ADVANCE DOMESTIC HEALTH FINANCING

Strengthening Malawi's health system: A call for sustainable financing

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Background

Malawi's health system plays a central role in improving the nation's human capital development and economic growth. However, it faces persistent challenges of inadequate and inefficient health financing system. In order to address these challenges and chart a path toward universal health coverage (UHC), the Government of Malawi developed the Health Sector Strategic Plan III (HSSP III) for 2023–2030. This strategy outlines key reforms and investment priorities aimed at increasing domestic resources, improve the efficiency of spending, and invest more in preventive and primary health care that can benefit everyone, especially the most vulnerable. Central to HSSP III is the need for a sustainable health financing system, one that mobilizes sufficient resources, pools them equitably, and ensures efficient purchasing of services to deliver quality care without financial hardship.

Recognising the need for accurate and comprehensive data to guide these reforms, the Ministry of Health (MoH), in collaboration with the African Institute for Development Policy (AFIDEP) and the World Health Organization (WHO), conducted the National Health Accounts (NHA) study covering 2019/20 to 2021/22 fiscal years in 2024. The aim of this study was to generate detailed evidence on where health funds come from, how they are managed, and where they are ultimately spent. This information provides policymakers with a clearer picture of gaps, inefficiencies, and imbalances in the system, helping to inform strategies to make health financing in Malawi more sustainable, equitable, and effective.

Key messages

- Nearly half (47%) of Malawi's healthcare system is donor-funded, posing a risk to long-term sustainability.
- Out-of-pocket spending makes up 25% of domestic health financing, highlighting the heavy financial burden placed on households, especially for non-communicable diseases (NCDs).
- Investment in primary healthcare (PHC) remains low at 43%, below the recommended 59%, while curative and hospital-based care remains dominant.
- A significant share of government (49%) and donor funds (42%) is allocated to governance and administration rather than frontline services, limiting efficiency.

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Methodology

The NHA study applied the System of Health Accounts (SHA 2011) framework developed by the Organisation for Economic Co-operation and Development (OECD), WHO, and Eurostat. This standardised methodology was adapted to reflect Malawi's specific health sector structure and financing arrangements, ensuring both international comparability and local relevance. The study covered fiscal years 2019/2020, 2020/2021, and 2021/2022, utilising both primary and secondary data sources to provide a comprehensive picture of health financing flows. Public sector health expenditure data were collected from MoH, Ministry of Finance and Economic Affairs, National AIDS Commission, District Councils, and other relevant ministries, departments, and agencies. Non-state sector data was gathered from development partners, private firms, parastatal organisations, health insurance companies, foundations, and local and international NGOs. Household out-of-pocket (OOP) spending was derived from the 2019 Integrated Household Survey (IHS) conducted by the National Statistical Office. Data was collected between December 2023 and June 2024.

In total, 250 institutions were surveyed, including 32 development partners, 133 NGOs, 45 employers, 7 ministries and government agencies, 29 district councils, 3 health insurance providers, and the Christian Health Association of Malawi (CHAM). This robust data collection process enabled a detailed assessment of resource mobilization, allocation, and spending patterns across Malawi's health sector.

Findings

Overall, nominal Current Health Expenditure (CHE) increased at an average annual growth rate of 7% over the period. It rose from MWK 523.6 billion (USD 718.2 million) in 2018/19 to MWK 573.3 billion (USD 778.5 million) in 2019/20, MWK 593.8 billion (USD 770.3 million) in 2020/21, and MWK 646.2 billion (USD 791.5 million) in 2021/22. However, in real terms, CHE showed significant fluctuations. In 2019/20, it increased by 8% to MWK 459.8 billion. This was followed by a 6% decline in 2020/21 to MWK 435.3 billion, and a further 12% drop in 2021/22 to MWK 388.7 billion.

The annual per capita spending fluctuated over the period, it rose from USD 39.9 to USD 42.2, reflecting initial growth, then slightly decreased to USD 40.8 before stabilising at $40.9 in 2021/22 which is below the WHO-recommended threshold of USD 86 per capita per year. The average growth rate between 2019/20 to 2021/22 was only 0.9%. Despite these low per capita spending levels, Malawi recorded the third highest current health expenditure (CHE) as a percentage of Gross Domestic Product (GDP) among Southern Africa Development Community (SADC) countries. This apparent paradox reflects structural economic constraints: Malawi's GDP is relatively small compared to its regional peers, while its high population density further dilutes available health resources across more people. These trends indicate modest and uneven growth in health financing, which remains insufficient to meet the demands of a growing population and rising health needs (Table 1).

Table 1: Key health accounts findings

Indicators	2018/19 FY (Base year)	2019/20FY	2020/21FY	2021/22 FY
Population	18,005,268	18,449,828	18,898,441	19,351,892
USD dollar exchange rate*	729	744	822	934
Nominal Current Health Expenditure (MWK billions)	523,623	573.3	593.8	646.2
Real Current Health Expenditure (MWK billions)	421.6	459.8	435.3	388.7
Nominal Current Health Expenditure (USD millions)	718.28	778.50	770.29	791.51
Total Government Health Expenditure (USD millions)	173	180	216	199

Annual per capita health expenditure (at nominal USD exchange rate)	39.9	42.2	40.8	40.9
CHE as percent of GDP	8.8 %	6.5 %	6.3 %	6.5%
Government health expenditure as percent of CHE	24.1%	23.1%	28.1%	25.1%
Government per capita CHE (nominal USD exchange rate)	9.6	9.8	11.5	10.3
Government health expenditure as percent of total government expenditure	8.4%	10.3 %	11.1%	7.9 %
Total private expenditure as percent of CHE	21.4 %	24.2%	23.7%	27.6 %
External/donor funding for health as per cent of CHE	54.4%	52.6 %	48.2%	47.3%
OOPs expenditure on health as percent of CHE	11.9%	11.7%	11.2%	13.2%
OOP as percent of domestic financing	26.1%	24.4%	21.5%	25.1%
Total expenditure on primary healthcare as a percent of CHE	39.7%	46.2%	41.5 %	42.7%

***Average exchange rates were derived from official Research Bank of Malawi website**

1. Persistent donor dependence and emerging sustainability risks

Donors remain the largest contributors to Malawi's health sector, accounting for over half (52.6%) of CHE in 2019/20. However, their contributions declined steadily to 48.2% in 2020/21 and further to 47.3% in 2021/22, signaling a gradual reduction in external support. While government spending increased from 23.1% in 2019/20 to 28.1% in 2020/21, it dropped to 25% in 2021/22, indicating that domestic financing was insufficient to offset the decline in donor funding and the growth was not sustained beyond the Coronavirus disease (COVID-19) period, during which resources were increased to curb the pandemic.

Furthermore, government contributions continue to fall short of the Abuja target, with only 7.9% of total government expenditure allocated to health in 2021/22 well below the 15% commitment. Private sector contributions rose overall from 21.4% in 2018/19 to 27.6% in 2021/22, but the trend remains volatile, highlighting the need for a more structured approach to leveraging private investment.

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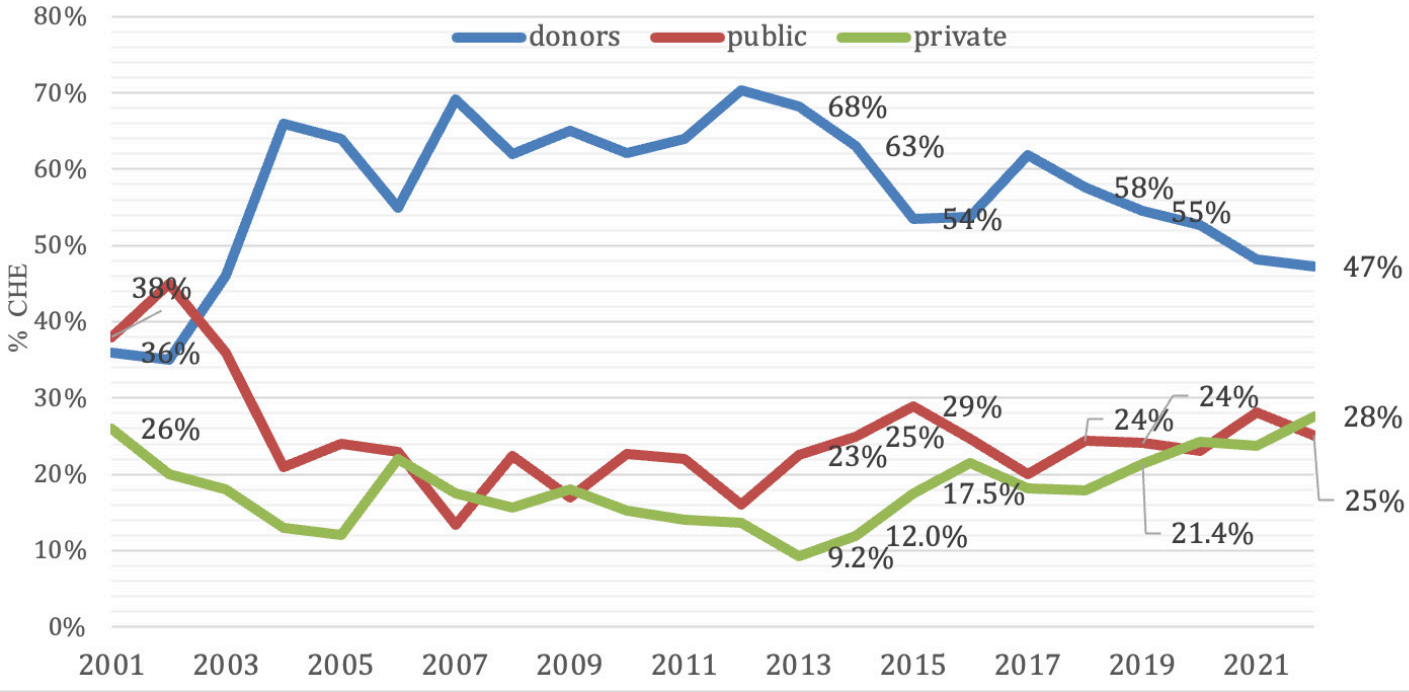
Figure 1: Trend Analysis of Major Financing Sources of Health Funds: 2001/02–2021/22



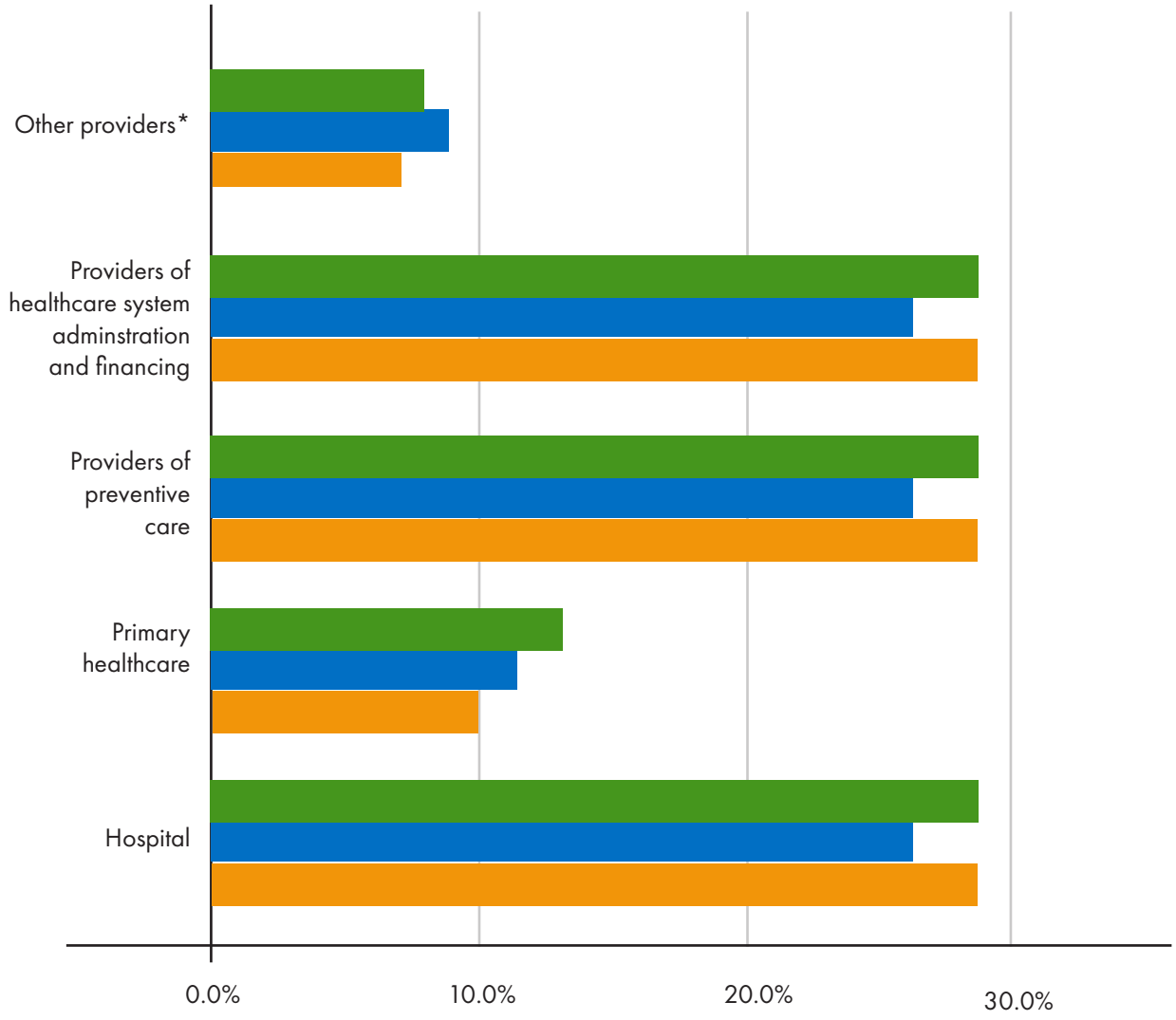
2. High OOP payments relative to domestic financing

Over the study period, OOP spending as a percentage of CHE remained relatively low and stable, ranging from 11.2% to 13.2% between 2018/19 and 2021/22. When examined in relation to domestic health financing, the burden of OOP payments becomes more pronounced. In 2021/22, OOP spending accounted for 25.1% of domestic health financing, meaning households were responsible for nearly one-quarter of locally funded health expenditures. Such reliance on OOP payments, especially in a context of limited insurance coverage, places a disproportionate burden on poorer households, risking delayed care-seeking, unmet health needs, and increased vulnerability to catastrophic health expenditures.

3. Health spending by providers: Underinvestment in primary healthcare (PHC)

Despite some gains in preventive care rising from 28.9% to 30.8% of CHE between 2019/20 and 2021/22, Malawi continues to underinvest in primary-level ambulatory care, which only received 11.9% of CHE in 2021/22. The combined spending of primary-level ambulatory and preventive care was 42.7% falling below the benchmark for low-income countries of spending 59% of Current Health Expenditure on PHC. This level of investment remains insufficient for achieving UHC, with consequences for system efficiency and equity. The heavy allocation to hospital-based services (28%) may indicate an overreliance on costly tertiary care at the expense of more accessible and cost-effective preventive interventions (Figure 2).

Figure 2: Health spending by providers[1]



4. Health spending by health functions: Imbalanced allocation favoring curative care

From 2019/20 to 2021/22, curative care's share of CHE rose from 39.1% to 43.3%, while preventive care increased from 26.3% to 29.1%. Governance and administrative functions consistently absorbed a high proportion of CHE (averaging 26.5%), raising concerns about opportunity costs and the diversion of resources from essential service delivery. This spending pattern reflects a reactive health system that addresses disease after onset, rather than proactively preventing it thereby compromising long-term efficiency and outcomes.

5. Donors fund disease prevention and households bear the burden of NCD care

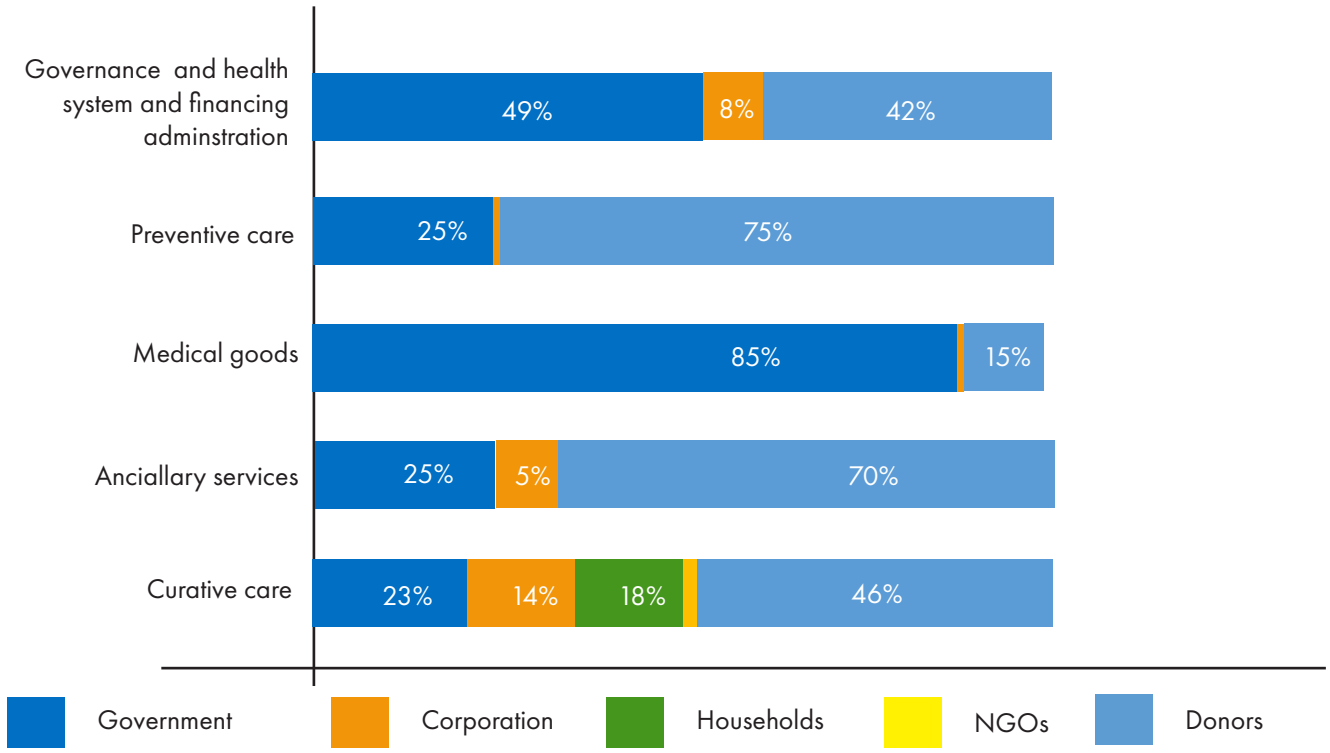
Health expenditure in Malawi reveals a dual challenge of donor dependency and household financial burden across disease categories. Communicable diseases such as HIV/AIDS, malaria, TB, and reproductive health are overwhelmingly financed by donors with external sources covering up to 79% of costs making these essential services highly vulnerable to shifts in global funding priorities. Conversely, NCDs and injuries receive minimal donor and public support and rely heavily on household out-of-pocket payments (49% and 32%, respectively), placing significant financial strain on individuals and potentially limiting access to care. Mixed financing patterns for conditions like diarrheal diseases and nutritional deficiencies suggest some progress toward diversified funding but underscore the need for strategic resource mobilisation tailored to disease burden and equity considerations.

[1]Health providers are entities that receive money from a financing agents in order to provide services or perform health functions for consumers of health care goods and services.

6. Allocation of goods and services expenditure by financing source

Government and donor funding show a skewed allocation toward governance and administration, which consumed 49% and 42% of their respective resources, while only 23% and 46% went to curative care, and 25% and 75% to preventive services. Households allocated only 18% of their health spending to curative care and almost nothing to prevention, reflecting affordability constraints and limited engagement in preventive behaviors. Corporate and non-profit contribution remained marginal across all categories, indicating underutilized potential.

Figure 3: Allocation of goods and services expenditure by financing sources



Policy implications

The findings from the 2019/20-2021/22 National Health Accounts underscore urgent and strategic policy shifts needed to address critical vulnerabilities in Malawi's health financing system. The country's continued overreliance on donor funding especially for communicable diseases exposes the health sector to external volatility, reducing long-term sustainability and limiting the government's ability to independently set priorities. With donor contributions declining over recent years, Malawi must intensify efforts to expand and diversify domestic financing sources, ensuring stable funding for essential health services.

Simultaneously, the growing burden of OOP payments, particularly for non-communicable diseases (NCDs) and injuries, places significant financial strain on households and undermines equity in access. High OOP spending increases the risk of catastrophic health expenditures, especially for low-income and informally employed populations, potentially leading to delayed treatment or unmet health needs. This calls for urgent expansion of financial protection mechanisms, such as affordable health insurance schemes and improving current public health services targeting vulnerable and underserved groups.

The underfunding of PHC and preventive services, coupled with disproportionate investments in tertiary care and system administration, points to inefficiencies that compromise value for money. Investing more in PHC would not only improve service accessibility but also reduce hospital overload and long-term system costs. Moreover, the high share of administrative spending at the expense of direct service delivery reflects inefficiencies that must be addressed through public financial management reforms and improved accountability mechanisms.

Recommendations

- Ministry of Finance and Economic Affairs (MoF) to raise government health spending to meet regional commitments (e.g., Abuja Declaration 15% target).
- Ministry of Health (MoH), in collaboration with MoF, to fast-track implementation of earmarked health taxes and private sector engagement reforms
- MoH and MoF to develop a phased domestic co-financing roadmap for key donor-supported programmes (e.g., HIV, TB, malaria), including budget integration plans
- MoH to design and scale up affordable health insurance schemes for informal and low-income populations
- Ministry of Local Government and Rural Development to ensure availability and quality of public services at primary care facilities, especially in underserved areas
- MoH to progressively reallocate the national health budget so that at least 59% of Current Health Expenditure goes to PHC and community health systems, aligning with WHO benchmarks.

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