POLICY DIALOGUES

Inequalities in Healthcare Spending on Curative Services: Evidence from Malawi

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MAIN MESSAGE

Both public spending and overall spending on curative services have become more egalitarian in Malawi with the rollout of Universal Health Coverage policies across the country. The findings reveal increased equality in public spending, but not in overall spending on healthcare. For example, at the level of the not-for-profit Christian Health Association (CHAM) facilities, the distribution of benefits in 2017 still favor the least poor.

While differences between districts in the distribution of public and overall benefits persist, they have become considerably smaller over time. Further policy action is needed to tackle persistent causes of inequality and to reduce district differences.

CONTEXT AND MOTIVATION

In 2016, total healthcare spending in Malawi was nearly 10% of GDP, with the government contributing 16%, out-of-pocket expenditures by households 10%, and the rest covered by development partners.

Malawi is one of a handful of countries in sub-Saharan Africa that has long not introduced user fees for basic healthcare services.

In 2004, the government established an 'essential health package' (EHP), defining coverage for a comprehensive list of services to prevent and treat communicable and non-communicable diseases, malnutrition, and maternal and perinatal conditions.

Both public facilities and CHAM facilities contracted by the Ministry of Health via 'service level agreements' are expected to provide EHP services free of charge to all residents. Around 60% of all health facilities belong to the government; 36% to the CHAM; and the remaining 4% to private for-profit and not-for-profit providers.

Over the last two decades, national and donor efforts have been channeled towards strengthening health service provision, including curative services, and financial management across all operational levels. But no major health financing reform has taken place. Between 2015 and 2017, the Ministry of Health with financial support from development partners, piloted a performance-based incentive program targeting a broad spectrum of EHP services, including curative services, in three districts (Chitipa, Nkhotakota, and Mangochi).

METHODS

This study analyzes the distribution of healthcare spending for curative services over time. The objective is to understand whether consistently relying on free healthcare provision, spending on curative services has been distributed in an egalitarian manner to reach people in different socio-economic strata.

The study applies Benefit Incidence Analysis to analyze the distribution of healthcare spending on curative services. There are two levels of analysis: one focused on public spending (including only recurrent government spending on curative services); and one focused on overall spending (including donor and private spending on curative services).
Utilization rates are extracted from the 2004, 2010 and 2016 Living Conditions Monitoring Survey. To compute unit costs, the study uses data from National Health Accounts.
The study also examines differences across regions, and looks at what proportion of healthcare spending has reached individuals using curative services across socio-economic groups from the poorest to the least poor.

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Find out more about this project: afd.fr/en/carte-des-projets/assessing-equity-health-spending-sub-saharan-africa

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RESULTS

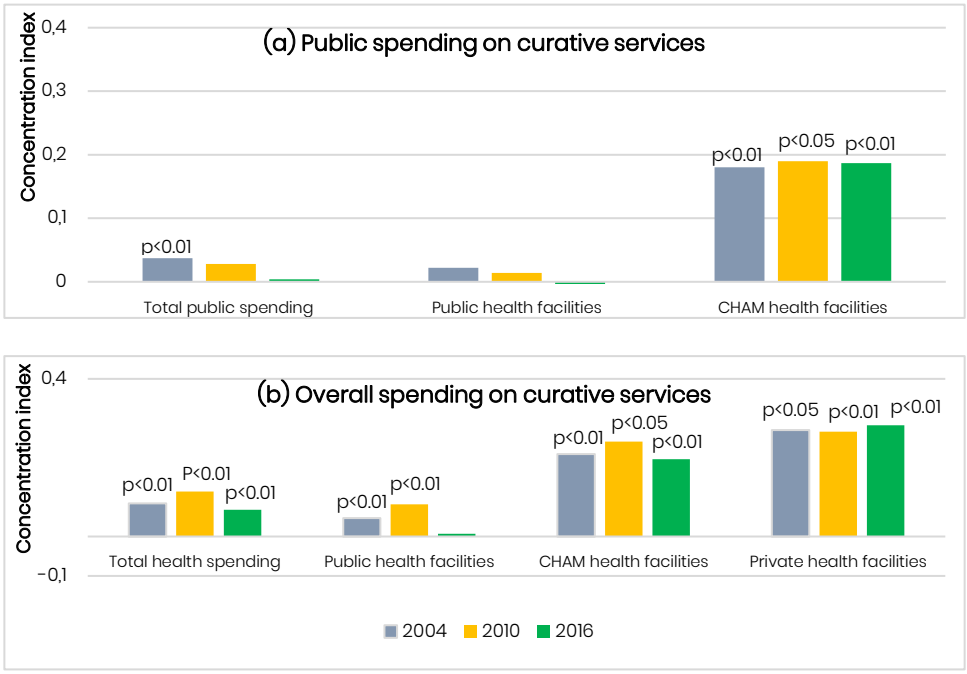
Public spending on curative services is egalitarian, but inequalities remain in CHAM facilities compared with public facilities

Public spending on curative services in public facilities has remained highly egalitarian over the years, with values very close to the line of equality. By 2016, public spending in public facilities had become pro-poor. In contrast, public spending on curative services in CHAM facilities continued to favor the least poor, although the magnitude of the inequality was not as big as elsewhere in sub-Saharan Africa. Over time, equality in public spending increased significantly; by 2016, total public spending, considering public and CHAM facilities together, had reached a value just minimally above the line of equality (see Figure 1).

There have been no substantial changes in equality of overall spending on curative services, except for public facilities

The distributional incidence of overall spending on curative services has remained largely unchanged over time, both for spending on CHAM facilities and for total public spending. Reduced inequality has been seen only for public health facilities, suggesting more pro-poor management of donor funding, with probable reductions in informal fees to be paid in these settings. Since private sector provision is subject to the payment of market-defined user charges, spending on private health facilities continued to favor the least poor (see Figure 1).

Distributional incidence of public and overall spending on curative services by level of care and over time



Geographical disparities in the distributional incidence of public and overall spending persist over time

Reflecting the patterns at the national level, districts have experienced increased equality in total public spending over time, but not necessarily in total overall spending on curative services. While both public and overall spending remain heterogeneous across districts, distributional inequalities are substantially greater for overall spending.

In particular, inequality in overall healthcare spending has been striking in districts such as Likoma, Zomba, and Nkhotakota, compared with districts and cities such as Ntcheu, Lilongwe City, Zomba City, Phalombe, and Salima, where contrary to the national trend, even overall healthcare spending on curative services had become pro-poor by 2016.

RECOMMENDATIONS

- There is a need for further investment in public-private partnerships to expand and strengthen service level agreements with both CHAM and private facilities as means of reducing formal and informal fees, and hence ensuring greater equality in healthcare spending across all types of facility.
- Deeper investigations into the origin of differences across districts are needed, especially to understand positive outliers, i.e. what makes public and overall spending pro-poor in some districts and not in others.
- Both government and development partners are advised to channel more resources towards the regions that currently experience the most substantial inequalities in the distribution of healthcare spending, specifically targeting the most vulnerable segments of society.

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