

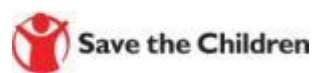


Patients at a hospital in Ngabu, Malawi, some lying on beds with no mattresses. Photo: Joseph Mawale/Oxfam

# THE RIGHT CHOICES

## Achieving universal health coverage in Malawi

Malawi has a proud history of delivering free healthcare for its citizens, but this is now seriously under threat. Bypass fees for hospitals are already causing major hardship by excluding poor people from accessing the healthcare they need. The Government of Malawi must reject the fees system completely and instead use tax financing and development aid. Development partners must support the health sector with adequate financing to fulfil world leaders' commitment to ensuring that no one is left behind. Malawi cannot be the first country in a generation to introduce these dangerous fees while the world watches.



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# 1 INTRODUCTION

Malawi has a long tradition of free healthcare. In the 1990s, when African countries from Angola to Zambia introduced user fees for health services, often as a result of World Bank and IMF loan conditions,<sup>1</sup> Malawi resisted, putting the interests of its citizens first. The past two decades have seen significant progress in health outcomes,<sup>2</sup> while the country has maintained a public health service that is free at the point of use. Following the global adoption of the new Sustainable Development Goals (SDGs) in 2015, Vice-President Saulos Chilima outlined Malawi's vision of achieving the target of universal health coverage (UHC),<sup>3</sup> where all people can access the healthcare they need without facing financial hardship.

However, Malawi is currently facing a health sector funding crisis. A series of corruption scandals, including 2013's infamous 'Cashgate' affair, has seen mass donor withdrawal of direct budget support for health.<sup>4</sup> As aid accounted for as much as 70 percent of Malawi's health spending,<sup>5</sup> its withdrawal has had a dire impact. Compounded by the country's overall economic woes, health services are battling widespread staff shortages and medicine stock-outs, and hospitals and clinics are overwhelmed by demand. Even ambulance services and meals for patients have been suspended in recent months.<sup>6</sup> Malawi's health workers face an impossible situation in trying to maintain a functioning health system, while the Ministry of Health (MoH) is unable to address the current crisis without additional revenue.

Faced with this emergency, in 2015 the Government of Malawi convened a series of committees to investigate potential healthcare reforms, including one exploring the expansion of paid-for services in hospitals. An outcry from civil society groups saw the committee rule out any introduction of universal user fees for healthcare,<sup>7</sup> and ministry officials have since publicly highlighted the regressive nature of direct payments.<sup>8</sup> Yet despite this, Malawi's central hospitals have increasingly been charging user fees, allowing those who can afford it to pay for higher-quality, hospital-based care, while leaving the poorest people behind. For many people these fees have been unavoidable, necessitating the selling of assets critical to their livelihoods, or their going without much-needed care altogether. Recent reports indicate that fees will be expanded to district-level facilities in July 2016, and a policy governing user fees will be submitted for Cabinet approval in the coming months.<sup>9</sup>

This paper presents the results of interviews commissioned by Oxfam, Save the Children International, Médecins Sans Frontières, National Association of People Living with HIV and AIDS in Malawi (NAPHAM) and Global Hope Mobilization.<sup>10</sup> The interviews illustrate how Malawi's current experiment with hospital user fees is a highly regressive step that simply pushes the burden of financing the health sector onto the country's poorest people. If the Government of Malawi is to achieve

UHC, it must urgently abolish user fees in all health facilities, and instead prioritize mechanisms to raise more public finances for all levels of the health system.

Free and high-quality public healthcare could mitigate the growing gap between rich and poor seen in Malawi today and afford every Malawian the chance to live a healthy, productive life. As such, this should be a presidential, government and donor priority.

## 2 HEALTHCARE USER FEES, THE FLAWS

### The wrong solution: bypass fees and fee-paying wards

Bypass fees – fees charged when treatment is sought directly at hospital level, circumventing primary healthcare – are being charged in four tertiary hospitals in Malawi. A charge of Malawian Kwacha (MK) 1,500 at Kamuzu (in the capital Lilongwe), Mzuzu and Zomba Central Hospitals was drastically scaled up in the first half of 2015 as part of the government's health reform agenda, with fees since implemented also at Queen Elizabeth Central Hospital (QECH) in Blantyre.<sup>11</sup> The bypass fee now stands at MK 2,500 in at least two of these facilities, while there are reports of an increasingly arbitrary charging system in others.<sup>12</sup>

At the same time, fee-paying wings have been expanded in Kamuzu, Queen Elizabeth and Zomba Central Hospitals, where people seeking care and who are able to pay can choose to receive treatment in a separate ward. User fees will also reportedly be charged at district-level facilities from July 2016.<sup>13</sup> According to statements from the MoH, these will be levied on an opt-in basis, and will secure higher-quality services and preferential treatment for those who can afford them.<sup>14</sup>

#### Box 1: Healthcare fees and ongoing debt

*'I am Mrs Mwale<sup>15</sup> and I live in Mzuzu. I am a mother of five and a vegetable vendor. My third-born child died of malaria when she was six years old. In May this year [2015] my last-born child had malaria. I went to our Central Hospital (Mzuzu) for medical attention. I was told I should pay MK 1,500 or go to Mzuzu Health Centre. I only had MK 500 on me. Knowing that there are very long queues at the health centre, I called my friends and borrowed the money so that I could have my child attended. I didn't want to go and queue and end up losing her. I lost one before and I didn't want to go through the pain again. I was helped out by my friends, paid the MK 1,500 bypass fee, and the child was attended.*

*My business was, however, not going well. I failed to raise money to repay the friends who helped me. I ended up selling my bicycle that we were using for the vegetable vending business to pay off my debt. I am struggling to make ends meet but I am happy I have my child with me. With God's grace, I will make some more money and buy another bicycle.'*

### Life-or-death decisions

Even the smallest fee for healthcare can have a catastrophic impact on people living in poverty. For some, like Mrs Mwale, fees necessitate the selling of household assets to pay for vital care, jeopardizing their livelihoods. Each year 100 million people worldwide are pushed into

poverty through having to make direct payments for health services.<sup>16</sup> For countless others, user fees mean going without healthcare altogether, with women and girls especially likely to be denied treatment.<sup>17</sup>

Reports abound of the toll of unnecessary suffering and death that healthcare user fees take on the lives of ordinary people across the world. For example, the horrific account of a pregnant woman and her unborn twins dying on the steps of a hospital in Cameroon.<sup>18</sup> These tragedies are entirely avoidable.

The MoH has argued that Malawi's healthcare fees will remain optional and that the poorest patients will therefore be protected from their impacts.<sup>19</sup> Yet situations where user fees are in effect compulsory are already widespread. Lilongwe city has small number of primary healthcare centres serving an estimated total population of one million people. Each centre shuts in the afternoon, leaving patients with no choice but to pay fees for hospital-based care outside of clinic opening hours, or go without treatment altogether.<sup>20</sup> For patients living close to fee-charging facilities only, bypass fees are seen simply as 'a punishment or abandonment'.<sup>21</sup>

Furthermore, evidence shows that when user fees exist, exemptions for those who remain entitled to free care do not work in practice.<sup>22</sup> Instead, the poorest people usually face the same fees as everyone else, even when they cannot afford them.<sup>23</sup> As the charging of fees expands into more and more of Malawi's health system, there is also an increased risk of health centres unilaterally charging more for their services and even making unaffordable and arbitrary demands for payment.

The expansion of user fees can only lead to countless Malawians going without the healthcare they need. Evidence on service uptake when fees are removed gives an indication of how much service use could decline if more fees are introduced. Deliveries at Christian Health Association of Malawi (CHAM) facilities increased by between 50 percent and 169 percent after fees were removed, for example;<sup>24</sup> facilities facing the introduction of fees could expect to see their utilization rates plummet to a similar degree. The impacts of this on individuals would be horrific, and increased fees would engender a reversal of Malawi's hard-won gains in health outcomes.

*'For so many ordinary Malawians, these bypass fees represent an effective ban on accessing hospital care. With primary healthcare facilities overwhelmed and barely functioning, this is a clear violation of Malawians' right to health'*

Safari Mbewe, Executive Director, MANET+

## Shifting the burden

MoH officials cite the introduction of bypass fees as a control measure, deployed to deter people from seeking hospital care when they can be treated in health centres.<sup>25</sup> Their introduction aims both to ease congestion at hospital level and to rationalize the referral system. While rational referrals are indeed a pre-requisite for an effective, equitable and efficient healthcare system, these must be based on need. If someone first attends a primary healthcare facility for a health condition, there must be the capacity to effectively escalate them to hospital level as required.

Conversely, research by Oxfam and its partners found that the bypass fees introduced in Malawi's hospitals simply convert the referral system into one based predominantly on the ability to pay. The majority of people interviewed who could afford to pay the bypass fee reported that they would continue to seek care directly at hospital level, due to concerns about poor-quality services at other facilities.<sup>26</sup>

*'Why should I waste my time going to my designated health facility in Kawale when I know if I go there I will spend hours queuing and I still won't get the services I need? I would rather go to KCH [Kamuzu Central Hospital], pay the bypass and get the services I want.'*

In depth Interviewee, Lilongwe

*'The situation in most primary health facilities is dire. There are serious staff shortages, with the problem most serious in the evenings; stock-outs of basic medical supplies are common; there are poor or no reliable transportation systems between primary, secondary and tertiary health centres (no ambulances). You avoid all these weaknesses by going straight to a Central Hospital and you are asked to pay MK 1,500 bypass.'*

Participant in focus group discussion (FGD), Pilimiti Health Centre catchment area, Zomba

Unsurprisingly, however, most poor people living in urban areas had stopped seeking treatment directly in hospitals due to the prohibitive cost of the fees, and the majority of people in rural areas said they would do the same.<sup>27</sup>

*'I want to get better services but I would be lying if I said that I would go and pay bypass fees. I struggle to buy medication when I am told there is no medicine in the facility. I am even struggling to feed my children.'*

Participant in FGD, Makawa village, Zomba

*'The bypass fee of MK 1,500 is prohibitive. It's too much money for some of us. I need to also pay for transport. At times I need to buy drugs. It means only the well-to-do can access better services at central hospitals.'*

In-depth Interviewee, Likuni

Furthermore, without significant investment in primary healthcare, bypass fees condemn poor people to low-quality services and long queues, the very same drivers of hospital self-referrals. As demand for primary healthcare grows among poor people, the quality of services can be expected to decline even further. Kawale Health Centre in Lilongwe reported a significant increase in patient numbers when fees were raised to MK 1,500 at the nearby Kamuzu Central Hospital.<sup>28</sup> The better-off have the luxury of bypassing these services by paying for better-quality healthcare that is nonetheless still subsidized by government (i.e. taxpayers') money – a double inequity.

Furthermore, the evidence cited above from the Mzimba health centre shows how easily referral procedures can be ignored once they become monetized, with referral letters themselves being treated as an overpriced commodity.<sup>29</sup> Poor patients attending that particular facility effectively face a blanket ban on hospital-level care, no matter how much they are in need of specialist treatment. The head of the World Health Organization (WHO) said in 2009: 'User fees for health care were put forward as a way to recover costs and discourage the excessive use of health services and the over-consumption of care. This did not happen.'<sup>30</sup>

*'People do not have enough money, and bypass fees would just be a punishment. Sometimes they come here because they have been to health centres where they were not helped fully due to shortage or lack of drugs, and to punish such people with bypass fees would be unreasonable.'*

District health worker

## **Two-tier systems deepen inequality**

Any system where paying fees gives access to higher-quality services, leaving lower quality for those who cannot afford to pay, is fundamentally inequitable and incompatible with the values of UHC. Already inequality is growing in Malawi; in just seven years the gap between the richest 10 percent of the population and the poorest 40 percent has increased by almost a third.<sup>31</sup> Oxfam has estimated that 1.5 million more Malawians could be living in poverty by 2020 if inequality is allowed to continue growing at this rate.<sup>32</sup>

Free, quality, public services could help to reverse this trend, by ensuring that all Malawians have access to the same opportunities in life. Conversely, allowing two-tier systems to grow in vital sectors like health will only fuel the deterioration of life opportunities for the poorest and deepen inequality. When only people in poverty use free, public systems, there are fewer incentives for others to defend investment in public services or to pay their taxes, setting in motion a downward spiral of deteriorating quality of care.<sup>33</sup>

The inequity of bypass fees is further entrenched and exacerbated in Malawi by the growth of fee-paying services, which are soon to be expanded to district hospital level.<sup>34</sup> Even where free care remains available (and fees do not become universal), it is clear that the expansion of direct payments for higher-quality services will dramatically escalate health inequalities.

Moreover, concerns have been raised that in already short-staffed hospitals doctors and nurses will inevitably spend more time in paying wards, where better services will be expected. The MoH has itself made it clear that fees will buy 'special treatment'.<sup>35</sup> Unsurprisingly, Oxfam and

partners' research found that most poor people would never attend paying wings in hospitals, as they would not be able to afford to.<sup>36</sup>

*'I have seen some patients with a problem like my daughter's getting help within a day or two, but for us it's over a month now. Each time we have an appointment for an operation we are told that there is no equipment for the procedure and to just give her paracetamol. The hospital only has equipment for the paying ward and not the poor like me. That is unfair, and scaling up these paying services will not help us at all.'*

Mrs Brighton, whose daughter is a patient at Kamuzu Central Hospital

## **Fees raise minimal revenues**

While Malawi's health sector is urgently in need of additional revenue, evidence shows that user fees will contribute very little to addressing this problem. User fees raise only a minimal amount of funding for health, rarely contributing more than 5 percent of health budgets.<sup>37</sup> Such schemes come with their own administrative costs too; one study in Zambia found that the expense of administering user fees was almost equal to the revenue raised.<sup>38</sup>

Malawi's experiment with bypass fees and fee-paying wards has proved no exception, with research by Oxfam and partners finding that finances raised have been minimal. Kamuzu Central Hospital generates an average of just 9 percent of its monthly budget from direct payments, for instance, while for Zomba Central Hospital the figure falls to less than 7 percent.<sup>39</sup> Based on this track record, revenue raised by the two hospitals would likely contribute just 0.25 percent of Malawi's total planned government health expenditure.<sup>40</sup> Thus the catastrophic impacts of fees on progress towards UHC – and on the lives of ordinary Malawians – would all be incurred for a negligible amount of money, sufficient to secure barely any improvements to the country's health system.



# 3 ACHIEVING UHC

## Investing in primary healthcare: a cost-effective solution

Not only would investing in primary healthcare facilities address the quality concerns and overcrowding that are causing the current congestion at hospitals in Malawi, it would also make economic sense. Evidence suggests that scaling up primary healthcare can lead to significant progress in health outcomes at a comparatively low cost. For example, Ethiopia made such strides through its Health Extension Worker programme, which trained and deployed 24,000 community health workers between 2004 and 2008.<sup>41</sup> During this period, child mortality rates fell by almost a quarter, while health expenditure increased from less than \$6 per capita to just under \$14 per capita.<sup>42</sup> Since 2008, child mortality rates have fallen by a further 27 percent.<sup>43</sup> While health spending in Ethiopia still falls short of the recommended \$86 per capita needed to achieve universal primary healthcare, this shows how limited domestic public resources augmented by donor support can go a long way when invested effectively at the primary level.<sup>44</sup>

### **Box 2: Expanding Service Level Agreements with The Christian Health Association of Malawi (CHAM): A leap forward towards UHC**

The Government of Malawi has decided to expand the Service Level Agreements (SLAs) governing support to CHAM services. This is a welcome move to scale up investment in primary healthcare. Previous SLAs tended to cover maternal, newborn and child health only, leaving those outside these categories living near CHAM facilities having to pay for care. Research by Oxfam and partners found evidence of people living in CHAM catchment areas selling household assets, incurring debts and avoiding treatment until they were in a critical condition because they could not afford to pay fees.<sup>45</sup>

As CHAM provides 37 percent of all healthcare in Malawi, expanding SLAs to ensure that CHAM facilities provide the full Essential Health Package for free would have a dramatic impact on service utilization.<sup>46</sup> The introduction of SLAs for maternal healthcare increased delivery rates at CHAM facilities by as much as 169 percent.<sup>47</sup>

Implementing this proposed reform would rapidly deliver significant health benefits to communities and could prove an appealing proposition to donors re-engaging with Malawi's health system.<sup>48</sup> While the current reform applies only to facilities outside an 8km radius of a government health facility, expanding SLAs to cover all CHAM centres would be an even greater step towards achieving UHC in Malawi.

## Paying for UHC

Public financing has been shown to provide the most sustainable, reliable and equitable funding for healthcare; the majority of countries that have attained UHC have done so by prioritizing public spending on health through general taxation.<sup>49</sup> Taxation revenues inherently form national-level risk pools, which are key for maximizing equity and progress towards UHC.<sup>50</sup> For Malawi, significant scale-up of health spending from public finances will be required in order to realize this goal.<sup>51</sup> One vital first step would be realizing Malawi's commitment to the Abuja Declaration, ensuring that 15 percent of the national budget is consistently spent on health.

Aid is also needed to cover Malawi's health financing gap in the short to medium term in order to achieve UHC. WHO has highlighted that 41 of 49 low-income countries would need aid to support their health systems for the foreseeable future if global health goals are to be reached, as domestic resources would be insufficient.<sup>52</sup> It is critical that the Malawian government prioritizes the strengthening of accountability and transparency mechanisms in order to win back the trust of donors.

Donors in their turn should implement transitional arrangements for aid for essential health system interventions such as health worker salaries, rather than taking a piecemeal, project-based approach. Ideally they should re-establish set sector-based budget support for the health sector in Malawi as a matter of urgency, with basket funding guaranteed for the medium term. If they are concerned about accountability, then this basket funding could be held outside of general government accounts in the first instance. Donors with a history of funding Malawi's health sector or with a focus on the reduction of out-of-pocket payments for healthcare, such as the UK's Department for International Development (DFID) and the World Bank, must support the country to maintain free healthcare at this challenging time.

In the long term, UHC should increasingly be financed through the mobilization of domestic resources, particularly through general taxation and innovative financing. Donor governments and multilateral institutions must support the Government of Malawi through increasing aid to health and providing technical assistance in both health and mobilizing tax financing.

## Efficiency savings: potential to recover financing for health

The government's investigation into the potential for efficiency savings in the health sector is a welcome element of Malawi's health reforms. An Oxfam study in Ghana found the potential for \$239m in savings each year if specific efficiency measures were to be implemented in the health sector, including strengthening preventive healthcare and tackling fraud and leakages.<sup>53</sup> In Malawi, clamping down on drug pilferage alone could

present significant cost savings for the health sector. Ensuring the provision of free, quality generic medicines could support these efforts further by minimizing demand for medicines from the expensive private sector market.

### **Box 3: Clamping down on tax dodging**

Malawi is losing out on significant revenue as a result of corporate tax avoidance. Recent research has shown that the country lost out on \$43m over six years through the tax practices of just one company – the Australian mining firm Paladin.<sup>54</sup> That is equivalent to a third of Malawi's annual health budget,<sup>55</sup> and is enough to pay the annual salaries of 17,000 Malawian nurses.<sup>56</sup>

The \$43m that Paladin cut from its tax bill in Malawi has robbed the country of vital revenues that could have been invested in an overwhelmed healthcare system serving people in poverty. Companies must be held to account for their national operations and be taxed accordingly.

Governments must end the practice of providing tax incentives that deprive the public purse from much needed revenue. Furthermore, governments must cooperate at a global level to reform the broken global tax system that makes large-scale corporate tax avoidance easy and inevitable.

Governments of richer countries, where most of these multinational companies are based, have a particular responsibility for stopping these exploitative tax practices.

## **Progressive taxes, innovative financing and a Health Fund**

Exploration of a Health Fund mechanism as part of the government's health reform process is a welcome step with the potential to expand public financing for UHC. The Health Fund Committee proposed numerous mechanisms that have high revenue-raising potential. These include 'sin' taxes on tobacco and alcohol and an extractive industry tax, additional visa fees for incoming tourists and contributions from development partners. WHO estimates that a 50 percent increase in tobacco excise taxes in 22 low-income countries would generate \$1.42bn in additional funds.<sup>57</sup> In 2009, Gabon raised \$30m for its health sector via a 1.5 percent levy on the post-tax profits of companies that handle remittances and a 10 percent tax on mobile phone operators.<sup>58</sup> Ensuring robust financial safeguards for any Health Fund would help secure new aid flows. In this scenario, a Health Fund may be a useful mechanism through which donors could channel restored aid to the health sector.

#### **Box 4: Health insurance schemes: another approach to avoid**

A far less welcome proposal currently being explored as part of Malawi's health sector reforms is one for a health insurance scheme (HIS), which would only benefit the better-off. This scheme would introduce medical insurance for people in formal employment, starting with public civil servants.<sup>59</sup> Worryingly, reports indicate that its beneficiaries would access the higher-quality paying services at central and district hospital level, thus establishing a clear divide between salaried workers and the majority of Malawians working in the informal sector. The proposed scheme would not only further widen the gap between paying and non-paying services, but would also entrench the large-scale exclusion of informal sector workers from higher-quality healthcare, widening overall inequality.

Moreover, there is strong evidence that such SHI models are ill suited to countries that have large informal economies, even when they set out to include the informal sector. Ten years after the introduction of SHI schemes in Ghana and Tanzania, coverage had reached only 36 percent and 17 percent respectively, due to challenges in enrolling people outside of salaried employment, including the prohibitive cost of premiums.<sup>60</sup>

A study assessing the impact of insurance on poor people and informal workers stated: 'There is no strong evidence to support widespread scaling up of social health insurance schemes as a means of increasing financial protection from health shocks or of improving access to health care<sup>61</sup>.' Pursuing an SHI scheme can even result in a reduction in the overall resources available for health spending, as perceptions about the additional income expected from premiums can signal to finance ministries that they can reduce tax-based funding for health. Similarly, employer contributions can result in large bills for governments rolling out such schemes to civil servants, while the administration involved in initiating an SHI scheme from scratch (and identifying and chasing informal workers for enrolment) also comes at a significant cost.<sup>62</sup>

# 4 CONCLUSION AND RECOMMENDATIONS

As Malawi's deliberations on potential health reforms conclude, it is vital that the right choices are made to deliver equitable progress towards UHC, and to help tackle Malawi's growing inequality gap. Malawi must remain committed to its tradition of free, publicly delivered healthcare, paid for by publicly raised revenue.

While the country's fiscal challenges should not be underestimated, the common assumption that there is insufficient fiscal space to increase government spending on health needs to be challenged and additional revenue-raising mechanisms should be explored. Regressive initiatives like bypass fees, which only deepen the gap between the haves and the have-nots and which fail to address the real challenges facing Malawi's health sector, must be abolished.

## **The Government of Malawi should:**

- Reverse the introduction of bypass fees in all hospitals, and ensure that fee-paying wings are suspended. Ensure that tertiary hospitals receive sufficient funding from central government revenues to support the removal of fees;
- Increase investment in healthcare in line with the Abuja Declaration, ensuring that 15 percent of the national budget is consistently spent on health;
- Implement its proposal to broaden CHAM SLAs to incorporate the full essential Health Package, ensuring that this can be accessed for free throughout Malawi;
- Implement its proposal to establish an accountable and transparent Health Fund, and continue to investigate innovative financing mechanisms and progressive taxes to mobilize additional health sector resources;
- Prioritize investment in primary healthcare, to deliver cost-effective, equitable progress towards UHC;
- Implement transparency and accountability mechanisms to help restore donors' trust and aid to the health sector;
- Stand up to corporations demanding unfair tax breaks, which starve government accounts of vital revenues for public services.

## **Donor governments and agencies should:**

- Support mechanisms for transitional support to the health sector to help advance UHC, rather than adopting piecemeal project-based approaches, until satisfactory progress is made in implementing transparency and accountability mechanisms with a view to restoring budget support for the health sector;

- Support the Government of Malawi to remove existing user fees in the public healthcare system, and expand public financing for the sector;
- Push for collective, international action to limit tax avoidance and evasion practices, and eliminate harmful tax incentives.

# ANNEX

**Table 1: Income realized from bypass fees and paying wings, January–July 2015: Kamuzu Central Hospital (KCH)<sup>63</sup>**

Month (2015)	Amount raised from Out Patients Department (MK)	Amount raised from paying wing (MK)	Total	Total as a percentage of KCH required monthly budget (%)
January	6,384,000	6,321,000	12,705,000	8.47
February	8,961,000	8,862,000	17,823,000	11.88
March	14,401,500	4,578,000	18,979,500	12.65
April	5,506,500	7,602,000	13,108,500	8.74
May	3,061,500	8,652,000	11,713,500	7.80
June	8,131,500	4,704,000	12,835,500	8.56
July	4,176,000	4,179,000	8,355,000	5.57
<b>TOTAL</b>	<b>50,622,000</b>	<b>44,898,000</b>	<b>95,520,000</b>	<b>9.1</b>

# NOTES

- 1 See, for example, M. Froystad et al. (2011). *Health Services in Angola: Availability, Quality and Utilisation*. CMI. <http://www.cmi.no/publications/file/4319-health-services-in-angola.pdf>; and F. Masiye et al. (2008). *Removal of User Fees at Primary Health Care Facilities in Zambia: A Study of the Effects on Utilisation and Quality of Care*. University of Zambia/Equinet. <http://equinetafrica.org/sites/default/files/uploads/documents/Dis57FINchitah.pdf>
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- 10 The research was carried out across six districts of Malawi in November 2015: Lilongwe, Zomba, Mzuzu, Phalombe, Mzimba and Dedza. In total, 56 key informant interviews were conducted, 31 in-depth interviews and 52 focus group discussions.
- 11 See, for example, P. Kumbani (2016). *MoH Hails By-pass Fee System*. *The Nation*, 9 February 2016. <http://mwnation.com/moh-hails-by-pass-fee-system/>; and E. Nantchengwa (2016). *Congestion Hit Malawi Hospitals*. *The Daily Star*, 23 March 2016. <https://www.malawistar.com/2016/03/23/congestion-hit-malawi-hospitals/>
- 12 A. Makina (2015). *Malawi Hospitals Start Charging K25,000 Per Referral*. Malawi24, 5 December 2015. <http://malawi24.com/2015/12/05/malawi-hospitals-start-charging-k25000-per-referral/>
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- 15 Not her real name.
- 16 WHO (2005). *Medical costs push millions of people into poverty across the globe*. 5 December 2005. <http://www.who.int/mediacentre/news/releases/2005/pr65/en/>
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[http://www.governmentspendingwatch.org/spending-data/data?countries%5B0%5D=Malawi&sector%5B0%5D=agriculture&sector%5B1%5D=health&sector%5B2%5D=education&sector%5B3%5D=environment&sector%5B4%5D=gender&sector%5B5%5D=social\\_protection&sector%5B6%5D=wash&sect](http://www.governmentspendingwatch.org/spending-data/data?countries%5B0%5D=Malawi&sector%5B0%5D=agriculture&sector%5B1%5D=health&sector%5B2%5D=education&sector%5B3%5D=environment&sector%5B4%5D=gender&sector%5B5%5D=social_protection&sector%5B6%5D=wash&sect)
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