Channeling Funds to Private Providers for HIV Services in Malawi

Malawi, a low-income country in southeastern Africa, has experienced one of the most severe HIV epidemics in the world. In 1997, prevalence among the adult population peaked at 16.1 percent. Over the last decade, increased commitment by the government of Malawi and donors has helped expand and strengthen the national HIV response, reducing the HIV prevalence rate to 14.6 percent in 2003, 11.5 percent in 2009, and 10.8 percent in 2012. Enrollment in antiretroviral therapy (ART) increased from 46 to 76 percent of eligible people living with HIV (PLHIV) between 2009 and 2012 (UNAIDS, 2013).

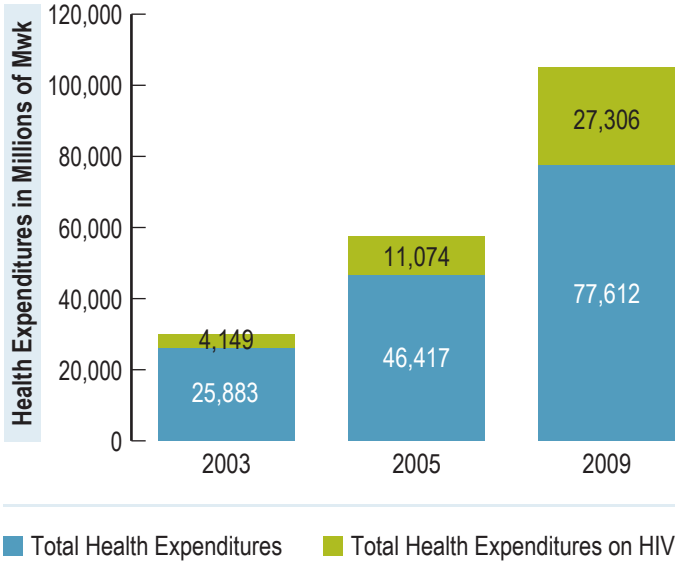
These gains in the fight against HIV occurred during a period of economic and political change. In 2011, donors significantly reduced budgetary support due to a perceived anti-democratic direction of the government. After the installment of new leadership, the government initiated sweeping economic reforms and re-engaged international partners and donors. Although these reforms have improved long-term development prospects (International Monetary Fund, 2013), they led to a severe devaluation of Malawi's currency, compounding effects of the global recession. In 2012, the per capita income at $220 was lower than in 2009 (World Bank, 2014).

Greater fiscal and political stability have led to improved strategic thinking about how to increase available public resources for health and HIV services. Possible approaches include collaborating with donors, reforming governance structures, and engaging the private sector. Malawi's nonprofit and commercial private health sectors have long contributed to the delivery of health care services. There are significant opportunities to further strengthen private sector contributions to the HIV response through groups like the Christian Health Association of Malawi (CHAM), which has had contractual relations with the government of Malawi since 2002 to deliver essential health services. The government of Malawi can further leverage groups like CHAM, commercial providers, private employer groups like the Malawi Business Coalition against AIDS, and other private health sector partners to strengthen the country's HIV response.

Jessica Scranton

A private provider at a rural clinic in Malawi conducts an HIV test.

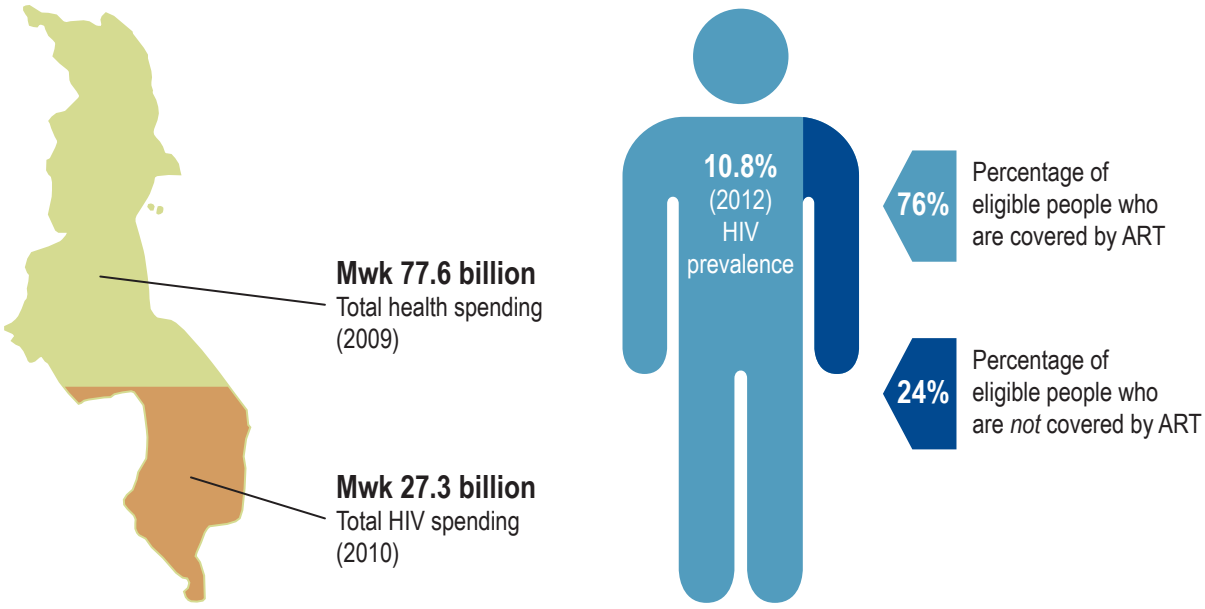
HIV Spending in Malawi, 2003–2009



All financial figures were converted to 2010 Malawian kwacha (Mwk) using GDP deflator estimates from the International Monetary Fund World Economic Outlook Database. U.S. dollar equivalents were estimated using exchange rates from the World Bank.

SHOPS
Strengthening Health Outcomes *through* the Private Sector

Financing and ART Coverage in Malawi



Data on past HIV spending in Malawi's health sector, tracked using the national health accounts (NHA) and HIV subaccounts methodologies, help explain private sector engagement in the HIV response and can support the government of Malawi's efforts to improve the sustainability of its HIV programs. The SHOPS project used data from the 2003, 2005, and 2009 Malawi NHA (Ministry of Health, 2007 and 2012) to track how HIV funds flow through Malawi's health system and to identify implications for how donors and the government can better work with the private health sector.

NHA tracks the flow of health spending in a country. This flow begins with an entity (source), which may be the Ministry of Finance, an external partner, or household, before moving to an agent (manager), such as the Ministry of Health or an NGO. Managers spend the funds at health care providers. NHA identifies the amount of funds spent at each type of provider (public or private, health clinic or hospital), as well as the types of health care goods and services consumed there.*

While the general NHA tracks total health spending, the HIV subaccounts detail health spending on HIV. Estimates for total health spending used in this analysis only include spending on HIV activities that aim to improve, maintain, or prevent deterioration of health. They do not include non-health programs such as those focused on orphans and vulnerable children. NHA and HIV subaccount data can inform decisions about resource allocation and strategic planning, increase transparency, track progress toward spending goals, and inform civil society advocacy efforts.

Private Health Sector Composition

- The nonprofit sector consists of:
- Faith-based organizations
- Charities
- NGOs
- Community-based organizations

The for-profit sector consists of a wide range of commercial entities, including:

- Private health insurance companies
- Privately owned clinics, hospitals, and medical centers
- Companies with employee health programs
- Private pharmacies
- Provider associations and coalitions

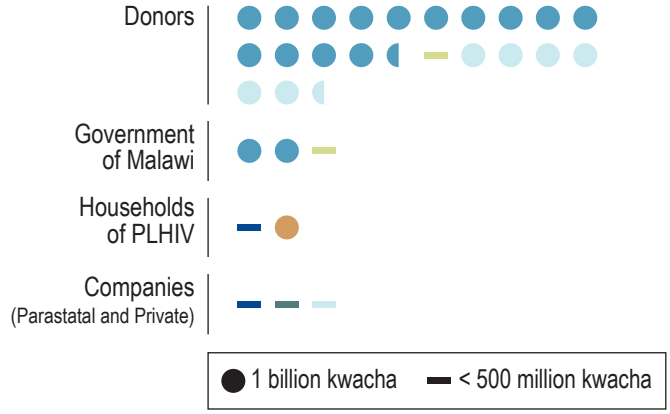
* This methodology was updated in 2011. The Malawi data used in this fact sheet was generated before the update.

Sources of HIV Funds

The diagram below illustrates the flow of HIV funds from various sources to public and private managers, and depicts the following findings:

- Donors accounted for 83 percent of the 27.3 billion Malawian kwacha (Mwk) spent in 2009, which is more than their share of general health funding (61 percent). Between 2003 and 2009, growth in donor spending on HIV increased at a much greater rate than growth in domestic financing.
- In 2009, 30 percent of HIV funds provided by donors were managed by donors and other international partners, a 15 percent decrease from 2003. Between 2003 and 2009, donors increasingly channeled their funds through the government of Malawi.
- Even though increased donor and government financing kept out-of-pocket payments by PLHIV at 4 percent of HIV financing in 2009, the absolute amount of out-of-pocket payments has increased since 2003 and, at about Mwk 1,300 per person living with HIV in 2009, was greater than the average Mwk 585 per capita expenditure in the general population.
- Private entities such as employers, NGOs, and insurance companies only provided 3 percent of HIV spending in 2009, and managed about 7 percent.

Where Do the Funds Originate?



Who Decides How to Spend HIV Funds?

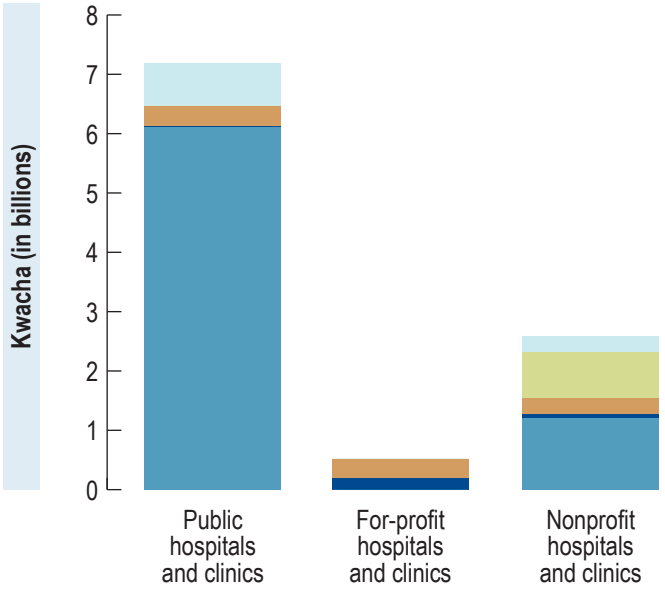
- Public agencies
- Private insurance
- Households (out-of-pocket spending by people living with HIV)
- Companies (parastatal and private)
- International and national NGOs
- Donors

HIV Spending at Providers

The graph below shows HIV spending at public and private facilities. NHA data indicate that HIV spending at public facilities is much larger than spending at for-profit and nonprofit facilities. However, spending at nonprofit facilities (primarily CHAM) has more than doubled as a share of HIV spending since 2003.

- HIV spending at nonprofit facilities (primarily CHAM) increased from Mwk 277.3 million in 2003 to Mwk 2.6 billion in 2009, and became increasingly reliant on donor financing.
- Donors sent funding for HIV to private nonprofit facilities (primarily CHAM) through three different channels: public agencies, donors and international partners, and direct payments to CHAM.
- As of 2009, very little funding from the government of Malawi or donors reached for-profit facilities.
- Between 2003 and 2009, spending on HIV at for-profit facilities increased from Mwk 154.7 to Mwk 522.6 million. Despite effective subsidization by donor and government programs at public and nonprofit facilities, growth in HIV spending at for-profit facilities was primarily financed by out-of-pocket spending by PLHIV in 2009.

Facilities that Receive HIV Funds



10.3 billion Malawian kwacha were spent at all health facilities on HIV services in 2009. Seventy percent went to public facilities, 25 percent went to nonprofit (primarily Christian Health Association of Malawi) facilities, and 5 percent went to for-profit facilities.

Figures based on 2009 data.

Policy and Program Implications

Spending by donors has largely driven the increase in HIV spending, effectively expanding Malawi's HIV response but also increasing donor dependence.
Between 2003 and 2009, general health spending in Malawi increased dramatically (by 200 percent), as did the share of this spending allocated to HIV (16 to 35 percent of all health spending). The shift was largely due to an increased focus on HIV by donors, who provided 83 percent of HIV funds in 2009. This increased investment helped scale up prevention programs and get more PLHIV on treatment, but has led to serious concerns about the sustainability of these programs. At the same time, the government of Malawi is limited by a small economic base, with approximately 80 percent of the population living on less than $2 per day (World Bank, 2014). The government and its partners will need to consider domestic and international options for expanding health and HIV funding as part of the country's fiscal and macroeconomic reforms. Possible options include increased engagement with private sector organizations to finance HIV services through expanded workplace or HIV-related corporate social responsibility programs.

Donor funding remains important for HIV financing in Malawi, but should be linked to long-term strategies for sustainability.
Major donors, including PEPFAR, the Global Fund, and the World Bank, have all identified private sector engagement as a key strategy to expand access to HIV services in a sustainable, country-driven way. The Malawi experience, especially the partnerships with CHAM, provides an example of how private sector engagement can open opportunities for increasing access and equitable coverage. In the future, donors can continue to strengthen and expand the relationship between CHAM and the government by addressing weaknesses and strengthening payment mechanisms. In addition, stakeholders should look for more opportunities to engage for-profit providers. The Malawi Business Coalition against AIDS has taken a lead in training more for-profit providers in HIV services and in representing the private sector in national-level dialogue. Stakeholders could support these and similar efforts to build a more inclusive HIV response.

Rising out-of-pocket spending on HIV at for-profit facilities indicates a need for developing equitable and sustainable financing approaches.
Though out-of-pocket spending on HIV goods and services decreased from 7 to 4 percent of HIV spending between 2003 and 2009, out-of-pocket spending per person living with HIV increased from $2 to $9 over the same period. At for-profit facilities, out-of-pocket payments grew from 32 to 64 percent of HIV spending. Even as donor and government spending has subsidized care, there may still be a need for increased financial protection for low-income PLHIV. As part of efforts to increase sustainability of HIV programs in an equitable way, the government and donors should pursue strategies that replace out-of-pocket payments with financing mechanisms that may provide better financial protection for vulnerable PLHIV who seek care in the private sector.

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For more information about the SHOPS project, visit: www.shopsproject.org

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