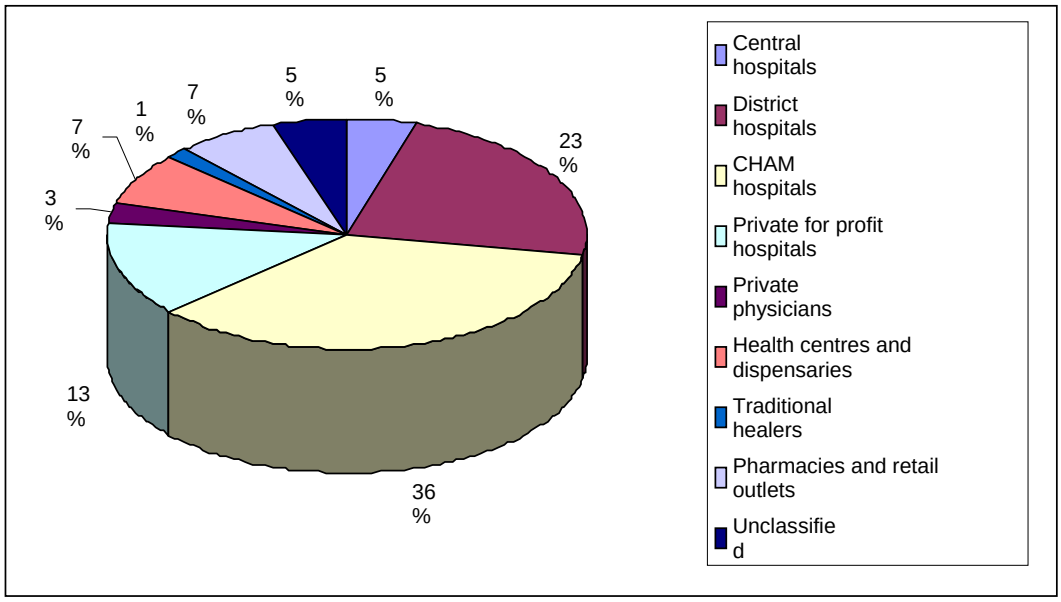
In contrast to NAC expenditures on prevention and public health, health-related activities and administration, household expenditures that go to providers are for personal treatment related to opportunistic infections. This includes not only medical fees and purchase of drugs, but also transport to and from facilities. The large sums spent on accessing in- and outpatient care in CHAM facilities, which amounted to MK532 or US$4.88 per PLWHA in 2004/05, indicate the burden of user fees placed on PLWHA who use these facilities. Still, for many PLWHA, CHAM is the nearest facility – many poor people in Malawi live in rural areas where mission facilities provide the only accessible formal health care. In addition CHAM facilities are perceived as providing better quality services than public health facilities. Thus poor PLWHA will continue to access CHAM facilities, paying fees which could ultimately prove catastrophic. The alternative is to go without care.

As is discussed elsewhere, where there is not a MoH facility (with adequate capacity) within a reasonable distance, the MoH is currently pursuing a policy of establishing service agreements with CHAM facilities, so that selected services are provided free of charge, as in public facilities. Selected services will initially include priority interventions (such as reproductive and child health). Agreements need to be configured in a way which is both equitable and provides value for money, i.e. ensuring levels of subsidy are comparable between CHAM facilities, and avoiding over-subsidization.

A unified and comprehensive contract between the government as financier and the CHAM (or other NGO) facility as service provider is the best means to improve equity in access to health care services and goods. In addition, this would be a key step to help ensure greater cohesion in the financing of government and CHAM facilities. Agreements will cover staff salary subventions from the Ministry of Finance, provision of drugs, and service agreements for other recurrent transactions. They also can be used to end the current situation in which the Ministry of Finance pays salaries for CHAM employees, and then CHAM provides additional allowances, a practice that draws health workers away from government facilities, leaving a public health sector which is free use but unable to meet patient demands due to inadequacy of human resources and leaving the poor to choose between visiting an understaffed (or unstaffed) MoH facility, forgoing care, or paying for care at a CHAM facility.

[23] This amount of expenditure covers all administrative functions for HIV and AIDS from the NAC Secretariat to the umbrella organizations which directly administer funds to CBOs.

FIGURE 13: DISTRIBUTION OF PLWHA OUT-OF-POCKET EXPENDITURES BY PROVIDER TYPE, 2005



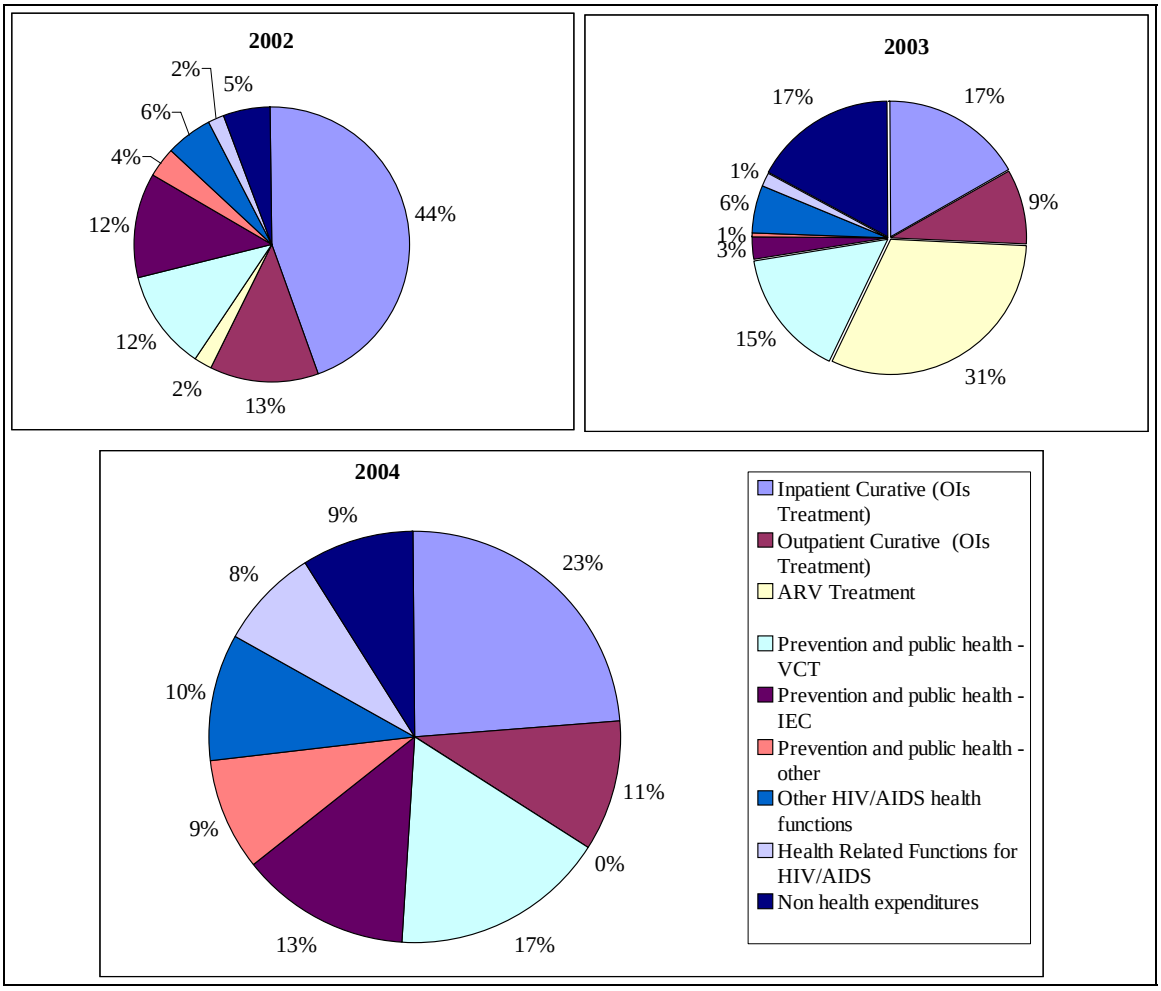
Source: HIV and AIDS Tables in Annex 7-B

6.8 DISTRIBUTION OF FINANCING AGENTS OF HIV AND AIDS EXPENDITURES BY FUNCTION: ON WHAT DID HIV AND AIDS FINANCING AGENTS SPEND FUNDS?

As explained in the general NHA chapter above, a "function" is the actual health care service or good provided. Examples of functions include: inpatient and outpatient curative care (because there is no cure for HIV and AIDS, this is equivalent to receiving ART, and treatment and care of opportunistic infections), rehabilitative care, prevention and public health, education and training, and care for orphans and vulnerable children. In order to have maximum impact from HIV and AIDS funding, there is a need to fund functions that will produce the greatest benefit to individuals suffering from HIV and AIDS, halting and starting to reverse the spread of the virus and mitigating its social and economic consequences.

During the period under review treatment and care initially received most HIV and AIDS expenditures, amounting to 57% of total HIV/AID spending in 2002/03. This remained constant in 2003/04, and then fell drastically to 34% in 2004/05 (for details see Figure14 and Annex 7-B). By 2004/05 spending on prevention and public health, health-related, and non-health functions amounted to 65 percent of the total, up from 37% in 2003/04 and only 23% in 2002/03. In other words, the proportions of the funding of functions reversed. There is an interesting funding mix for the two major functions taking place.

FIGURE 14: DISTRIBUTION OF HIV AND AIDS EXPENDITURES BY FUNCTION: 2002/03-2004/05



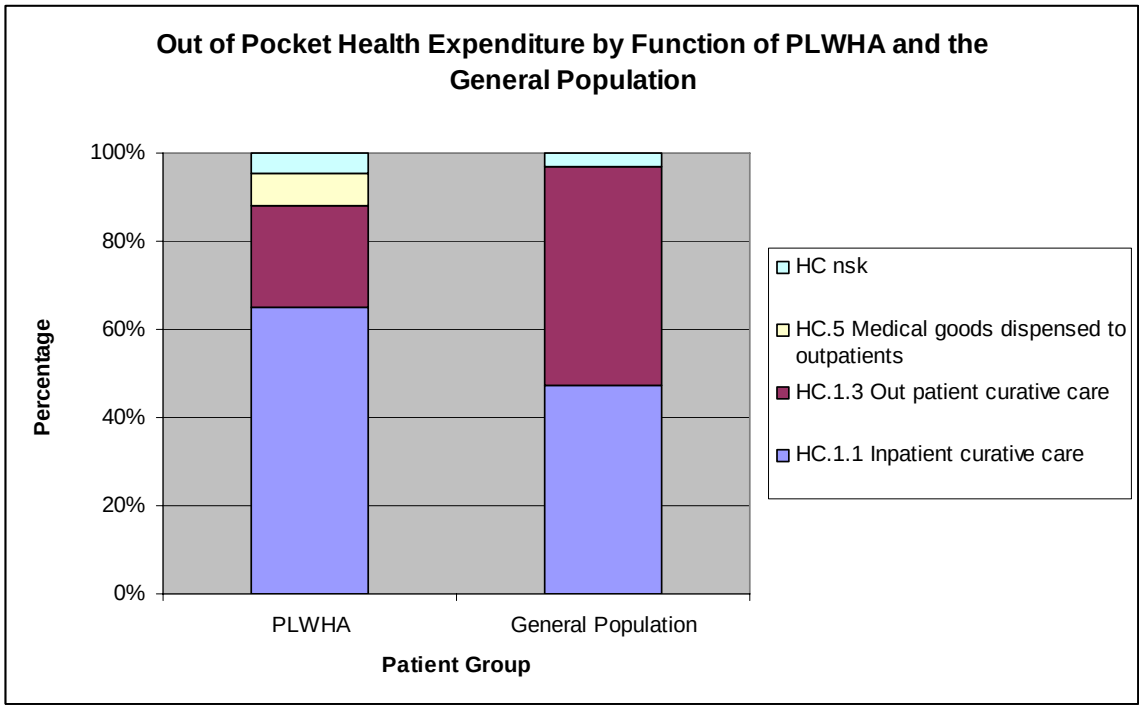
Source: HIV and AIDS Tables in Annex 7-B

The Ministry of Finance, with its funding of the MoH, is the major financing agent for HIV and AIDS treatment and care goods and services (apart from ARVs, which are funded by donors). Donors, with their funding via NAC, are the major financing agent for HIV and AIDS preventive and public health services, health-related services such as education and training (which consumed 12% of total NAC HIV and AIDS expenditures in 2004/05), and other mitigation interventions (for more details see Annex 7-B). Therefore, as long as donors regard NAC as the optimal entity through which to spend money on HIV and AIDS, and NAC continues to give priority to prevention and mitigation, this funding distortion will widen – and accelerate as further donor resources rush into the sector. There is therefore a call for NAC to place treatment and care amongst its priorities, and for donors to monitor the uses of their funds. Furthermore, the MoH and NAC must be partners in the fight against HIV and AIDS and not act as two distinct institutions – as is implied by their respective governance structures.

As noted above as long as government and donors continue to fund two distinct functions, PLWHA will continue to pay a higher price for treatment of their opportunistic infections. As seen in Figure 15 PLWHA out-of-pocket expenditures on inpatient care were much higher than those of other individuals

in the general population (65 percent compared to 43 percent) in 2004. This indicates the costly nature of HIV and AIDS and many opportunistic infections. It also highlights the importance of mitigating the financial consequences of ill health for PLWHA and to ensure safety nets are in place and are effective.

FIGURE 15: DISTRIBUTION OF OUT-OF-POCKET SPENDING BY FUNCTION OF PLWHA AND GENERAL POPULATION, 2004



Source: HIV and AIDS Tables in Annex 7-B

6.9 DISTRIBUTION OF PROVIDERS OF HIV AND AIDS SERVICES BY FUNCTION: ON WHAT DID THE PROVIDERS SPEND THE HIV AND AIDS FUNDS?

Annex 7-B shows the flow of HIV and AIDS funds from providers to functions. About 75 percent of inpatient care and 45 percent of outpatient care was provided by public facilities, with the remainder provided at private (not-for-profit, CHAM, and for-profit) facilities for 2004/05. Anecdotal evidence suggests that HIV and AIDS patients often visit facilities that charge fees in the initial stages of an illness, but revert to free-use public facilities for more complicated, and expensive, conditions.

Furthermore, 23 percent of curative (treatment and care) expenditures are at the primary level and 77 percent at hospitals. This is likely indicative of a number of factors, primarily the serious and costly nature of many opportunistic infections, but also by: the unavailability of drugs and health workers in government health centres, forcing patients further up the ladder of care to hospitals; an already dysfunctional referral system resulting in an unclear division of services between hospitals and health centres; and patients seeking private care in the initial stages of illness but returning to the free public sector when their conditions become more serious.

6.10 HEALTH SPENDING BY PEOPLE LIVING WITH HIV AND AIDS

This section presents additional findings from the PLWHA survey. The findings are based on a sample of PLWHA who are currently on ART[24]. The objectives of this special study were (1) to estimate total out-of-pocket spending by PLWHA and its distribution by gender, socio-economic group, stage of the disease and region, among others and (2) to investigate utilization of health services by PLWHA by stage of the disease, provider type, socio-economic group, gender and region among others. (For more details see Annex 5 on PLWHA study methodology and data sources.)

6.10.1 EXPENDITURE BY GENDER

There are differences in spending patterns based on the gender of AIDS patients. In 2005, adult men made significantly higher outpatient out-of-pocket expenditures than did women or younger men (age 15-24) (see Table 23). Men spent about four times more than women. Furthermore men older than 54 years spent about 15 times more than men age 15-24. This could be attributed to the older group's greater capacity to pay.

TABLE 23: AVERAGE ANNUAL OUT-OF-POCKET EXPENDITURE FOR OUTPATIENT CARE BY PATIENTS ON ART, BY AGE GROUP AND GENDER, 2005 (IN MK)

Age	Gender		
	Male	Female	Average
15-24	260	0	70
25-39	700	520	585
40-54	2,378	343	1,417
Over 54	4,105	0	2053
National	1,581	400	892

Source: PLWHA Survey 2005

As can be seen in Table 24, in all categories of marital status except the widowed, men spent more out-of-pocket than did women. Divorced men spent significantly more than other groups. Divorced and single women spent almost nothing for outpatient care (97% of the 70 divorced women in our sample reported zero out-of-pocket spending). This may be attributed to the fact that female-headed households are the poorest in Malawi (NSO 2004) and most seek free public health care services and rely on walking as the mode of transport to take them to health care facilities.

[24] The survey was taken between November 2005 and January 2006, using a sample size of 900 patients currently receiving ART from various public and private hospitals and health centres.

TABLE 24: AVERAGE ANNUAL OUT-OF-POCKET FOR OUTPATIENT CARE BY ART PATIENTS, BY MARITAL STATUS AND GENDER, 2005 (IN MK)

Marital Status	Male	Female	Average
Single	1371	1	570
Married	1385	563	1032
Widowed	0	550	451
Divorced/Separated	5054	19	1494
Co-Habitant	0	0	0
Not Declared	0	0	0
National	1581	400	892

Source: PLWHA Survey 2005

6.10.2 OUT-OF-POCKET EXPENDITURE BY SOCIO-ECONOMIC GROUP

In the study, households were categorized into wealth quintiles based on their asset ownership using the method of Principal Components Analysis (PCA)[25]. The findings indicate that the expected positive relationship between socio-economic status and out-of-pocket spending is weak (see Table 25). This distribution of expenditure by wealth quintiles may signify inequity as the poor may be spending a higher proportion of their income on health care than the wealthy.

TABLE 25: AVERAGE ANNUAL OUT-OF-POCKET EXPENDITURE FOR OUTPATIENT CARE BY ART PATIENTS, STRATIFICATION BY SOCIO-ECONOMIC GROUP (BY ASSET SCORE), 2005 (IN MK)

Household Wealth	Mean Expenditure
Quintile 1 (Poorest)	208
Quintile 2	130
Quintile 3	1212
Quintile 4	455
Quintile 5 (Richest)	2300
National	892

Source: PLWHA Survey 2005

6.10.3 PLWHA OUT-OF-POCKET EXPENDITURE, BY REGION

The findings shown in Table 26 indicate that out-of-pocket spending by PLWHAs is the highest in the Central region. It is also more in urban areas than in rural areas. This is attributed mainly to differences in capacity to pay; the Central region has the lowest number of people living in poverty (NSO 2004). Furthermore, this could be due to the availability of health care facilities that charge for services and goods in particular in the capital city, Lilongwe, where most private for-profit facilities exist. The PLWHA survey found that the distribution of out-of-pocket spending is as follows: consultation 15%, opportunistic infections 31%, X-ray 2%, laboratory 41% and "other" 11%.

[25] PCA is used to determine the weights of asset indices based on given variables. PCA is helpful in situations where data have been collected on many variables and there is need to develop a smaller number of artificial variables (principal component) that will explain most of the variance in observed variables. In PCA, there is an assumption that there is no redundancy in the variables that were collected, implying that some of the variables are correlated with one another and are possibly measuring the same thing.

TABLE 26: AVERAGE ANNUAL OUT-OF-POCKET EXPENDITURE FOR OUTPATIENT CARE BY ART PATIENTS, STRATIFICATION BY REGION, 2005 (IN MK)

Region	Urban	Rural	Average
North	119	270	194
Central	1,871	1,496	1,680
South	685	427	512
National	1,052	686	833

PLWHA Survey 2005

6.11 SUMMARY AND POLICY IMPLICATIONS

6.11.1 SUMMARY

This study has revealed that total HIV and AIDS expenditures have risen dramatically in the three-year period of the study, from MK2.54 billion in 2002/03 to MK7.53 billion in 2004/05. The increase is the result of a steep rise in donor support for HIV and AIDS, from MK1,168 billion in 2002/03 to MK5,503 billion in 2004/05. This brings into question:

- The absorptive capacity in the public sector to ensure an efficient and equitable use of the considerable resources being spent on HIV and AIDS;
- The sustainability of HIV and AIDS goods and services given a possible decrease or suspension of donor support; and
- Whether government is really in managing the funds given its limited contribution to HIV and AIDS relative to donor partners.

The analysis indicates a donor bias for HIV and AIDS over other forms of health expenditure. Donors account for 73% of HIV and AIDS expenditures, compared to only 54% of general health expenditures. Employers contributed only 2% of total HIV and AIDS expenditures in 2004/05. An interesting funding duality is revealed whereby:

- Donors, through NAC, are the major contributors to prevention and mitigation services for HIV and AIDS (IEC, PMTCT, distribution of contraceptives, support to orphans and vulnerable children).
- In contrast, the Treasury, through the MoH, is the major financier of treatment and care for HIV and AIDS, which is delivered at hospitals and health centres.

As additional resources flow into the HIV and AIDS sector, there is concern that, if these are directed through NAC and the funding priority remains on prevention and public health and mitigation, treatment and care for opportunistic infections could be underfunded in comparison. Approval by the Global Fund for Malawi's Fifth Round Proposal for health systems strengthening in 2006 is a welcome development even though there are indications that the Sixth Round will require that system strengthening components be integrated into disease-specific priorities. NAC as a financing agent through umbrella organizations spent MK606 million (14% of its total expenditure) in 2004/05 on general administration for HIV and AIDS, including education and training and coordination of workshops.

PLWHA out-of-pocket expenditures on health care increased from MK169 million in 2002/03 (MK190 per PLWHA) to MK334 million (MK379 per PLWHA) in 2004/05. Although this is a substantial amount, PLWHA in Malawi contribute less out-of-pocket (5% of total HIV and AIDS spending in 2004/05) than do PLWHA in Rwanda (15%) and Kenya (26%). This is primarily due to Malawian government health facilities being free at the point of service delivery.

As the HIV and AIDS pandemic continues to scourge Malawi and constrain its overall development, it is essential that sufficient resources are made available to halt, mitigate and start to reverse the spread of the disease. It is also imperative that these resources are spent in ways that are most effective to achieve the intended purpose. This analysis therefore leads to the following key policy implications:

6.11.2 POLICY IMPLICATIONS

- Inadequate funding for HIV and AIDS services by employers: NAC and other key stakeholders – the MoH in particular – need to initiate campaigns encouraging employers to increase their spending on HIV and AIDS workplace programmes (including condom distribution, VCT, provision of ARVs, treatment of opportunistic infections). Evidence indicates such programmes are a cost-effective means for firms to improve productivity through reduced staff illness and lower absenteeism.

- Increased flow of HIV and AIDS resources in the face of limited capacity: NAC need to build national capacity to effectively handle and allocate increased resources for HIV and AIDS. This should involve developing skills in the procurement, planning and budgeting, and distribution functions through training and offering of remuneration packages suitable to attract highly skilled workers.

- Existence of biased funding priorities: NAC need to reconsider funding priorities to ensure that the Treasury uses a fairer proportion of HIV and AIDS funds to finance health systems strengthening, in particular treatment and care of patients with opportunistic infections, in addition to prevention and public health and mitigation of the disease.

- Huge expenditures on administration of HIV and AIDS activities: Need to reduce the administrative channels for disbursement and management of HIV and AIDS so as to reduce administrative costs and hence more funds reach the real beneficiaries.

- Increase in out-of-pocket expenditure by PLWHA in the face of increased donor funding for HIV and AIDS: Government need to (1) consider alternative ways of funding services targeting PLWHA such as direct cash transfers and (2) develop risk pooling mechanisms such as mandatory health insurance for formal sector employees and their dependents.

- Existence of inequities in access to care for PLWHA suffering from opportunistic infections: MoH need to continue negotiating for a comprehensive contract between government as financier and CHAM as service provider to cover staff salaries, provision of drugs, and service agreements in such a way that CHAM reduces or abolishes user fees for PLWHA suffering from opportunistic infections. This will help to avoid PLWHA incurring catastrophic costs for care.

6.11.3 CONCLUSION

This NHA study has clearly shown that resources to fight HIV and AIDS, especially those from donors, increased substantially during the three years for which estimates were done, and there are indications that this will continue into the foreseeable future. It is therefore incumbent upon the Government of Malawi to ensure that the increased resources are used effectively, equitably and efficiently so as to begin to reverse the high HIV prevalence rates in the country.

7. REPRODUCTIVE HEALTH SUB-ACCOUNTS RESULTS

7.1 INTRODUCTION

The maternal mortality ratio in Malawi is currently estimated at 984 per 100,000 live births (DHS 2004), down from 1,120 per 100,000 live births in 2000 but still substantially higher than the 620 per 100,000 live births in 1992. The major determinants of this high mortality ratio are: early childbearing (the mean age of mothers at first childbirth is 19 years); a high fertility rate, currently 6.0 (down from 6.3 in 2000); and a large percentage of pregnancies which are high risk due to poor access to, and late utilization of, essential obstetric health care services. The most common causes of maternal deaths such as postpartum sepsis, ruptured uterus (22%), hemorrhage (14%), obstructed labour (14%), complications of abortions (5%) and others are preventable (MoH 2005b). Adolescent pregnancies constitute about 25% of all births and 20% of maternal deaths. The lifetime risk of maternal death in Malawi is therefore estimated at a shocking 1:7, one of the highest globally. The socio-economic consequences of this situation are immense, and include leaving many children in the country motherless.

RH services are free at almost all public facilities (health centres/dispensaries/maternity units, district and central hospitals except for deliveries in private wings of central hospitals) and are heavily subsidized in NGO facilities. However, few births are attended by trained health personnel and take place in health facilities (for more details see Table 27). Some of the major reasons cited for this are poor quality of emergency obstetrics care services provided in health facilities, difficulty of access to facilities and high transport costs, and traditional socio-cultural beliefs and practices which cause many women to deliver at home or at a traditional birth attendant, instead of seeking assistance in a formal health facility.

TABLE 27: REPRODUCTIVE HEALTH INDICATORS IN MALAWI

Women of reproductive age (15-49 years)	24% (2002)
Population growth rate	2% (1998)
Maternal mortality (per 100,000 live births)	984 (2004)
Total fertility rate (Number of births/ woman in reproductive years)	6.0 (2004)
Percentage of women in union using a modern birth control method	51% (2004)
Contraceptive prevalence rate	28% (2004)
Use of antenatal care delivered by trained professionals as a proportion of total number of births	56% (2004)
Percentage of births taking place in a health care facility	57% (2004)
Percentage of births with a trained birth attendant	26% (2004)
Use of postnatal care	31% (2004)

Sources: DHS 2000 & 2004, NSO 1998

Recent global evidence clearly indicates that availability of emergency obstetric care and skilled attendance at birth are key to the reduction of maternal mortality. Realizing the importance of this global finding, Malawi undertook a national assessment of availability, quality and utilization of emergency obstetric care services. The results of this assessment clearly show that poor access to and utilization of

emergency obstetric care services, and poor quality of general health care, are indeed responsible for high case fatality rates.

There is also great concern by various countries in the whole of Africa on the issue of high maternal mortality ratios. In 2004 the African Union urged each member state to develop a country-specific road map to accelerate attainment of Millennium Development Goals related to maternal and newborn health. In response to the International Conference on Population and Development Plan of Action, and in recognition of its own worsening maternal health indicators, the Government of Malawi developed its Road Map to accelerate the reduction of maternal and newborn mortality and morbidity; the vision of which is to have:

All women in Malawi go through pregnancy, childbirth and postpartum period safely and their newborns are born alive and healthy through the implementation of effective maternal and newborn health interventions

Furthermore, the goal of Malawi's Road Map is '*To accelerate the reduction of maternal and newborn morbidity and mortality towards the achievements of the Millennium Development Goals (MDGs)*. The Malawi Government has hence set two major objectives with regards to maternal and neonatal health:

- *To increase the availability, accessibility, utilization and quality of skilled obstetric care during pregnancy, childbirth and postnatal period at all levels of the health care delivery system.*

- *To strengthen the capacity of individuals, families, communities, civil society organizations and government to improve MNH.*

7.2 POLICY PURPOSE OF RH SUB-ACCOUNTS IN MALAWI

Despite claimed heavy investment in RH services and goods in Malawi, there was no information on total expenditures and uses of RH funds. Thus the RH sub-account was undertaken in order to answer the following key policy questions:

Policy Issues Addressed by RH Sub-accounts

- How much is spent on RH care? Who pays for RH services and goods?
- What is the reliance on donors for RH services and commodities? What share of donor health funds are targeted for RH?
- Who manages RH funds?
- What share of public health funds is spent on RH care?
- What is the financial burden on households to pay for RH care?
- What types of services are financed by RH funds?
- Who provides what RH services and where?

7.3 CONCEPT AND SCOPE OF RH SUB-ACCOUNTS

The RH sub-accounts were conducted in conjunction with the general NHA in order to estimate the expenditures for RH for the period 2002/03-2004/05.

What is RH?

The scope of the RH sub-accounts is based on the WHO definition of RH as indicated in the box below.

WHO Definition of Reproductive Health

Reproductive health is a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this is the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate healthcare services that enable women to safely go through pregnancy and childbirth. Reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted infections.

What are Reproductive Health Expenditures?

The RH sub-accounts measures expenditures on activities whose primary purpose is to (1) limit and/or space births, (2) support and promote the limiting and spacing of births and maternal health (such as training and IEC), and (3) deliver healthy babies (including postnatal care). Thus, expenditures on the following activities are expected to be captured:

1. Maternal health services:
    - Prenatal care, perinatal (labour/delivery)
    - Postnatal care
2. Family planning services
    - Counselling and issuance of contraceptives
    - Retail pharmaceutical sale of products such as oral contraceptives and condoms
3. Services that support or promote family planning and maternal health
    - IEC, behaviour change communication (BCC), public awareness campaigns etc.
    - Sexual health (including STIs)
    - PMTCT
    - Early detection and treatment of RH cancers (cervical, prostate and breast)
    - Youth Friendly Health Services
    - Modifying harmful RH practices
4. Treatment of gynaecological problems
5. Administration and coordination of RH
6. Expenditure on RH care-related services
    - Training (particularly of community health care workers as part of public awareness campaigns) and workshops for health workers
    - RH research

In fact this study captures the following RH activities expenditures[26]: maternal health services (prenatal, perinatal-labour/delivery, postnatal); family planning services (counselling and issuance of contraceptives, retail pharmaceutical sales of products such as oral contraceptives and condoms); services that support or promote family planning and maternal health (programme expenditures on IEC, BCC, public awareness campaigns etc); administration and coordination of RH; expenditure on RH-related services (training, particularly of community health care workers as part of public awareness campaigns, workshops for health workers and RH research).

Methods and Data Sources

Table 28 summarizes the methods and data sources for the RH sub-accounts.

TABLE 28: SUMMARY OF METHODS AND DATA SOURCES USED FOR REPRODUCTIVE HEALTH SUB ACCOUNTS

Entity	Type of data collected	Methods and data sources
MoH	• Actual expenditures • Audited expenditures • Utilization figures • Inpatient days	• Budget and expenditure review of budget books, Consolidated Appropriation Accounts, audited accounts • HIMS review • Survey of selected providers by level of care and region
Other government departments	• Actual expenditures	• Survey of all institutions involved in financing health including RH services and goods • Survey of selected providers by level of care and region
Donor	• Budgets • Disbursements • Actual expenditures	• National survey of all donors involved in funding all health services including RH • Public Expenditure Review reports • Consultant's reports
NGOs	• Budgets • Actual expenditures	• National survey of all NGOs involved in financing and delivery of RH services and goods
Firms and corporations	• Actual expenditures	• National survey of all firms and corporations involved in health including RH services and goods
Providers	• Actual expenditures • Utilization figures • Inpatient days	• National sample survey of selected facilities by ownership (MoH, private not-for-profit, private for-profit), by level of care (health centre, district hospital, central hospital) and by region (North, Centre and South)
Households	• Actual expenditures • Utilization	• Integrated Household Survey Report of 2004/05 • Household Health Expenditure and Utilization Survey Report 2000

26 PTMCT expenditures were included in the HIV and AIDS sub-accounts; as such they were omitted from the RH subaccounts to avoid double counting. Expenditures for the remaining services were difficult to isolate; hence they were treated as other RH expenditures not identified by kind.

7.4 RESULTS OF REPRODUCTIVE HEALTH SUB-ACCOUNTS

The RH sub-accounts revealed that total RH expenditures in Malawi in per capita dollar terms for women of reproductive age (15-49 years) was around US$ 12 per annum during the period under review (for more details see Table 29). Although RH spending in absolute terms has increased, it has shrunk as a percentage of THE. This is despite worsening trends in RH, and a perceived high profile of RH on the national health policy agenda.

TABLE 29: SUMMARY OF REPRODUCTIVE HEALTH SUB-ACCOUNTS FINDINGS FOR 2002/03-2004/05

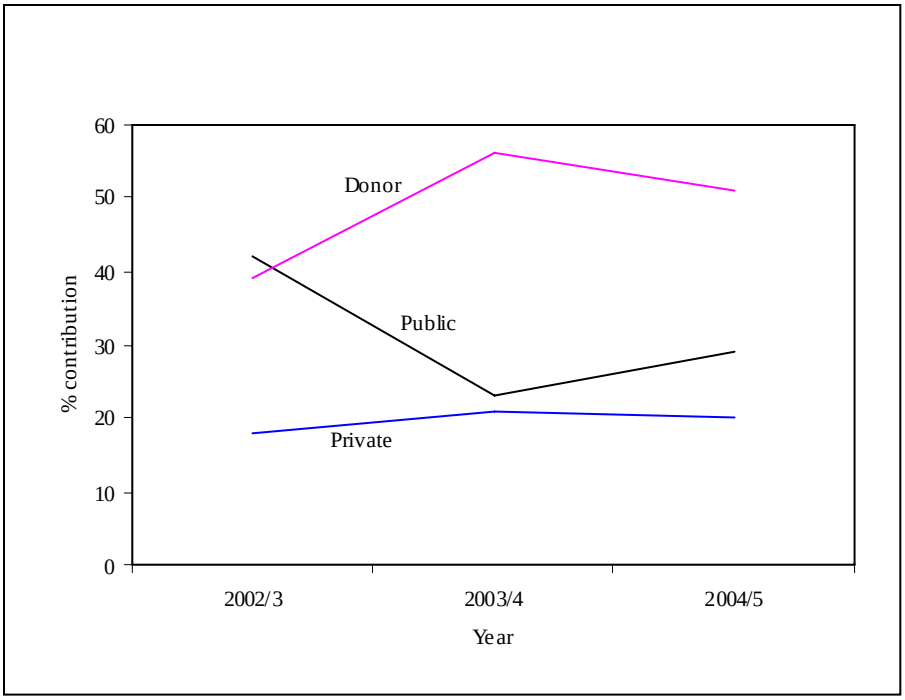
Variable	Financial Year		
	2002/03	2003/04	2004/05
Total RH expenditure (MK)	2,752,787,802	3,422,459,097	3,560,767,096
Total RH expenditure (at average US$ exchange rate)	31,539,081	31,524,025	32,648,620
RH expenditures per woman of reproductive age (MK)	1,028	1,240	1,251
RH expenditures per woman of reproductive age (at average US$ exchange rate)	11.8	11.4	11.4
RH expenditures as a % of GDP	2	2	2
RH expenditures as a % of overall health spending	19	16	14
Financing Sources of RH Funds (as % of THE for RH)			
• Public	42	23	29
• Private	19	21	20
• Donor	39	56	51
Household spending			
• Total household spending as % of THE for RH	13	16	14
• OOP spending as a % of THE for RH	13	16	14
Financing Agents of RH Funds			
• Public	65	58	61
• Private	30	33	35
• Donor	5	10	4
Provider distribution (as % of THE for RH)			
• **Hospital:**			
• Public	23	24	29
• Private	9	10	11
• **Health centre:**			
• Public	33	23	21
• Private	13	11	7
• Private clinics	2	3	4
• Pharmacies	2	3	3
• Providers of prevention and public health programmes	18	20	22
• Administration	1	6	4
Functions (as % of THE for RH)			
• Curative care	57	47	48
• Pharmaceuticals	2	3	3
• Prevention and public health	40	43	43
• Administration	2	6	4
• Capital formation	0.1	0.4	0.4

Variable	Financial Year	Variable	Financial Year
RH-specific functional categories (as % of THE for RH)			
• Maternal health services (curative)	57	47	47
• Family planning	24	26	26
• Prevention & public health programmes on maternal health & family planning	18	20	22
• Administration	2	6	4

Source: RH Tables in Annex 7-C

The major source of funds for RH services in 2002/03 was government, which contributed about 42% of the total expenditure on RH. This was followed by donors at 39% and private sources (principally households) at 18%. In the subsequent two years, the donor funding surpassed the contribution of government, rising 17 percentage points to stand at more than 50% of spending on RH (see Figure 16). Public funding for RH declined by almost half from 2002/03 to 2003/04. The reason for this decline is unclear. However, it could be due to the substitution of government funds in light of the increased donor funding for RH. Households continued to be a third major source of RH financing, their proportion increasing to 21% of THE for RH in 2003/04 and 20% in 2004/05.

FIGURE 16: TOTAL REPRODUCTIVE HEALTH EXPENDITURE BY SOURCE



Source: RH Tables in Annex 7-C

The public sector (in particular the MoH) was the major financing agent during the period. The public sector averaged 61% of THE for RH, followed by private sector at 33% (of which household out-of-pocket averaged 14% of THE for RH). Rest of the World (donors and international NGOs) controlled an average 5% of RH funds.

The majority of RH resources are spent in public sector facilities (hospitals and health centres) accounting for 55%, 47% and 49% of THE for RH in years 2002/03, 2003/04 and 2004/05 respectively (Only expenditures which actually occurred at the facility were captured under public providers, i.e. excluding general administration for RH at the central level). Private not-for-profit facilities totalled an average of 18%, and private for-profit facilities 7%.

In terms of functions, most RH resources are spent on curative care which, without including family planning consultations and commodities, accounted for 55% of THE for RH in 2002/03, 44% in 2003/04, and 45% in 2004/05. Most of these expenditures related to maternal health services, such as deliveries, and pre- and postnatal care. Family planning consultations and issuance of modern family planning methods consumed 24%, 26% and 26% in the three years respectively. Provision of preventive and public health programmes accounted for 18%, 20% and 22% of the THE for RH for the same years.

7.5 REPRODUCTIVE HEALTH FINANCING IN THE CONTEXT OF OVERALL HEALTH

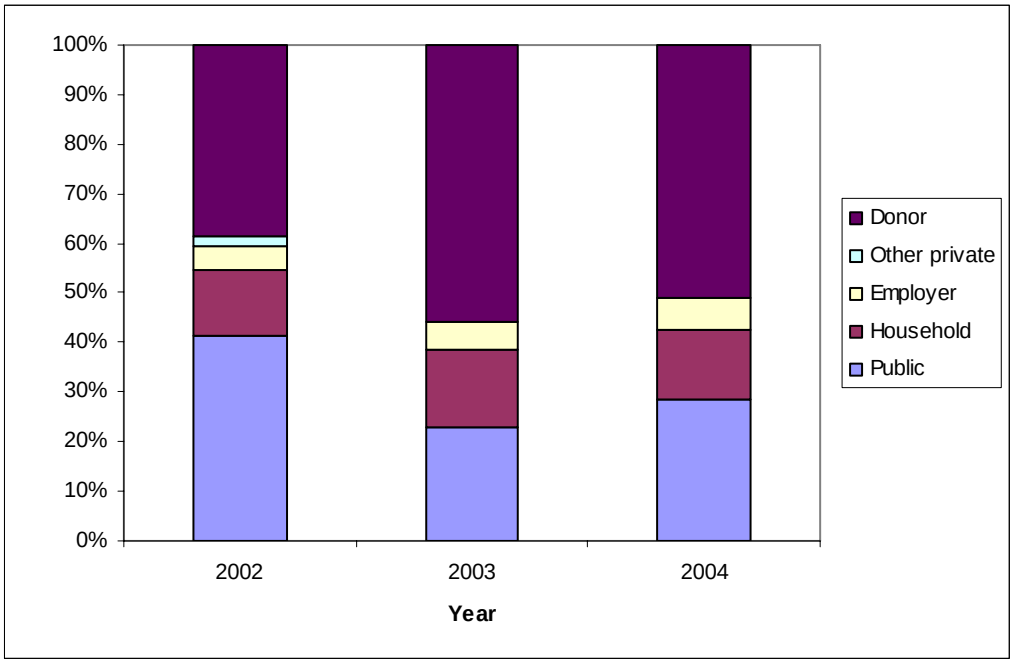
As indicated in Table 29 above, RH was 19% of THE in 2002/03, fell to 16% and then fell further to 14% in 2003/04 and 2004/05 respectively. The reasons behind this decline could include a huge decrease (14 percentage points in overall public health expenditure between 2002/03 and 2003/04 (see Annex 7-C for more details). While there was an increase in both public and donor resources for RH from 2003/04 to 2004/05, this was not in proportion to the overall increase in health spending in particular for donors. Donors (through the Global Fund) substantially increased the funding for HIV and AIDS during the same period from 46% in 2002/03 to 76% in 2003/04 of total HIV and AIDS expenditures (including expenditures on non-health activities) thereby crowding out other priority activities such as RH.

7.6 REPRODUCTIVE HEALTH RESULTS BY NHA DIMENSIONS

Financing Sources: Who pays for reproductive health services and goods?

The major financing sources for RH services and goods in Malawi are the public sector (Ministry of Finance) and donors. The Ministry of Finance was the major source of RH spending in 2002/03; subsequently donors became the major sources of funding for RH services and goods contributing 56% and 51% of total RH resources in 2003/04 and 2004/05 respectively (see Table 29 above and Figure 17 below).

FIGURE 17: PERCENTAGE CONTRIBUTION OF FINANCING SOURCES TO REPRODUCTIVE HEALTH EXPENDITURE



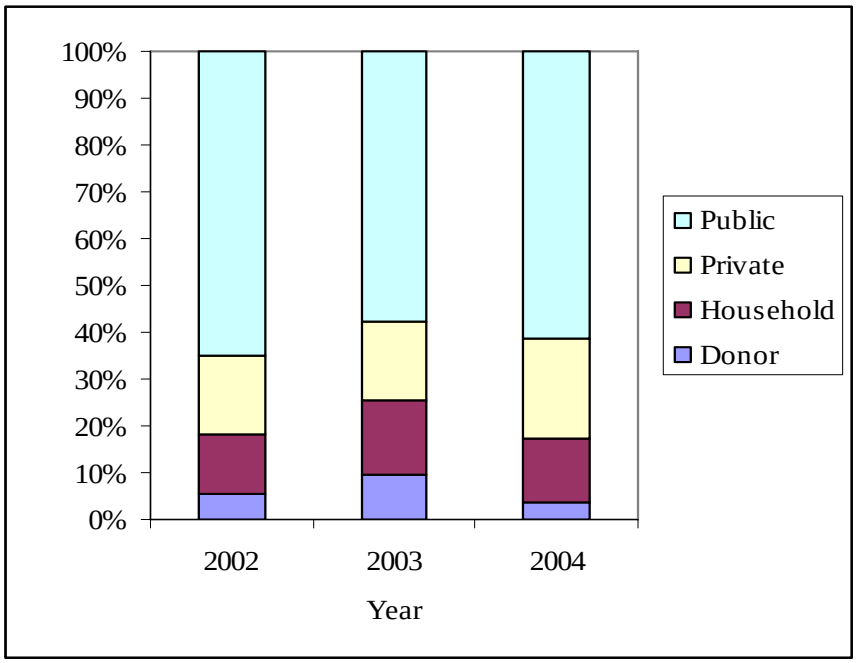
Source: RH Tables in Annex 7-C

An interesting finding is that, despite health services and goods being essentially free in all public health facilities (except in private wings of central and selected district hospitals) and being highly subsidized in major NGOs (e.g. CHAM), households bear a great burden of financing for RH services and goods (see Table 29 and Figure 17). This finding is worrisome, considering the fact that maternal morbidity and mortality is a serious problem in Malawi and that the majority of households live below the national poverty line. This financial barrier therefore implies that the majority of women of reproductive age (15-49 years) are not able to access maternal health care services.

7.7 FINANCING AGENTS: WHO MANAGES REPRODUCTIVE HEALTH FUNDS?

The RH sub-accounts revealed that the public sector (in particular the MoH) is the major manager of RH funds accounting for 65%, 58%, and 61% in 2002/03, 2003/04 and 2004/05 respectively. NGOs such as Banja La Mtsogolo, CHAM, private firms and corporations (onsite facilities and reimbursements to employees) and health insurance (MASM) managed 14%, 17% and 21% of RH funds in 2002/03, 2003/04 and 2004/05 respectively. Households' direct out-of pocket spending on RH goods and services accounted for 13%, 16% and 14% of total RH funds in the three years. The Rest of the World (donors and international NGOs) managed only 5%, 10% and 4% of RH funds in the three years (see Figure 18; for more details go to Annex 7-C).

FIGURE 18: DISTRIBUTION OF TOTAL REPRODUCTIVE HEALTH SPENDING BY FINANCING AGENT, 2002/03-2004/05



Source: RH Tables in Annex 7-C

Because the public sector (MoH) manages the largest share of funds for RH (received from donors and Ministry of Finance), it bears the major responsibility for the quality of essential obstetric care provided, and in turn for influencing the maternal mortality ratio in Malawi. The MoH should therefore carefully examine all its planning, resource allocation, budgeting and service delivery strategies for RH services and goods to gain maximum benefits from the large amount of RH resources under its control. Furthermore, instead of undertaking both roles of financing and delivery of RH in its facilities, the MoH could enter into service contracts with other providers such as NGOs and the private for-profit sector to provide certain RH services. It is gratifying to note that recently, the MoH entered into service agreements for provision of certain RH services in particular perinatal care-labour/deliveries with CHAM and other essential RH services with the NGO Banja La Mtsogolo. It is hoped that this move will improve access to and utilization of maternal health services.

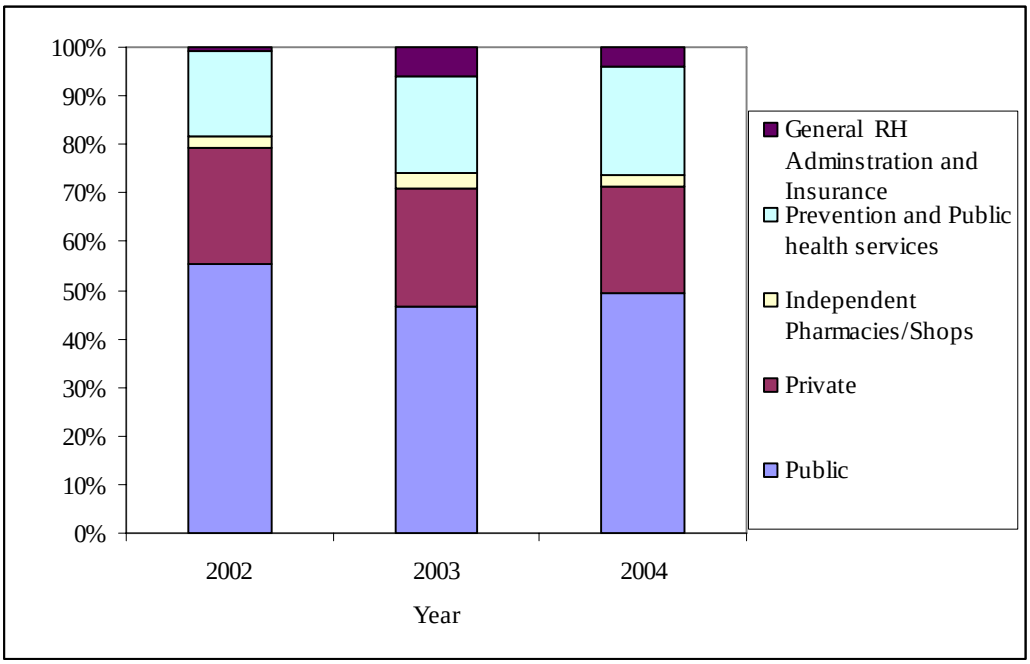
Evidence has shown that direct household out-of-pocket spending dissuades the very poor from utilizing health services (WHO 2000). In Malawi women of childbearing age are in the majority, and thus there is great need for quality RH services. The high level of household out-of-pocket contributions for RH care could be one reason for poor access to high-quality health care services, and this has a direct impact on high maternal deaths. This calls for the MoH as the steward of the health of the Malawian population to work with all health system stakeholders to investigate ways of expanding the existing health insurance scheme (MASM) to include all formal sector workers and comprehensive RH services in the benefit package. This strategy would greatly reduce household out-of-pocket spending on RH services and encourage utilization of RH services.

7.8 HEALTH PROVIDERS: WHERE DO REPRODUCTIVE HEALTH FUNDS GO?

Data indicate that the distribution of RH resources by provider type follows the distribution of health facilities and beds: the MoH with 60%, CHAM with 37%, Ministry of Local Government with 1%, and private providers and the army and police with the remaining 2%. This suggests that, although the exact mapping owes somewhat to coincidence, resource allocation for RH follows health facilities (and in particular hospitals) rather than the health *needs* of the population.

The public health sector is the largest recipient of RH funds: 55%, 47% and 49% in 2002/03, 2003/04 and 2004/05 respectively (see Figure 19). Public sector funds come mainly from public financing agents such as the Ministries of Health and of Local Government. Private not-for-profit providers (CHAM and NGOs) are second large recipient of RH resources though their share fell from 25% in 2002/03 to only 13% in 2004/05.

FIGURE 19: REPRODUCTIVE HEALTH FUNDS BY PROVIDER TYPE, 2002/03-2004/05



Source: RH Tables in Annex 7-C

The majority of financing for RH is prepaid through general taxation and donations. This, theoretically, should encourage utilization of health services. Nevertheless, utilization of RH services remains low and a main reason for poor maternal and child health indicators (McCoy et al. 2004, MoH 2005b). Access to essential emergency health care services is poor, not only due to inadequate financial resources, but because quality of health care is poor (MoH 2005b). This calls for better human resources management to improve health worker behaviour with patients, availability of appropriately skilled workers, and technical knowledge of the equipment used, among others.

In 2004/05 public hospitals consumed 29% and public health centres 21% of total resources for RH. However, most RH services such as prenatal care and deliveries occur at health centres and most health centres, dispensaries and maternity units are located in rural areas. Provision of RH services at the hospital level is both inefficient –it could be provided at a cheaper cost at health centers – and inequitable, because most women of childbearing age live in rural locations (DHS 2004). It is the responsibility of the MoH to review its resource allocation decisions to ensure its RH resources are utilized in the most cost-effective and equitable manner.

The MoH is also the primary provider and administrator of RH prevention and public health services, which include support of family planning and its promotion through IEC, BCC and public awareness campaigns. These services received 18%, 20% and 22% of THE for RH in 2002/03, 2003/04, 2004/05 respectively. The MoH must decide whether such funding levels are appropriate for these activities.

7.9 HEALTH CARE FUNCTIONS: ON WHAT ARE REPRODUCTIVE HEALTH FUNDS SPENT?

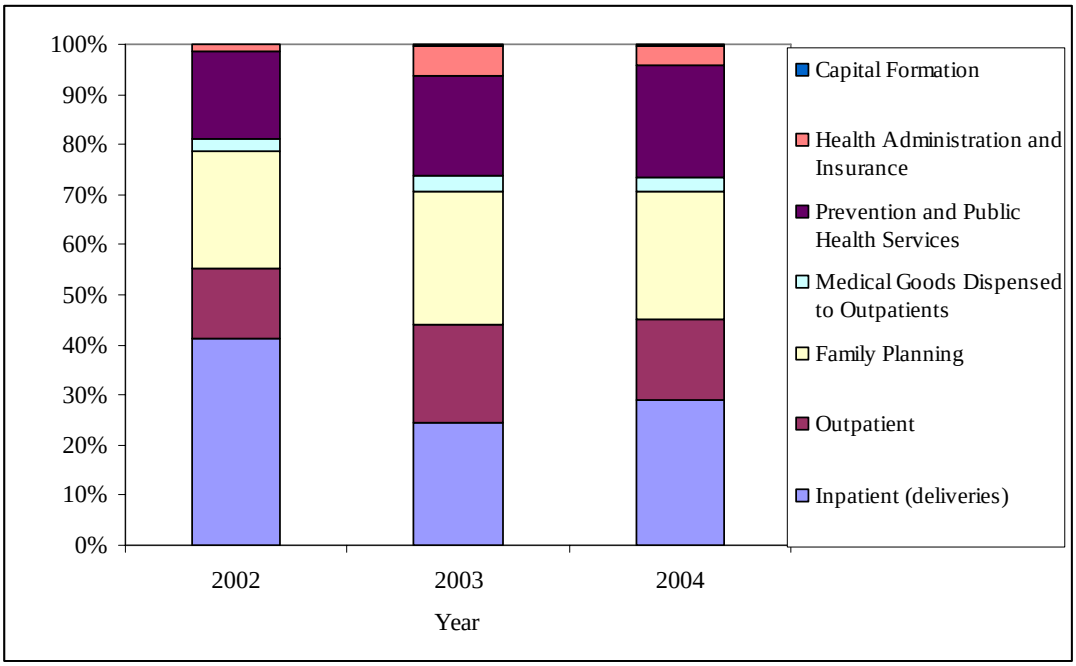
In order to improve the current poor maternal health situation in Malawi, resources must be spent on services that produce the greatest benefit to individuals and the population of women of reproductive age such as investing in essential obstetric care services, hospital equipment, communications equipment, ambulances and training of birth attendants.

The RH sub-accounts revealed that 55%, 44% and 45% of total RH resources in 2002/03, 2003/04 and 2004/05 respectively, were spent on curative care[27] (excluding family planning consultations and commodities). Inpatient curative care, mainly deliveries, consumed 41%, 24% and 29% of total RH curative health expenditures in the three years. This compares to a slight increase in outpatient curative care, from 14% in 2002/03 to 16% in 2004/05 (again excluding family planning consultations and commodities). Family planning expenditures accounted for an average 24% of the total. See Table 27 above, Figure 20 below and Annex 7-C.

Despite this appreciable share of expenditure on family planning consultations and commodities, contraceptive prevalence rates in Malawi remain low at 26% while the total fertility rate remains high, at 6.5. One could assume that this is because households bear the majority of expenditures via direct out-of-pocket spending, and thus there are issues of ineffective demand or prices are too high. However, this is not the case in Malawi. The MoH is the major financing agent of these services and goods, with funding from donors, representing an average of 90%. Family planning goods are distributed free at point of use in all public facilities and are heavily subsidized in NGO facilities. Further evidence is therefore required to determine the effectiveness of this spending.

[27] There was a debate by the Malawi NHA Team that even though family planning consultations and commodities are delivered in an outpatient setting, these services are more preventive than curative in nature. Therefore they cannot be grouped with other outpatient curative services under HC.1: Services of curative care. It was felt that they were more fitting to be under HC.6

FIGURE 20: REPRODUCTIVE HEALTH EXPENDITURE BY FUNCTION, 2002/03-2004/05



Source: RH Tables in Annex 7-C

7.10 SUMMARY, POLICY IMPLICATIONS AND CONCLUSIONS

7.10.1 SUMMARY

The Malawi RH sub-accounts study is only the third ever to be undertaken in Africa. It has revealed that on average donors are the major source of RH funding as in other countries in Africa[28], a situation that was not recognized prior to the study. Government also contributes substantially to RH services and goods, through its funding for the MoH recurrent and development budget and CHAM recurrent budget, in particular for salaries for all local staff. Households pay a significantly amount through direct out-of-pocket expenditures.

Donors largely finance public health programmes, including family planning commodities. Government through its funding to MoH and CHAM (including contributions for salaries of health personnel, drugs and medical supplies) provides the bulk of all inpatient and outpatient RH services. Government expenditure on RH has often been overlooked in the past.

Households also finance a significant proportion of RH care, despite high levels of poverty in Malawi, and in particular among women of reproductive age.

[28] Other countries in Africa that have undertaken the NHA RH sub-accounts are Rwanda and Ethiopia; outside of Africa, Jordan has done so.

7.10.2 POLICY IMPLICATIONS

- Inadequate funding for maternal health: Government need to increase funding for training and paying salaries for nurses and enrolled midwives, who are critical to maternal health service delivery.

- Inequities in access to RH services: MoH need to continue strengthening service contracts with NGOs in particular CHAM and Banja La Mtsogolo for provision of some of its RH services and in the medium term enter into service agreements with private for-profit providers.

- Huge donor financing for RH prevention and public health programmes including procurement of contraceptives and commodities: Donors need to increase funding for procurement of materials to deliver maternal health services, such as drugs and medical supplies, medical equipment and ambulances for emergency obstetric care, prenatal, labour, delivery and postnatal care and for training of enrolled nurses and midwives, among others.

- Huge expenditures on RH contraceptives and commodities while contraceptive prevalence rates are low and fertility rate is high: Government need to investigate the effectiveness of RH spending on contraceptives and commodities, i.e. investigate whether the RH contraceptives and commodities are indeed used by the clients once they are obtained.

- High household direct out-of-pocket spending for RH services: Need to reduce out-of-pocket financing for RH especially because maternal health status is so poor in Malawi. One way to do this is expand prepaid health insurance schemes such as MASM and include RH in benefit packages. Another strategy is to introduce cash transfers to scheme members so to encourage pregnant women to deliver in formal health facilities, and ensure supervision from appropriately trained health personnel.

7.10.3 CONCLUSION

The RH sub-accounts clearly show that resources for RH services and goods in Malawi are inadequate. Over the years studied, there has been an increase in the resources spent on RH, attributable mainly to donors that fund prevention and public health services. There is strong need for government and donors to jointly review their RH funding priorities to begin to reduce the high maternal mortality ratio.

8. CHILD HEALTH SUB-ACCOUNTS RESULTS

8.1 INTRODUCTION

Poor CH remains one of the major public health and developmental problems facing Malawi. Although key indicators have improved steadily since the 1980s, the rate is insufficient for the country to achieve its Millennium Development Goals. The under-five mortality rate (per 1,000) is improving from 258 in the 1980s, 234 in the mid-1990s, 187 in the late 1990s/early 2000s, and 133 in 2004, but not fast enough to meet the goal of about 80/1,000 by 2015. The decline in the infant mortality rate is even slower, from 138 per 1,000 live births in the late 1980s to 76 in 2004. One recent study estimated that two thirds of Malawi's 91,000 child deaths per year could be averted using current technologies (World Bank 2004). As such, a thorough analysis of the organization of CH service delivery, and its financing, is essential. This will enable identification of key issues affecting CH and, thereafter, assist in the design of the necessary strategies for improvement.

The CH sub-accounts were conducted in conjunction with the general NHA, for the period 2002/03-2004/05. This is only the fourth CH sub-accounts ever to be undertaken in the world. Ethiopia is the only other African country to have undertaken CH sub-accounts[29].

As with the general NHA, the CH sub-accounts include four core tables (shown in Annex 7-D); these illustrate the flow of funds between the principle dimensions of financing sources, financing agents, providers and functions relating to CH care expenditures.

8.2 POLICY PURPOSE OF CHILD HEALTH SUB-ACCOUNTS

A key area of concern for policymakers in the Malawian health system is the scale-up of interventions targeted at CH. However, there is currently a lack of good information on the level of funding available to this vital cluster of health interventions. In order to achieve the CH and other Millennium Development Goals, there is need for proper allocation of resources to various disease interventions and prevention programmes. An important prerequisite for such health sector planning is an understanding of the organization and financing of key CH services, one that includes a review of expenditures incurred by donors, public sector entities, and the private sector, including households. It is with this understanding, that the CH sub-accounts was undertaken in 2005 using data for financial years 2002/03, 2003/04 and 2004/05.

Major Policy Questions Addressed by Child Health Sub-Accounts in Malawi

- What is the current level of funding for CH at national level?
- What are the current sources of funding for CH and who manages these funds?
- What is the distribution of child health resources between various CH interventions?
- Who provides child health care services and with what resources?

[29] The other two countries that have undertaken the CH sub-accounts are Bangladesh and Sri Lanka.

8.3 DEFINITION AND CONCEPT OF CHILD HEALTH SUB-ACCOUNTS

8.3.1 WHAT ARE CH EXPENDITURES?

To ensure transparency and clarity in data collection for the CH sub-accounts, it was important to precisely define CH expenditures, i.e. *expenditures on activities whose primary purpose is to improve, maintain or restore the health of a child between 0 to less than 5 years*. In other words, two issues are key to determining the boundaries for CH expenditures; namely age (0 to less than 5 years old), and interventions, which must be delivered directly to the child and not to the mother for the benefit of the child. Table 30 shows the types of activities included in and excluded from CH sub-accounts globally.

TABLE 30: TYPES OF ACTIVITIES INCLUDED IN AND EXCLUDED FROM CHILD HEALTH SUB-ACCOUNTS

Included as CH expenditure	Not included as CH expenditure
• Integrated management of childhood illnesses	• Family planning and birth spacing related activities and programmatic support
• Malaria activities targeting children under five. Includes all preventive activities, treatment of malaria using anti-malarials and programmatic support	• Maternal and reproductive health-related activities and programmatic support. Includes prenatal care, basic comprehensive emergency obstetric care, and all other interventions given directly to the mother
• ARI activities	• All HIV and AIDS activities except PMTCT
• Care of the newborn • Management of neonatal sepsis activities	• General food supplementation activities
• Control of diarrhoeal activities	• Care of orphans
• All immunization activities to children under five. Includes procurement of vaccines, materials and cold chain equipment as well as programmatic support	• Water and sanitation activities except those that target water-borne diseases
• Breastfeeding counselling and promotion of complementary feeding	• Education
• Micronutrient supplementation given to children under five	•
• Fortification of food. Includes activities related to iodized salt and vitamin A fortification as well as any support to government programmes	•
• Treatment of severely malnourished children activities	•
• Targeted food (macronutrient) supplementation to identified malnourished children	•
• PMTCT activities	•
• Water and sanitation activities targeting the elimination of water-borne diseases	•
• Training of community health workers and in-service training of health facility staff for the delivery of CH services	

In this study, expenditures on the following functional classifications were captured, to retain consistency with the general NHA[30]:

[30] PMTCT given to mothers was included under the HIV and AIDS sub-accounts; hence it was not included under CH sub-accounts. Only interventions including PMTCT given to children 0-under five years are included in CH sub-accounts.

- Curative care services (inpatient and outpatient): e.g. IMCI, malaria activities targeting child under five years, ARI, care of newborns and management of neonatal sepsis, treatment of severely malnourished children;
- Rehabilitative care services;
- Medical goods dispensed to outpatients (pharmaceuticals);
- Prevention and public health activities: control of diarrhoeal activities, all immunization activities to children under five (including procurement of vaccines, materials and cold chain equipment as well as programmatic support);
- Capital formation: purchase of equipment such as baby courts; and
- Training.

It should be noted that General Health Administration at the central level was not estimated due to the difficulties associated with separating the allocation of staff time for CH activities. Inpatient and outpatient services include some administrative expenses for the facility at which the service took place and services that are ancillary to the health care services.

8.3.2 METHODS AND DATA SOURCES

Table 31 summarizes the methods and data sources used in the Malawi CH sub-accounts study.

TABLE 31: SUMMARY OF METHODS AND SOURCES USED IN THE MALAWI CHILD HEALTH SUB-ACCOUNTS STUDY

Entity	Type of data collected	Methods and data sources
MoH	• Actual expenditures • Audited expenditures • Utilization figures • Inpatient days	• Budget and expenditure review of budget books, Consolidated Appropriation Accounts, audited accounts • HIMS review • Survey of selected providers by level of care and region
Other government departments	• Actual expenditures	• Survey of all institutions involved in financing health • Survey of selected providers by level of care and region
Donor	• Budgets • Disbursements • Actual expenditures	• National survey of all donors involved in funding health • Public Expenditure Review reports • Consultant's reports
NGOs	• Budgets • Actual expenditures	• National survey of all NGOs involved in financing and delivery of health
Firms and corporations	• Actual expenditures	• National survey of all firms and corporations involved in health
Providers	• Actual expenditures • Utilization figures • Inpatient days	• National sample survey of selected facilities by ownership (MoH, private not-for-profit, private for-profit), by level of care (health centre, district hospital, central hospital) and by region (North, Centre and South)
Households	• Actual expenditures • Utilization	• Integrated Household Survey Report of 2004/05 • Household Health Expenditure and Utilization Survey Report 2000

8.4 RESULTS OF THE CHILD HEALTH SUB-ACCOUNTS

Total Child Health Expenditures

The CH sub-accounts revealed that total CH expenditures in Malawi were MK2.42 billion (US$27.7 million), MK2.86 billion (US$26.4 million) and MK3.91 billion (US$35.9 million) in 2002/03, 2003/04 and 2004/05 respectively. These amounts represent 17%, 14% and 15% of THE in the three years respectively. On a per capita basis, it amounted to US$12 per child in 2002/03, US$11 per child in 2003/04, and US$15 per child in 2004/05. If these figures are compared to other countries which have previously done CH sub-accounts, Malawi's total and per CH expenditure is relatively high – particularly given the constrained size of the Malawian economy (Tables 32). However, its health indicators are notably worse (child mortality rate is 133 per 1,000 in Malawi, compared to 69 in Bangladesh and 15 in Sri Lanka). This can indicate that (1) Malawi is not spending its CH resources as effectively as it could, and (2) factors other than the services provided have a serious impact on CH – including household income, nutrition levels, and the education of the mother (for more details see Annex 7-D).

TABLE 32: COMPARATIVE ANALYSIS OF CHILD HEALTH EXPENDITURES AND CHILD HEALTH INDICATORS IN COUNTRIES THAT HAVE DONE THE CH SUB-ACCOUNTS, 2002/03

Country	CH expenditure as % of THE	CH expenditures per child (US$)	THE/capita (US$)	Infant mortality rate per 1000 live births	Child mortality rate per 1000
Malawi (2002)	17	12	15	76	133
Ethiopia (2004)	19	7.8	7.1	110	166
Bangladesh (2002)	12.2	10.7	11.4	46	69
Sri Lanka (2002)	4	14.6	30.9	13	15

Sources: Malawi DHS 2000 & 2004, Institute for Health Policy Studies Sri Lanka (2006) and Data International Bangladesh (2006), Federal Ministry of Health Ethiopia (2006).

In 2002/03 alone, the major financing source for CH was public, in particular the Ministry of Finance through its funding to the annual health budget managed by the MoH. This was at a high of 41% of total CH expenditures in 2002/03, but it subsequently fell to a low of 30% of total CH expenditures by 2004/05. In 2003/04 and 2004/05 donors were the major financiers of CH activities, contributing 49% of total CH expenditures in both financial years. Private funds also made a significant contribution, ranging from 20% to 23% in the three years. Among private sources, households were the major contibutor, accounting for 14%, 18% and 15% of CH expenditures in 2002/03, 2003/04 and 2004/05 respectively.

The major financing agent (controller of funds) for CH is the public health sector, mainly the MoH, accounting for a high of 63% of total CH expenditures in 2002/03 and a low of 54% by 2004/05. The private health sector is the second major financing agent, controlling on average 30% of total CH expenditures during the period (see Table 33).

The major provider of CH services and goods in Malawi is the public health sector, which received a high of 53% of total CH funds in 2002/03, 46% in 2003/04 and 49% in 2004/05. Private providers received about 17% of total CH funds in 2002/03, rising to a constant share of 27% total CH funds in 2003/04 and 2004/05 (see Table 33).

TABLE 33: SUMMARY OF KEY STATISTICS FOR CHILD HEALTH SUB-ACCOUNTS, 2002/03-2004/05

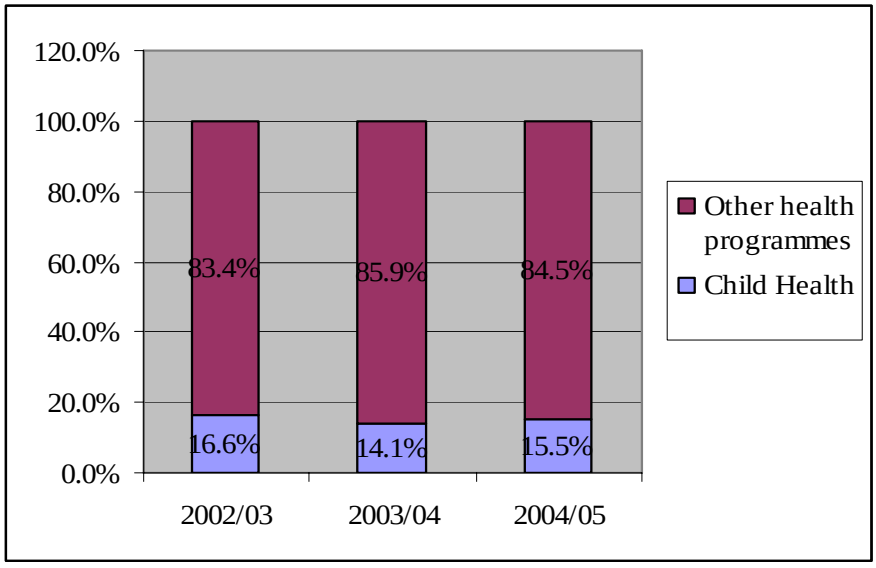
Variable	Financial Year		
	2002/03	2003/04	2004/05
Total CH expenditure (MWK)	2,421,792,266	2,860,751,577	3,905,794,966
Total CH expenditure (at average US$ exchange rate)	27,746,819	26,350,178	35,851,664
CH expenditures per child 0-5 years of age (MK)	1,029	1,186	1,581
CH expenditures per child 0-5 years of age (at average US$ exchange rate)	12	11	15
CH expenditures as a % of GDP	1.6	1.7	1.9
CH expenditures as a % of overall health spending	16.8	14.1	15.5
Financing Sources of CH Funds (as % of THE for CH)			
Public	41	28	30
Private	20	23	21
Donor	39	49	49
Household spending			
Total household spending as % of THE for CH	15	18	15
OOP spending as a % of THE for CH	14	18	14
OOP spending per child (0-5 years) (MK)	239	218	227
OOP spending per child (0-5 years) (US$)	2.7	2.0	2.1
Financing Agents of CH Funds (as % of THE for CH)			
Public	63	58	54
Private	30	32	30
Donor	7	11	16
Provider distribution (as % of THE for CH)			
Hospital:	48	35	39
Public	39	25	29
Private	9	10	10
Health centre:	19	36	33
Public	14	27	25
Private	5	9	8
Private clinics	3	2	4
Pharmacies	3	4	4
Providers of prevention and public health programmes	27	23	20
Functions (as % of THE for CH)			
Curative care	58	71	68
Medical goods dispensed to outpatients	3	4	8
Rehabilitative care	5	2	4
Prevention and Public Health	27	23	20
Capital formation	6	0	1

Source CH Tables in Annex 7-D

8.5 CHILD HEALTH RESOURCES IN THE CONTEXT OF THE GENERAL HEALTH SYSTEM

Figure 21 shows that CH expenditures as a proportion of THE have fallen from 16.6% in 2002/03 to 15.5% in 2004/05. With an estimated 17.9 percent of the population under five years of age (DHS 2004), CH is a national priority. Improvement in CH would represent a particularly desirable outcome from the health system, due to a child's longer projected remaining life expectancy, future income generating potential, as well as the sentimental wish that nobody wants to see a child in ill health. In this respect, expenditure on CH was very modest compared to the total resources available in the Malawian health system per annum.

FIGURE 21: CHILD HEALTH AS A PROPORTION OF TOTAL HEALTH EXPENDITURE

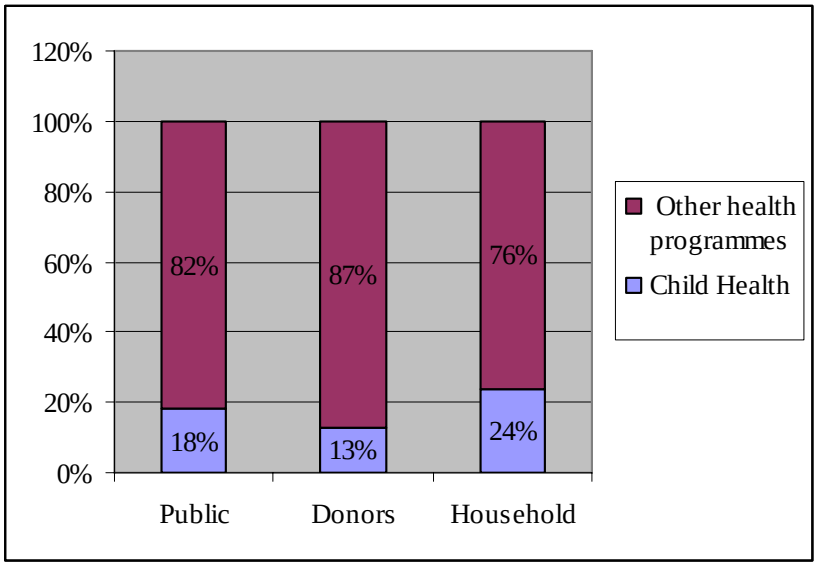


Source CH Tables in Annex 7-D and General NHA in Annex 7-A

The various financing sources contribute different proportions of their THE to CH (see Figure 22, which shows the 2004/05 distribution, as an example). In 2004/05 the public sector spent 18% of its THE on CH. Donors provided only 13%; their preference was for other areas such as HIV and AIDS and RH. Households, however, spend 24% of their THE on CH.

This shows both the importance placed upon CH at the household level, and the costs associated with ensuring the health of children. A child is a vital asset to a family, both for the present and for their future income generating potential. Government and donors might learn from this, and back well-articulated policies with action, i.e. more substantial financial support for CH.

FIGURE 22: DISTRIBUTION OF CHILD HEALTH EXPENDITURES BY SOURCE, 2004/05

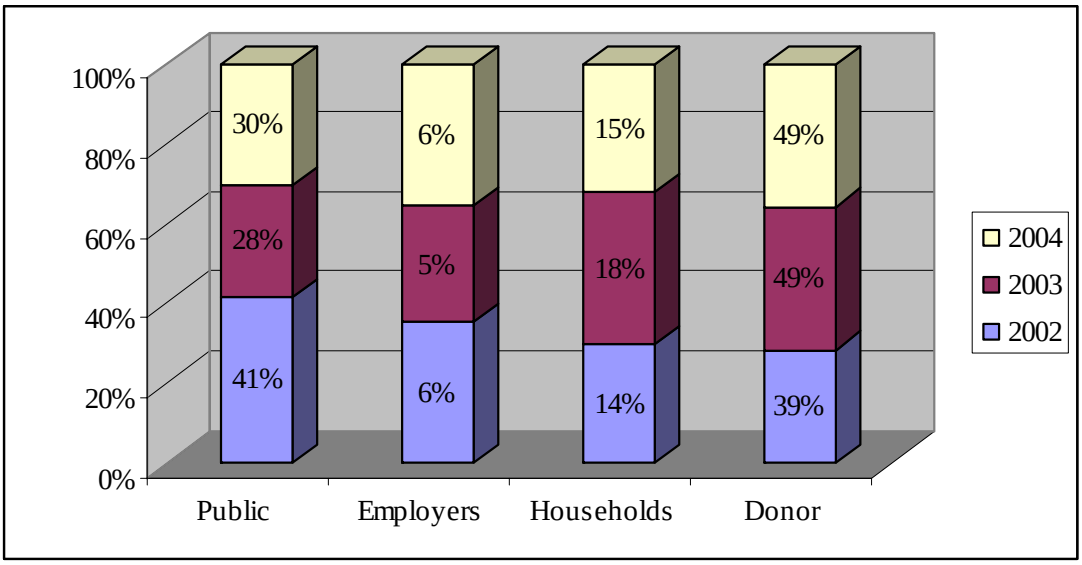


Source CH tables in Annex 7-D and general NHA in Annex 7-A

8.6 FINANCING SOURCES: WHERE DO THE FUNDS FOR CHILD HEALTH COME FROM?

Despite their low relative preference for spending on CH, approximately half of all expenditures were financed by donors in 2004/05 (for more details see Figure 23). This indicates the importance of donors throughout the health sector. The public sector contributed 30 percent, households 15 percent, employers 6 percent and donors 49% of the total child health expenditures. Comparison with 2002/03 has shown a relative increase in donor expenditure of 10 percent of the total, and an accompanying decrease in relative public expenditure. In absolute dollar terms, public expenditure has actually fallen from US$4.78 per child of 0-5 years of age in 2002/03 to US$4.37 in 2004/05. Given the increased resources available to the public sector, this is a worrisome trend.

FIGURE 23: CH EXPENDITURE BY SOURCE, 2002/03-2004/05



Source CH Tables in Annex 7-D

8.7 FINANCING AGENTS: WHO CONTROLS/MANAGES CHILD HEALTH FUNDS?

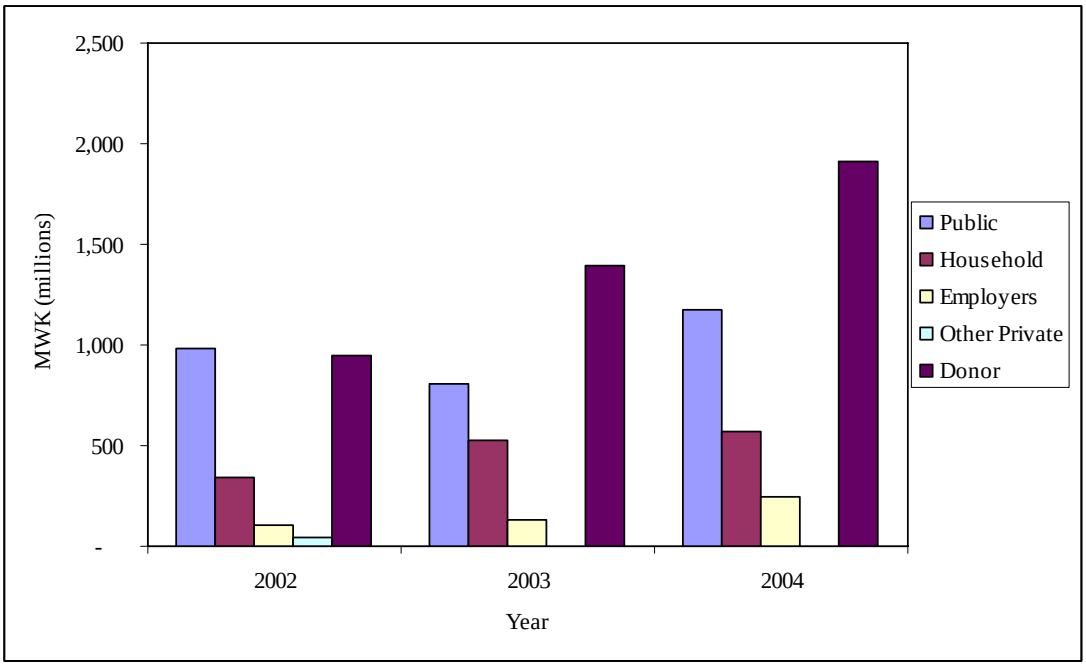
Transfers of funds are made initially from funding sources, such as the Ministry of Finance and donors, to financing agents, such as the MoH and NGOs, which allocate the funds to providers. That is, financing agents manage and control the use of child health funds; in doing so, they make the programmatic decisions on how the funds will be spent.

The flow of funds from sources of funds to financing agents can be seen in Appendix 7-D, and Figure 24 shows the breakdown of financing agents. Government funds for CH in 2004/05/05 (MK1.169 billion) were principally allocated to the MoH, which received MK984 million, and CHAM, which received MK164 million. Donor funds (MK1.909 billion) were primarily allocated to the MoH (MK1.084 billion). However, a large amount, MK622 million, was managed by the donors themselves and by international NGOs.

This last finding conflicts with the vision of the SWAp, which partially commenced in 2004/05, in which government is expected to take a leading role in the use and allocation of resources and the MoH in particular is expected to be the principal financing agent. As the NHA revealed a large proportion of external resources remained in the hands of donors and international NGOs. Further support to the MoH would assist in a more coordinated national approach to CH.

So that donors comply with its SWAp-envisioned role, however, government must illustrate that it has the capacity to manage finances effectively and transparently, i.e. use the funds for their intended purpose. The MoH cannot do this at present because it does not have a single reference point for CH issues. Current functions are split between IMCI, the Department of Nutrition, the Malaria Control Programme, EPI and others. The establishment of a single high-level authority, with reporting and stewardship responsibilities for CH, would greatly assist in ensuring a more coordinated approach and sound financial planning.

FIGURE 24: BREAKDOWN OF CHILD HEALTH EXPENDITURES BY FINANCING AGENTS, 2002/03-2004/05



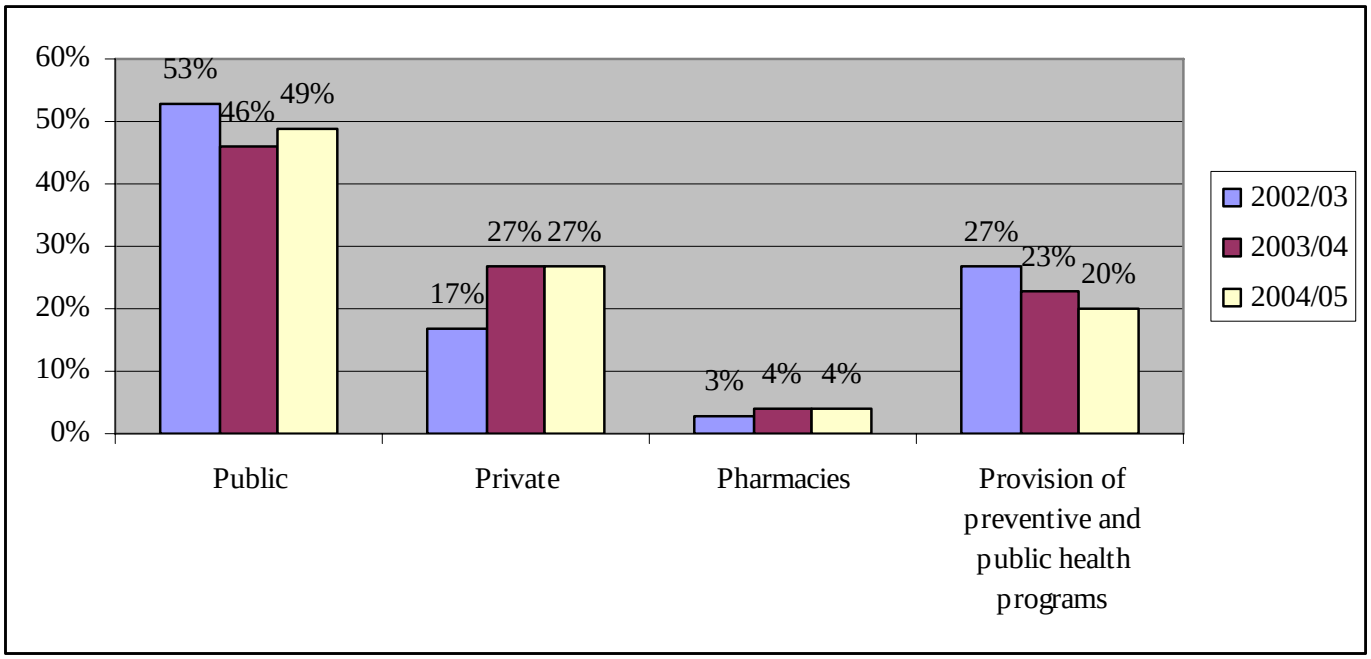
Source CH Tables in Annex 7-D

8.8 PROVIDERS: WHERE DO CHILD HEALTH FUNDS MANAGED BY FINANCING AGENTS GO?

Providers use funds to deliver the goods and services that constitute CH care. Providers consist of hospitals and health centres, both public and private. Expenditures are captured at these facilities only if the activity actually takes place there and relies on use of the facility. Other provider classifications include providers of prevention and public health programmes such as immunization campaigns and IEC, independent pharmacies and shops, and providers of health-related functions such as education and training.

Figure 25 shows the breakdown of CH expenditures by provider. Most expenditures occur in public health facilities (53% in 2002/03, 46% in 2003/04, and 49% in 2004/05). In 2004/05, 27 percent of expenditure took place in private health facilities, including the mission and private for-profit facilities. A limited amount (4 percent) was spent at private pharmacies, shops and dispensaries. The remaining 20% was spent on the provision of public health programmes, such as immunization, IEC and other prevention programmes.

FIGURE 25: DISTRIBUTION OF CHILD HEALTH EXPENDITURES BY TYPE OF HEALTH PROVIDER, 2002/03-2004/05



Source CH Tables in Annex 7-D
Note: In this figure public stands for public hospitals, health centres and dispensaries while private stands for private for-profit hospitals and clinics and private not for-profit hospitals, health centres and dispensaries.

Analysis by provider type illustrates the central role that the public sector plays in the provision of CH services. It also can be noted, however, that the share of private provision increased, from 17% in 2002/03 to 27% in both 2003/04 and 2004/05. This is likely in response to declining quality of health care services in the public sector, due to drug stock-outs and inadequate human resources[31]. Moreover the percentage of preventive health services has fallen, from 27% in 2002/03 to 23% in 2003/04 and 20% in 2004/05. This is unfortunate, given the proven cost effectiveness of prevention strategies for CH. It is therefore important that MoH seriously consider scaling up expenditures on CH prevention and public health programmes. A study to determine potential areas for increased expenditure could be included in District Implementation Plans and central-level coordination.

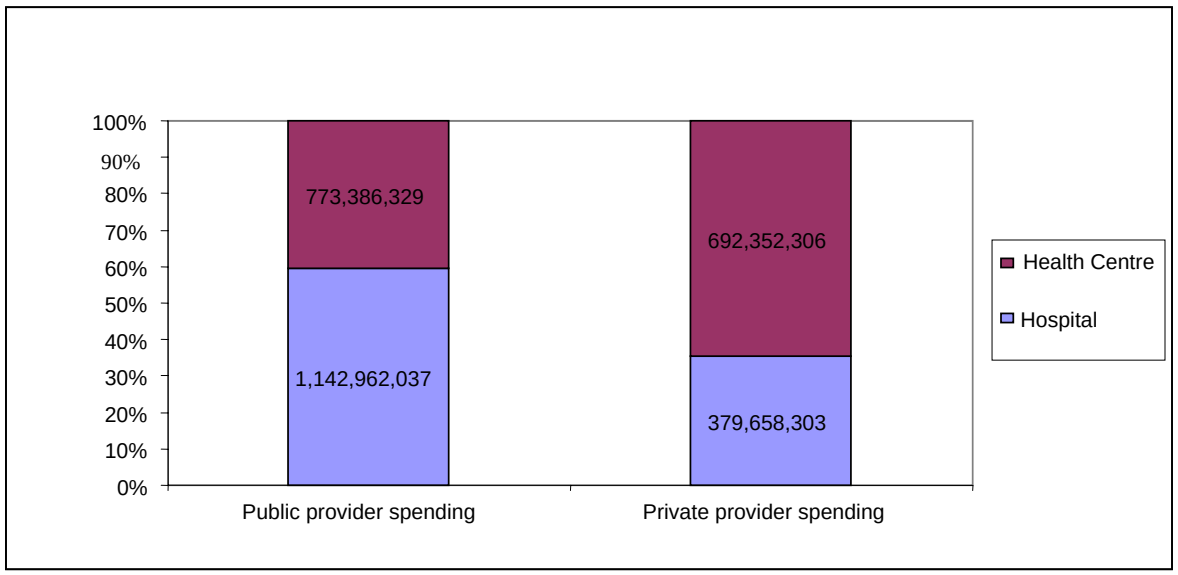
Figure 26 shows the breakdown of CH expenditures by level of public and private care in the 2002/03 to 2004/05 period. A higher proportion of total public facility provision of CH (60%) is hospital care, including both district and central hospitals. This is an inefficient allocation of scarce resources because almost all CH interventions (for malaria, diarrhoea, ARI, pneumonia etc.) could be provided cost effectively at the primary care level (family, community and health centres and dispensaries) (MoH 2004). Only a few complicated cases need be referred to more expensive district and central hospitals (Mills 1991, Mwambaghi et al 1995, Mwase 1998).

[31] A MEJN study in 2005 indicates that more than half of patients who first go to a public facility and do not receive drugs or treatment end up going to a private facility (MEJN 2005).

There are several reasons for the preference for hospital care, including: (1) poor quality of public health care services at the primary level, due to unavailability of drugs and health workers, which forces patients to bypass this level, (2) an already dysfunctional referral system resulting in an unclear division of services between hospitals and health centres, i.e. at present many mothers of sick children just walk into district and central hospitals without being referred by lower levels, and (3) patients initially seeking private care but returning to free-use public facilities for more complicated, and costly, conditions.

The private sector, in contrast, spent a lower proportion at the hospital level – in 2004/05, only 35%. Because there is a smaller number of private hospitals and they charge high prices, the majority of households seek care at lower levels of private facilities.

FIGURE 26: DISTRIBUTION OF PROVIDER CHILD HEALTH CARE EXPENDITURE BY LEVEL OF CARE: 2002/03-2004/05



Source CH Tables in Annex 7-D

Table 34 shows the distribution of household out-of-pocket expenditure for CH by provider type. During the period under review, households spent about a quarter of their funds out-of-pocket on CHAM hospitals and an additional 9% on CHAM health centres. This is quite high bearing in mind that CHAM is highly subsidized by government and children under the age of five are in highest need of health care services (MoH 2004, DHS 2004). Thus the majority could be denied access to CHAM CH services due to the user fees charged by CHAM facilities.

Pharmacies/shops are the second recipient of total CH household out-of-pocket expenditures, on average receiving about 20% of these expenditures during the period under review. However, it should be noted that most of this spending was not on pharmaceuticals prescribed by health personnel but rather self-prescribed ones (the parent/guardian buys drugs for the child directly from the pharmacy/shop/grocery/vendors). Buying this way could endanger the child's health either because the drugs are not the right ones for the child's illness (there is high illiteracy rate among women in Malawi) or the drugs could be expired. This strongly suggests that government should enforce its regulatory framework for pharmaceuticals. Since CH services are free in public facilities, there is need to improve the inventory of essential drugs for child illness; otherwise continued use of unprescribed medicines could exacerbate child mortality.

TABLE 34: PERCENTAGE DISTRIBUTION OF HOUSEHOLD OUT-OF-POCKET SPENDING FOR CHILD HEALTH BY PROVIDER TYPE

Provider type	2002/03	2003/04	2004/05	Average 2002/03-2004/05
	(%)	(%)	(%)	(%)
Central hospitals	3	3	4	3
District hospitals	18	19	19	19
Private-not-for-profit hospital (CHAM)	26	25	25	26
Private for-profit hospitals	11	10	10	10
Private clinics	7	5	8	7
Health centres/dispensaries (CHAM)	7	10	9	9
Health centres/dispensaries/maternity units (other)*	5	6	4	5
Traditional practitioners	4	0	0	1
Pharmacies/shops	19	21	21	20

Source CH Tables in Annex 7-D

* Includes health centres/dispensaries/maternity units owned by Ministry of Local Government, company clinics and NGO clinics which charge user fees for their health services and goods

8.9 USE OF CHILD HEALTH RESOURCES BY FINANCING AGENTS: ON WHAT ARE CH EXPENDITURES MADE?

Health service delivery is a key function of any health system. The poor infant and child health indicators for Malawi cited earlier in this chapter make delivery of priority CH services and goods a key function of that country's health system. Examples of CH functions include curative care (both inpatient and outpatient), rehabilitative care, prevention and public health services, and health-related functions such as education and training related to CH.

Figure 27 shows the distribution of CH expenditures by function. The major trend is towards increased funding on inpatient and outpatient curative care. By contrast, spending on prevention and public health programmes has increased only marginally. In fact, in US dollar terms it has fallen, from US$7.56 million in 2002/03 to US$7.10 million in 2004/05 (or from US$3.21 per child in 2002/03 to only US$2.87 per child in 2004/05). This is despite increased resources flowing into the health sector. The decline is worrisome because most childhood illnesses could be prevented through effective prevention and public health programmes, including immunization, breastfeeding counselling and promotion of complementary feed, micronutrient supplementation and fortification of food such as Vitamin A programmes and iodised salt. It reflects the health system's clear underprioritization of preventive CH measures.

It should be noted that the decrease in expenditures on preventive CH care came in interventions such as micronutrient supplementation and food fortification, principally by the MoH, which reduced these expenditures from US$1.87 million in 2002/03 to US$1.43 million in 2004/05. Activities related to immunizations for children under five received a steady increase in funding, in both relative and absolute terms. This included procurement of vaccines, materials and cold chain equipment. As can be seen in Table 35, immunization expenditures were US$2.90 million (10% of total CH expenditure) in 2002/03,

fell to US$2.80 million (13%) in 2003/04[32], but then increased substantially to US$3.52 million (16%) in 2004/05. Of course, almost all funding (approximately 90%) for immunization programmes was by donors. This raises serious issues with regard to sustainability of the most vital CH interventions should donor assistance stop, for political or other reasons.

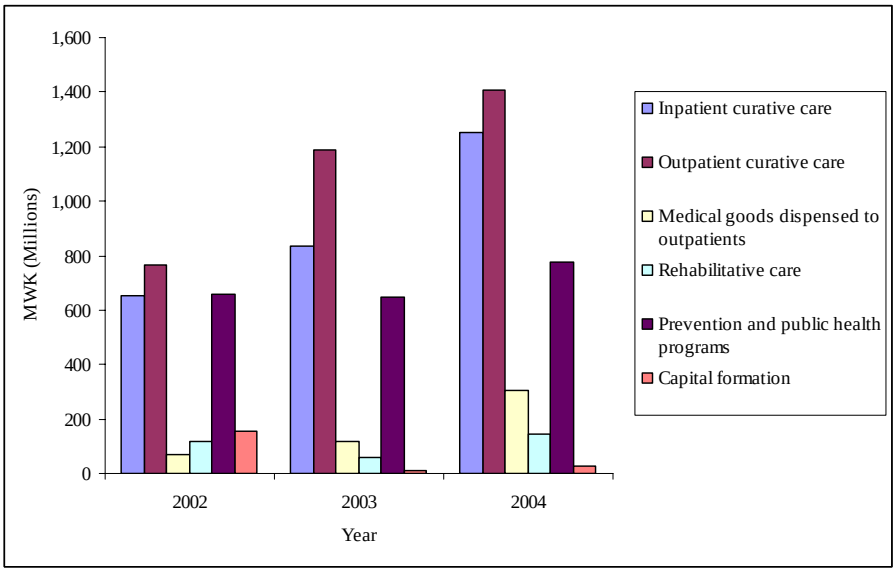
TABLE 35: DISTRIBUTION OF IMMUNIZATION EXPENDITURES

	2002/03	2003/04	2004/05
Expenditure on immunization (in US$ millions)	2.90	2.80	3.52
Expenditure on immunization % of total expenditure on preventive and public health expenditures	38	46	58
Expenditure on immunization % of total CH expenditures	10	13	16

Source CH tables in Annex 7-D

Expenditure on medical goods disbursed to outpatients, which were financed by household's direct out-of-pocket expenditures, increased from MK72 million in 2002/03 to MK304 million in 2004/05. This is a huge increase considering the poverty levels in Malawi. It is due mainly to frequent drug stock-outs in public health facilities, which force households to visit private facilities where costs rose substantially during the period under review due to the depreciation of the national currency (a huge amount of pharmaceuticals and medical supplies are imported).

FIGURE 27: DISTRIBUTION OF CHILD HEALTH EXPENDITURE BY FUNCTION, 2002/03-2004/05



Source CH tables in Annex 7-D

[32] As noted elsewhere, this decrease was due largely to an exchange rate devaluation of the Malawi kwacha from 87.28 to the US dollar in 2002/03, to 108.57 to the dollar in 2004/05. The rate maintained at 108.94 to the dollar in 2004/05.

8.10 USE OF CHILD HEALTH RESOURCES BY PROVIDERS: ON WHAT ARE CHILD HEALTH FUNDS SPENT BY PROVIDERS? (HP X HC)

Annex 7-D shows the flow of funds from providers to functions for CH expenditures.

It was noted above that there seems to be a bias towards funding CH curative care, with less financing going to prevention and public health. Much of the expenditure on curative care is from households who turn to expensive private facilities due to poor quality of services in public facilities (unavailability of drugs and health personnel, among others), particularly at the primary level.

The MoH can help remedy this by strengthening care at the peripheral level. That is, resources saved on curative care at central, and particularly district hospitals, can be used to improve the supply of drugs and health workers at lower-level facilities. The resources might also be used to strengthen cost-effective preventive and public health care services.

On average, about 40% of MoH CH funds are spent at district hospitals whereas health centres and dispensaries receive only 30%. This is contrary to the MoH goal of ensuring equitable access to care. The majority of children under five who are in greatest health *need* are in rural areas, where health centres and dispensaries are located but are not fully staffed with well-trained personnel and face constant drug stock-outs. This lack of quality primary care represents an inefficient allocation of resources, since health centres and dispensaries usually provide health care at lower costs than do hospitals. It also means that many cases of childhood illnesses become serious and complicated and hence require more expensive hospital-level care. Furthermore, there is also need to improve referral system rules and regulations as soon as is practically possible, to ensure effective functioning of the system. District hospitals should serve only as referral facilities for complicated child illnesses.

8.11 SUMMARY, POLICY IMPLICATIONS AND CONCLUSION

8.11.1 SUMMARY

The CH sub-accounts have revealed a steady growth in total spending for CH in Malawi. However, childhood morbidity and mortality rates there remain among the highest in the region and in the world. Countries such as Sri Lanka and Bangladesh, which like Malawi are classified as low-income countries and spent even less during the years covered by this NHA study, have better infant and child health indicators than Malawi.

The public health sector is the major controller of CH funds. Almost half of CH resources are expended in public health facilities with public hospitals receiving the largest share. Another quarter is consumed by providers and administrators of preventive and public health services. These funds are prepaid through general tax revenues and donor contributions and therefore are expected to ease barriers to financial access to CH care by lowering fees that households must pay out-of-pocket when seeking care. Data show, however, that persons who would be expected to use public health facilities (in particular the poor) perceive quality of care in public facilities to be poor. This is mainly due to low expenditures at the lowest levels of the health care system (health centres/dispensaries), which does result in poor quality of care. As a result, households seek care in facilities that charge for that care, including for

drugs, or they forgo care. Indeed, there was an increase in household direct out-of-pocket spending for CH services during the period under review.

8.11.2 POLICY IMPLICATIONS

- Steady increase in CH spending while childhood illnesses and mortality are high: This implies that, apart from increasing CH resources, there is great need to improve efficiency and equity in resource allocation and utilization for CH interventions. There is also need to investigate patterns of CH seeking behaviour, factors which negatively affect utilization of CH services.

- The public sector is the major financing agent of CH care: This needs a two-stage approach to improve the quality of care in public facilities. In the short term, the major responsibility lies with public providers, and in particular public hospitals and providers of preventive and public health services, to ensure the resources they continue to receive for child health are utilized efficiently and equitably. In the longer term, however, the MoH and key partners need to improve the capabilities of health centres and peripheral facilities to meet patient demands, addressing factors which impede utilization of CH services – increasing the availability of appropriately trained human resources, making infrastructure improvements and in particular ensuring stocks of essential drugs and medical supplies.

- Increased household direct out-of-pocket spending for child health: There is need to reduce household direct out-of-pocket spending through expansion of health insurance schemes to cover all formal sector employees and their dependants.

8.11.3 CONCLUSION

This study has shown that (1) the public health sector, and in particular the MoH, has the biggest responsibility to allocate CH resources where they will yield the greatest benefits to individuals and the population. This can be achieved by shifting CH resources from curative care at district and central hospitals to lower-level peripheral facilities and demonstrating sustained commitment to funding preventive CH measures. (2) Direct household out-of-pocket spending for quality CH care is likely to continue to rise unless MoH significantly strengthens lower-level facilities. Increased need for out-of-pocket spending will further reduce utilization of cost-effective CH interventions, particularly by the poor, as their households are more likely to incur catastrophic expenditures and be pushed into poverty.

9. CONCLUSIONS AND NEXT STEPS

This second round of NHA in Malawi had four components: the general NHA and sub-analyses for HIV and AIDS, RH and CH. These sub-analyses were done in Malawi for the first time and are one of the few such exercises conducted in Africa and the developing world at large.

The study demonstrates that THE per capita in Malawi is critically short of the minimum amount that is estimated to provide essential health services in developing countries. Furthermore, it has been observed that the donor component of health financing has been increasing while government financing has been decreasing. This has serious implications for sustainability of Malawi's health care system, unless a reliable flow of donor funds can be ensured.

Allocation of the public sector health care resources was observed to follow the historical incrementalist approach. This calls for the development of a resource allocation formula based on health care needs. Furthermore, in line with regional initiatives and commitments, there is a need for the Government of Malawi to increase its allocation of resources to the health sector and to explore the feasibility of prepaid health financing mechanisms to increase the resource base and avoid an increased financial burden on households. There is also a crucial need for introducing measures that enhance allocative efficiency so as to purchase (produce) the mix of inputs and outputs that correctly address the health problems of the majority of the population – the current analysis indicates that the health care system is biased in favour of hospital-based curative services to the detriment of primary care. In addition, technical efficiency and productivity must improve in order to maximize outputs from limited health care resources.

The sub-analyses also demonstrated critical shortages of resources relative to the burden of morbidity and mortality in the three major programme areas investigated. This is not surprising as they reflect the overall health system. It is thus necessary to solicit more funds and utilize them in an equitable and efficient manner in order to achieve the Millennium Development Goals by all segments of the Malawian population.

In the final analysis, it is essential that the government and its development partners utilize the information generated by this NHA study for evidence-based decision making as it relates to all aspects of the health financing function. The MoH must exert its stewardship role, so that the recommendations are implemented appropriately. Health financing is one the core functions of a health system; it is therefore necessary to institutionalize and integrate it into the routine health information system. To this end there is a need to build more capacity in health financing and NHA.

ANNEX 1: ECONOMIC OBJECTIVES OF HEALTH CARE

Excerpted from Mwase T. (2006) Application of NHA in Hospital Efficiency Analysis in Eastern and Southern Africa. Partners for Health Reformplus, Abt Associates Inc.: Bethesda, MD, USA. Available at **www.phrplus.org.**

There are mainly two economic objectives of health, namely efficiency and equity.

EFFICIENCY IN THE DELIVERY AND FINANCING OF HEALTH CARE

Technical efficiency

Technical efficiency is defined as production of any given output at a minimum cost or, alternatively, maximization of output with a given level of resources. For example, resources in the health care system can be said to be operating in a technically efficient manner if the number of inputs e.g. personnel, drugs, diagnostic procedures are producing as many outputs as possible[33]. Equivalently, achieving the same output using a minimum combination of inputs (i.e. at lowest cost) also achieves technical efficiency.

It is widely recognized that not all input combinations used in the process of health care delivery are technically efficient in Malawi. Situations arise where inappropriate inputs are combined, and this leads to wastage of scarce resources. Such scenarios are common in developing countries and have included poor deployment of staff, poor distribution of drugs and medical supplies, and inappropriate use of equipment.

Allocative efficiency

Allocative efficiency is defined as allocation of resources between the most cost-effective interventions with the aim of maximizing the net benefit to the society from services provided.

In this case, interventions whose benefit to cost ratio is highest are undertaken. When resources are efficiently allocated, it is not possible to make someone better off without making another person worse off – this fulfills the criterion of Pareto Optimality. McGuire et al (1988) state that, in a situation of allocative inefficiency, individuals' well-being can be increased by changing the current resource allocation patterns, thus moving towards Pareto optimality

In the health care system, allocative efficiency can take the form of allocation of resources between different types of diseases, patients, geographical areas (urban/rural), socio-economic groups, services (curative/preventive); and levels of care (tertiary, secondary and primary).

[33] The most useful measure of output is the number of lives saved, or improvement in quality and quantity of life. However, such measures require extensive data, hence the number of patients treated is often used as a measure of output.

Equity

The concept of equity can be defined as 'a system of justice based on conscience and fairness', whereas 'equality' is 'the condition of being equal'. However, there is a central view of unifying the various definitions of equity i.e. equity is about fairness in the distribution of something or another (e.g. health services) among different individuals and groups in society (Mooney 1983).

Equity in health and health care is viewed through three perspectives: equity in health, equity in health services delivery and equity in health financing.

Equity in health

Defined as minimizing avoidable inequalities in health and its determinants between groups of people who have different levels of underlying social advantage or privilege.

Equity in health service delivery

Defined as ensuring that all people have access to a minimum standard of health care according to need and not criteria such as ability to pay. In short, it is equal access for equal need. In this case access refers to the absence of barriers such as geographic and financial barriers; while need refers to capacity to benefit or severity of illness.

Equity in health financing

Defined as access to health services and interventions according to need, but paying for the health services according to ability to pay.

ANNEX 2: BASIC NATIONAL HEALTH ACCOUNTS (NHA) CONCEPTS AND DEFINITIONS

HEALTH EXPENDITURE

Health expenditures are defined as expenditures on activities *whose primary purpose is to improve, restore and maintain the health of an individual or population*. Conceptually, this includes three groups of activities: (1) personal health services and goods: services of curative care, services of rehabilitative care, long-term care, ancillary services to health, and medical goods dispensed to outpatients; (2) collective health services: prevention and public health services and health administration and insurance; and (3) health care-related functions: capital formation of health care provider institutions, education and training of health personnel, research and development, food, hygiene and drinking water, and environment health.

SOURCES OF FINANCE

These are entities which are responsible for mobilizing/generating funds for health and HIV and AIDS services and goods. In Malawi they include:

1. Ministry of Finance: The Ministry of Finance collects general tax revenues from households and employers. It also receives budget support from donors. Parts of these funds are allocated for health annually as the 'Health Budget' for both Recurrent and Development Budgets. Funds also are allocated to various ministries/departments for HIV and AIDS services and goods, some of which are used for health services and goods by the ministries/fepartments.

2. Ministry of Local Government: The Ministry of Local Government through its district and city assemblies collects revenue such as license fees, city rates etc which are not passed on to the central government-Ministry of Finance. Part of these funds is used to finance health and HIV and AIDS services.

3. Employers: These are private firms and parastatals which pay for the health/HIV and AIDS services of their employees through:
    - Onsite health facilities;
    - Reimbursements to employees who have incurred medical expenses;
    - Employer contribution to an outside health insurance scheme in particular Medical Aid Society of Malawi (MASM); and
    - In-house health insurance schemes.

4. Households: Through their contributions to health insurance schemes such as MASM and direct payments to providers (out-of-pocket spending) of health and HIV and AIDS services and goods.

5. Donors: Bilateral, multi-lateral and international foundations fund health and HIV and AIDS services through funding Part I of Development Budget of Ministry of Health, vertical programmes such as EPI, HIV and AIDS, IMCI, Sector Wide Approaches (SWAPs) that pool fund for general health and the HIV and AIDS pool fund, among others.

Note: For all the funds that donors give directly to the Ministry of Finance as budget support, the source is recorded as the Ministry of Finance. The same applies to general tax revenue collected from households and companies. This is because when the funds are given to or collected by the Ministry of Finance, they are not clearly earmarked for health. It is therefore the Ministry of Finance which decides which sector will benefit from the funds.

FINANCING AGENTS

Once the funds are mobilized at the source level, such as at the Ministry of Finance, they are passed on to institutions which pool, allocate and/or purchase health care and HIV and AIDS services from providers. These institutions which control the use of funds in a health system, i.e. have programmatic responsibility are known as financing agents. In Malawi, the following financing agents were identified:

1. Public sector: MoH, NAC, Ministries of Foreign Affairs, Local Government (and its district/city assemblies), Defence, Home Affairs, Education, Gender, Children and Social Welfare, and Agriculture; Nurses and Midwives Council, Medical Council; Pharmacy, Medicines and Poisons Board, School of Health Sciences

2. Private sector: private firms and parastatals; CHAM[34], local NGOs, Health Insurance-MASM, household direct out-of-pocket spending on health and HIV and AIDS services and goods

3. Rest of the World: donors and international NGOs

HEALTH CARE PROVIDERS

These are institutions which provide health and HIV and AIDS services and goods to individuals and the population. In this study, providers were grouped as follows:

1. Public sector: central hospitals, district and rural hospitals, mental hospital, health centres/dispensaries/maternity units, providers of prevention and public health programmes, administration of general health and HIV and AIDS at central levels

2. Private sector: general hospitals, health centres/dispensaries/maternity units, private clinics, pharmacies/shops/groceries; general health and HIV and AIDS administration at central levels

HEALTH CARE FUNCTIONS

These are the activities/services provided by health providers. Examples of health care functions include curative care, rehabilitative care, long-term care, ancillary services to health, medical goods dispensed to outpatients, prevention and public health services and general health administration and insurance.

[34] The CHAM Secretariat was treated as a financing agent because it receives funds from government on behalf of all other institutions under its control.

Health-related functions include capital formation of health care provider institutions, education and training of health personnel, research and development, food, hygiene and drinking water and environment

ANNEX 3: NHA INTERNATIONAL CLASSIFICATION OF HEALTH ACCOUNTS

Adapted to the Malawi Health System for the General NHA and RH and CH Sub-accounts

Sources

FS.1	Public Funds
FS.1.1	Territorial Government Funds
FS.1.1.1	General Government
FS.1.1.1.1	Ministry of Finance
FS.1.1.2	Local Government revenue (City, Town and District Assemblies)
FS.2	Private Funds
FS.2.1	Employer Funds
FS.2.2	Household Funds
FS.2.4	Other Private funds
FS.3	Rest of the World

Financing Agents

HF.1.1	Territorial government
HF.1.1.1	Central Government
HF.1.1.1.1	Ministry of Health
HF.1.1.1.2	National AIDS Commission
HF.1.1.1.3	Other Ministries and Government Agencies (Ministries of Defence, Home Affairs, Education, Training Institutions, Regulatory Bodies-Nursing, Medical, Pharmacy and Poisonous Board etc)
HF.1.1.1.4	Local Authorities (Cities, Town and District Assemblies)
HF.2.2	Private Insurance Enterprises (Medical Aid Society of Malawi)
HF.2.3	Private Households' Out-of-Pocket payment
HF.2.4	Non-Governmental Organizations (non-profit institutions)
HF.2.4.1	Christian Health Association of Malawi (CHAM)
HF.2.4.1	Local Non-Governmental Organizations
HF.2.5	Private Firms and Corporations
HF.3	Rest of the World (donors and international Non-Governmental Organizations)

Providers

HP.1	**Hospitals**
HP.1.1	General Hospitals
HP.1.1.1	Government general hospitals
HP.1.1.1.1	Central hospitals
HP.1.1.1.2	District Hospitals
HP.1.1.2	Private Not for Profit hospitals
HP.1.1.2.1	Private Not-for profit hospital: Other
HP.1.1.2.2	Private Not-for Profit hospitals: CHAM
HP.1.1.3	Private For-profit hospitals
HP.1.2	Specialized hospital (Mental Hospitals)
HP.3	**Providers of ambulatory health care**
HP.3.1	Offices of physicians (private doctors' clinics)
HP.3.4.9.1	Health centres/dispensaries/maternity
HP.3.9.3	Alternative or traditional practitioners
HP.3.9.9	All other ambulatory health care services
HP.4	**Retail Sale and other providers of medical goods**
HP.5	**Provision and administration of public health programmes**
HP.6	**General Health administration and insurance**
HP.6.1	Government administration of health
HP.6.4	Other (private) insurance
HP.6.9	All other providers of health administration
HP.7	**All other industries (rest of the economy)**
HP.8	**Institutions providing health related services**
HP.8.1	Research Institutions
HP.8.2	Education and Training Institutions
HP.8.3	Other institutions providing health-related services
HP.9	**Rest of the World**
HP.*nsk*	**Provider expenditure not specified by kind**

Functions

HC.1	**Services of Curative Care**
HC.1.1	Inpatient Curative Care
HC.1.3	Outpatient curative care
HC.2	**Services of Rehabilitative Care**
HC.5	**Medical Goods Dispensed to Outpatients**
HC.6	**Prevention and Public Health Services**
HC.7	**Health Administration and Health Insurance**
HC.7.1	General Government administration of health
HC.7.2	Health Administration and Health Insurance: private
HC.7.2.2	Health Administration and Health Insurance: other private
HC.*n.s.k*	***HC expenditure not specified by any kind***
HCR.1-5	**Health-related Functions**
HCR.1	Capital formation for health care provider institutions
HCR.2	Education and Training of Health Personnel
HCR.3	Research and development in health
HCR.4	Food, hygiene and Drinking Water Control
HCR.5	Environmental Health
HCR. n.s.k	***HCR expenditure not specified by any kind***

ANNEX 4: INTERNATIONAL CLASSIFICATION OF HEALTH ACCOUNTS

Adapted to the Malawi Health System for HIV and AIDS Sub-accounts

The NHA study adapted the ICHA to the Malawi health system for the general NHA, and RH and CH sub-accounts.

Sources

FS.1	Public Funds
FS.1.1	Territorial Government Funds
FS.1.1.1	General Government
FS.1.1.1.1	Ministry of Finance
FS.1.1.2	Local Government revenue (City, Town and District Assemblies)
FS.2	Private Funds
FS.2.1	Employer Funds
FS.2.2	Household Funds
FS.2.4	Other Private funds
FS.3	Rest of the World

Financing Agents

HF.1.1	Territorial government
HF.1.1.1	Central Government
HF.1.1.1.1	Ministry of Health
HF.1.1.1.2	National AIDS Commission
HF.1.1.1.3	Other Ministries and Government Agencies (Ministries of Defence, Home Affairs, Education, Training Institutions, Regulatory Bodies-Nursing, Medical, Pharmacy and Poisonous Board etc)
HF.1.1.1.4	Local Authorities (Cities, Town and District Assemblies)
HF.2.2	Private Insurance Enterprises (Medical Aid Society of Malawi)
HF.2.3	Private Households' Out-of-Pocket payment
HF.2.4	Non-Governmental Organizations (non-profit institutions)
HF.2.4.1	Christian Health Association of Malawi (CHAM)
HF.2.4.1	Local Non-Governmental Organizations
HF.2.5	Private firms and Corporations
HF.3	Rest of the World (donors and international Non-Governmental Organizations)

Providers

HP.1	**Hospitals**
HP.1.1	General Hospitals
HP.1.1.1	Government general hospitals
HP.1.1.1.1	Central hospitals
HP.1.1.1.2	District Hospitals
HP.1.1.2	Private Not for Profit hospitals
HP.1.1.2.1	Private Not-for profit hospital: Other
HP.1.1.2.2	Private Not-for Profit hospitals: CHAM
HP.1.1.3	Private For-profit hospitals
HP.1.2	Specialized hospital (Mental Hospitals)
HP.3	**Providers of ambulatory health care**
HP.3.1	Offices of physicians (private doctor's clinics)
HP.3.4.9.1	Health centres/dispensaries/maternity
HP.3.9.3	Alternative or traditional practitioners
HP.3.9.9	All other ambulatory health care services
HP.4	**Retail Sale and other providers of medical goods**
HP.5	**Provision and administration of public health programmes**
HP.6	**General health administration and insurance**
HP.6.1	Government administration of health
HP.6.4	Other (private) insurance
HP.6.9	All other providers of health administration
HP.7	**All other industries (rest of the economy)**
HP.8	**Institutions providing health related services**
HP.8.1	Research Institutions
HP.8.2	Education and Training Institutions
HP.8.3	Other institutions providing health-related services
HP.9	**Rest of the World**
HP.*n.s.k*	**Provider expenditure not specified by kind**

Providers of services of Non-Health Expenditures

Mitigation
Support to PLWHA
Policy Advocacy

Functions

HC.1	**Services of Curative Care**
HC.1.1	Inpatient Curative Care
HC.1.3	Outpatient curative care
HC.1.3.7	ARV Treatment
HC.2	**Services of Rehabilitative Care**
HC.5	**Medical Goods Dispensed to Outpatients**
HC.6	**Prevention and Public Health Services**
HC.6.3.1	Voluntary Counselling and Testing
HC.6.3.4	Information Education and Communication
HC.6.3.5	STI Prevention programme
HC.6.3.7	Condom distribution programmes

HC.7	**Health Administration and Health Insurance**
HC.7.1	General government administration of health
HC.7.2	Health Administration and Health Insurance: private
HC.7.2.2	Health Administration and Health Insurance: other private
HC.*n.s.k*	***HC expenditure not specified by any kind***
HCR.1-5	**Health-related Functions**
HCR.1	Capital formation for health care provider institutions
HCR.2	Education and Training of Health Personnel
HCR.3	Research and development in health
HCR.4	Food, hygiene and Drinking Water Control
HCR.5	Environmental Health
HCR. n.s.k	***HCR expenditure not specified by any kind***

AD	**Non Health Expenditures**
AD.1	**Mitigation**
AD.1.1.2	Support to PLWHA
AD.1.2	Non-health services to orphans and vulnerable children
AD.2	Policy Advocacy
AD. n.s.k	Non health expenditures not specified by kind

ANNEX 5: PEOPLE LIVING WITH HIV AND AIDS: SAMPLING STRATEGY FOR MALAWI

PLWHA STUDY 2005.

The sampling frame for the selection of health facilities (hospitals and health centres) will be the list of hospitals and health centres by region. The list also has information on the location of facilities by urban and rural areas. We will use a stratified two-stage design to select patients. At the first stage a sample of facilities will be selected in each of the two areas (urban/rural) in each region. Then in each selected facility, a sample of patients will be selected. We will create 6 strata (3 regions stratified by urban/rural) for sample of selection facilities

We propose selecting a sample of 800 patients from the hospitals and a sample of 100 patients from the health centres. As a first step in sample selection, large facilities (in terms of the number of patients treated) will be identified in each region. The following 5 facilities were identified as large facilities as the number of patients in these facilities is much larger than other facilities. Including these facilities in the sample with certainty will lead to a reduction in the variance of the estimates. The number of patients is taken from the column, which is labeled "Patients ever started ARVs".

TABLE A5.1: FACILITIES INCLUDED IN THE SAMPLE WITH CERTAINTY

Region	Urban/Rural	Name of Hospital	Number of Patients
Northern	Urban	Mzuzu Central Hospital	2,335
Central	Urban	Lighthouse-LL Central Hospital	4,695
Southern	Urban	QECH (Central Hospital)	2,634
Southern	Rural	Chiradzulu District Hospital	6,228
Southern	Rural	Thyolo District Hospital	2,732

These hospitals account for 61% of the patients in the population. The remaining patients come from the smaller facilities. I suggest that we allocate the total sample of 800 patients (completes) to the certainty stratum not in direct proportion to the number of patients, but slightly less so that we give adequate representation to the smaller hospitals and health centres. The following is the allocation of the total sample to the certainty stratum and non-certainty stratum.

TABLE A5.2: ALLOCATION OF THE SAMPLE (PATIENTS) TO CERTAINTY AND NONCERTAINTY STRATA

Stratum	Number of patients in population	Number to be selected for sample
Certainty	18,624	425
Noncertainty	11,891	375
Total	30,515	800

The sample of 425 patients will be selected from the 5 hospitals shown in Table 1 and included with certainty in the sample. The number of patients to be included from each of the 5 hospitals will be in proportion to the number in the hospital and is shown in Table 3.

TABLE A5.3: NUMBER OF PATIENTS IN THE SAMPLE BY HOSPITALS SELECTED WITH CERTAINTY

Region	Urban/ Rural	Name of hospital	Number of patients in the population	Number of patients in the sample
Northern	Urban	Mzuzu Central Hospital	2,335	50
Central	Urban	Lighthouse-LL Central Hospital	4,695	110
Southern	Urban	QECH (Central Hospital)	2,634	60
Southern	Rural	Chiradzulu District Hospital	6,228	140
Southern	Rural	Thyolo District Hospital	2,732	65
Total			18,624	425

SELECTION OF PATIENTS FROM NONCERTAINTY STRATUM

As indicated earlier, for selecting a sample of 375 patients, we first select a sample of hospitals and health centres and then select a sample of patients from each selected hospital or health centre. The distribution of health centres and hospitals by region and urban/rural is shown in Table 4.

TABLE A5.4: DISTRIBUTION OF FACILITIES BY REGION AND URBAN/RURAL

Region	Urban	Rural	Total
Northern	4	8	12
Central	12	20	32
Southern	9	25	34
Total	25	53	78

The distribution of patients in these facilities by region and urban/rural is shown in Table 5.

TABLE A5.5: DISTRIBUTION OF PATIENTS BY REGION AND URBAN/RURAL

Region	Urban	Rural	Total
Northern	208	2,024	2,232
Central	1,156	3,571	4,727
Southern	827	4,105	4,932
Total	2,191	9,700	11,891

The total sample of 375 will be allocated to the 6 strata approximately in proportion to the number of patients in each stratum with a minimum of 20 patients in each cell. The allocation is shown in Table 6.

TABLE A5.6: DISTRIBUTION OF THE SAMPLE OF PATIENTS IN HOSPITALS BY REGION AND URBAN/RURAL

Region	Urban	Rural	Total
Northern	20	60	80
Central	30	110	140
Southern	25	130	155
Total	75	300	375

TABLE A5.7: DISTRIBUTION OF HOSPITALS IN THE SAMPLE BY REGION AND URBAN/RURAL

Region	Urban	Rural	Total
Northern	1	3	4
Central	2	5	7
Southern	1	7	8
Total	4	15	19

The number of health centres to be selected in each region is shown in Table 8.

TABLE A5.8: NUMBER OF HEALTH CENTRES IN THE SAMPLE

Region	Urban	Rural	Total
Northern	1	0	1
Central	1	0	1
Southern	2	1	3
Total	4	1	5

The sample of patients from the health centres will be mainly from PMTCT.

The total final sample in terms of health facilities and health centres will be 19+5 =24 facilities and a total sample of 900 patients.

ANNEX 6. DETAILED METHODOLOGY FOR ESTIMATING SUB-ACCOUNTS FOR HIV/AIDS, REPRODUCTIVE HEALTH AND CHILD HEALTH: THE USE OF THREE-DIMENSIONAL TABLE-HFXHPXHC ("COMBO")

1. HIV/AIDS SUB-ACCOUNTS

1. Ministry of Health

MoH hospitals and health centres/dispensaries in Malawi provide health care services in an integrated manner. Furthermore, budgeting and funding is by programme and subprogramme. For example in 2002/03-2004/05 financial years the budgeting systems was as follows. Programmes: Tertiary Curative for Central Hospitals, Secondary Curative for District Hospitals, Primary Health Care Services for Health Centres/Dispensaries and subprogrammes such as Buildings/Equipment Provision & Maintenance, Inpatient Services, Outpatient Services, Patient Care Technical Services, Patient Care General Support, Hospital Services Management, etc (for more details see example below). As it can be seen in this example, it is extremely difficult to tease out expenditure related to a particular disease or intervention but very easy to estimate general health expenditures by function.

Programme	Subprogramme	Budget 2002/03	Actual Expenditure 2002/03
Tertiary Curative	Buildings/Equipment provisions & maintenance		
	Inpatient Services		
	Outpatient Services		
	Patient Care Technical Services		
	Patient Care General Support Services		
	Hospital Services Management		

Cost centre (Name of facility/level of care)	Programme No	Sub-programme	2002/03 APRROVED ESTIMATES	2002/03 ACTUAL
	10. Tertiary Curative Services	01 BUILDING/EQUIPMENT PROVISION AND MAINTENANCE PERSONAL EMOLUMENTS AND BENEFITS OTHER RECURRENT TRANSACTIONS 21 Internal Travel 24 Office supplies 28 Training Expenses 33 Other Goods and Services		
		02 IN-PATIENT SERVICES PERSONAL EMOLUMENTS AND BENEFITS OTHER RECURRENT TRANSACTIONS 21 Internal Travel 24 Office supplies 28 Training Expenses 33 Other Goods and Services		
		02 IN-PATIENT SERVICES PERSONAL EMOLUMENTS AND BENEFITS OTHER RECURRENT TRANSACTIONS 21 Internal Travel 24 Office supplies 28 Training Expenses 33 Other Goods and Services		
		03 OUT-PATIENT SERVICES PERSONAL EMOLUMENTS AND BENEFITS OTHER RECURRENT TRANSACTIONS 21 Internal Travel 24 Office supplies 28 Training Expenses 33 Other Goods and Services		
		04 PATIENT CARE TECHNICAL SERVICES PERSONAL EMOLUMENTS AND BENEFITS OTHER RECURRENT TRANSACTIONS 21 Internal Travel		

	24 Office supplies 28 Training Expenses 33 Other Goods and Services
	05 PATIENT CARE GENERAL SUPPORT SERVICES PERSONAL EMOLUMENTS AND BENEFITS OTHER RECURRENT TRANSACTIONS 21 Internal Travel 24 Office supplies 28 Training Expenses 33 Other Goods and Services
	06 HOSPITAL SERVICES MANAGEMENT PERSONAL EMOLUMENTS AND BENEFITS OTHER RECURRENT TRANSACTIONS 21 Internal Travel 24 Office supplies 28 Training Expenses 33 Other Goods and Services

Thus in order to estimate HIV expenditures in MoH facilities the following methodology was used:

HP x HC

Inpatient HIV/AIDS services:

A few studies conducted in Malawi show that bed occupancy rate for HIV/AIDS-related illness (opportunistic infections, or OIs) ranges from 40% to 70% at central, district and health centre levels. There are no studies which have been conducted on the unit costs of various OIs in Malawi and there was no earmarked funding for treatment and care of HIV/AIDS-related OIs in MoH facilities from 2002/03-2004/05. A review of health services utilization for the general population and PLWHA in other countries in the region such as Kenya, Rwanda and Zambia which are facing the similar epidemic was conducted. Furthermore, the team also reviewed the methodology for estimating inpatient HIV/AIDS expenditure in Kenya, which used inpatient utilization figures for HIV/AIDS-related illnesses as a proxy for HIV/AIDS expenditures in MoH facilities.

In order to estimate inpatient HIV/AIDS expenditures Malawi, the NHA team decided that inpatient utilization data should be adjusted by patient days. Thus *inpatient days* for HIV/AIDS-related illnesses were used as a proxy for HIV/AIDS spending. This was based on the assumption that unit costs are almost the same for various inpatient services. Furthermore, because 40-50% of MoH expenditure is on personal emoluments and health personnel are responsible for the treatment and care of 40-70% of HIV/AIDS illness in health facilities, this meant that the salaries that were paid to health workers by the MoH in its health facilities were mostly paid to them as a compensation for treatment and care of

HIV/AIDS illnesses. Thus the NHA team applied different inpatient days to different levels of MoH facilities.

Outpatient HIV/AIDS services:

After reviewing several utilization patterns and methodologies for estimating outpatient HIV/AIDS services such as those in Thailand, Kenya, Rwanda and Zambia, the NHA team decided that the Kenya methodology, which used the HIV prevalence rate of 6.7% for 2003 to estimate HIV/AID outpatient expenditures, was the most plausible one. This is because the prevalence rate represents the average in almost all issues pertaining to HIV/AIDS including expenditures which could be made on PLWHA by institutions such as the MoH. Thus the team decided to use prevalence rates for HIV as follows: 2002/03=16%, 2003/04=14% and 2004/05=12%.

Prevention and public health services:

The MoH does not significantly fund all public health care services in Malawi including HIV/AIDS despite having the National AIDS Control Programme in 2002/03 and the National AIDS Commission from 2003/04. All prevention and public health activities are funded by donors, other than salaries of managers of vertical public health programmes. Thus in order to estimate the MoH HIV/AIDS prevention and public health expenditures, a review of salaries of staff who were working on HIV/AIDS prevention activities was conducted; it was estimated that this represented 10% of all public health vertical programmes salaries for MoH staff.

General administration of health:

The NHA team reviewed the activities of key personnel at MoH headquarters (in particular Health Planning, Preventive Health Services and Curative Health Care Services departments) which were instrumental in supporting the development of HIV/AIDS plans in 2002/03 and implementation in 2003/04 and 2004/05. Thus a 10% of the total MoH general administration for health was estimated as HIV/AIDS expenditure.

2. Donor HIV/AIDS Spending

Donor HIV/AIDS expenditures were obtained from several sources, namely:

- Donor mapping study: A comprehensive study by a DfID consultant was conducted in early 2005
- MoH study on all donor support in the health sector in readiness for the SWAp in 2004
- NHA Team donor survey in late 2005
- NHA Team survey of NGOs in late 2005
- Government budget documents: they contain Part I=development expenditures funded by donors and all vertical programme expenditures

The figures were then triangulated and HIV/AIDS expenditures were then estimated.

3. Other Government Ministries and Mission facilities

The same methodology for estimating inpatient and outpatient HIV/AIDS services in MoH facilities was used whereby inpatient days by type of facility (hospital and health centre) were used to calculate inpatient expenditures while prevalence rates were used to calculate outpatient expenditures.

4. National AIDS Commission

All direct health and health care-related expenditures in the general NHA were treated as HIV/AIDS expenditures. Only non-health expenditures were added in order to come up with total HIV/AIDS expenditures in Malawi.

5. Local Nongovernmental Organizations and Rest of the World

Data from surveys of donors and NGOs were used to estimate HIV/AIDS expenditures after triangulation. See above on the number of donor and NGO data sources.

6. Private Insurance

Inpatient: Applied ratio of inpatient days as per facility ownership and type

Outpatient: Used prevalence rate as a proxy for HIV/AIDS outpatient expenditures

7. Employer Onsite Facilities

Inpatient: Applied the ratio inpatient days

Outpatient: Used prevalence rate as a proxy for HIV/AIDS outpatient expenditures

8. PLWHA Out-of-Pocket Spending

A specialized survey of 900 PLWHA receiving various HIV/AIDS services in health facilities was conducted. R results were extrapolated to the entire population of PLWHA in each year of estimation.

2. REPRODUCTIVE HEALTH SUB-ACCOUNTS

1. Ministry of Health

Inpatient RH services:

The only major RH inpatient service in Malawi is delivery. However, the budgeting, funding and delivery of health services in Malawi is integrated; hence it is impossible to directly estimate RH inpatient expenditures. Furthermore, there are no unit costs which could be used in conjunction with utilization data so as to estimate expenditures using the Price x Quantity (PxQ) approach (an attempt to use the unit costs from previous studies multiplied by the utilization data in the year of estimation yielded total RH expenditures which were higher than total MoH expenditures in the year of estimation) or ratios which could then be applied to total MoH expenditures. However, there were available utilization data in Malawi such as number of deliveries by facility type and ownership: district hospital, health centre and maternity unit for the MoH. In order to estimate the RH inpatient expenditures for deliveries, the proportion of inpatient days for deliveries in total MoH inpatients days was used rather than the

utilization ratio as was done in Sri Lanka. This was because the ratio of utilization for RH in total MoH utilization figures was very high, i.e. more than 30% of total MoH utilization figures.

In the absence of direct expenditures for RH outpatient services and unit costs for various RH outpatient services, the NHA Team used utilization figures to develop ratios for MoH district hospitals and health centres.

Prevention and public health services:

The MoH does not significantly fund public health care services in Malawi including RH services. All prevention and public health activities are funded by donors other than salaries of managers of vertical public health programmes. Thus in order to estimate MoH expenditures on RH prevention and public health, a review of salaries of staff who were working on RH preventive health activities was conducted. It was estimated that this represented 20% of all public health vertical programmes salaries for MoH staff.

2. Mission Facilities

Inpatient: Average inpatient days ratio was used to estimate RH inpatient expenditures.

Outpatient: Utilization ratios by level of facility (hospital and health centre) were used to estimate RH outpatient expenditures.

3. Local Government

Inpatient: Inpatient days were used to estimate expenditure on deliveries for RH.

Outpatient: The ratio of RH utilization figures in total MoH utilization figures was used to estimate RH outpatient expenditures.

4. Private Insurance

Inpatient: Average inpatient days for RH in total utilization by ownership and facility type was used to estimate RH inpatient expenditures.

Outpatient: Utilization ratio for RH in total utilization by provider level and ownership

5. Employer Onsite Facilities

Inpatient: Average inpatient days ratio for RH in total utilization was used to calculate inpatient RH expenditures.

Outpatient: Utilization ratio for RH in total utilization by provider level was used to calculate RH outpatient expenditures.

6. Household Out-of-Pocket Spending for RH

Inpatient: Ratio of inpatient days by facility type and ownership

Outpatient: Utilization ratio of RH in total utilization by provider type

7. Donor RH Spending

A combination of the following donor sources was used in estimating RH public health expenditure funded by donors:

- Donor mapping study: A comprehensive study by a DfID consultant was conducted in early 2005
- MoH study on all donor support in the health sector in readiness for the SWAp in 2004
- NHA Team donor survey in late 2005
- NHA Team survey of NGOs in late 2005
- Government budget documents: they contain Part I=development expenditures funded by donors and all vertical programme expenditures.

Division of RH prevention and public health expenditure estimated from donor contribution was as follows:

- Family planning services: Contraceptive commodities (condoms, IUDs, injectables): 60%
- IEC-BCC: 30%
- Other: 10%

3. CHILD HEALTH SUB-ACCOUNTS

HPxHC

1. Ministry of Health

Inpatient CH services:

Inpatient days obtained from the MoH HMIS patient registers by type of ownership and type of facility (hospital, health centres) were applied to the general health expenditures figures which were also by ownership and level of care. The use of utilization data multiplied by unit cost data obtained from other studies (i.e. PxQ approach) yielded CH expenditures which were higher than the MoH total expenditures in the year of estimation, hence they were dropped.

Outpatient CH services:

In the absence of direct expenditures for CH outpatient services and unit costs for various CH outpatient services in the year of estimation, the NHA Team used utilization figures (applied ratios of utilization by children under five) for under-fives in various facilities by ownership and type of facility in order to estimate CH outpatient expenditures. This was based on the understanding that unit costs for various health services in a given year were the same.

2. Donor Spending

Donors funded most CH prevention and public health programmes. Donors CH expenditures were obtained from the following sources after several iterations:

- Donor mapping study: A comprehensive study by a DfID consultant was conducted in early 2005
- MoH study on all donor support in the health sector in readiness for the SWAp in 2004
- NHA Team donor survey in late 2005
- NHA Team survey of NGOs in late 2005
- Government budget documents: they contain Part I=development expenditures funded by donors and all vertical programmes expenditures.

There were two major components in CH prevention and public health programmes:

- EPI programme: immunization which was estimated to consume 65% of the total CH prevention and public health expenditures;
- IMCI programme: a combination of various vertical programmes such as diarrhea control and ARI, which was estimated to consume 25% of the total CH prevention and public health programmes; and
- Other non-classified activities were estimated at 10% of the total CH prevention and public health programmes.

3. Mission Facilities

Inpatient: Average inpatient days ratio was used to estimate CH inpatient expenditures.

Outpatient: Utilization ratios by level of facility (hospital and health centre) were used to estimate CH outpatient expenditures.

4. Local Government

Inpatient: Inpatient days were used to estimate expenditure on deliveries for CH.

Outpatient: The ratio of CH utilization figures in total local government facilities utilization figures was used to estimate CH outpatient expenditures.

5. Private Insurance

Inpatient: Average inpatient days for CH in total utilization by type of provider and level of care was used to estimate CH inpatient expenditures.

Outpatient: Utilization ratio for CH in total utilization by provider level and ownership.

6. Employer Onsite Facilities

Inpatient: Average inpatient days ratio for CH in total utilization was used to calculate inpatient CH expenditures.

Outpatient: Utilization ratio for CH in total utilization by provider level was used to calculate CH outpatient expenditures.

7. Household Out-of-Pocket Spending for CH

Inpatient: Ratio of inpatient days by facility type and ownership

Outpatient: Utilization ratio of CH in total utilization by provider type

Limitations

- Lack of data on earmarked health expenditures for treatment and care for HIV/AIDS, RH and CH activities: All budgeting, funding and service delivery are integrated at provider level. Where some unit costs and utilization figures were available from other studies, an attempt to use PxQ approach yielded expenditures which were higher than total MoH expenditures for RH and CH in the year of estimation.

- Lack of unit costs which are consistent with expenditures in the year of estimation: The unit costs contained items in an ideal situation or were calculated based on expenditures in the previous year which was not equal to expenditures obtained from expenditure books/surveys in the year of estimation. As such multiplying unit costs from previous studies by utilization figures in the year of estimation yielded total expenditure for a particular sub-account which was higher than the total MoH expenditures.

- Lack of detailed data on utilization for OIs, under-fives for both inpatient and outpatient in published HMIS reports: The raw data were found only in patient registers and were not in good state. Retrieving them consumed a lot of resources.

ANNEX 7. GENERAL NHA TABLES, HIV/AIDS TABLES, REPRODUCTIVE HEALTH TABLES AND CHILD HEALTH TABLES

Annex A.1: Financing Sources x Financing Agents (FS x HF), 2002/03 for General NHA

	FS.1 Public Funds*		FS.2 Private Funds*			FS.3	
	FS.1.1 Territorial government		FS.2.1 Employer Funds	FS.2.2 Household Funds	FS.2.4 Other Private Funds		
	FS.1.1.1. General government	FS.1.1.2 Local Government (City, town and district assemblies)					
	FS.1.1.1.1 Ministry of Finance					Rest of the World Funds	Row Totals
HF.1.1.1.1 Ministry of Health	4,702,751,181					4,095,792,987	**8,798,544,168**
HF.1.1.1.2 National AIDS Commission	22,467,011					243,118,920	**265,585,931**
HF.1.1.1.3 Other Ministries	38,375,074				24,666,540	43,665,838	**106,707,452**
HF.1.1.1.4 Local Authorities	7,190,000	2,270,903			19,607,037	73,495,870	**102,563,810**
HF.2.2 Private Insurance Scheme			311,550,000	23,450,000			**335,000,000**
HF.2.3 Household Out of Pocket Payments				1,764,419,800			**1,764,419,800**
H.F.2.4 Non-Governmental Organizations	400,482,517	-	-	-	147,244,969	695,523,159	**1,243,250,645**
H.F.2.4.1 CHAM	400,482,517				34,800,000	174,943,436	610,225,953
H.F.2.4.2 Other NGOs					112,444,969	520,579,723	633,024,692
HF.2.5 Private Firms/Employers			445,382,759				**445,382,759**
HF.3 Rest of the World					992,295	1,554,691,932	**1,555,684,227**
HF.NsK Not Specified by Kind							-
THE	**5,171,265,783**	**2,270,903**	**756,932,759**	**1,787,869,800**	**192,510,841**	**6,706,288,706**	**14,617,138,792**
%	**35%**	**0%**	**5%**	**12%**	**1%**	**46%**	**100%**
Financing agents expenditure on Health Care related activities	**496,556,700**	**-**	**-**	**-**	**23,175,159**	**355,927,638**	**875,659,497**
NHE	**5,667,822,483**	**2,270,903**	**756,932,759**	**1,787,869,800**	**215,686,000**	**7,062,216,344**	**15,492,798,289**
%	37%	0%	5%	12%	1%	46%	100%

Annex A.1: Financing agent x Health Provider (HFx HP), 2002/03 for General NHA

	HF.1 Public				HF.2 Private Sector						
	HF.1.1.1.1	HF.1.1.1.2	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	Row totals and total expenditure measures
Provider	**Ministry of Health**	**National AIDS Commission**	**Other Ministries**	**Local Authorities**	**Private Insurance Scheme**	**Household OOP Payments**	**CHAM**	**Other NGOs**	**Private Firms / Employers**	**Rest of the World**	
HP.1 Hospital	2,855,316,830	-	-	-	92,000,000	1,113,172,452	313,666,199	27,760,490	12,424,700	120,302,550	**4,534,643,221**
HP.1.1 General Hospitals	2,830,990,069	-	-	-	92,000,000	1,113,172,452	313,666,199	27,760,490	12,424,700	120,302,550	4,510,316,460
HP.1.1.1 Government general hospitals	2,830,990,069	-	-	-	-	416,403,073	-	-	-	120,300,115	3,367,693,257
HP1.1.1.1 Central Hospitals	912,784,377					63,519,113					976,303,490
HP1.1.1.2 District Hospitals	1,918,205,692					352,883,960				120,300,115	2,391,389,767
HP.1.1.2 Private Not-for-profit hospitals.	-	-	-	-	-	495,801,964	313,666,199	27,760,490	12,424,700	2,435	849,655,788
HP1.1.2.1 Private-Not-for-profit hosp.(Other)								27,760,490	12,424,700	2,435	40,187,626
HP1.1..2.2 Private-not-for-profit hospitals (CHAM)						495,801,964	313,666,199				809,468,163
HP1.1.3 Private For-profit hospitals					92,000,000	200,967,415					292,967,415
HP.1.2 Specialized hospitals (mental hospital)	24,326,761										24,326,761
HP.3 Providers of ambulatory health care	2,203,957,520	-	19,246,600	8,813,150	142,000,000	342,473,883	100,120,629	27,046,649	416,117,460	435,931,392	**3,695,707,283**
HP3.1 Offices of physicians					142,000,000	98,983,951			53,823,000		294,806,951
HP.3.4.9.1 health centres/dispensaries/maternity	2,203,957,520		19,246,600	8,813,150		195,850,597	100,120,629	27,046,649	362,294,460	435,931,392	3,353,260,997
HP3.9.3 Traditional practitioners						47,639,335					47,639,335
HP.4 Retail sale and other providers of medical goods					32,000,000	254,076,451				301,138	**286,377,590**
HP.5 Provision and administration of public health programs	2,540,388,601	206,700,424		86,560,659			97,739,125	475,030,298	16,190,729	572,006,034	**3,994,615,870**
HP.6 General health administration and insurance	1,161,325,641	58,885,507	87,460,852	7,190,000	67,000,000	-	98,700,000	103,187,255	-	427,143,113	**2,010,892,368**
HP 6.1 General Administration of Health	1,161,325,641	58,885,507	87,460,852	7,190,000							1,314,862,000
HP.6.4 Other (private) Insurance					67,000,000						67,000,000
HP.6.9 All other providers of health administration							98,700,000	103,187,255		427,143,113	629,030,368
HP.9 Rest of the world	37,555,576				2,000,000						**39,555,576**
Provider not specified by kind						54,697,015			649,870		**55,346,885**
THE	8,798,544,168	265,585,931	106,707,452	102,563,810	335,000,000	1,764,419,800	610,225,953	633,024,692	445,382,759	1,555,684,228	**14,617,138,793**
HP.8 Institutions providing health related services	451,556,700		45,000,000	23,175,159			204,700,000	56,695,275		94,532,363	875,659,497
NHE	9,250,100,868	265,585,931	151,707,452	125,738,969	335,000,000	1,764,419,800	814,925,953	689,719,967	445,382,759	1,650,216,591	**15,492,798,290**

Annex A.1 Financing Agent x Function (HFxHC), 2002/03 for General NHA

	HF.1 Public				HF.2 Private Sector						Total function
	HF.1.1.1.1	HF.1.1.1.2	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	
Function	**Ministry of Health**	**National AIDS Commission**	**Other Ministries**	**Local Authorities**	**Private Insurance Scheme**	**Household OOP Payments**	**CHAM**	**Other NGOs**	**Private Firms / Employers**	**Rest of the World**	
HC.1 Services of curative care	3,804,107,320	-	19,246,600	8,813,150	236,000,000	1,455,646,334	413,786,828	54,807,139	428,542,160	436,234,966	**6,857,184,497**
HC.1.1 Inpatient curative care	2,506,298,652				71,000,000	834,879,339	310,340,121	20,284,986	281,039,370	108,982,848	4,132,825,316
HC.1.3 Out patient curative care	1,297,808,668		19,246,600	8,813,150	165,000,000	620,766,996	103,446,707	34,522,152	147,502,790	327,252,118	2,724,359,181
HC.2 Services of rehabilitative care										120,300,115	**120,300,115**
H5. Medical goods dispensed to outpatients					32,000,000	254,076,451					**286,076,451**
HC.6 Prevention and public health services	2,540,388,601	206,700,424		86,560,659			97,739,125	475,030,298	16,190,729	572,006,034	**3,994,615,870**
HC.7 Health administration and health insurance	1,161,325,641	58,885,507	87,460,852	7,190,000	67,000,000		98,700,000	103,187,255		427,143,113	**2,010,892,368**
HC 7.1 General Government Administration of Health	1,161,325,641	58,885,507	87,460,852	7,190,000							1,314,862,000
HC 7.2.2 Health Adminstration and Health Insurance: Other Private					67,000,000		98,700,000	103,187,255		427,143,113	696,030,368
HCR.nsk Expenditure not specified by kind						54,697,015			649,870		**55,346,885**
HC.R.1 Capital formation	1,292,722,606										**1,292,722,606**
THE	**8,798,544,168**	**265,585,931**	**106,707,452**	**102,563,810**	**335,000,000**	**1,764,419,800**	**610,225,953**	**633,024,692**	**445,382,759**	**1,555,684,228**	**14,617,138,793**
HC.R Health related functions	451,556,700		45,000,000	23,175,159			204,700,000	56,695,275		94,532,363	875,659,497
HCR.2 Eduation and Training of health personnel	370,326,136		45,000,000	603,940			153,700,000	56,695,275		94,532,363	720,857,714
HCR.3 Research and Development in health	78,641,048			18,321,533							96,962,581
HCR.4 Food Hygiene and Drinking water Control	749,687			38,980							788,667
HCR.5 Environmental Health	1,839,829			4,210,706			51,000,000				57,050,535
NHE	**9,250,100,868**	**265,585,931**	**151,707,452**	**125,738,969**	**335,000,000**	**1,764,419,800**	**814,925,953**	**689,719,967**	**445,382,759**	**1,650,216,591**	**15,492,798,290**

Annex A.1: Provider x Function (HPx HC), 2002/03 for General NHA

	HP.1 Hospital						HP.3 Providers of ambulatory health care			HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance			HP.9 Rest of the world	Provider not specified by kind	HP.8 Institutions providing health related services	Total function
	HP.1.1 General Hospitals					HP.1.2 Specialized hospitals (including mental hospital)												
	HP.1.1.1 Government general		HP.1.1.2 Private Not-for-profit		HP1.1.3													
	HP1.1.1.1 Central Hospitals	HP1.1.1.2 District Hospitals	HP1.1.2.1 Private-Not-for-profit hospitals (Other)	HP1.1.2.2 Private-not-for-profit hospital (CHAM)	Private For-profit hospitals		HP3.1 Offices of physicians	HP.3.4.9.1 health centres/dispensaries/maternity	HP3.9.3 Traditional practitioners			HP 6.1 General Administration of Health	HP.6.4 Other (private) Insurance	HP.6.9 All other providers of health administration				
HC.1 Services of curative care	926,158,087	1,584,305,198	40,187,626	809,468,163	292,967,415	23,626,917	294,806,951	2,798,168,092	47,639,335						39,555,576			6,856,883,358.97
HC.1.1 Inpatient curative care	682,010,049	1,227,806,281	9,318,525	607,101,122	219,725,561	23,626,917		1,323,681,285							39,555,576			4,132,825,316.11
HC.1.3 Out patient curative care	244,148,038	356,498,917	30,869,101	202,367,041	73,241,854		294,806,951	1,474,486,807	47,639,335									2,724,058,042.86
HC.2 Services of rehabilitative care		120,300,115																120,300,115.00
H5. Medical goods dispensed to outpatients										286,377,590								286,377,589.57
HC.6 Prevention and public health services											3,994,615,870							3,994,615,870.25
HC.7 Health administration and health insurance												1,314,862,000	67,000,000	629,030,368				2,010,892,368.00
HC 7.1 General Government Administration of Health												1,314,862,000						1,314,862,000.00
HC 7.2.2 Health Adminstration and Health Insurance: Other Private													67,000,000	629,030,368				696,030,368.00
HC.R.1 Capital formation	50,145,403	686,784,454				699,844		555,092,905										1,292,722,606.00
HCR.nsk Expenditure not specified by kind																55,346,885		55,346,884.80
THE	**976,303,490**	**2,391,389,767**	**40,187,626**	**809,468,163**	**292,967,415**	**24,326,761**	**294,806,951**	**3,353,260,997**	**47,639,335**	**286,377,590**	**3,994,615,870**	**1,314,862,000**	**67,000,000**	**629,030,368**	**39,555,576**	**55,346,885**	**0**	**14,617,138,792.58**
HC.R Health related functions																	875,659,497	875,659,497.00
HCR.2 Eduation and Training																	720,857,714	720,857,714.00
HCR.3 Research and Development																	96,962,581	96,962,581.00
HCR.4 Food Hygiene and Drinking water Control																	788,667	788,667.00
HCR.5 Environmental Health																	57,050,535	57,050,535.00
NHE	**976,303,490**	**2,391,389,767**	**40,187,626**	**809,468,163**	**292,967,415**	**24,326,761**	**294,806,951**	**3,353,260,997**	**47,639,335**	**286,377,590**	**3,994,615,870**	**1,314,862,000**	**67,000,000**	**629,030,368**	**39,555,576**	**55,346,885**	**875,659,497**	**15,492,798,289.58**

CHAM

Annex A.2: Financing Sources x Financing Agents (FS x HF), 2003/04 for General NHA

	FS.1 Public Funds*		FS.2 Private Funds*			FS.3	
463,257,895	FS.1.1 Territorial government		FS.2.1 Employer Funds	FS.2.2 Household Funds	FS.2.4 Other Private Funds		
	FS.1.1.1. General government	FS.1.1.2 Local Government (City, town and district assemblies)					
	FS.1.1.1.1 Ministry of Finance					Rest of the World Funds	Row Totals
HF.1.1.1.1 Ministry of Health	3,769,647,755					6,973,313,101	10,742,960,856
HF.1.1.1.2 National AIDS Commission	39,016,527					722,922,414	761,938,941
HF.1.1.1.3 Other Ministries	40,494,194				27,413,769	98,138,757	166,046,720
HF.1.1.1.4 Local Authorities	202,146,635	107,638,358				16,266,648	326,051,640
HF.2.2 Private Insurance Scheme			411,720,000	26,280,000			438,000,000
HF.2.3 Household Out of Pocket Payments				2,085,305,300			2,085,305,300
H.F.2.4 Non-Governmental Organizations	412,868,574	-	-	-	26,155,459	1,909,916,032	2,348,940,064
H.F.2.4.1 CHAM	412,868,574				26,155,459	195,993,541	635,017,574
H.F.2.4.2 Other NGOs						1,713,922,490	1,713,922,490
HF.2.5 Private Firms/Employers			492,573,800				492,573,800
HF.3 Rest of the World						4,342,508,860	4,342,508,860
HF.NsK Not Specified by Kind							
THE	**4,464,173,684**	**107,638,358**	**904,293,800**	**2,111,585,300**	**53,569,228**	**14,063,065,812**	**21,704,326,182**
%	**21%**	**0%**	**4%**	**10%**	**0%**	**65%**	**100%**
Financing agents of Health Care Related Activities	**111,174,445**	**30,805,565**	**-**	**-**	**26,944,541**	**1,255,869,598**	**1,424,794,149**
NHE	**4,575,348,129**	**138,443,923**	**904,293,800**	**2,111,585,300**	**80,513,769**	**15,318,935,411**	**23,129,120,331**
%	**20%**	**1%**	**4%**	**9%**	**0%**	**66%**	**100%**

Annex A.2: Financing Agent x Function (HFxHC), 2003/04 for General NHA

	HF.1 Public				HF.2 Private Sector						Row totals and total expenditure measures
	HF.1.1.1.1	HF.1.1.1.2	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	
Function	**Ministry of Health**	**National AIDS Commission**	**Other Ministries**	**Local Authorities**	**Private Insurance Scheme**	**Household OOP Payments**	**CHAM**	**Other NGOs**	**Private Firms / Employers**	**Rest of the World**	
HC.1 Services of curative care											
HC.1.1 Inpatient curative care	2,543,716,429	5,863,526	4,427,224	4,695,759	90,750,000	986,714,335	251,696,144	163,096,021	138,004,753	266,363,752	**4,455,327,943**
HC.1.3 Out patient curative care	2,398,067,610	1,954,509	13,281,673	95,842,355	210,250,000	733,662,537	166,472,430	489,288,063	333,304,048	2,551,939,081	**6,994,062,304**
HC.2 Services of rehabilitative care	283,249							192,692,287			**192,975,536**
HC.5 Medical goods dispensed to outpatients					41,000,000	300,283,963					**341,283,963**
HC.6 Prevention and public health services	3,432,448,762	382,928,902	98,138,758	96,564,101			106,806,000	392,594,925	21,265,000	930,190,677	**5,460,937,125**
HC.7 Health administration and health insurance											
HC 7.1 General Government Administration of Health	1,137,187,320	232,827,952	50,199,066	128,949,425							**1,549,163,763**
HC 7.2.2 Health Adminstration and Health Insurance: Other Private					96,000,000		110,043,000	476,251,194		594,015,352	**1,276,309,546**
HC.R.1 Capital formation	1,231,257,485										**1,231,257,485**
HCR.nsk Expenditure not specified by kind		138,364,052				64,644,465					**203,008,517**
THE	**10,742,960,855**	**761,938,941**	**166,046,721**	**326,051,640**	**438,000,000**	**2,085,305,301**	**635,017,574**	**1,713,922,490**	**492,573,800**	**4,342,508,862**	**21,704,326,184**
HC.R Health related functions	584,243,425	36,463,676	48,486,933	93,314,365			228,851,000	275,114,539		158,320,211	**1,424,794,150**
HCR.2 Eduation and Training	483,410,753	1,039,356	48,486,933	4,995,546			140,460,000	150,119,612		154,936,065	**983,448,265**
HCR.3 Research and Development	95,998,526	35,424,321		70,900,688				2,394,531		3,384,146	**208,102,211**
HCR.4 Food Hygiene and Drinking water Control	1,036,732			145,887			44,891,000	77,130,347			**123,203,966**
HCR.5 Environmental Health	3,797,414			17,272,245			43,500,000	45,470,049			**110,039,707**
NHE	**11,327,204,280**	**798,402,617**	**214,533,654**	**419,366,004**	**438,000,000**	**2,085,305,301**	**863,868,574**	**1,989,037,030**	**492,573,800**	**4,500,829,073**	**23,129,120,333**

Annex A.2: Financing Agents x Providers (HF x HP), 2003/04 for General NHA

	HF.1 Public				HF.2 Private Sector						
	HF.1.1.1.1	HF.1.1.1.2	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	Row totals and total expenditure measures
Provider	Ministry of Health	National AIDS Commission	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HP.1 Hospital											-
HP.1.1 General Hospitals											-
HP.1.1.1 Government general hospitals											-
HP1.1.1.1 Central Hospitals	831,155,044					75,070,991				580,493,126	1,486,719,161
HP1.1.1.2 District Hospitals	1,787,722,915	7,818,035				417,061,060				1,047,519,502	3,260,121,512
HP.1.1.2 Private Not-for-profit hospitals											-
HP1.1.2.1 Private-Not-for-profit hospitals (Other)								192,692,287			192,692,287
HP1.1..2.2 Private-not-for-profit hospital (CHAM)						585,970,789	294,308,002			272,472,844	1,152,751,635
HP1.1.3 Private For-profit hospitals					117,000,000	237,516,274			68,580,270		423,096,544
HP.1.2 Specialized hospitals (including mental hospital)	68,636,304										68,636,304
HP.2 Nursing and residential care facilities											-
HP.3 Providers of ambulatory health care											-
HP3.1 Offices of physicians					181,000,000	116,985,628			56,450,330		354,435,958
HP.3.4.9.1 health centres/dispensaries/maternity	3,442,582,635		17,708,897	100,538,114		231,468,887	123,860,572	652,384,084	346,278,200	917,817,360	5,832,638,749
HP3.9.3 Traditional practitioners						56,303,243					56,303,243
HP.4 Retail sale and other providers of medical goods					41,000,000	300,283,963					341,283,963
HP.5 Provision and administration of public health programs	3,432,448,762	382,928,902	98,138,758	96,564,101			106,806,000	392,594,925	21,265,000	930,190,677	5,460,937,125
HP.6 General health administration and insurance											-
HP 6.1 General Administration of Health	1,137,187,320	232,827,952	50,199,066	128,949,425							1,549,163,763
HP.6.4 Other (private) Insurance					96,000,000						96,000,000
HP.6.9 All other providers of health administration							110,043,000	476,251,194		594,015,352	1,180,309,546
HP.9 Rest of the world	43,227,876				3,000,000						46,227,876
Provider not specified by kind		138,364,052				64,644,465					203,008,517
THE	**10,742,960,856**	**761,938,941**	**166,046,721**	**326,051,640**	**438,000,000**	**2,085,305,300**	**635,017,574**	**1,713,922,490**	**492,573,800**	**4,342,508,861**	**21,704,326,183**
HP.8 Institutions providing health related services	584,243,425	36,463,676	48,486,933	93,314,365			228,851,000	275,114,539		158,320,211	1,424,794,150
NHE	**11,327,204,281**	**798,402,617**	**214,533,654**	**419,366,004**	**438,000,000**	**2,085,305,300**	**863,868,574**	**1,989,037,030**	**492,573,800**	**4,500,829,072**	**23,129,120,333**

Annex A.2: Provider x Function (HPxHC), 2003/04 for General NHA

	HP.1 Hospital						HP.3 Providers of ambulatory health care			HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance			HP.9 Rest of the world	Provider not specified by kind	HP.8 Institutions providing health related services	Total function
	HP.1.1 General Hospitals					HP.1.2 Specialized hospitals (including mental hospital)												
	HP.1.1.1 Government general hospitals		HP.1.1.2 Private Not-for-profit hospitals		HP1.1.3 Private													
	HP1.1.1.1 Central Hospitals	HP1.1.1.2 District Hospitals	HP1.1.2.1 Private-Not-for-profit hospitals (Other)	HP1.1..2.2 Private-not-for-profit hospital (CHAM)	For-profit hospitals		HP3.1 Offices of physicians	HP.3.4.9.1 health centres/dispensaries/maternity	HP3.9.3 Traditional practitioners			HP 6.1 General Administration of Health	HP.6.4 Other (private) Insurance	HP.6.9 All other providers of health administration				
HC.1 Services of curative care																		
HC.1.1 Inpatient curative care	715,504,007	1,728,367,584		660,209,093	317,322,408	68,553,046		919,143,930							46,227,876			4,455,327,943
HC.1.3 Out patient curative care	765,724,970	1,472,886,359		492,542,542	105,774,136		354,435,958	3,746,395,097	56,303,243									6,994,062,304
HC.2 Services of rehabilitative care		283,249	192,692,287															192,975,536
HC.5 Medical goods dispensed to outpatients										341,283,963								341,283,963
HC.6 Prevention and public health services											5,460,937,125							5,460,937,125
HC.7 Health administration and health insurance																		
HC 7.1 General Government Administration of Health Services												1,549,163,763						1,549,163,763
HC 7.2.2 Health Adminstration and Health Insurance: Other Private													96,000,000	1,180,309,546				1,276,309,546
HC.R.1 Capital formation	5,490,184	58,584,320				83,258		1,167,099,723										1,231,257,485
HCR.nsk Expenditure not specified by kind																203,008,517		203,008,517
THE	**1,486,719,161**	**3,260,121,511**	**192,692,287**	**1,152,751,635**	**423,096,544**	**68,636,304**	**354,435,958**	**5,832,638,750**	**56,303,243**	**341,283,963**	**5,460,937,125**	**1,549,163,763**	**96,000,000**	**1,180,309,546**	**46,227,876**	**203,008,517**		**21,704,326,184**
HC.R Health related functions																	1,424,794,150	1,424,794,150
HCR.2 Eduation and Training																	983,448,265	983,448,265
HCR.3 Research and Development																	208,102,211	208,102,211
HCR.4 Food Hygiene and Drinking water Control																	123,203,966	123,203,966
HCR.5 Environmental Health																	110,039,707	110,039,707
NHE	**1,486,719,161**	**3,260,121,511**	**192,692,287**	**1,152,751,635**	**423,096,544**	**68,636,304**	**354,435,958**	**5,832,638,750**	**56,303,243**	**341,283,963**	**5,460,937,125**	**1,549,163,763**	**96,000,000**	**1,180,309,546**	**46,227,876**	**203,008,517**	**1,424,794,150**	**23,129,120,333**

Annex A.3: Financing Sources x Financing Agents (FS x HF), 2004/05 for General NHA

	FS.1 Public Funds*		FS.2 Private Funds*			FS.3	
	FS.1.1 Territorial government		FS.2.1 Employer Funds	FS.2.2 Household Funds	FS.2.4 Other Private Funds		
	FS.1.1.1. General	FS.1.1.2 Local Government (City, town and district assemblies)					
	FS.1.1.1.1 Ministry of Finance					Rest of the World Funds	Row Totals
HF.1.1.1.1 Ministry of Health	5,301,159,324					8,228,002,151	13,529,161,475
HF.1.1.1.2 National AIDS Commission	126,799,568					2,987,609,569	3,114,409,137
HF.1.1.1.3 Other Ministries	49,817,077				27,187,107	109,654,385	186,658,569
HF.1.1.1.4 Local Authorities	29,826,687	72,558,738				4,159,333	106,544,758
HF.2.2 Private Insurance Scheme			668,670,000	50,330,000			719,000,000
HF.2.3 Household Out of Pocket Payments				2,347,914,965			2,347,914,965
H.F.2.4 Non-Governmental Organizations							
H.F.2.4.1 CHAM	837,025,824				20,698,733	242,744,267	1,100,468,824
H.F.2.4.2 Other NGOs						1,673,353,224	1,673,353,224
HF.2.5 Private Firms/Employers			568,023,020				568,023,020
HF.3 Rest of the World						2,868,071,342	2,868,071,342
HF.NsK Not Specified by Kind							
THE	**6,344,628,480**	**72,558,738**	**1,236,693,020**	**2,398,244,965**	**47,885,840**	**16,113,594,270**	**26,213,605,314**
%	**24%**	**0%**	**5%**	**9%**	**0%**	**61%**	**100%**
Financing agents spending on health related items	251,696,327	30,109,299			20,401,267	1,831,490,402	**2,133,697,295**
NHE	**6,596,324,808**	**102,668,036**	**1,236,693,020**	**2,398,244,965**	**68,287,107**	**17,945,084,672**	**28,347,302,609**
%	**23%**	**0%**	**4%**	**8%**	**0%**	**63%**	**100%**

Annex A.3: Financing Agent x Function (HFxHC), 2004/05 for General NHA

	HF.1 Public				HF.2 Private Sector						Row totals and total expenditure measures
	HF.1.1.1.1	HF.1.1.1.2	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	
Function	Ministry of Health	National AIDS Commission	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HC.1 Services of curative care											
HC.1.1 Inpatient curative care	3,384,846,576	395,411,323	6,725,440	3,717,678	160,000,000	1,110,974,664	505,123,583	179,405,623	148,575,585	143,448,174	6,038,228,645
HC.1.3 Out patient curative care	2,976,405,293	131,803,774	20,176,319	10,045,552	365,000,000	826,055,182	335,779,692	538,216,869	391,546,595	625,306,073	6,220,335,349
HC.2 Services of rehabilitative care	66,668,290									305,983,836	372,652,126
H5.Medical goods dispensed to outpatients					71,000,000	338,099,755					409,099,755
HC.6 Prevention and public health services	4,329,357,187	1,980,998,140	109,654,385	92,781,528.00			159,895,549.00	431,854,418	27,900,840	1,089,094,112	8,221,536,159
HC.7 Health administration and health insurance											
HC 7.1 General Government Administration of Health Services	1,143,390,660	606,195,901	50,102,426								1,799,688,987
HC 7.2.2 Health Adminstration and Health Insurance: Other Private					123,000,000		99,670,000	523,876,314		704,239,146	1,450,785,460
HC.R.1 Capital formation	1,628,493,469										1,628,493,469
HCR.nsk Expenditure not specified by kind						72,785,365					72,785,365
THE	**13,529,161,475**	**3,114,409,137**	**186,658,569**	**106,544,758**	**719,000,000**	**2,347,914,965**	**1,100,468,824**	**1,673,353,224**	**568,023,020**	**2,868,071,341**	**26,213,605,313**
HC.R Health related functions	857,565,855	507,327,913	49,718,049	44,212,290	-	-	259,657,000	233,634,055	-	181,582,133	2,133,697,295
HCR.2 Eduation and Training	563,479,865	504,275,905	49,718,049	1,008,178			192,900,000	233,634,055		177,551,946	1,722,567,998
HCR.3 Research and Development	104,484,727	3,052,008		36,524,869						4,030,187	148,091,792
HCR.4 Food Hygiene and Drinking water Control	176,071,319			165,837			28,257,000				204,494,157
HCR.5 Environmental Health	13,529,943			6,513,406			38,500,000				58,543,349
NHE	**14,386,727,330**	**3,621,737,050**	**236,376,618**	**150,757,048**	**719,000,000**	**2,347,914,965**	**1,360,125,824**	**1,906,987,279**	**568,023,020**	**3,049,653,474**	**28,347,302,608**

Annex A.3: Financing Agent x Provider, 2004/05 for General NHA

	HF.1 Public				HF.2 Private Sector						Row totals and total expenditure measures
	HF.1.1.1.1	HF.1.1.1.2	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	
Provider	Ministry of Health	National AIDS Commission	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HP.1 Hospital											-
HP.1.1 General Hospitals											-
HP.1.1.1 Government general hospitals											-
HP1.1.1.1 Central Hospitals	943,488,534					84,524,939					1,028,013,473
HP1.1.1.2 District Hospitals	2,266,041,478	527,215,097				469,582,993				305,983,836	3,568,823,404
HP.1.1.2 Private Not-for-profit hospitals											-
HP1.1.2.1 Private-Not-for-profit hospitals (Other)											-
HP1.1..2.2 Private-not-for-profit hospital (CHAM)						659,764,105	589,795,528				1,249,559,633
HP1.1.3 Private For-profit hospitals					204,000,000	267,427,514			72,800,500		544,228,014
HP.1.2 Specialized hospitals (including mental hospital)	84,011,298										84,011,298
HP.2 Nursing and residential care facilities											-
HP.3 Providers of ambulatory health care											-
HP3.1 Offices of physicians					314,000,000	131,718,030			91,420,840		537,138,870
HP.3.4.9.1 health centres/dispensaries/maternity	4,538,269,211		26,901,758	13,763,230		260,618,560	251,107,747	717,622,492	375,900,840	768,754,247	6,952,938,085
HP3.9.3 Traditional practitioners						63,393,705					63,393,705
HP.4 Retail sale and other providers of medical goods					71,000,000	338,099,755					409,099,755
HP.5 Provision and administration of public health programs	4,329,357,187	1,980,998,140	109,654,385	92,781,528			159,895,549	431,854,418	27,900,840	1,089,094,112	8,221,536,159
HP.6 General health administration and insurance											-
HP 6.1 General Administration of Health	1,239,135,116	606,195,901	50,102,426								1,895,433,443
HP.6.4 Other (private) Insurance					123,000,000						123,000,000
HP.6.9 All other providers of health administration							99,670,000	523,876,314		704,239,146	1,327,785,460
HP.9 Rest of the world	128,858,651				7,000,000						135,858,651
Provider not specified by kind						72,785,365					72,785,365
THE	**13,529,161,475**	**3,114,409,137**	**186,658,569**	**106,544,758**	**719,000,000**	**2,347,914,965**	**1,100,468,824**	**1,673,353,224**	**568,023,020**	**2,868,071,342**	**26,213,605,313**
HP.8 Institutions providing health related services	857,565,855	507,327,913	49,718,049	44,212,290	-	-	259,657,000	233,634,055	-	181,582,133	2,133,697,295
NHE	**14,386,727,330**	**3,621,737,050**	**236,376,618**	**150,757,048**	**719,000,000**	**2,347,914,965**	**1,360,125,824**	**1,906,987,279**	**568,023,020**	**3,049,653,475**	**28,347,302,608**

Annex A.3: Provider x Function (HPx HC), 2004/05 for General NHA

	HP.1 Hospital						HP.3 Providers of ambulatory health care			HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance			HP.9 Rest of the world	Provider not specified by kind	HP.8 Institutions providing health related services	Total function
	HP.1.1 General Hospitals					HP.1.2 Specialized hospitals (including mental hospital)												
	HP1.1.1.1 Central Hospitals	HP1.1.1.2 District Hospitals	HP1.1.2.1 Private-Not-for-profit hospitals (Other)	HP1.1..2.2 Private-not-for-profit hospital (CHAM)	HP1.1.3 Private For-profit hospitals		HP3.1 Offices of physicians	HP.3.4.9.1 health centres/dispensaries/maternity	HP3.9.3 Traditional practitioners			HP 6.1 General Administration of Health	HP.6.4 Other (private) Insurance	HP.6.9 All other providers of health administration				
HC.1 Services of curative care																		
HC.1.1 Inpatient curative care	819,576,971	2,332,775,816		937,169,725	408,171,011	39,909,904		1,364,766,568							135,858,651			6,038,228,645
HC.1.3 Out patient curative care	159,161,761	746,145,629		312,389,908	136,057,003	6,404,399	537,138,870	4,259,644,075	63,393,705									6,220,335,349
HC.2 Services of rehabilitative care	7,785,549	357,630,500				1,041,750		6,194,327										372,652,126
H5.Medical goods dispensed to outpatients										409,099,755								409,099,755
HC.6 Prevention and public health services											8,221,536,159							8,221,536,159
HC.7 Health administration and health insurance																		
HC 7.1 General Government Administration of Health Services												1,799,688,987						1,799,688,987
HC 7.2.2 Health Adminstration and Health Insurance: Other Private													123,000,000	1,327,785,460				1,450,785,460
HC.R.1 Capital formation	41,489,193	132,271,460				36,655,245		1,322,333,115				95,744,456						1,628,493,469
HCR.nsk Expenditure not specified by kind																72,785,365		72,785,365
THE	**1,028,013,473**	**3,568,823,404**		**1,249,559,633**	**544,228,014**	**84,011,298**	**537,138,870**	**6,952,938,085**	**63,393,705**	**409,099,755**	**8,221,536,159**	**1,895,433,443**	**123,000,000**	**1,327,785,460**	**135,858,651**	**72,785,365**		**26,213,605,313**
HC.R Health related functions																	2,133,697,295	2,133,697,295
HCR.2 Eduation and Training																	1,722,567,998	1,722,567,998
HCR.3 Research and Development																	148,091,792	148,091,792
HCR.4 Food Hygiene and Drinking water Control																	204,494,157	204,494,157
HCR.5 Environmental Health																	58,543,349	58,543,349
NHE	**1,028,013,473**	**3,568,823,404**		**1,249,559,633**	**544,228,014**	**84,011,298**	**537,138,870**	**6,952,938,085**	**63,393,705**	**409,099,755**	**8,221,536,159**	**1,895,433,443**	**123,000,000**	**1,327,785,460**	**135,858,651**	**72,785,365**	**2,133,697,295**	**28,347,302,608**

Annex B.1: Financing Sources x Financing Agents (FS x HF), 2002/03 for HIV/AIDS

	FS.1 Public Funds*			FS.2 Private Funds*					
	FS.1.1 Territorial government		FS.1.2 Other Public Funds	FS.2.1 Employer Funds	FS.2.2 Household Funds	FS.2.4 Other Private Funds	FS.3 ROW	FS.NsK Not Specified by Kind (NsK)	Totals Financing Agent
	FS.1.1.1. General government	FS.1.1.2 Local Government (City, town and district assemblies)							
	FS.1.1.1.1 Ministry of Finance								
HF.1.1.1.1 Ministry of Health	915,115,516						103,526,899		**1,018,642,415**
HF.1.1.1.2 National AIDS Commission	22,467,011						243,118,920		**265,585,931**
HF.1.1.1.3 Other Ministries	3,877,448						7,771,846		**11,649,294**
HF.1.1.1.4 Local Authorities							8,245,359		**8,245,359**
HF.2.2 Private Insurance Scheme				51,773,100	3,896,900				**55,670,000**
HF.2.3 Household Out of Pocket Payments					169,370,777				**169,370,777**
H.F.2.4 Non-Governmental Organizations									-
H.F.2.4.1 CHAM	80,675,573						63,387,951		**144,063,524**
H.F.2.4.2 Other NGOs							107,311,766		**107,311,766**
HF.2.5 Private Firms/Employers				121,964,226					**121,964,226**
HF.3 Rest of the World							440,804,098		**440,804,098**
HF.NsK Not Specified by Kind									-
THE	**1,022,135,548**	-	-	**173,737,326**	**173,267,677**	-	**974,166,838**	-	**2,343,307,389**
Financing agents of Health Care related activities									-
HCR.2 Training							**54,257,451**		**54,257,451**
NHE	**1,022,135,548**	-	-	**173,737,326**	**173,267,677**	-	**1,028,424,289**	-	**2,397,564,840**
Non-Health Expenditures							**139,303,962**		**139,303,962**
OVC							18,274,842		**18,274,842**
Policy Advocacy									
Legistration									
Non-health expenditures not specified by kind							**121,029,120**		**121,029,120**
Total National HIV/AIDS Expenditure	**1,022,135,548**	-	-	**173,737,326**	**173,267,677**	-	**1,167,728,252**	-	**2,536,868,803**

Annex B.1: Financing Agent (HFx HC), 2002/03 for HIV

	HF.1 Public				HF.2 Private Sector						
	HF.1.1.1.1	HF.1.1.1.2	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	**Total Function**
Function	Ministry of Health	National AIDS Commission	Other Ministries	Local Authorities	Private Insurance Scheme	Household Out-of - pocket payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HC.1 Services of curative care											
HC.1.1 Inpatient curative care	684,752,957				24,150,000	101,058,988	107,868,138	2,028,499	98,363,780	107,649,210	1,125,871,571
HC.1.3 Out patient curative care	158,771,202			881,315	31,520,000	68,311,789	16,551,473	5,117,845	23,600,446	35,883,070	340,637,141
HC.1.1.3 ARV Treatment	58,691,950										58,691,950
HC.6 Prevention and public health services	107,960,087	206,700,424	7,771,846	6,645,044			9,773,913	95,006,060		267,910,539	701,767,913
HC.6.3.1 VCT	46,496,329	89,021,889					4,209,436	40,917,279		115,383,906	296,028,838
HC.6.3.4 I.E.C	47,117,193	90,210,597	7,771,846	6,645,044			4,265,644	41,463,647		116,924,625	314,398,596
HC.6.3.5 STI Prevention program	2,288,619	4,381,790					207,195	2,014,010		5,679,368	14,570,981
HC.6.3.7 Condom Distribution programs	10,589,131	20,273,955					958,662	9,318,552		26,277,673	67,417,973
HC.6.8 Surveillance	1,468,815	2,812,194					132,976	1,292,573		3,644,968	9,351,525
HC.7 Health administration and health insurance											116,338,816
HC 7.1 General Government Administration of Health	8,466,219	58,885,507	3,877,448	719,000							71,948,174
HC 7.2.2 Health Adminstration and Health Insurance: Other Private							9,870,000	5,159,363		29,361,279	44,390,642
Total Health Expenditure	**1,018,642,415**	**265,585,931**	**11,649,294**	**8,245,359**	**55,670,000**	**169,370,777**	**144,063,524**	**107,311,766**	**121,964,226**	**440,804,098**	**2,343,307,390**
HC.R Health related functions	-	-	-	-	-		-	-	-	54,257,451	54,257,451
HCR.2 Eduation and Training of health personnel										54,257,451	54,257,451
Sub-total	**1,018,642,415**	**265,585,931**	**11,649,294**	**8,245,359**	**55,670,000**	**169,370,777**	**144,063,524**	**107,311,766**	**121,964,226**	**495,061,549**	**2,397,564,841**
Non-Health Expenditures	-	18,274,842	-	-	-		-	-	-	121,029,120	139,303,962
OVC		18,274,842									18,274,842
Not specified by kind										121,029,120	121,029,120
Total National HIV/AIDS Expenditure	**1,018,642,415**	**283,860,773**	**11,649,294**	**8,245,359**	**55,670,000**	**169,370,777**	**144,063,524**	**107,311,766**	**121,964,226**	**616,090,669**	**2,536,868,803**

Annex B.1: Financing Agents x Providers (HF x HP), 2002/03 for HIV/AIDS

	HF.1 Public				HF.2 Private Sector						
	HF.1.1.1.1	HF.1.1.1.2	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	Row totals and total expenditure measures
Provider	Ministry of Health	National AIDS Commission	Other Ministries	Local Authorities	Private Insurance Scheme	Household Out-of-pocket payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HP.1 Hospital											-
HP.1.1 General Hospitals											-
HP.1.1.1 Government general hospitals											-
HP1.1.1.1 Central Hospitals	320,541,324					6,892,433					327,433,757
HP1.1.1.2 District Hospitals	399,287,493					36,786,666					436,074,160
HP.1.1.2 Private Not-for-profit hospitals											-
HP1.1.2.1 Private-Not-for-profit hospitals (Other)								4,441,678	3,758,472		8,200,150
HP1.1..2.2 Private-not-for-profit hospital (CHAM)						53,532,488	94,884,025				148,416,514
HP1.1.3 Private For-profit hospitals					27,830,000	20,950,006					48,780,006
HP.3 Providers of ambulatory health care											-
HP.3.1 Offices of physicians					22,720,000	7,265,129			8,611,680		38,596,809
HP.3.4.9.1 health centres/dispensaries/maternity	182,387,292			881,315		15,322,770	29,535,586	2,704,665	109,594,074	143,532,280	483,957,982
HP.3.9.3 Traditional Healers						3,496,586					
HP.4 Retail sale and other providers of medical goods					5,120,000	18,648,459					23,768,459
HP.5 Provision and administration of public health programs	107,960,087	206,700,424	7,771,846	6,645,044	-		9,773,913	95,006,060	-	267,910,539	701,767,913
HP.6 Health administration and insurance											-
HP 6.1 Government Administration of Health	8,466,219	58,885,507	3,877,448	719,000							71,948,174
HP.6.9 All other health administration							9,870,000	5,159,363		29,361,279	44,390,642
HP nsk						6,476,239					
THE	**1,018,642,415**	**265,585,931**	**11,649,294**	**8,245,359**	**55,670,000**	**169,370,777**	**144,063,524**	**107,311,766**	**121,964,226**	**440,804,098**	**2,343,307,390**
HP.8 Institutions providing health related services										54,257,451	54,257,451
Sub-total	**1,018,642,415**	**265,585,931**	**11,649,294**	**8,245,359**	**55,670,000**	**169,370,777**	**144,063,524**	**107,311,766**	**121,964,226**	**495,061,549**	**2,397,564,841**
Non-Health Expenditures	-	18,274,842	-	-	-		-	-	-	121,029,120	139,303,962
OVC		18,274,842									18,274,842
Not specified by kind										121,029,120	121,029,120
Total National HIV/AIDS Expenditure	**1,018,642,415**	**283,860,773**	**11,649,294**	**8,245,359**	**55,670,000**	**169,370,777**	**144,063,524**	**107,311,766**	**121,964,226**	**616,090,669**	**2,536,868,803**

Annex B.1: Provider X Function (HP x HC), 2002/03 for HIV

	HP.1 Hospital					HP.3 Providers of ambulatory health care			HP.4 Retail sale and other providers of medical goods, HP.4.1 Pharmacies	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance				HP.8 Institutions providing health related services	Providers of non-health expenditures	
	HP.1.1 General Hospitals																
	HP.1.1.1 Government general		HP.1.1.2 Private Not-for-profit		HP1.1.3												
18648458.84	HP1.1.1.1 Central Hospitals	HP1.1.1.2 District Hospitals	HP1.1.2.1 Private-Not-for-profit hospitals (Other)	HP1.1..2.2 Private-not-for-profit hospital (CHAM)	Private For-profit hospitals	HP3.1 Offices of physicians	HP.3.4.9.1 health centres/dispensaries/maternity	HP.3.9.3 Traditional Healers			HP 6.1 General Administration of Health	HP.6.4 Other (private) Insurance	HP.6.9 All other providers of health administration	HP.nsk			**Total function**
HC.1 Services of curative care																	0.00
HC.1.1 Inpatient services	240,444,068.78	386,674,532.09	3,261,483.75	125,397,266.75	41,412,403		323,983,532							4,698,284			1,125,871,571
HC.1.3 Out patient	28,297,738.28	49,399,627.64	4,938,666.45	23,019,246.79	7,367,603	38,596,809	159,974,449	3,496,586	23,768,459					1,777,955			340,637,141
HC.1.3.1 ARV Treatment	58,691,950																58,691,950
HC.6 Prevention and public health services										701,767,913							**701,767,913**
HC.6.3.1 VCT										296,028,838							296,028,838
HC.6.3.4 I.E.C										314,398,596							314,398,596
HC.6.3.5 STI Prevention program										14,570,981							14,570,981
HC.6.3.7 Condom Distribution programs										67,417,973							67,417,973
HC.6.8 Surveillance										9,351,525							9,351,525
HC.7 Health administration and health insurance											71,948,174		44,390,642				**116,338,816**
HC 7.1 General Government Administration of Health											71,948,174						71,948,174
HC 7.2.2 Health Adminstration and Health Insurance: Other Private													44,390,642				44,390,642
THE	**327,433,757.05**	**436,074,159.73**	**8,200,150.20**	**148,416,513.54**	**48,780,006**	**38,596,809**	**483,957,982**	**3,496,586**	**23,768,459**	**701,767,913**	**71,948,174**		**44,390,642**	**6,476,239**			**2,343,307,390**
HC.R Health related functions															54,257,451		54,257,451
HCR.2 Eduation and Training of health personnel															54,257,451		54,257,451
Sub-total	327,433,757.05	436,074,159.73	8,200,150.20	148,416,513.54	48,780,006	38,596,809	483,957,982	3,496,586	23,768,459	701,767,913	71,948,174		44,390,642	6,476,239	54,257,451		**2,397,564,841**
Non-Health Expenditures																139,303,962	139,303,962
OVC																18,274,842	18,274,842
Not specified by kind																121,029,120	121,029,120
Total National HIV/AIDS Expenditure	**327,433,757.05**	**436,074,159.73**	**8,200,150.20**	**148,416,513.54**	**48,780,006**	**38,596,809**	**483,957,982**	**3,496,586**	**23,768,459**	**701,767,913**	**71,948,174**		**44,390,642**	**6,476,239**	**54,257,451**	**139,303,962**	**2,536,868,803**

Annex B.2: Financing Sources x Financing Agents (FS x HF), 2003/04 for HIV/AIDS

	FS.1 Public Funds*		FS.2 Private Funds*			FS.3	
	FS.1.1 Territorial government		FS.2.1 Employer Funds	FS.2.2 Household Funds	FS.2.4 Other Private Funds		
	FS.1.1.1. General government	FS.1.1.2 Local Government (City, town and district assemblies)					
	FS.1.1.1.1 Ministry of Finance					Rest of the World Funds	Row Totals
HF.1.1.1.1 Ministry of Health	888,740,957					138,738,300	1,027,479,257
HF.1.1.1.2 National AIDS Commission	39,016,527					584,558,362	623,574,889
HF.1.1.1.3 Other Ministries						44,990,637	44,990,637
HF.1.1.1.4 Local Authorities	24,906,155	12,284,025					37,190,180
HF.2.2 Private Insurance Scheme			63,252,300	5,500,200			68,752,500
HF.2.3 Household Out of Pocket Payments				202,565,557			202,565,557
H.F.2.4 Non-Governmental Organizations							
H.F.2.4.1 CHAM	72,098,785				4,567,498	56,418,407	133,084,691
H.F.2.4.2 Other NGOs						205,960,106	205,960,106
HF.2.5 Private Firms/Employers			97,090,730				97,090,730
HF.3 Rest of the World						2,673,093,708	2,673,093,708
HF.NsK Not Specified by Kind							
Total National HIV/AIDS Health Expenditures	**1,024,762,425**	**12,284,025**	**160,343,030**	**208,065,757**	**4,567,498**	**3,703,759,521**	**5,113,782,256**
%							
Financing agents of Health Care Related Activities							
HCR.2 Training						92,552,827	92,552,827
Total HCR	**-**	**-**	**-**	**-**	**-**	**92,552,827**	**92,552,827**
Total National HIV/AIDS Health Expenditures	**1,024,762,425**	**12,284,025**	**160,343,030**	**208,065,757**	**4,567,498**	**3,796,312,348**	**5,206,335,083**
Non-health expenditures							
Financing Agents for Non-health expenditures	**121,579,781**					**805,688,978**	**927,268,759**
Not specified by kind						162,882,449	**162,882,449**
Total National HIV/AIDS Expenditures	**1,146,342,205**	**12,284,025**	**160,343,030**	**208,065,757**	**4,567,498**	**4,764,883,775**	**6,296,486,290**
Total National HIV/AIDS by source	**18%**	**0%**	**3%**	**3%**	**0%**	**76%**	**100%**

Annex B.2: Financing Agent x Function (HFxHC), 2003/04 for HIV/AIDS

	HF.1 Public				HF.2 Private Sector							Row totals and total expenditure measures
	HF.1.1.1.1	HF.1.1.1.2	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3		
Function	Ministry of Health	National AIDS Commission	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	HPnsk	
HC.1 Services of curative care												
HC.1.1 Inpatient curative care (OIs treatment)	729,793,784	5,863,526		1,220,897	33,577,500	122,020,151	88,093,651	16,167,971	48,301,663	29,450,581		1,074,489,724
HC.1.3 Out patient curative care (OIs treatment)	151,168,029	1,954,509		13,417,930	35,175,000	71,141,842	23,306,140	48,503,912	46,662,567	176,902,474		568,232,402
HC.1.3.7 ARV Treatment										1,967,475,960		1,967,475,960
HC.2 Services of rehabilitative care	138,322							104,529				242,851
HC.6 Prevention and public health services	140,323,295	372,726,284	44,990,637	9,656,410			10,680,600	141,183,695	2,126,500	457,052,660		1,178,740,081
HC.6.3.1 VCT	120,678,034	320,544,604					9,185,316	121,417,978		393,065,288		964,891,219
HC.6.3.4 I.E.C	14,032,330	37,272,628	44,990,637	9,656,410			1,068,060	14,118,369		45,705,266		166,843,700
HC.6.3.5 STI Prevention program	1,403,232.95	3,727,262.84					106,806	1,411,837		4,570,527		11,219,665
HC.6.3.7 Condom Distribution programs	4,209,699	11,181,789					320,418	4,235,511		13,711,580		33,658,996
Not Specified									2,126,500			2,126,500
HC.7 Health administration and health insurance												0
HC 7.1 General Government Administration of Health	6,055,827	104,666,519		12,894,943								123,617,289
HC 7.2.2 Health Adminstration and Health Insurance: Other Private							11,004,300			42,212,034		53,216,334
HC.nsk Expenditure not specified by kind		138,364,052									9,403,564	147,767,616
THE	**1,027,479,257**	**623,574,890**	**44,990,637**	**37,190,180**	**68,752,500**	**193,161,993**	**133,084,691**	**205,960,106**	**97,090,730**	**2,673,093,708**	**9,403,564**	**5,113,782,256**
HC.R Health related functions	-	-	-	-	-	-	-	-	-	92,552,826		92,552,826
HCR.2 Eduation and Training										92,552,826		92,552,826
National HIV/AIDS Health Expenditures	**1,027,479,257**	**623,574,890**	**44,990,637**	**37,190,180**	**68,752,500**	**193,161,993**	**133,084,691**	**205,960,106**	**97,090,730**	**2,765,646,534**		**5,196,931,518**
Non-Health Expenditures	-	927,268,761	-	-	-	-	-	-	-	162,882,449		1,090,151,210
AD1.1.2 Support to PLWHA		308,114,876										308,114,876
AD.1.2 Non-health services to orphans		291,861,744										291,861,744
AD.2 Policy advocacy		29,608,806										29,608,806
Not Specified by kind		297,683,335								162,882,449		460,565,784
Total National HIV/AIDS Expenditure	**1,027,479,257**	**1,550,843,651**	**44,990,637**	**37,190,180**	**68,752,500**	**193,161,993**	**133,084,691**	**205,960,106**	**97,090,730**	**2,928,528,983**	**-**	**6,287,082,728**

Annex B.2: Financing Agents x Providers (HF x HP), 2003/04 for HIV/AIDS

	HF.1 Public				HF.2 Private Sector						
	HF.1.1.1.1	HF.1.1.1.2	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	Row totals and total expenditure measures
Provider	Ministry of Health	National AIDS Commission	Other Ministries	Local Authorities	Private Insurance Scheme	Household out-of-pocket	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HP.1 Hospital											-
HP.1.1 General Hospitals											-
HP.1.1.1 Government general hospitals											-
HP1.1.1.1 Central Hospitals	267,209,256					8,863,632				580,493,126	856,566,014
HP1.1.1.2 District Hospitals	533,296,987	7,818,035				44,317,714				855,554,376	1,440,987,111
HP.1.1.2 Private Not-for-profit hospitals											-
HP1.1.2.1 Private-Not-for-profit hospitals (Other)								104,529			104,529
HP1.1..2.2 Private-not-for-profit hospital (CHAM)						68,312,384	87,556,631		20,402,630	272,472,844	448,744,489
HP1.1.3 Private For-profit hospitals					36,562,500	25,238,938					61,801,438
HP.3 Providers of ambulatory health care											-
HP.3.1 Offices of physicians					25,340,000	7,189,092			7,903,046		40,432,138
HP.3.4.9.1 health centres/dispensaries/maternity	80,593,892			14,638,827		17,326,958	23,843,160	64,671,883	66,658,554	465,308,668	733,041,941
HP.3.9.3 Traditional healers						3,459,991					
HP.4 Retail sale and other providers of medical goods					5,740,000	18,453,285					24,193,285
HP.5 Provision and administration of public health programs	140,323,295	372,726,284	44,990,637	9,656,410	-		10,680,600	141,183,695	2,126,500	457,052,660	1,178,740,081
HP.6 Health administration and insurance											-
HP 6.1 Government Administration of Health	6,055,827	104,666,519		12,894,943							123,617,289
HP.6.9 All other providers of health administration							11,004,300			42,212,034	53,216,334
HP.9 Rest of the world					1,110,000						1,110,000
Provider not specified by kind		138,364,052				9,403,564					147,767,616
THE	**1,027,479,257**	**623,574,890**	**44,990,637**	**37,190,180**	**68,752,500**	**202,565,557**	**133,084,691**	**205,960,106**	**97,090,730**	**2,673,093,708**	**5,113,782,256**
HP.8 Institutions providing health related services										92,552,826	92,552,826
Sub-total	**1,027,479,257**	**623,574,890**	**44,990,637**	**37,190,180**	**68,752,500**	**202,565,557**	**133,084,691**	**205,960,106**	**97,090,730**	**2,765,646,534**	**5,206,335,082**
Providers of Non-Health Expenditure		927,268,761								162,882,449	1,090,151,210
Total National HIV/AIDS Expenditure	**1,027,479,257**	**1,550,843,650**	**44,990,637**	**37,190,180**	**68,752,500**	**202,565,557**	**133,084,691**	**205,960,106**	**97,090,730**	**2,928,528,983**	**6,296,486,291**

Annex B.2: Provider x Function (HP x HC), 2003/04 for HIV/AIDS

	HP.1 Hospital					HP.3 Providers of ambulatory health care					HP.6 Health administration and insurance							
	HP.1.1 General Hospitals																	
	HP.1.1.1 Government general hospitals		HP.1.1.2 Private Not-for-profit		HP1.1.3 Private													
18453284.58	HP1.1.1.1 Central Hospitals	HP1.1.1.2 District Hospitals	HP1.1.2.1 Private-Not-for-profit hospitals (Other)	HP1.1..2.2 Private-not-for-profit hospital (CHAM)	For-profit hospitals	HP3.1 Offices of physicians	HP.3.4.9.1 health centres/dispensaries/maternity	HP.3.9.3 Traditional Healers	**HP.4 Retail sale and other providers of medical goods**	**HP.5 Provision and administration of public health programs**	HP 6.1 Government Administration of Health	HP.6.9 All other health administration	HP.9 Rest of the world	Provider not specified by kind	Providers of non health care expenditure	HP.8 Institutions providing health related services	**Total function**
HC.1 Services of curative care	**856,566,014.04**	**1,440,848,789.22**		**448,744,489.07**	**61,801,437.98**	**40,432,138.33**	**733,041,941.34**	**3,459,990.86**	**24,193,285**				**1,110,000**				**3,610,198,085**
HC.1.1 Inpatient curative care (OIs treatment)	251,614,583.88	512,095,584.22		150,067,768.68	54,057,429.09		105,544,357.82						1,110,000				**1,074,489,724**
HC.1.3 Out patient curative care (OIs treatment)	24,458,303.76	73,198,829.07		26,203,876.58	7,744,008.89	40,432,138.33	368,541,969.66	3,459,990.86	24,193,285								**568,232,402**
HC.1.3.7 ARV Treatment	580,493,126.39	855,554,375.94		272,472,843.81			258,955,613.86										**1,967,475,960**
HC.2 Services of rehabilitative care		138,322.00	104,528.85														**242,851**
HC.6 Prevention and public health services										**1,178,740,081**							**1,178,740,081**
HC.6.3.1 VCT										964,891,219							**964,891,219**
HC.6.3.4 I.E.C										166,843,700							**166,843,700**
HC.6.3.5 STI Prevention program										11,219,665							**11,219,665**
HC.6.3.7 Condom Distribution programs										33,658,996							**33,658,996**
Not Specified										2,126,500							**2,126,500**
HC.7 Health administration and health insurance																	**0**
HC 7.1 General Government Administration of Health											123,617,289						**123,617,289**
HC 7.2.2 Health Adminstration and Health Insurance: Other Private												53,216,334					**53,216,334**
HC.nsk Expenditure not specified by kind														147,767,616			**147,767,616**
THE	856,566,014.04	1,440,987,111.22	104,528.85	448,744,489.07	61,801,437.98	40,432,138.33	733,041,941.34	3,459,990.86	24,193,285	1,178,740,081	123,617,289	53,216,334	1,110,000	147,767,616			**5,113,782,256**
HC.R Health related functions																92,552,826	**92,552,826**
HCR.2 Eduation and Training																92,552,826	**92,552,826**
Sub-total	856,566,014.04	1,440,987,111.22	104,528.85	448,744,489.07	61,801,437.98	40,432,138.33	733,041,941.34	3,459,990.86	24,193,285	1,178,740,081	123,617,289	53,216,334	1,110,000	147,767,616		92,552,826	**5,206,335,082**
Non-Health Expenditures															1,090,151,210		**1,090,151,210**
AD1.1.2 Support to PLWHA															308,114,876		**308,114,876**
AD.1.2 Non-health services to orphans															291,861,744		**291,861,744**
AD.2 Policy advocacy															29,608,806		**29,608,806**
Not Specified by kind															460,565,784		**460,565,784**
Total National HIV/AIDS Expenditure	**856,566,014.04**	**1,440,987,111.22**	**104,528.85**	**448,744,489.07**	**61,801,437.98**	**40,432,138.33**	**733,041,941.34**	**3,459,990.86**	**24,193,285**	**1,178,740,081**	**123,617,289**	**53,216,334**	**1,110,000**	**147,767,616**	**1,090,151,210**	**92,552,826**	**6,296,486,291**

Annex B.3: Financing Sources x Financing Agents (FS x HF), 2004/05 for HIV/AIDS

	FS.1 Public Funds*		FS.2 Private Funds*			FS.3	
	FS.1.1 Territorial government		FS.2.1 Employer Funds	FS.2.2 Household Funds	FS.2.4 Other Private Funds		
	FS.1.1.1. General government	FS.1.1.2 Local Government (City, town and district assemblies)					
	FS.1.1.1.1 Ministry of Finance					Rest of the World Funds	Row Totals
HF.1.1.1.1 Ministry of Health	1,171,165,341					150,287,121	1,321,452,462
HF.1.1.1.2 National AIDS Commission	126,799,568					2,987,609,569	3,114,409,137
HF.1.1.1.3 Other Ministries	4,304,281					50,195,279	54,499,560
HF.1.1.1.4 Local Authorities	3,335,702	8,166,718					11,502,419
HF.2.2 Private Insurance Scheme			98,031,300	7,378,700			105,410,000
HF.2.3 Household Out of Pocket Payments				334,094,693			334,094,693
H.F.2.4 Non-Governmental Organizations							
H.F.2.4.1 CHAM	166,350,854					48,243,095	214,593,948
H.F.2.4.2 Other NGOs						229,669,524	229,669,524
HF.2.5 Private Firms/Employers			81,191,822				81,191,822
HF.3 Rest of the World						787,245,575	787,245,575
HF.NsK Not Specified by Kind							-
THE	**1,471,955,745**	**8,166,718**	**179,223,122**	**341,473,393**	**-**	**4,253,250,163**	**6,254,069,140**
%							
Financing agents of Health Care Related Activities						**610,587,509**	**610,587,509**
HCR.1							-
HCR.2 Training						607,535,502	607,535,502
HCR.3 Research and Develop						3,052,008	3,052,008
HCR.4 Nutrition							-
HCR.5 Environmental health							-
Total HCR	**-**	**-**	**-**	**-**	**-**	**610,587,510**	**610,587,510**
NHE	**1,471,955,745**	**8,166,718**	**179,223,122**	**341,473,393**	**-**	**4,863,837,673**	**6,864,656,650**
%							
Financing Agents for Non Health HIV/AIDS Expenditures (NAC)	**23,200,432**					**639,466,368**	**662,666,800**
Total Non-health	**23,200,432**	**-**	**-**	**-**	**-**	**639,466,368**	**662,666,800**
Total HIV/AIDS Expenditures	**1,495,156,177**	**8,166,718**	**179,223,122**	**341,473,393**	**-**	**5,503,304,040**	**7,527,323,450**

Annex B. Financing Agent x Function (HFx HC), 2004/05 for HIV/AIDS

	HF.1 Public				HF.2 Private Sector						
	HF.1.1.1.1	HF.1.1.1.2	HF1.1.1.3	HF.1.1.1.4	HF.2.2	H.F.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	Row totals and total expenditure measures
Function	Ministry of Health	National AIDS Commission	Other Ministries	Local Authorities	Private Insurance Scheme	Household out-of-pocket payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HC.1 Services of curative care											
HC.1.1 Inpatient curative care	892,139,073	395,411,323	1,479,597	817,889	44,370,000	222,242,908	151,595,237	18,038,327	31,416,146	32,857,506	1,790,368,004
HC.1.3 Out patient curative care	187,138,841	131,803,774	2,824,685	1,406,377	61,040,000	95,598,831	47,009,157	54,114,980	46,985,591	197,367,044	825,289,280
HC.2 Services of rehabilitative care	138,923										138,923
HC.6 Prevention and public health services	184,029,373	1,980,998,140	50,195,279	9,278,153			15,989,555	157,516,218	2,790,084	509,925,785	2,910,722,586
HC 6.1.1 PMTCT	2,933,643	31,579,422					254,892.2	2,510,992.2		8,128,811.7	45,407,760
HC.6.3.1 VCT	80,690,642	868,600,535					7,010,878	69,065,522		223,585,172	1,248,952,749
HC.6.3.4 I.E.C	61,063,872	657,326,678	50,195,279	9,278,153			5,305,588.56	52,266,385.42		169,201,483	1,004,637,438
HC.6.3.5 STI Prevention	25,316,743	272,524,000					2,199,667.63	21,669,353.88		70,149,997	391,859,761
Infection	645,432	6,947,800					56,078.92	552,444.36		1,788,423	9,990,179
HC.6.3.7 Condom Distribution	6,867,395	73,924,597					596,679.72	5,878,008.01		19,028,821	106,295,501
Surveillance	6,511,646	70,095,108					565,770.14	5,573,511.73		18,043,078	100,789,114
Not specified by kind									2,790,084		2,790,084
HC.7 Health administration and health insurance											
HC 7.1 General Government Administration of Health Services	35,647,906	606,195,901									641,843,806
HC 7.2.2 Health Adminstration and Health Insurance: Other Private										47,095,240	47,095,240
HC nsk						16,252,954					16,252,954
HC.R.1 Capital formation	22,358,347										22,358,347
THE	**1,321,452,462**	**3,114,409,137**	**54,499,560**	**11,502,419**	**105,410,000**	**334,094,693**	**214,593,948**	**229,669,524**	**81,191,822**	**787,245,575**	**6,254,069,140**
HC.R Health related functions	-	507,327,913	-	-	-		-	-	-	103,259,596	610,587,509
HCR.2 Eduation and Training		504,275,905								103,259,596	607,535,501
HCR.3 Research and Development		3,052,008									3,052,008
Sub-total	**1,321,452,462**	**3,621,737,050**	**54,499,560**	**11,502,419**	**105,410,000**	**334,094,693**	**214,593,948**	**229,669,524**	**81,191,822**	**890,505,171**	**6,864,656,649**
Non-Health Expenditures	-	662,666,800	-	-	-		-	-	-	-	662,666,800
OVC Care and Support		488,358,059									488,358,059
PLWHA Support		117,339,366									117,339,366
Advocacy		42,863,502									42,863,502
IGA		14,105,873									14,105,873
Total National HIV/AIDS Expenditure	**1,321,452,462**	**4,284,403,850**	**54,499,560**	**11,502,419**	**105,410,000**	**334,094,693**	**214,593,948**	**229,669,524**	**81,191,822**	**890,505,171**	**7,527,323,449**

Annex B.3: Financing Agents x Providers (HF x HP), 2004/05 for HIV/AIDS

	HF.1 Public				HF.2 Private Sector						Row totals and total expenditure measures
	HF.1.1.1.1	HF.1.1.1.2	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	
Provider	Ministry of Health	National AIDS Commission	Other Ministries	Local Authorities	Private Insurance Scheme	Household out-of-pocket payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HP.1 Hospital											-
HP.1.1 General Hospitals											-
HP.1.1.1 Government general hospitals											-
HP1.1.1.1 Central Hospitals	288,137,336					15,436,011					303,573,347
HP1.1.1.2 District Hospitals	637,750,561	527,215,097				77,522,282					1,242,487,940
HP1.1..2.2 Private-not-for-profit hospital (CHAM)						119,026,807	162,193,770				281,220,577
HP1.1.3 Private For-profit hospitals					51,510,000	44,148,940			18,564,128		114,223,067
HP.3 Providers of ambulatory health care											-
HP3.1 Offices of physicians					43,960,000	9,378,324			10,970,501		64,308,825
HP.3.4.9.1 health centres/dispensaries/maternity	175,887,286		4,304,281	2,224,266		23,743,041	36,410,623	72,153,306	48,867,109	230,224,550	593,814,464
HP.3.9.3 Traditional Healers						4,513,632					
HP.4 Retail sale and other providers of medical goods					9,940,000	24,072,703					34,012,703
HP.5 Provision and administration of public health programs	184,029,373	1,980,998,140	50,195,279	9,278,153			15,989,555	157,516,218	2,790,084	509,925,785	2,910,722,586
HP.6 General health administration and insurance											-
HP 6.1 General Administration of Health	35,647,906	606,195,901									641,843,806
HP.6.9 All other providers of health administration										47,095,240	47,095,240
HP nsk						16,252,954					
THE	**1,321,452,462**	**3,114,409,137**	**54,499,560**	**11,502,419**	**105,410,000**	**334,094,693**	**214,593,948**	**229,669,524**	**81,191,822**	**787,245,575**	**6,254,069,141**
HP.8 Institutions providing health related services		507,327,913								103,259,596	610,587,509
Sub-total	**1,321,452,462**	**3,621,737,050**	**54,499,560**	**11,502,419**	**105,410,000**	**334,094,693**	**214,593,948**	**229,669,524**	**81,191,822**	**890,505,171**	**6,864,656,649**
Providers of Non-Health Care Expenditure		662,666,800									662,666,800
Total National HIV/AIDS Expenditure	**1,321,452,462**	**4,284,403,850**	**54,499,560**	**11,502,419**	**105,410,000**	**334,094,693**	**214,593,948**	**229,669,524**	**81,191,822**	**890,505,171**	**7,527,323,449**

Annex B.3: Provider x Function (HP x HC), 2004/05 for HIV/AIDS

	HP.1 Hospital				HP.3 Providers of ambulatory health care			HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance			Providers of non health care expenditure	HP.8 Institutions providing health related services	Total function
	HP.1.1 General Hospitals														
	HP.1.1.1 Government general			HP1.1.3											
	HP1.1.1.1 Central Hospitals	HP1.1.1.2 District Hospitals	HP1.1..2.2 Private-not-for-profit hospital (CHAM)	Private For-profit hospitals	HP3.1 Offices of physicians	HP.3.4.9.1 health centres/dispensaries/maternity	HP.3.9.3 Traditional Healers			HP 6.1 General Administration of Health	HP.6.9 All other providers of health administration	HP nsk			
HC.1 Services of curative care															
HC.1.1 Inpatient services	278,595,610	1,019,387,065	241,309,933	100,138,842		150,936,554									1,790,368,004
HC.1.3 Out patient	20,828,818	209,734,806	39,910,645	14,084,225	64,308,825	437,895,628	4,513,632	34,012,703							825,289,280
HC.2 Services of rehabilitative care		138,923													138,923
HC.6 Prevention and public health services									2,910,722,586						2,910,722,586
HC 6.1.1 PMTCT									45,407,760						45,407,760
HC.6.3.1 VCT									1,248,952,749						1,248,952,749
HC.6.3.4 I.E.C									1,004,637,438						1,004,637,438
HC.6.3.5 STI Prevention									391,859,761						391,859,761
Infections									9,990,179						
HC.6.3.7 Condom Distribution									106,295,501						
Surveillance									100,789,114						
Not specified by kind									2,790,084						
HC.7 Health administration and health insurance															
HC 7.1 General Government Administration of Health										641,843,806					641,843,806
HC 7.2.2 Health Adminstration and Health Insurance: Other Private											47,095,240				47,095,240
HC nsk												16,252,954			16,252,954
HC.R.1 Capital formation of health care provider institutions	4,148,919	13,227,146				4,982,281									22,358,347
THE	**303,573,347**	**1,242,487,940**	**281,220,577**	**114,223,067**	**64,308,825**	**593,814,464**	**4,513,632**	**34,012,703**	**2,910,722,586**	**641,843,806**	**47,095,240**	**16,252,954**			**6,254,069,141**
HC.R Health related functions														610,587,509	610,587,509
HCR.2 Eduation and Training														607,535,501	607,535,501
HCR.3 Research and Development														3,052,008	3,052,008
NHE	**303,573,347**	**1,242,487,940**	**281,220,577**	**114,223,067**	**64,308,825**	**593,814,464**	**4,513,632**	**34,012,703**	**2,910,722,586**	**641,843,806**	**47,095,240**	**16,252,954**		**610,587,509**	**6,864,656,649**
OVC Care and Support													488,358,059		488,358,059
PLWHA Support													117,339,366		117,339,366
Advocacy													42,863,502		42,863,502
IGA													14,105,873		14,105,873
Total Non-health expenditure													**662,666,800**		**662,666,800**
Total National HIV/AIDS Expenditures	**303,573,347**	**1,242,487,940**	**281,220,577**	**114,223,067**	**64,308,825**	**593,814,464**	**4,513,632**	**34,012,703**	**2,910,722,586**	**641,843,806**	**47,095,240**	**16,252,954**	**662,666,800**	**610,587,509**	**7,527,323,449**

Annex C.1: Financing Sources x Financing Agents (FS x HF), 2002/03 for Reproductive Health

	FS.1 Public Funds*			FS.2 Private Funds*			FS.3	
	FS.1.1 Territorial government		FS.1.2 Other Public Funds	FS.2.1 Employer Funds	FS.2.2 Household Funds	FS.2.4 Other Private Funds		
	FS.1.1.1. General government	FS.1.1.2 Local Government (City, town and district assemblies)						
	FS.1.1.1.1 Ministry of Finance						Rest of the World Funds	Row Totals
HF.1.1.1.1 Ministry of Health	1,061,135,019						700,841,528	1,761,976,547
HF.1.1.1.3 Other Ministries	762,165					486,939	868,022	2,117,126
HF.1.1.1.4 Local Authorities	309,917	475,206				4,194,209	15,681,797	20,661,129
HF.2.2 Private Insurance Scheme				49,486,230	3,724,770			53,211,000
HF.2.3 Household Out of Pocket Payments					353,170,193			353,170,193
H.F.2.4 Non-Governmental Organizations	79,970,633	-	-	-	-	42,379,432	198,605,626	320,955,691
H.F.2.4.1 CHAM	79,970,633					6,948,668	34,987,152	121,906,453
H.F.2.4.2 Other NGOs						35,430,764	163,618,474	199,049,238
HF.2.5 Private Firms/Employers				91,016,403				91,016,403
HF.3 Rest of the World						149,680	149,530,032	149,679,712
HF.NsK Not Specified by Kind								-
THE	**1,142,177,735**	**475,206**	**-**	**140,502,633**	**356,894,963**	**47,210,260**	**1,065,527,004**	**2,752,787,802**
%	**41%**	**0%**	**0%**	**5%**	**13%**	**2%**	**39%**	**100%**
Financing agents expenditure on Health Care related activities							**55,073,965**	**55,073,965**
NHE	**1,197,251,700**	**475,206**	**-**	**140,502,633**	**356,894,963**	**47,210,260**	**1,120,600,969**	**2,807,861,767**
%	**43%**	**0%**	**0%**	**5%**	**13%**	**2%**	**40%**	**100%**

Annex C.1 Financing Agent X Function (HFxHC), 2002/03 for Reproductive Health

	HF.1 Public			HF.2 Private Sector						Total function
	HF.1.1.1.1	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	
Function	Ministry of Health	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HC.1 Services of curative care	1,388,596,730	2,117,126	3,348,997	47,067,000	295,240,762	102,358,628	111,907,545	87,778,258	127,341,520	2,165,756,566
HC.1.1 Inpatient curative care	728,081,504			14,559,000	176,445,376	79,673,865	4,280,132	59,457,722	68,986,143	1,131,483,742
HC.1.3 Out patient curative care	660,515,226	2,117,126	3,348,997	32,508,000	118,795,386	22,684,764	107,627,413	28,320,536	58,355,377	1,034,272,825
HC.1.3.9 Prenatal care	87,212,742	952,707	1,507,049	19,829,880	29,698,846	13,610,858		10,846,536	15,157,334	178,815,953
HC.1.3.10 Postnatal care	20,349,640			4,551,120	11,879,539	3,223,925		3,881,381	3,478,733	144,798,195
HC.1.3.11 Family planning consultation and issuance of modern FP method	515,160,655						99,756,363		33,507,288	648,424,306
HC.1.3 nsk	37,792,188	1,164,419	1,841,948	8,127,000	77,217,001	5,849,981	4,073,416	7,288,869	6,212,022	149,566,844
HC.2 Services of rehabilitative care										-
HC.5 Medical goods dispensed to outpatients				6,144,000	57,929,431					64,073,431
HC.6 Prevention and public health services	355,946,504		17,312,132			19,547,825	66,504,241	3,238,146	22,338,192	484,887,040
HC.7 Health administration and health insurance										-
HC 7.1 General Government Administration of Health										-
HC 7.2.2 Health Adminstration and Health Insurance: Other Private							20,637,451			20,637,451
HCR.nsk Expenditure not specified by kind										-
HC.R.1 Capital formation	17,433,314									17,433,314
THE	**1,761,976,547**	**2,117,126**	**20,661,129**	**53,211,000**	**353,170,193**	**121,906,453**	**199,049,238**	**91,016,403**	**149,679,712**	**2,752,787,802**
HC.R Health related functions	87,187,528	-	-	-	-	-	-	-	94,532,363	181,719,891
HCR.2 Eduation and Training of health personnel	55,073,965								94,532,363	149,606,328
HCR.3 Research and Development in health	32,113,563									32,113,563
HCR.4 Food Hygiene and Drinking water Control										-
HCR.5 Environmental Health										-
NHE	**1,849,164,075**	**2,117,126**	**20,661,129**	**53,211,000**		**121,906,453**	**199,049,238**	**91,016,403**	**244,212,075**	**2,934,507,693**

Table 2: Allocation to Health Care Providers by Payers / Purchasers
Financing Agents x Providers (FA x P)

Annex C.1: Financing Agent x Provider (HFx HP), 2002/03 for Reproductive Health

	HF.1 Public			HF.2 Private Sector						Row totals and total expenditure measures
	HF.1.1.1.1	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	
Provider	Ministry of Health	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HP.1 Hospital	**542,946,265**	**-**	**-**	**19,803,000**	**227,820,517**	**67,516,649**	**6,329,392**	**2,721,009**	**-**	**867,136,833**
HP.1.1 General Hospitals	542,946,265	-	-	19,803,000	227,820,517	67,516,649	6,329,392	2,721,009	-	867,136,833
HP.1.1.1 Government general hospitals	542,946,265	-	-	-	77,840,908	-	-	-	-	620,787,173
HP1.1.1.1 Central Hospitals	245,513,129				12,116,271					257,629,399
HP1.1.1.2 District Hospitals	297,433,136				65,724,638					363,157,774
HP.1.1.2 Private Not-for-profit hospitals	-	-	-	-	106,721,373	67,516,649	6,329,392	2,721,009	-	411,537,280
HP1.1.2.1 Private-Not-for-profit hospitals (Other)	-	-	-				6,329,392	2,721,009	-	237,299,258
HP1.1..2.2 Private-not-for-profit hospital (CHAM)					106,721,373	67,516,649				174,238,022
HP1.1.3 Private For-profit hospitals				19,803,000	43,258,236					63,061,236
HP.1.2 Specialized hospitals (including mental hospital)										-
HP.3 Providers of ambulatory health care	**863,083,779**	**2,117,126**	**3,348,997**	**27,264,000**	**67,420,245**	**34,841,979**	**105,578,154**	**85,057,248**	**127,341,520**	**1,316,053,048**
HP3.1 Offices of physicians				27,264,000	22,766,309			10,334,016		60,364,325
HP.3.4.9.1 health centres/dispensaries/maternity	863,083,779	2,117,126	3,348,997		44,653,936	34,841,979	105,578,154	74,723,232	127,341,520	1,255,688,723
HP.3.1.1 MOH Health centres/dispensaries/maternity	863,083,779								38,202,456	901,286,235
HP.3.1.2 Other Ministries Health centres/dispensaries/maternity		2,117,126								2,117,126
HP.3.1.3 Local Authories Health centres/dispensaries/maternity			3,348,997							3,348,997
HP.3.1.4 CHAM Health centres/dispensaries/maternity					13,396,181	34,841,979				48,238,160
HP.3.1.5 Other NGOs Health centres/dispensaries/maternity					31,257,755		105,578,154		89,139,064	225,974,973
HP.3.1.5 Private firms Health centres/dispensaries/maternity								74,723,232		74,723,232
HP.4 Retail sale and other providers of medical goods				**6,144,000**	**57,929,431**					**64,073,431**
HP.5 Provision and administration of public health programs	**355,946,504**		**17,312,132**			**19,547,825**	**66,504,241**	**3,238,146**	**22,338,192**	**484,887,040**
HP.6 General health administration and insurance	-	-	-	-	-	-	**20,637,451**	-	-	**20,637,451**
HP 6.1 General Administration of Health										-
HP.6.4 Other (private) Insurance										-
HP.6.9 All other providers of health administration							20,637,451			20,637,451
HP.9 Rest of the world										-
Provider not specified by kind										-
THE	**1,761,976,547**	**2,117,126**	**20,661,129**	**53,211,000**	**353,170,193**	**121,906,453**	**199,049,238**	**91,016,403**	**149,679,712**	**2,752,787,802**
HP.8 Institutions providing health related services	87,187,528								94,532,363	181,719,891
NHE	**1,849,164,075**	**2,117,126**	**20,661,129**	**53,211,000**	**353,170,193**	**121,906,453**	**199,049,238**	**91,016,403**	**244,212,075**	**2,934,507,693**

Annex C.1: Provider x Function (HPx HC), 2002/03 for Reproductive Health

	HP.1 Hospital						HP.3 Providers of ambulatory health care			HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance			HP.9 Rest of the world	Provider not specified by kind	HP.8 Institutions providing health related services	
	HP.1.1 General Hospitals					HP.1.2 Specialized hospitals (including mental hospital)												
	HP.1.1.1 Government general		HP.1.1.2 Private Not-for-profit		HP1.1.3 Private													
	HP1.1.1.1 Central Hospitals	HP1.1.1.2 District Hospitals	HP1.1.2.1 Private-Not-for-profit hospitals (Other)	HP1.1..2.2 Private-not-for-profit hospital (CHAM)	For-profit hospitals		HP3.1 Offices of physicians	HP.3.4.9.1 health centres/dispensaries/maternity	HP3.9.3 Traditional practitioners			HP 6.1 General Administration of Health	HP.6.4 Other (private) Insurance	HP.6.9 All other providers of health administration				**Total function**
HC.1 Services of curative care																		
HC.1.1 Inpatient curative care	147,996,181	264,845,985	2,124,624	128,098,337	46,362,093			542,056,522										1,131,483,742
HC.1.3 Out patient curative care	104,618,679	91,443,944	6,925,777	46,139,685	16,699,143		60,364,325	708,081,272										1,034,272,825
HC.1.3.9 Prenatal care	16,424,534	24,055,535	4,224,724	27,966,418	10,186,477		36,594,575	112,192,286										231,644,548
HC.1.3.10 Postnatal care	3,828,241	5,589,903	969,609	6,459,556	2,337,880		8,451,005	25,449,567										53,085,761
HC.1.3.11 Family planning consultation and issuance of modern FP method	77,274,098	51,516,066						519,634,142										648,424,306
HC.1.3 nsk	7,091,806	10,282,441	1,731,444	11,713,711	4,174,786		15,318,744	50,805,278										
HC.2 Services of rehabilitative care																		
HC.5 Medical goods dispensed to outpatients										64,073,431								64,073,431
HC.6 Prevention and public health services											484,887,040							484,887,040
HC.7 Health administration and health insurance																		
HC 7.1 General Government Administration of Health																		
HC 7.2.2 Health Adminstration and Health Insurance: Other Private														20,637,451				20,637,451
HC.R.1 Capital formation	5,014,540	6,867,845						5,550,929										17,433,314
HCR.nsk Expenditure not specified by kind																		
THE	**257,629,399**	**363,157,774**	**9,050,401**	**174,238,022**	**63,061,236**		**60,364,325**	**1,255,688,723**		**64,073,431**	**484,887,040**			**20,637,451**				**2,752,787,802**
HC.R Health related functions																	181,719,891	181,719,891
HCR.2 Eduation and Training																	149,606,328	149,606,328
HCR.3 Research and Development																	32,113,563	32,113,563
HCR.4 Food Hygiene and Drinking water Control																		
HCR.5 Environmental Health																		
NHE	**257,629,399**	**363,157,774**	**9,050,401**	**174,238,022**	**63,061,236**		**60,364,325**	**1,255,688,723**		**64,073,431**	**484,887,040**			**20,637,451**			**181,719,891**	**2,934,507,693**

Annex C.2: Financing Sources x Financing Agents (FS x HF), 2003/04 for Reproductive Health

	FS.1 Public Funds*		FS.2 Private Funds*		FS.3	
	FS.1.1 Territorial government		FS.2.1 Employer Funds	FS.2.2 Household Funds		
	FS.1.1.1. General government	FS.1.1.2 Local Government (City, town and district assemblies)				
	FS.1.1.1.1 Ministry of Finance				Rest of the World Funds	Row Totals
HF.1.1.1.1 Ministry of Health	587,334,289				1,250,756,795	1,838,091,084
HF.1.1.1.3 Other Ministries	2,567,790				33,693,658	36,261,448
HF.1.1.1.4 Local Authorities	66,866,548	35,604,874				102,471,422
HF.2.2 Private Insurance Scheme			86,637,450	5,530,050		92,167,500
HF.2.3 Household Out of Pocket Payments				540,085,596		540,085,596
H.F.2.4 Non-Governmental Organizations						
H.F.2.4.1 CHAM	84,770,031				40,241,325	125,011,356
H.F.2.4.2 Other NGOs					262,377,804	262,377,804
HF.2.5 Private Firms/Employers			97,983,602			97,983,602
HF.3 Rest of the World						
HF.Not Specified by Kind					328,009,284	328,009,284
THE	**741,538,659**	**35,604,874**	**184,621,052**	**545,615,646**	**1,915,078,866**	**3,422,459,097**
%	**22%**	**1%**	**5%**	**16%**	**56%**	**100%**
Financing agents expenditure on Health Care Related Activities	87,187,528					87,187,528
NHE	**828,726,187**	**35,604,874**	**184,621,052**	**545,615,646**	**1,915,078,866**	**3,509,646,625**
%	**24%**	**1%**	**5%**	**16%**	**55%**	**100%**

Annex C.2: Financing Agent x Function (HFxHC), 2003/04 for Reproductive Health

	HF.1 Public			HF.2 Private Sector						Total function
	HF.1.1.1.1	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	
Function	Ministry of Health	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HC.1 Services of curative care	1,385,403,431	2,567,790	92,815,012	80,277,500	442,036,667	103,650,156	207,131,947	93,730,602	3,590,516	2,411,203,622
HC.1.1 Inpatient curative care	441,556,591	973,989	2,305,275	19,305,000	244,414,426	55,373,152	35,881,125	29,119,003	3,590,516	832,519,077
HC.1.3 Out patient curative care	943,846,840	1,593,801	90,509,737	60,972,500	197,622,241	48,277,005	171,250,822	64,611,600		1,578,684,545
HC.1.3.9 Prenatal care	91,865,433	1,051,908	59,736,427	33,534,875	130,430,679	31,862,823	34,250,164	42,643,656		425,375,965
HC.1.3.10 Postnatal care	20,878,507	239,070	13,576,461	10,975,050	35,572,003	7,241,551	25,687,623	9,691,740		123,862,005
HC.1.3.11 Family planning consultation and issuance of modern FP method	804,656,791						94,187,952			898,844,743
HC.1.3 nsk	26,446,109	302,822	17,196,850	16,462,575	31,619,559	9,172,631	17,125,082	12,276,204		130,601,832
HC.2 Services of rehabilitative care										
HC.5 Medical goods dispensed to outpatients				11,890,000	98,048,929					109,938,929
HC.6 Prevention and public health services	440,703,137	33,693,658	9,656,410			21,361,200	55,245,857	4,253,000	116,513,395	681,426,657
HC.7 Health administration and health insurance										
HC 7.1 General Government Administration of Health										
HC 7.2.2 Health Adminstration and Health Insurance: Other Private									207,905,373	207,905,373
HCR.nsk Expenditure not specified by kind										
HC.R.1 Capital formation	11,984,516									11,984,516
THE	**1,838,091,084**	**36,261,448**	**102,471,422**	**92,167,500**	**540,085,596**	**125,011,356**	**262,377,804**	**97,983,602**	**328,009,284**	**3,422,459,097**
HC.R Health related functions	87,187,528									87,187,528
HCR.2 Eduation and Training of health personnel	55,073,965									55,073,965
HCR.3 Research and Development in health	32,113,563									32,113,563
HCR.4 Food Hygiene and Drinking water Control										
HCR.5 Environmental Health										
NHE	**1,925,278,612**	**36,261,448**	**102,471,422**	**92,167,500**	**540,085,596**	**125,011,356**	**262,377,804**	**97,983,602**	**328,009,284**	**3,509,646,625**

Annex C.2: Financing Agents x Providers (HP x HP), 2003/04 for Reproductive Health

	HF.1 Public			HF.2 Private Sector						Row totals and total expenditure measures
	HF.1.1.1.1	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	
Provider	Ministry of Health	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HP.1 Hospital	706,607,591	-	-	27,787,500	328,259,056	69,898,150	-	14,761,903	-	**1,147,314,201**
HP.1.1 General Hospitals	706,607,591	-	-	27,787,500	328,259,056	69,898,150	-	14,761,903	-	**1,147,314,201**
HP.1.1.1 Government general hospitals	706,607,591	-	-	-	108,051,047	-	-	-	-	**814,658,638**
HP1.1.1.1 Central Hospitals	286,247,397				16,482,363					**302,729,760**
HP1.1.1.2 District Hospitals	420,360,194				91,568,684					**511,928,878**
HP.1.1.2 Private Not-for-profit hospitals	-	-	-	-	156,693,975	69,898,150	-	-	-	**226,592,125**
HP1.1.2.1 Private-Not-for-profit hospitals (Other)										-
HP1.1..2.2 Private-not-for-profit hospital (CHAM)					156,693,975	69,898,150				**226,592,125**
HP1.1.3 Private For-profit hospitals				27,787,500	63,514,034			14,761,903		**106,063,438**
HP.1.2 Specialized hospitals (including mental hospital)										-
HP.3 Providers of ambulatory health care	690,780,356	2,567,790	92,815,012	52,490,000	113,777,611	33,752,006	207,131,947	78,968,699	3,590,516	**1,275,873,937**
HP3.1 Offices of physicians				52,490,000	38,198,229			10,838,463		**101,526,692**
HP.3.4.9.1 health centres/dispensaries/maternity	690,780,356	2,567,790	92,815,012		75,579,382	33,752,006	207,131,947	68,130,236	3,590,516	**1,174,347,245**
HP.3.1.1 MOH Health centres/dispensaries/maternity	690,780,356									**690,780,356**
HP.3.1.2 Other Ministries Health centres/dispensaries/maternity		2,567,790								**2,567,790**
HP.3.1.3 Local Authories Health centres/dispensaries/maternity			92,815,012							**92,815,012**
HP.3.1.4 CHAM Health centres/dispensaries/maternity					26,452,784	33,752,006				**60,204,790**
HP.3.1.5 Other NGOs Health centres/dispensaries/maternity					49,126,599		207,131,947			**256,258,545**
HP.3.1.5 Private firms Health centres/dispensaries/maternity								68,130,236		**68,130,236**
HP3.9.3 Traditional practitioners										-
HP.4 Retail sale and other providers of medical goods				11,890,000	98,048,929					**109,938,929**
HP.5 Provision and administration of public health programs	440,703,137	33,693,658	9,656,410			21,361,200	55,245,857	4,253,000	116,513,395	**681,426,657**
HP.6 General health administration and insurance	-	-	-	-	-	-	-	-	207,905,373	**207,905,373**
HP 6.1 General Administration of Health										-
HP.6.4 Other (private) Insurance										-
HP.6.9 All other providers of health administration									207,905,373	**207,905,373**
HP.9 Rest of the world										-
Provider not specified by kind										-
THE	**1,838,091,084**	**36,261,448**	**102,471,422**	**92,167,500**	**540,085,596**	**125,011,356**	**262,377,804**	**97,983,602**	**328,009,284**	**3,422,459,097**
HP.8 Institutions providing health related services	87,187,528									**87,187,528**
NHE	**1,925,278,612**	**36,261,448**	**102,471,422**	**92,167,500**	**540,085,596**	**125,011,356**	**262,377,804**	**97,983,602**	**328,009,284**	**3,509,646,625**

Annex C.2: Provider x Function (HPxHC), 2003/04 for Reproductive Health

	HP.1 Hospital						HP.3 Providers of ambulatory health care			HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance			HP.9 Rest of the world	Provider not specified by kind	HP.8 Institutions providing health related services	
	HP.1.1 General Hospitals					HP.1.2 Specialized hospitals (including mental hospital)												
	HP.1.1.1 Government general		HP.1.1.2 Private Not-for-profit		HP1.1.3													
171250822.1	HP1.1.1.1 Central Hospitals	HP1.1.1.2 District Hospitals	HP1.1.2.1 Private-Not-for-profit hospitals (Other)	HP1.1..2.2 Private-not-for-profit hospital (CHAM)	Private For-profit hospitals		HP3.1 Offices of physicians	HP.3.4.9.1 health centres/dispensaries/maternity	HP3.9.3 Traditional practitioners			HP 6.1 General Administration of Health	HP.6.4 Other (private) Insurance	HP.6.9 All other providers of health administration				**Total function**
HC.1 Services of curative care																		
HC.1.1 Inpatient curative care	158,970,783	355,942,766		157,421,898	74,283,368			85,900,263										832,519,077
HC.1.3 Out patient curative care	143,209,958	150,127,680		69,170,228	31,780,070		101,526,692	1,082,869,918										1,578,684,546
HC.1.3.9 Prenatal care	14,857,550	45,976,921		45,652,350	20,974,846		67,007,617	237,613,656										432,082,940
HC.1.3.10 Postnatal care	3,376,716	10,449,300		10,375,534	4,767,011		15,229,004	71,906,599										116,104,163
HC.1.3.11 Family planning consultation and issuance of modern FP method	120,698,519	80,465,679						697,680,545										898,844,743
HC.1.3 nsk	4,277,174	13,235,780		13,142,343	6,038,213		19,290,071	75,669,118										131,652,699
HC.2 Services of rehabilitative care																		0
HC.5 Medical goods dispensed to outpatients										109,938,929								109,938,929
HC.6 Prevention and public health services											681,426,657							681,426,657
HC.7 Health administration and health insurance																		
HC 7.1 General Government Administration of Health																		
HC 7.2.2 Health Adminstration and Health Insurance: Other Private														207,905,373				207,905,373
HC.R.1 Capital formation	549,018	5,858,432						5,577,065										11,984,516
HCR.nsk Expenditure not specified by kind																		
THE	**302,729,760**	**511,928,878**		**226,592,125**	**106,063,438**		**101,526,692**	**1,174,347,246**		**109,938,929**	**681,426,657**			**207,905,373**				**3,422,459,097**
HC.R Health related functions																	87,187,528	87,187,528
HCR.2 Eduation and Training																	55,073,965	55,073,965
HCR.3 Research and Development																	32,113,563	32,113,563
HCR.4 Food Hygiene and Drinking water Control																		
HCR.5 Environmental Health																		
NHE	**302,729,760**	**511,928,878**		**226,592,125**	**106,063,438**		**101,526,692**	**1,174,347,246**		**109,938,929**	**681,426,657**			**207,905,373**			**87,187,528**	**3,509,646,625**

Annex C.3: Financing Sources x Financing Agents (FS x HF), 2004/05 for Reproductive Health

	FS.1 Public Funds*		FS.2 Private Funds*			FS.3	
	FS.1.1 Territorial government		FS.2.1 Employer Funds	FS.2.2 Household Funds	FS.2.4 Other Private Funds		
	FS.1.1.1. General government	FS.1.1.2 Local Government (City, town and district assemblies)					
	FS.1.1.1.1 Ministry of Finance					Rest of the World Funds	**Row Totals**
HF.1.1.1.1 Ministry of Health	810,418,549					1,304,298,690	**2,114,717,239**
HF.1.1.1.3 Other Ministries	15,993,610				5,288,211	36,710,052	**57,991,873**
HF.1.1.1.4 Local Authorities	4,584,815	9,742,731					**14,327,545**
HF.2.2 Private Insurance Scheme			146,363,400	11,016,600			**157,380,000**
HF.2.3 Household Out of Pocket Payments				483,101,700			**483,101,700**
H.F.2.4 Non-Governmental Organizations	**174,178,746**	**-**	**-**	**-**	**4,574,651**	**338,386,850**	**517,140,246**
H.F.2.4.1 CHAM	174,178,746				4,574,651		**178,753,397**
H.F.2.4.2 Other NGOs						338,386,850	**338,386,850**
HF.2.5 Private Firms/Employers			85,252,388				**85,252,388**
HF.3 Rest of the World						130,856,105	**130,856,105**
THE	**1,005,175,719**	**9,742,731**	**231,615,788**	**494,118,300**	**9,862,862**	**1,810,251,696**	**3,560,767,096**
%	**28%**	**0%**	**7%**	**14%**	**0%**	**51%**	**100%**
Financing agents expenditure on Health Care Related Activities	90,442,699						**90,442,699**
NHE	**1,095,618,418**	**9,742,731**	**231,615,788**	**494,118,300**	**9,862,862**	**1,810,251,696**	**3,651,209,795**
%	**30%**	**0%**	**6%**	**14%**	**0%**	**50%**	**100%**

Annex C.3: Financing Agent x Function (HFxHC), 2004/05 for Reproductive Health

	HF.1 Public			HF.2 Private Sector						Total function
	HF.1.1.1.1	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	
Function	Ministry of Health	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HC.1 Services of curative care	1,626,657,566	3,900,755	1,925,148	141,050,000	405,338,756	153,816,988	104,055,261	79,672,220	3,911,954	2,520,328,649
HC.1.1 Inpatient curative care	587,762,206	1,479,597	355,313	35,200,000	244,414,426	86,678,247	39,469,237	32,686,629	977,989	1,029,023,643
HC.1.3 Out patient curative care	1,038,895,360	2,421,158	1,569,835	105,850,000	160,924,330	67,138,741	64,586,024	46,985,591	2,933,966	1,491,305,006
HC.1.3.9 Prenatal care	118,575,669	1,646,388	1,067,488	58,217,500	88,508,382	45,654,344	7,750,323	31,776,489	1,995,097	355,191,678
HC.1.3.10 Postnatal care	35,095,013	508,443	329,665	23,287,000	43,449,569	13,432,084	6,458,602	8,967,998	616,133	132,144,508
HC.1.3.11 Family planning consultation and issuance of modern FP method	864,519,376						45,210,217			909,729,593
HC.1.3 nsk	20,705,302	266,327	172,682	24,345,500	28,966,379	8,052,313	5,166,882	6,241,104	322,736	94,239,226
HC.2 Services of rehabilitative care										
HC.5 Medical goods dispensed to outpatients				16,330,000	77,762,944					94,092,944
HC.6 Prevention and public health services	439,477,789	54,091,118	12,402,397			24,936,410	129,556,325	5,580,168	126,944,151	792,988,359
HC.7 Health administration and health insurance										
HC 7.1 General Government Administration of Health	35,354,736									35,354,736
HC 7.2.2 Health Adminstration and Health Insurance: Other Private							104,775,263			104,775,263
HCR.nsk Expenditure not specified by kind										
HC.R.1 Capital formation	13,227,146									13,227,146
THE	**2,114,717,237**	**57,991,873**	**14,327,545**	**157,380,000**	**483,101,700**	**178,753,398**	**338,386,850**	**85,252,388**	**130,856,105**	**3,560,767,096**
HC.R Health related functions	90,442,699									90,442,699
HCR.2 Eduation and Training of health personnel	57,130,167									57,130,167
HCR.3 Research and Development in health	33,312,532									33,312,532
HCR.4 Food Hygiene and Drinking water Control										
HCR.5 Environmental Health										
NHE	**2,205,159,936**	**57,991,873**	**14,327,545**	**157,380,000**	**483,101,700**	**178,753,398**	**338,386,850**	**85,252,388**	**130,856,105**	**3,651,209,795**

Annex C.3: Financing Agents x Providers (HF x HP), 2004/05 for Reproductive Health

	HF.1 Public			HF.2 Private Sector						Row totals and total expenditure measures
	HF.1.1.1.1	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	
Provider	Ministry of Health	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HP.1 Hospital	915,750,631	-	-	48,450,000	328,259,056	109,258,412	-	14,196,098	-	**1,415,914,197**
HP.1.1 General Hospitals	915,750,631	-	-	48,450,000	328,259,056	109,258,412	-	14,196,098	-	**1,415,914,197**
HP.1.1.1 Government general hospitals	915,750,631	-	-	-	108,051,047	-	-	-	-	**1,023,801,678**
HP1.1.1.1 Central Hospitals	373,118,245				16,482,363					**389,600,608**
HP1.1.1.2 District Hospitals	542,632,386				91,568,684					**634,201,070**
HP.1.1.2 Private Not-for-profit hospitals	-	-	-	-	156,693,975	109,258,412	-	-	-	**265,952,387**
HP1.1.2.1 Private-Not-for-profit hospitals (Other)										-
HP1.1..2.2 Private-not-for-profit hospital (CHAM)					156,693,975	109,258,412				**265,952,387**
HP1.1.3 Private For-profit hospitals				48,450,000	63,514,034			14,196,098		**126,160,132**
HP.1.2 Specialized hospitals (including mental hospital)										-
HP.3 Providers of ambulatory health care	724,134,081	3,900,755	1,925,148	91,060,000	77,079,700	44,558,576	104,055,261	65,476,123	3,911,954	**1,116,101,599**
HP3.1 Offices of physicians				91,060,000	38,198,229			10,970,501		**140,228,729**
HP.3.4.9.1 health centres/dispensaries/maternity	724,134,081	3,900,755	1,925,148		31,274,227	44,558,576	104,055,261	54,505,622	3,911,954	**968,265,625**
HP.3.1.1 MOH Health centres/dispensaries/maternity	724,134,081									**724,134,081**
HP.3.1.2 Other Ministries Health centres/dispensaries/maternity		3,900,755								**3,900,755**
HP.3.1.3 Local Authories Health centres/dispensaries/maternity			1,925,148							**1,925,148**
HP.3.1.4 CHAM Health centres/dispensaries/maternity					9,382,268	44,558,576				**53,940,844**
HP.3.1.5 Other NGOs Health centres/dispensaries/maternity					21,891,959		104,055,261			**125,947,220**
HP.3.1.5 Private firms Health centres/dispensaries/maternity								54,505,622	3,911,954	**58,417,576**
HP3.9.3 Traditional practitioners					7,607,245					**7,607,245**
HP.4 Retail sale and other providers of medical goods				16,330,000	77,762,944					**94,092,944**
HP.5 Provision and administration of public health programs	439,477,789	54,091,118	12,402,397			24,936,410	129,556,325	5,580,168	126,944,151	**792,988,359**
HP.6 General health administration and insurance	35,354,736	-	-	-	-	-	104,775,263	-	-	**140,129,998**
HP 6.1 Government Administration of Health	35,354,736									**35,354,736**
HP.6.4 Other (private) Insurance										-
HP.6.9 All other providers of health administration							104,775,263			**104,775,263**
HP.9 Rest of the world				1,540,000						**1,540,000**
Provider not specified by kind										-
THE	**2,114,717,237**	**57,991,873**	**14,327,545**	**157,380,000**	**483,101,700**	**178,753,398**	**338,386,850**	**85,252,388**	**130,856,105**	**3,560,767,096**
%										
HP.8 Institutions providing health related services	90,442,699									**90,442,699**
NHE	**2,205,159,936**	**57,991,873**	**14,327,545**	**157,380,000**	**483,101,700**	**178,753,398**	**338,386,850**	**85,252,388**	**130,856,105**	**3,651,209,795**

Annex C.3: Provider x Function (HPxHC), 2004/05 for Reproductive Health

	HP.1 Hospital						HP.3 Providers of ambulatory health care			HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance			HP.9 Rest of the world	Provider not specified by kind	HP.8 Institutions providing health related services	Total function
	HP.1.1 General Hospitals					HP.1.2 Specialized hospitals (including mental hospital)												
	HP.1.1.1 Government general		HP.1.1.2 Private Not-for-profit		HP1.1.3													
	HP1.1.1.1 Central Hospitals	HP1.1.1.2 District Hospitals	HP1.1.2.1 Private-Not-for-profit hospitals (Other)	HP1.1..2.2 Private-not-for-profit hospital (CHAM)	Private For-profit hospitals		HP3.1 Offices of physicians	HP.3.4.9.1 health centres/dispensaries/maternity	HP3.9.3 Traditional practitioners			HP 6.1 Government Administration of Health	HP.6.4 Other (private) Insurance	HP.6.9 All other providers of health administration				
HC.1 Services of curative care																		
HC.1.1 Inpatient curative care	180,306,934	426,220,189		184,766,921	89,797,622			146,391,978							1,540,000			1,029,023,643
HC.1.3 Out patient curative care	209,293,674	194,753,736		81,185,466	36,362,510		140,228,729	821,873,647	7,607,245									1,491,305,006
HC.1.3.9 Prenatal care	12,987,600	50,130,295		55,206,117	21,599,104		95,574,946	182,635,247	4,564,347									
HC.1.3.10 Postnatal care	3,628,888	14,006,994		15,425,238	5,454,376		20,924,604	56,402,062	760,724									
HC.1.3.11 Family planning consultation and issuance of modern FP method	190,194,263	121,032,713						598,502,618										
HC.1.3 nsk	2,482,923	9,583,733		10,554,111	9,309,029		23,729,179	29,543,937	2,282,173									
HC.2 Services of rehabilitative care																		
HC.5 Medical goods dispensed to outpatients										94,092,944								94,092,944
HC.6 Prevention and public health services											792,988,359							792,988,359
HC.7 Health administration and health insurance																		
HC 7.1 General Government Administration of Health												35,354,736						35,354,736
HC 7.2.2 Health Adminstration and Health Insurance: Other Private														104,775,263				104,775,263
HC.R.1 Capital formation		13,227,146																13,227,146
HCR.nsk Expenditure not specified by kind																		
THE	**389,600,608**	**634,201,070**		**265,952,387**	**126,160,132**		**140,228,729**	**968,265,625**	**7,607,245**	**94,092,944**	**792,988,359**	**35,354,736**		**104,775,263**	**1,540,000**			**3,560,767,096**
%																		**1**
HC.R Health related functions																	90,442,699	90,442,699
HCR.2 Eduation and Training																	57,130,167	57,130,167
HCR.3 Research and Development																	33,312,532	33,312,532
HCR.4 Food Hygiene and Drinking water Control																		
HCR.5 Environmental Health																		
NHE	**389,600,608**	**634,201,070**		**265,952,387**	**126,160,132**		**140,228,729**	**968,265,625**	**7,607,245**	**94,092,944**	**792,988,359**	**35,354,736**		**104,775,263**	**1,540,000**		**90,442,699**	**3,651,209,795**
	11%	17%	0%	7%	3%	0%	4%	27%	0%	3%	22%	1%	0%	3%	0%	0%	2%	100%

Annex D.1: Financing Sources x Financing Agents (FS x HF), 2002/03 for Child Health

	FS.1 Public Funds*			FS.2 Private Funds*			FS.3	
	FS.1.1 Territorial government		FS.1.2 Other Public Funds	FS.2.1 Employer Funds	FS.2.2 Household Funds	FS.2.4 Other Private Funds		
	FS.1.1.1. General government	FS.1.1.2 Local Government (City, town and district assemblies)						
	FS.1.1.1.1 Ministry of Finance						Rest of the World Funds	Row Totals
HF.1.1.1.1 Ministry of Health	912,331,598						590,847,576	1,503,179,174
HF.1.1.1.3 Other Ministries	1,586,914					746,041	1,320,676	3,653,631
HF.1.1.1.4 Local Authorities	1,116,912	351,029					7,292,259	8,760,200
HF.2.2 Private Insurance Scheme				57,078,560	2,981,440			60,060,000
HF.2.3 Household Out of Pocket Payments					341,533,447			341,533,447
H.F.2.4 Non-Governmental Organizations	86,085,940	-	-	-	-	21,974,499	178,431,116	286,491,554
H.F.2.4.1 CHAM	86,085,940					2,643,402	13,309,762	102,039,104
H.F.2.4.2 Other NGOs						19,331,096	165,121,354	184,452,450
HF.2.5 Private Firms/Employers				49,224,405				49,224,405
HF.3 Rest of the World							168,889,853	168,889,853
THE	**1,001,121,363**	**351,029**	**-**	**106,302,965**	**344,514,887**	**22,720,540**	**946,781,479**	**2,421,792,266**
%	**41%**	**0%**		**4%**	**14%**	**1%**	**39%**	**100%**
Financing agents expenditure on Health Care related activities							**15,370,000**	**15,370,000**
NHE	**1,001,121,363**	**351,029**	**-**	**106,302,965**	**344,514,887**	**22,720,540**	**962,151,479**	**2,437,162,266**

Annex D.1: Financing Agent x Function (HFxHC), 2002/03 for Child Health

	HF.1 Public			HF.2 Private Sector						
	HF.1.1.1.1	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	Total function
Function	Ministry of Health	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HC.1 Services of curative care	931,201,180	3,653,631	2,115,156	60,060,000	341,533,447	82,491,279	18,191,845	47,605,332	-	1,486,851,872
HC.1.1 Inpatient curative care	387,377,014			13,110,000	149,258,005	65,722,765	10,954,289	25,479,914		651,901,988
HC.1.3 Out patient curative care	543,824,166	3,653,631	2,115,156	46,950,000	192,275,442	16,768,514	7,237,556	22,125,419		834,949,884
HC.2 Services of rehabilitative care									118,968,143	118,968,143
HC.6 Prevention and public health services	415,760,200		6,645,044			19,547,825	166,260,604	1,619,073	49,921,710	659,754,456
HC6.1.1 Immunization programme	241,502,261					11,728,695				253,230,956
HC6.1.2 IEC	60,375,565		2,658,018			2,932,174	74,817,272		22,464,770	163,247,798
HC 6.9 All Other Preventive Services	113,882,373		3,987,026			4,886,956	91,443,332	1,619,073	27,456,941	243,275,702
HC.7 Health administration and health insurance										
HC 7.1 General Government Administration of Health										
HC 7.2.2 Health Adminstration and Health Insurance: Other Private										
HCR.nsk Expenditure not specified by kind										
HC.R.1 Capital formation	156,217,795									156,217,795
THE	**1,503,179,174**	**3,653,631**	**8,760,200**	**60,060,000**	**341,533,447**	**102,039,104**	**184,452,450**	**49,224,405**	**168,889,853**	**2,421,792,266**
HC.R Health related functions						15,370,000				**15,370,000**
HCR.2 Eduation and Training of health personnel						15,370,000				**15,370,000**
HCR.3 Research and Development in health										
HCR.4 Food Hygiene and Drinking water Control										
HCR.5 Environmental Health										
NHE	**1,503,179,174**	**3,653,631**	**8,760,200**	**60,060,000**	**341,533,447**	**117,409,104**	**184,452,450**	**49,224,405**	**168,889,853**	**2,437,162,266**

Annex D.1: Financing Agents x Providers (HFx HP), 2002/03 for Child Health

	HF.1 Public			HF.2 Private Sector						
	HF.1.1.1.1	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	Row totals and total expenditure measures
Provider	Ministry of Health	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HP.1 Hospital										-
HP.1.1 General Hospitals										-
HP.1.1.1 Government general hospitals										
HP1.1.1.1 Central Hospitals	154,906,726				10,988,807					165,895,532
HP1.1.1.2 District Hospitals	595,655,970				61,048,925				118,968,143	775,673,038
HP.1.1.2 Private Not-for-profit hospitals										
HP1.1.2.1 Private-Not-for-profit hospitals (Other)							11,159,717	1,490,964		12,650,681
HP1.1..2.2 Private-not-for-profit hospital (CHAM)					89,244,354	56,459,916				145,704,269
HP1.1.3 Private For-profit hospitals				16,560,000	36,174,135					52,734,135
HP.1.2 Specialized hospitals (including mental hospital)										
HP.3 Providers of ambulatory health care										
HP3.1 Offices of physicians				35,500,000	24,745,988			8,073,450		68,319,438
HP.3.4.9.1 health centres/dispensaries/maternity	336,856,279	3,653,631	2,115,156		41,520,327	26,031,364	7,032,128	38,040,918		455,249,803
HP3.9.3 Traditional practitioners					14,291,801					14,291,801
HP.4 Retail sale and other providers of medical goods				8,000,000	63,519,113					71,519,113
HP.5 Provision and administration of public health programs	415,760,200		6,645,044			19,547,825	166,260,604	1,619,073	49,921,710	659,754,456
HP.6 General health administration and insurance										
HP 6.1 Government Administration of Health										
HP.6.4 Other (private) Insurance										
HP.6.9 All other health administration										
HP.9 Rest of the world										
Provider not specified by kind										
THE	**1,503,179,174**	**3,653,631**	**8,760,200**	**60,060,000**	**341,533,447**	**102,039,104**	**184,452,450**	**49,224,405**	**168,889,853**	**2,421,792,266**
%										
HP.8 Institutions providing health related services						15,370,000				15,370,000
NHE	**1,503,179,174**	**3,653,631**	**8,760,200**	**60,060,000**	**341,533,447**	**117,409,104**	**184,452,450**	**49,224,405**	**168,889,853**	**2,437,162,266**

Annex D.1: Provider x Function (HPxHC), 2002/03 for Child Health

	HP.1 Hospital						HP.3 Providers of ambulatory health care			HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance			HP.9 Rest of the world	Provider not specified by kind	HP.8 Institutions providing health related services	Total function
	HP.1.1 General Hospitals					HP.1.2 Specialized hospitals (including mental hospital)												
	HP1.1.1.1 Central Hospitals	HP1.1.1.2 District Hospitals	HP1.1.2.1 Private-Not-for-profit hospitals (Other)	HP1.1..2.2 Private-not-for-profit hospital (CHAM)	HP1.1.3 Private For-profit hospitals		HP3.1 Offices of physicians	HP.3.4.9.1 health centres/dispensaries/maternity	HP3.9.3 Traditional practitioners			HP 6.1 Government Administration of Health	HP.6.4 Other (private) Insurance	HP.6.9 All other health administration				
HC.1 Services of curative care																		
HC.1.1 Inpatient curative care	109,121,607.84	244,263,353	6,299,531	115,349,213	41,747,857			135,120,426										651,901,988
HC.1.3 Out patient curative care	51,759,384.06	286,243,243	6,351,150	30,355,056	10,986,278		68,319,438	295,124,421	14,291,801	71,519,113								834,949,884
HC.2 Services of rehabilitative care		118,968,143																118,968,143
HC.6 Prevention and public health services											659,754,456							659,754,456
HC6.1.1 Immunization programme											253,230,956							253,230,956
HC6.1.2 IEC											163,247,798							163,247,798
HC 6.9 All Other Preventive Services											243,275,702							243,275,702
HC.7 Health administration and health insurance																		
HC 7.1 General Government Administration of Health																		0
HC 7.2.2 Health Adminstration and Health Insurance: Other Private																		0
HC.R.1 Capital formation	5,014,540	126,198,299						25,004,956										156,217,795
HCR.nsk Expenditure not specified by kind																		0
THE	**165,895,532**	**775,673,038**	**12,650,681**	**145,704,269**	**52,734,135**		**68,319,438**	**455,249,803**	**14,291,801**	**71,519,113**	**659,754,456**							**2,421,792,266**
%																		**1**
HC.R Health related functions																	15,370,000	15,370,000
HCR.2 Eduation and Training																	15,370,000	15,370,000
HCR.3 Research and Development																		
HCR.4 Food Hygiene and Drinking water Control																		
HCR.5 Environmental Health																		
NHE	**165,895,532**	**775,673,038**	**12,650,681**	**145,704,269**	**52,734,135**		**68,319,438**	**455,249,803**	**14,291,801**	**71,519,113**	**659,754,456**						**15,370,000**	**2,437,162,266**

Annex D.2: Financing Sources x Financing Agents (FS x HF), 2003/04 for Child Health

	FS.1 Public Funds*		FS.2 Private Funds*			FS.3	
	FS.1.1 Territorial government		FS.2.1 Employer Funds	FS.2.2 Household Funds	FS.2.4 Other Private Funds		
	FS.1.1.1. General government	FS.1.1.2 Local Government (City, town and district assemblies)					
	FS.1.1.1.1 Ministry of Finance					Rest of the World Funds	Row Totals
HF.1.1.1.1 Ministry of Health	676,392,861					910,159,902	1,586,552,763
HF.1.1.1.3 Other Ministries	27,522,773						27,522,773
HF.1.1.1.4 Local Authorities	22,929,494	12,209,420					35,138,913
HF.2.2 Private Insurance Scheme			59,833,350	3,819,150			63,652,500
HF.2.3 Household Out of Pocket Payments				525,405,258			525,405,258
H.F.2.4 Non-Governmental Organizations	70,332,612					178,352,184	248,684,796
H.F.2.4.1 CHAM	70,332,612					33,387,713	103,720,325
H.F.2.4.2 Other NGOs						144,964,471	144,964,471
HF.2.5 Private Firms/Employers			68,365,880				68,365,880
HF.3 Rest of the World						305,428,695	305,428,695
HF.NsK Not Specified by Kind							
THE	**797,177,739**	**12,209,420**	**128,199,230**	**529,224,408**	**-**	**1,393,940,781**	**2,860,751,577**
%	**28%**	**0%**	**4%**	**18%**	**0%**	**49%**	**100%**
Financing agents expenditure on Health Care Related Activities							
Total HCR						**9,622,616**	**9,622,616**
NHE	**797,177,739**	**12,209,420**	**128,199,230**	**529,224,408**	**-**	**1,403,563,397**	**2,870,374,193**
%	**28%**	**0%**	**4%**	**18%**	**0%**	**49%**	**100%**

Annex D.2: Financing Agents x Providers (HF x HP), 2003/04 for Child Health

	HF.1 Public			HF.2 Private Sector						
	HF.1.1.1.1	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	Row totals and total expenditure measures
Provider	Ministry of Health	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HP.1 Hospital										
HP.1.1 General Hospitals										
HP.1.1.1 Government general hospitals										
HP1.1.1.1 Central Hospitals	171,791,536				17,750,237					189,541,773
HP1.1.1.2 District Hospitals	370,154,338				98,612,429				61,211,518	529,978,285
HP.1.1.2 Private Not-for-profit hospitals										
HP1.1.2.1 Private-Not-for-profit hospitals (Other)										
HP1.1..2.2 Private-not-for-profit hospital (CHAM)					133,602,231	59,597,370				193,199,602
HP1.1.3 Private For-profit hospitals				23,692,500	54,154,071			8,229,632		86,076,204
HP.1.2 Specialized hospitals (including mental hospital)										
HP.3 Providers of ambulatory health care										
HP3.1 Offices of physicians				32,580,000	23,709,245			8,467,550		64,756,795
HP.3.4.9.1 health centres/dispensaries/maternity	566,394,541	17,708,897	25,482,503		86,004,125	33,442,354	101,660,175	48,478,948	154,169,467	1,033,341,010
HP3.9.3 Traditional practitioners										
HP.4 Retail sale and other providers of medical goods				7,380,000	111,572,919					118,952,919
HP.5 Provision and administration of public health programs	478,212,348	9,813,876	9,656,410			10,680,600	43,304,296	3,189,750	90,047,710	644,904,990
HP.6 General health administration and insurance										
HP 6.1 Government Administration of Health										
HP.6.4 Other (private) Insurance										
HP.6.9 All other health administration										
HP.9 Rest of the world										
Provider not specified by kind										
THE	**1,586,552,763**	**27,522,773**	**35,138,913**	**63,652,500**	**525,405,258**	**103,720,325**	**144,964,471**	**68,365,880**	**305,428,695**	**2,860,751,577**
HP.8 Institutions providing health related services	9,622,616									9,622,616
NHE	**1,596,175,379**	**27,522,773**	**35,138,913**	**63,652,500**	**525,405,258**	**103,720,325**	**144,964,471**	**68,365,880**	**305,428,695**	**2,870,374,193**

Annex D.2: Financing Agent x Function (HFxHC), 2003/04 for Child Health

	HF.1 Public			HF.2 Private Sector						
	HF.1.1.1.1	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	Total function
Function	Ministry of Health	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HC.1 Services of curative care										
HC.1.1 Inpatient curative care	501,584,438		563,491	18,427,500	229,148,870	56,572,007		15,180,523	14,686,789	836,163,618
HC.1.3 Out patient curative care	593,657,487	17,708,897	24,919,012	45,225,000	296,256,388	36,467,717	101,660,175	49,995,607	139,482,678	1,305,372,962
HC.2 Services of rehabilitative care									61,211,518	61,211,518
HC.6 Prevention and public health services	478,212,348	9,813,876	9,656,410			10,680,600	43,304,296	3,189,750	90,047,710	644,904,990
HC6.1.1 Immunization programme	260,974,530					3,204,180			40,521,470	304,700,180
HC6.1.2 IEC	47,449,915	1,962,775	1,448,462			1,602,090	25,982,577		27,014,313	105,460,132
HC 6.9 All Other Preventive Services	169,787,903	7,851,101	8,207,949			5,874,330	17,321,718	3,189,750	22,511,928	234,744,678
HC.7 Health administration and health insurance										
HC 7.1 General Government Administration of Health										
HC 7.2.2 Health Adminstration and Health Insurance: Other Private										
HCR.nsk Expenditure not specified by kind										
HC.R.1 Capital formation	13,098,489									13,098,489
THE	**1,586,552,763**	**27,522,773**	**35,138,913**	**63,652,500**	**525,405,258**	**103,720,325**	**144,964,471**	**68,365,880**	**305,428,695**	**2,860,751,577**
%	**1**									**1**
HC.R Health related functions	9,622,616									9,622,616
HCR.2 Eduation and Training of health personnel	9,622,616									9,622,616
HCR.3 Research and Development in health										
HCR.4 Food Hygiene and Drinking water Control										
HCR.5 Environmental Health										
NHE	**1,596,175,379**	**27,522,773**	**35,138,913**	**63,652,500**	**525,405,258**	**103,720,325**	**144,964,471**	**68,365,880**	**305,428,695**	**2,870,374,193**

Annex D.2: Provider x Function (HPxHC), 2003/04 for Child Health

	HP.1 Hospital						HP.3 Providers of ambulatory health care			HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance			HP.9 Rest of the world	Provider not specified by kind	HP.8 Institutions providing health related services	Total function
	HP.1.1 General Hospitals					HP.1.2 Specialized hospitals (including mental hospital)												
	HP.1.1.1 Government general hospitals		HP.1.1.2 Private Not-for-profit		HP1.1.3 Private													
	HP1.1.1.1 Central Hospitals	HP1.1.1.2 District Hospitals	HP1.1.2.1 Private-Not-for profit hospitals (Other)	HP1.1..2.2 Private-not-for-profit hospital (CHAM)	For-profit hospitals		HP3.1 Offices of physicians	HP.3.4.9.1 health centres/dispensaries/maternity	HP3.9.3 Traditional practitioners			HP 6.1 Government Administration of Health	HP.6.4 Other (private) Insurance	HP.6.9 All other health administration				
HC.1 Services of curative care																		
HC.1.1 Inpatient curative care	144,518,893.55	323,584,332.61		150,266,356.87	66,205,205.73			151,588,829.65										836,163,618.42
HC.1.3 Out patient curative care	45,022,880	139,324,002		42,933,245	19,870,998		64,756,795	874,512,123		118,952,919								1,305,372,962
HC.2 Services of rehabilitative care		61,211,518																61,211,518
HC.6 Prevention and public health services											644,904,990							644,904,990
HC6.1.1 Immunization programme											304,700,180							304,700,180
HC6.1.2 IEC											105,460,132							105,460,132
HC 6.9 All Other Preventive Services											234,744,678							234,744,678
HC.7 Health administration and health insurance																		
HC 7.1 General Government Administration of Health																		
HC 7.2.2 Health Adminstration and Health Insurance: Other Private																		
HC.R.1 Capital formation		5,858,432						7,240,057										13,098,489
HCR.nsk Expenditure not specified by kind																		
THE	**189,541,773**	**529,978,285**		**193,199,602**	**86,076,204**		**64,756,795**	**1,033,341,010**		**118,952,919**	**644,904,990**							**2,860,751,577**
%																		**1**
HC.R Health related functions																	9,622,616	9,622,616
HCR.2 Eduation and Training																	9,622,616	9,622,616
HCR.3 Research and Development																		
HCR.4 Food Hygiene and Drinking water Control																		
HCR.5 Environmental Health																		
NHE	**189,541,773**	**529,978,285**		**193,199,602**	**86,076,204**		**64,756,795**	**1,033,341,010**		**118,952,919**	**644,904,990**						**9,622,616**	**2,870,374,193**

Annex D.3: Financing Sources x Financing Agents (FS x HF), 2004/05 for Child Health

	FS.1 Public Funds*		FS.2 Private Funds*		FS.3	
	FS.1.1 Territorial government		FS.2.1 Employer Funds	FS.2.2 Household Funds		
	FS.1.1.1. General government	FS.1.1.2 Local Government (City, town and district assemblies)				
	FS.1.1.1.1 Ministry of Finance				Rest of the World Funds	Row Totals
HF.1.1.1.1 Ministry of Health	984,385,310				1,084,718,971	2,069,104,281
HF.1.1.1.3 Other Ministries	17,287,352					17,287,352
HF.1.1.1.4 Local Authorities	3,250,160	7,906,594				11,156,753
HF.2.2 Private Insurance Scheme			145,665,900	10,964,100		156,630,000
HF.2.3 Household Out of Pocket Payments				560,814,750		560,814,750
H.F.2.4 Non-Governmental Organizations						
H.F.2.4.1 CHAM	164,223,949				47,626,275	211,850,224
H.F.2.4.2 Other NGOs					154,633,026	154,633,026
HF.2.5 Private Firms/Employers			102,414,885			102,414,885
HF.3 Rest of the World					621,903,695	621,903,695
HF.NsK Not Specified by Kind						
THE	**1,169,146,770**	**7,906,594**	**248,080,785**	**571,778,850**	**1,908,881,967**	**3,905,794,966**
%	**30%**	**0%**	**6%**	**15%**	**49%**	**100%**
Financing agents expenditure on Health Care Related Activities						**97,559,500**
NHE	**1,169,146,770**	**7,906,594**	**248,080,785**	**571,778,850**	**1,908,881,967**	**4,003,354,466**
%	**29%**	**0%**	**6%**	**14%**	**48%**	**100%**

Annex D.3: Financing Agent x Function (HFxHC), 2004/05 for Child Health

	HF.1 Public			HF.2 Private Sector						
	HF.1.1.1.1	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	Total function
Function	Ministry of Health	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HC.1 Services of curative care	1,448,427,032	6,321,913	1,878,601	156,630,000	560,814,750	195,860,669	121,874,284	96,276,701	210,432,610	2,798,516,560
HC.1.1 Inpatient curative care	703,949,445	874,307	371,768	33,660,000	245,048,363	115,521,574	91,405,713	17,829,070	41,599,971	1,250,260,210
HC.1.3 Out patient curative care	744,477,587	5,447,606	1,506,833	122,970,000	315,766,387	80,339,095	30,468,571	78,447,630	168,832,640	1,548,256,350
HC.2 Services of rehabilitative care	783,819								303,518,288	304,302,107
HC.6 Prevention and public health services	591,168,208	10,965,438	9,278,153			15,989,555	32,758,742	6,138,185	107,952,797	774,251,078
HC6.1.1 Immunization programme	317,486,502					6,395,822			59,374,038	383,256,362
HC6.1.2 IEC	111,398,773	1,535,161					17,362,133		32,385,839	162,681,906
HC 6.9 All Other Preventive Services	162,282,933	9,430,277	9,278,153			9,593,733	15,396,609	6,138,185	16,192,920	228,312,809
HC.7 Health administration and health insurance										
HC 7.1 General Government Administration of Health										
HC 7.2.2 Health Adminstration and Health Insurance: Other Private										
HCR.nsk Expenditure not specified by kind										
HC.R.1 Capital formation	28,725,222									28,725,222
THE	**2,069,104,281**	**17,287,352**	**11,156,753**	**156,630,000**	**560,814,750**	**211,850,224**	**154,633,026**	**102,414,885**	**621,903,695**	**3,905,794,966**
%	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
HC.R Health related functions	97,559,500									97,559,500
HCR.2 Eduation and Training of health personnel	97,559,500									97,559,500
HCR.3 Research and Development in health										
HCR.4 Food Hygiene and Drinking water Control										
HCR.5 Environmental Health										
NHE	**2,166,663,781**	**17,287,352**	**11,156,753**	**156,630,000**	**560,814,750**	**211,850,224**	**154,633,026**	**102,414,885**	**621,903,695**	**4,003,354,466.44**
	54%	**0%**	**0%**	**4%**	**14%**	**5%**	**4%**	**3%**	**16%**	**100%**

Annex D.3: Financing Agents x Providers (HF x HP), 2004/05 for Child Health

	HF.1 Public			HF.2 Private Sector						Row totals and total expenditure measures
	HF.1.1.1.1	HF1.1.1.3	HF.1.1.1.4	HF.2.2	HF.2.3	HF2.4.1	HF.2.4.1.2	HF.2.5	HF.3	
Provider	Ministry of Health	Other Ministries	Local Authorities	Private Insurance Scheme	Household OOP Payments	CHAM	Other NGOs	Private Firms / Employers	Rest of the World	
HP.1 Hospital										
HP.1.1 General Hospitals										
HP.1.1.1 Government general hospitals										
HP1.1.1.1 Central Hospitals	205,110,296				19,863,361					224,973,657
HP1.1.1.2 District Hospitals	507,639,961				106,830,131				303,518,288	917,988,380
HP.1.1.2 Private Not-for-profit hospitals										
HP1.1.2.1 Private-Not-for-profit hospitals (Other)										
HP1.1..2.2 Private-not-for-profit hospital (CHAM)					141,849,283	126,806,038				268,655,321
HP1.1.3 Private For-profit hospitals				43,860,000	57,496,915			9,646,066		111,002,982
HP.1.2 Specialized hospitals (including mental hospital)										
HP.3 Providers of ambulatory health care										
HP3.1 Offices of physicians				87,920,000	43,466,950			27,426,252		158,813,202
HP.3.4.9.1 health centres/dispensaries/maternity	765,185,816	6,321,913	1,878,601		72,973,197	69,054,630	121,874,284	59,204,382	210,432,610	1,306,925,433
HP3.9.3 Traditional practitioners										
HP.4 Retail sale and other providers of medical goods				24,850,000	118,334,914					143,184,914
HP.5 Provision and administration of public health programs	591,168,208	10,965,438	9,278,153			15,989,555	32,758,742	6,138,185	107,952,797	774,251,078
HP.6 General health administration and insurance										
HP 6.1 Government Administration of Health										
HP.6.4 Other (private) Insurance										
HP.6.9 All other health administration										
HP.9 Rest of the world										
Provider not specified by kind										
THE	**2,069,104,281**	**17,287,352**	**11,156,753**	**156,630,000**	**560,814,750**	**211,850,224**	**154,633,026**	**102,414,885**	**621,903,695**	**3,905,794,966**
HP.8 Institutions providing health related services	97,559,500									97,559,500
NHE	**2,166,663,781**	**17,287,352**	**11,156,753**	**156,630,000**	**560,814,750**	**211,850,224**	**154,633,026**	**102,414,885**	**621,903,695**	**4,003,354,466**

Annex D.3: Providers x Function (HPxHC), 2004/05 for Child Health

	HP.1 Hospital						HP.3 Providers of ambulatory health care			HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance			HP.9 Rest of the world	Provider not specified by kind	HP.8 Institutions providing health related services	Total function
	HP.1.1 General Hospitals					HP.1.2 Specialized hospitals (including mental hospital)												
	HP.1.1.1 Government general hospitals		HP.1.1.2 Private Not-for-profit		HP1.1.3 Private													
	HP1.1.1.1 Central Hospitals	HP1.1.1.2 District Hospitals	HP1.1.2.1 Private-Not-for-profit hospitals (Other)	HP1.1..2.2 Private-not-for-profit hospital (CHAM)	For-profit hospitals		HP3.1 Offices of physicians	HP.3.4.9.1 health centres/dispensaries/maternity	HP3.9.3 Traditional practitioners			HP 6.1 Government Administration of Health	HP.6.4 Other (private) Insurance	HP.6.9 All other health administration				
HC.1 Services of curative care	220,731,311	600,626,886		268,655,321	111,002,982		158,813,202	1,295,501,945		143,184,914								2,798,516,560
HC.1.1 Inpatient curative care	180,940,871	442,071,961		206,177,339	84,337,585			336,732,454										1,250,260,210
HC.1.3 Out patient curative care	39,790,440	158,554,925		62,477,982	26,665,397		158,813,202	958,769,490		143,184,914								1,548,256,350
HC.2 Services of rehabilitative care	93,427	304,134,349						74,332										304,302,107
HC.6 Prevention and public health services											774,251,078							774,251,078
HC6.1.1 Immunization programme											383,256,362							
HC6.1.2 IEC											162,681,906							
HC 6.9 All Other Preventive Services											228,312,809							
HC.7 Health administration and health insurance																		
HC 7.1 General Government Administration of Health																		
HC 7.2.2 Health Adminstration and Health Insurance: Other Private																		
HC.R.1 Capital formation	4,148,919	13,227,146						11,349,156										28,725,222
HCR.nsk Expenditure not specified by kind																		
THE	**224,973,657**	**917,988,380**		**268,655,321**	**111,002,982**		**158,813,202**	**1,306,925,433**		**143,184,914**	**774,251,078**							**3,905,794,966**
%																		**1**
HC.R Health related functions																	97,559,500	97,559,500
HCR.2 Eduation and Training																	97,559,500	97,559,500
HCR.3 Research and Development																		
HCR.4 Food Hygiene and Drinking water Control																		
HCR.5 Environmental Health																		
NHE	**224,973,657**	**917,988,380**		**268,655,321**	**111,002,982**		**158,813,202**	**1,306,925,433**		**143,184,914**	**774,251,078**						**97,559,500**	**4,003,354,466**
%																		**1**

ANNEX 8: REFERENCES

Aitken, Jean-Marion and Kemp, Julia. (2003) HIV and AIDS, Equity and Health Sector Personnel in Southern Africa. Equinet Discussion Paper No. 12. Regional Network for Equity in Health in Southern Africa. Funded by Department for International Development.

Castro-Leal F, Dayton L, Demery L, Mehtra K. Public Spending on Health Care in Africa: Do The Poor Benefit? Bulletin of the World Health Organization 78(1): pp.66-74.

Calcon H. (2003) Malawi Health Facilities Inventory Survey. Final Report. Funded by Japanese International Cooperation Agency.

Commission on Macroeconomics and Health. (2001) Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health, chaired by Jeffrey D. Sachs, editor. World Health Organization: Geneva.

Data International Bangladesh. 2006. Child Health Accounts Report.

Eholie S, Nolan M, Gaumon A et al. (2003) Antiretroviral treatment can be cost saving for industry and lifesaving for workers: A case study from Cote d'Ivoire's private sector.

Eichler R. (Feb 2007) Can "Pay for Performance" Increase Utilization by the Poor and Improve the Quality of Health Services? Discussion Paper.

Federal Ministry of Health. (2006) Ethiopia Third NHA Report. Draft. Planning and Programme Department, Health Financing Secretariat: Addis Ababa, Ethiopia.

Franco L, Mtonya B, Mwase T et al. (1995) Community Financing Experience and Options: A study to provide baseline information for ministry of health decision-making. Lilongwe, Malawi.

Gwatkin DR. (2003) Free Government Health Services: Are They the Best Way to Reach the Poor? World Bank Poverty Net Library: World Bank Seminars, Washington.

Institute for Health Policy Studies and Data International. (2006) Child Health Accounts Report. Draft: Colombo, Sri Lanka.

International Monetary Fund. (2003) The Impact of HIV/AIDS on the Malawian Economy. Working Paper. Lilongwe, Malawi.

Ministry of Economic Planning & Development. (2002) Malawi Core Welfare Indicators Questionnaire. Lilongwe, Malawi.

Ministry of Economic Planning and Development. (2002) Poverty Reduction Strategy Paper. (PRSP). Lilongwe, Malawi.

Malawi Economic Justice Network. (2005) Quality of Health Services Assessment Report. Lilongwe, Malawi.

Mills AJ. (1991) The cost of the district hospital: A case study from Malawi. World Bank Population and Human Resources Department. Washington DC and Lilongwe, Malawi.

Ministry of Health and Population (MoH). (1995) Health Policy Framework Paper. Lilongwe, Malawi.

MoH. (1999) Malawi National Health Plan: 1999-2004. Lilongwe, Malawi.

MoH (1997) Manpower Development Survey Report. Lilongwe, Malawi.

MoH. (2001) Malawi National Health Accounts Report. Lilongwe, Malawi. Accessed at http://www.who.int/nha

MoH. (February 2002) The Malawi Essential Health Package. Annex 3: Summary of February 2002 Dissemination Meetings. Lilongwe, Malawi.

MoH. (2004) Programme of Work. Lilongwe, Malawi.

MoH. (2005a) Malawi Public Expenditure Review (PER)-Health Chapter. Lilongwe, Malawi: MoH Headquarters.

MoH. (2005b) Emergency and Obstetric Care (EmOc Survey 2005). Lilongwe, Malawi.

Mwambaghi F, Mtonya B, Manda J. (1995) Rural Health Unit Expenditure Study in Lilongwe District. Planning Unit, Ministry of Health and Population. Lilongwe, Malawi.

Mwase TL. (1998) Health Expenditure and Finance in Malawi: Do Efficiency and Equity Matter? Ministry of Health and Population. A study funded by WHO/Malawi and WHO/AFRO.

McCoy, David, Esther Ratsma, and Mike Rowson. (2004) Going from Bad to Worse: Malawi's Maternal Mortality. Commissioned by Task Force 4 of the U.N. Millennium Project.

National Statistics Office (NSO). (1998) Population and Housing Census 1998. Lilongwe, Malawi.

NSO and Measure/DHS. (June 2005) Malawi Demographic and Health Survey 2004: Preliminary Report. Zomba, Malawi and Calverton, Maryland, USA.

NSO. (2005) Integrated Household Survey 2, 2005. Zomba, Malawi

Partners for Health Reformplus Project. (2003) National Health Accounts Training Manual. Produced by the Partners for Health Reformplus, Abt Associates Inc.: Bethesda, Maryland, USA. Accessed at www.phrplus.org.

United Nations Development Programme. (UNDP) (2005) Human Development Report International development at a crossroads: Aid, trade and security in an unequal world. UNDP: New York, USA.

UNDP. (2003) Human Development Report, Millennium Development Goals: A compact among nations to end human poverty. UNDP: New York, USA.

Vision 2020 (1999). The Vision of the Malawi Health Sector in 2020. Ministry of Health and Population, Planning Department, Lilongwe, Malawi.

World Health Organization (WHO). (1994) World Health Forum; International Journal of Health Development, Volume 15, Number 2. Geneva

WHO. (2004) National Health Accounts (NHA) in Eastern and Southern Africa: A Comparative Analysis. Accessed at www.who.int/nha/docs/en/NHA_in_eastern_and_southern_Africa.pdf

WHO. (2000) The World Health Report 2000. Health Systems: Improving Performance. Geneva.

WHO. (2001) Report of the Commission on Macro Economics and Health. Geneva.

WHO. (2005) Designing health financing systems to reduce catastrophic health expenditure. Technical Briefs for Policy Makers, No. 2, Department of Health Systems Financing.

WHO. (2006) Are African countries achieving the Abuja target of spending 15% of their national budget on health? WHO/NHA Policy Highlight No. 2/2006. Accessed at: http://www.who.int/nha/use/highlights/en/index.html on 26 July 2004.

Wagstaff A. (1986) The Demand for Health: A simplified Grossman Model. Bulletin of Economic Research, Vol 38, Issue 1: pp93-95.

Wagstaff A, van Doorslaer E. (1993) Equity in the finance and delivery of health care: Concepts and definitions. In: Van Dooeslaer E, Wagstaff A F. Equity in the finance and delivery of health care: An International Perspective. Oxford University Press: New York.

World Bank. (1994) Better Health in Africa: Experience and Lessons Learned. Washington D.C.

World Bank. (2004) Achieving the Millennium Development Goals for Malawi, 2003/04.