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The evolving two tier health system in Malawi

Elvis Mpakati Gama and Barbara McPake
Public and private health sector

- Previously health system dominated by public health sector
- A growing private health sector operating parallel to the public health sector
- Hint on the evolving of a two tier health system
Private health sector

- 40% of health care provided by private health sector (Ngalande Banda & Simukonda, 1994)

- 58% of all health-care financing spent on private provision (WHO secretariat report, 2008)

- Number of clinical officers and medical attendant in the private sector increased by 79% and 33% respectively between 2005 and 2006 (GTZ, 2007)
Private health sector

- Business registrar report
- Medical Council of Malawi
- WHOSIS data indicate stagnation of private expenditure as depicted in figure 1 on the next slide.
General public and private health expenditure

Source: By Author using data from World Health Organisation–National Health Accounts server.
A reflection on the impact of two tier health system in Malawi on:

- Human resources
- Factor prices and quality
- Distribution of users
- Distribution of benefit incidence across user groups
Human resources

Public sector: Push factors
- Poor remuneration
- Bad working conditions
- Heavy workloads

Pull factors
- Higher remuneration
- Reduced workloads
- Improved professional resources

Private sector
Human Resources

Resignations

Institute for International Health and Development--IIHD
Human resources

- Exacerbate the existing skills shortages in the public health sector

- Diversion of trained health care personnel to local private sector—For profit and non-profit

- For example, in 2005 only 1 out of 22 doctor graduates joined the civil service
Factor prices and quality

- Like all production processes, health care provision requires inputs (Factors of production)
- Different factors of production
- Human resource and drugs (Medicine)
- Factors are subject to forces demand and supply
- Factor prices particularly labour has gone up due to competition for factors between Public and private health sector
- Retention of skilled personnel
- Government can not compete based on price
The dynamics of domestic labour market and disparities between public and private remuneration could seriously affect the provision of healthcare (Mc Coy et al., 2006).

The labour markets adhere to economic theory in that a skilled health worker will accept a job if the benefits of doing so outweigh the opportunity cost (Hongoro and Normand, 2006).
Factor prices and quality

- Malpractices
  - Employment of unskilled personnel due to high wages of skilled health personnel
  - Counterfeit drugs (medicine)
  - Leakage of drugs from public institution to private sector providers.
Distribution of users

- Contrary to the assumption that private health care services are mainly utilised by people of higher socioeconomic status,

- More than 40% of people in the lowest economic quintile receive medical care from private providers.
- The private sector serves both the rich and poor.

- The poor people living in rural areas rely on informal private sector providers like drug peddlers

- The rich in urban centres benefit from higher quality private sector providers
Distribution of benefits

- Due to the wide range of private sector providers price and quality vary considerably
- Good quality services in affluent urban areas
- Frankly dangerous practices in rural and poor neighbourhood
Conclusion

- Diversion of trained health care personnel to local private sector – For profit and non-profit
- Exacerbate the existing skills shortages in the public health sector
- Low income people forced to use private health care
- Top up salaries through SWAP’s
- Sustainability of salary top ups
Reference

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- WHO, 2008, Capacity building to constructively engage the private sector in the providing essential health care services, Secretariat report, EB124/18
Thank you