

BOTSWANA BUDGET BRIEF 2018

Health

Highlights

Botswana's National Health Policy and Integrated Health Service Plan for 2010-2020 (IHSP) are child-sensitive and include specific commitments to reducing infant, child and maternal mortality, as well as improving nutritional status of children. Over the past years, the Government has invested substantial resources in healthcare services.

Although policies are in place to promote maternal and child health, their implementation is complicated by the weak and/or absence of M&E tools and limited capacity to effectively make use of these tools. As part of the IHSP monitoring, the government may consider conducting a costing of health services by levels of health care to determine cost-effective health interventions at an affordable price.

In the 2016/17 fiscal year, the Ministry of Finance and Economic Development established the Medium-Term Expenditure Framework (MTEF) with the aim of gradually adopting programme based budgeting. An evaluation of this MTEF would allow to understand the impact of funding policies on achievement of the IHSP goals and objectives. It would be also helpful in establishing policy priorities within an overall resource constraint.

The Government may introduce "performance-based budgeting" in the health system, which is in line with international best practice. This alternative budget classification will improve aggregate fiscal discipline, accountability of budget managers, and allocation of resources to the priority areas and activities.

The high (by international standards) and increasing recurrent health expenditure reflects government's response to availability of skilled labour resources and a large variety of drugs and supplies. The Government may consider developing a comprehensive human resources strategy informed by mapping of existing gaps and resource needs.

With respect to child malnutrition, the evidence-based and cost-effective interventions would have considerable impact on health outcomes. There is need for more in-depth analysis of child feeding practices and value-for-money evaluation of nutrition-sensitive programmes.

Availability of comprehensive HIV/AIDS expenditure information would reveal underlying trends and issues and allow for better informed decisions on feasible options to scale up public investment in this area.



The budget briefs explore the extent to which the public budget addresses the needs of children under 18 years in Botswana. Their main objectives are to synthesize complex budget information so that stakeholders easily understand it and to put forth key messages to inform financial decision-making processes.

1. Introduction

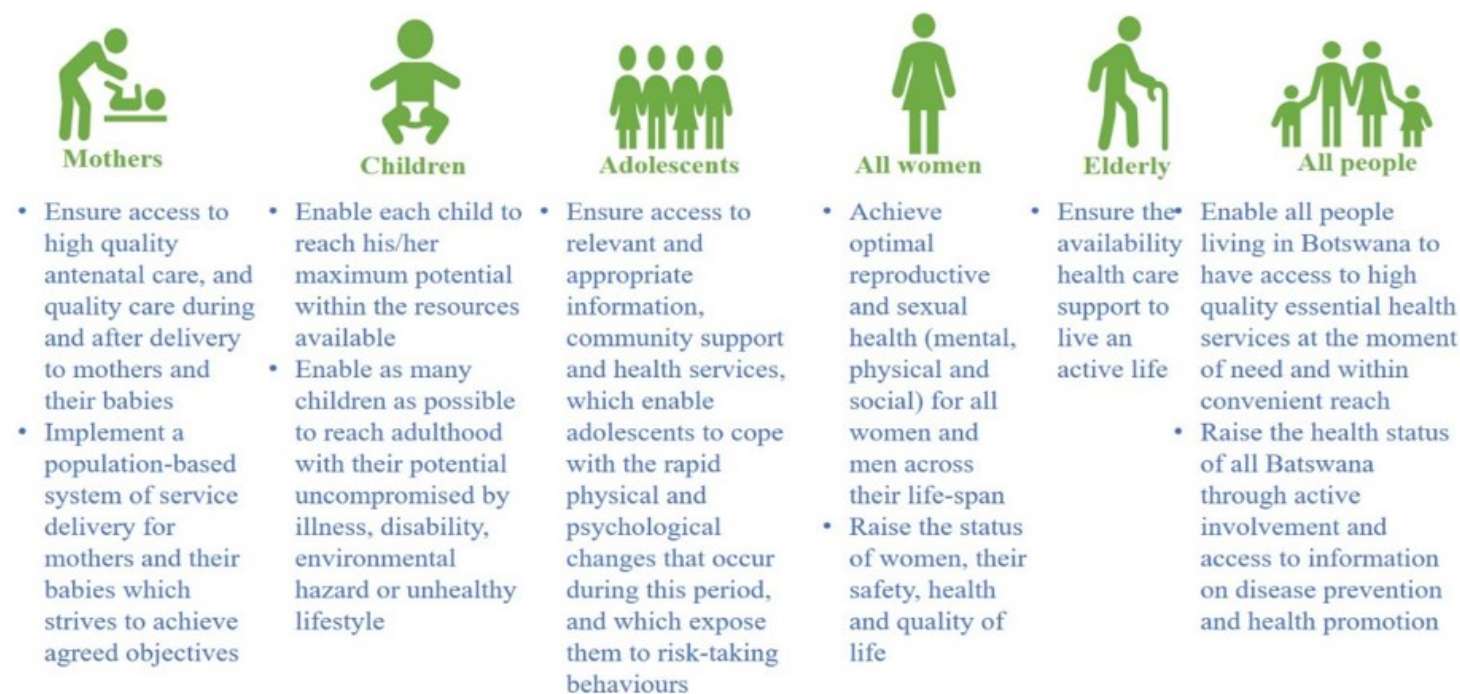
National Development Plans (NDPs) and strategic sector plans guide Botswana’s health sector. The overarching plan, the National Vision 2036, is based on a series of medium term plans. The current plan, NDP 11, runs from April 2017 to March 2023. The plan includes various health sector priorities: strengthen health promotion interventions; household food security and nutrition; prevention of non-communicable diseases; universal coverage of essential health services; and promotion of mental health.

The Integrated Health Services Plan for 2010-2020 (IHSP) also guides health sector strategic priorities. The IHSP aims to address the following key challenges: reducing shortage of health professionals; increasing and strengthening partnerships with the private sector and NGOs; scaling up utilization of essential health service packages; and redefining service delivery levels and delineating types of health services for each level. At the same time, the IHSP

emphasizes bottlenecks related to shortage of health professionals and inequitable distribution of health professionals, predominantly in remote areas. The key component of the IHSP is the delivery of an essential health service package, which is a set of health interventions that the Government is committed to making accessible to the entire population (Figure 1).

The 2011 revised National Health Policy (NHP) will guide the health development of Botswana for the next 10 years. The NHP recommends MOHW to adopt sector-wide approaches to harmonise and align planning, financing, implementation, monitoring and evaluation of the health sector.¹ Particularly, it is encouraged to conduct periodic review and revision of resource allocation criterion in favour of more equitable and timely disbursement of funds to all districts and health facilities as well as national health programmes. In terms of management structures, the MOHW is defined as a responsible agency for overseeing and coordinating health service provision (Figure 2).

Figure 1: Botswana’s Essential Health Service Package



Source: Adapted from the Botswana’s Integrated Health Services Plan for 2010-2020 (IHSP).

¹ MOHW, National Health Policy: Towards a Healthier Botswana, December 2011, page 22.

Figure 2: Organisation of health service delivery in Botswana



Source: MOHW, National Health Policy: Towards a Healthier Botswana, 2011, p22.

Botswana’s health sector provisions fall under the Ministry of Health and Wellness (MOHW), which is responsible for the formulation of policies, regulation and norms, and standards and guidelines for health services. Recent reorganisation and the relocation of primary health care development expenditure from the Ministry of Local Government and Regional Development to the MOHW makes the MOHW the main public-sector health care provider in the country. The District Health Management Teams (DHMT) facilitate communication with all clinics in the 27 health districts, the primary and/or district hospital, and other sectors within the district.

Botswana’s health care services are primarily delivered through public health facilities; however, the private sector does play a vital role. Health service delivery is pluralistic, as there are public, private for profit and non-profit, and traditional practices.² Public health infrastructure is widely distributed with facilities ranging from health posts to tertiary hospitals. There are public, private for-profit, private non-profit and traditional medicine practices in the country. An estimated 84 per cent of Botswana’s population lives within 5 kilometres of a health facility, while 95 per cent reside within a 15-kilometre radius of the nearest health facility.

One worrisome trend is that Botswana has similar rates of malnutrition to other countries in Southern Africa with much lower levels of income. For instance, in terms of underweight and wasting among children under-five years, countries like Lesotho and Zimbabwe perform much better despite being much poorer (Figure 3). This suggests that malnutrition is not merely a function of income. In 2015, according to UNICEF’s “The State of the World’s Children 2016,” the prevalence of stunting among Botswana children stood at 31%, while 11% and 7% of children were underweight and wasted, respectively. In April 2015, Botswana joined the Scaling up Nutrition (SUN) movement, which was triggered by the observed prevalence of low birth weight linked to poor maternal nutritional status. The SUN initiative aims at ensuring that the objectives of agriculture, nutrition and health are mutually reinforcing, further underscoring that a multidimensional approach is required to effectively combat malnutrition challenges.

The 2015 Leadership summit came up with a Road Map, which is aimed at addressing the challenges and reshaping Botswana’s health care system through paradigm shift from curative to preventive services. In this regard, key intervention areas include promoting a culture of healthy life styles, creating an enabling

² Botswana Health and HIV/AIDS Public Expenditure Review, The World Bank, 15 June 2016, page 14.

environment, revitalizing the primary health care approach and strengthening integration of health services. The government sees public private partnership as vital for improving health service delivery and economic diversification. As well, this policy shift brings changes in staffing models, resource allocation, management and technology to meet population needs.

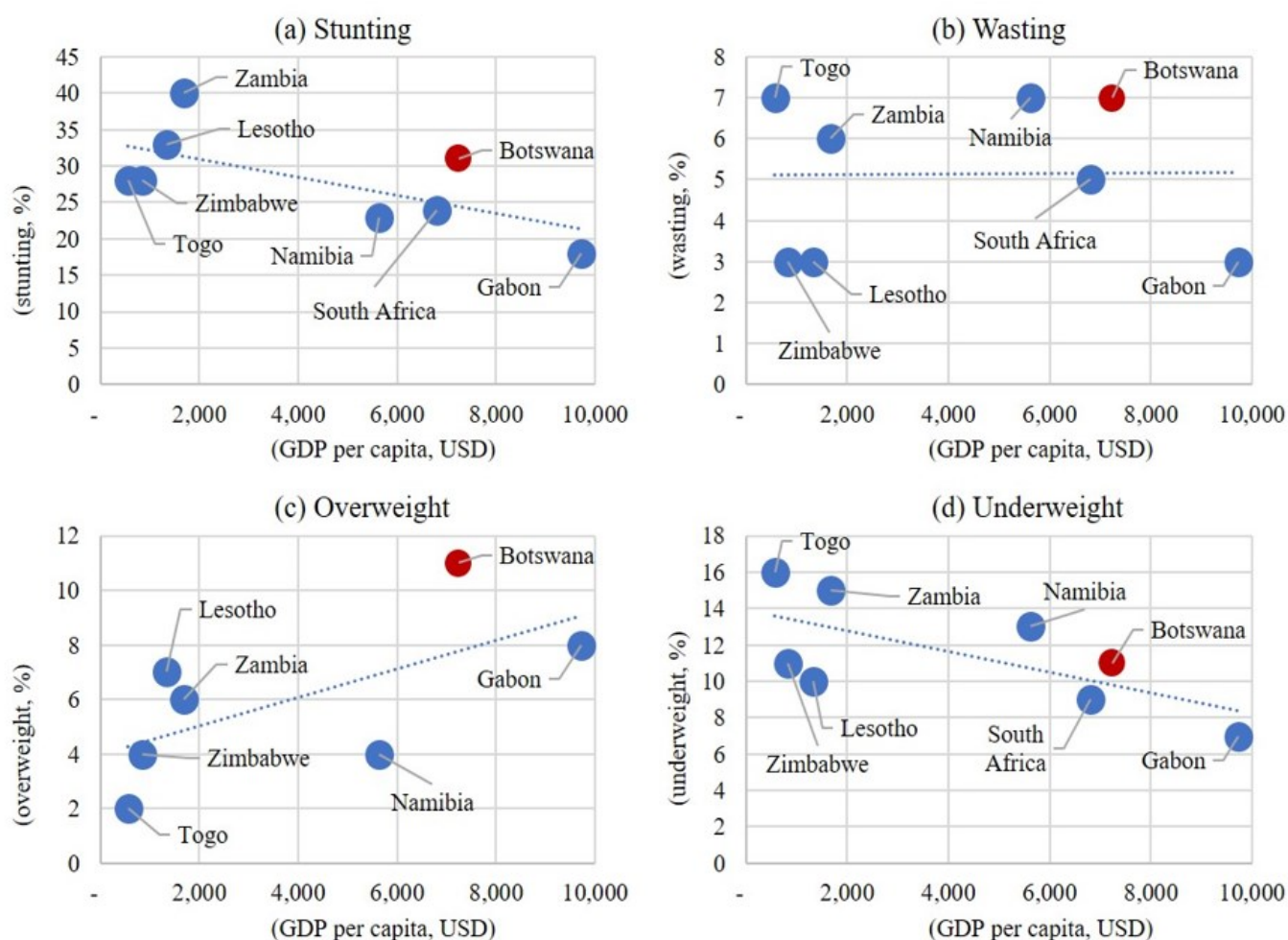
Takeaways:

⇒ Both the 2011 Revised National Health Policy and IHSP 2010-2020 are child-sensitive and include specific commitments to reducing infant/child mortality and maternal mortality, as well as improving nutritional status of children.

⇒ The effective implementation of health policies and programmes is complicated by the weak and/or absence of M&E tools and limited capacity to effectively make use of these tools. Within the IHSP monitoring and reporting framework (for example, during the Mid-Term Review), the government may consider conducting a costing of health services by levels of health care to determine cost-effective health interventions at an affordable price.³

⇒ Botswana has not performed well on addressing malnutrition, which needs to continue to be a key priority for the government.

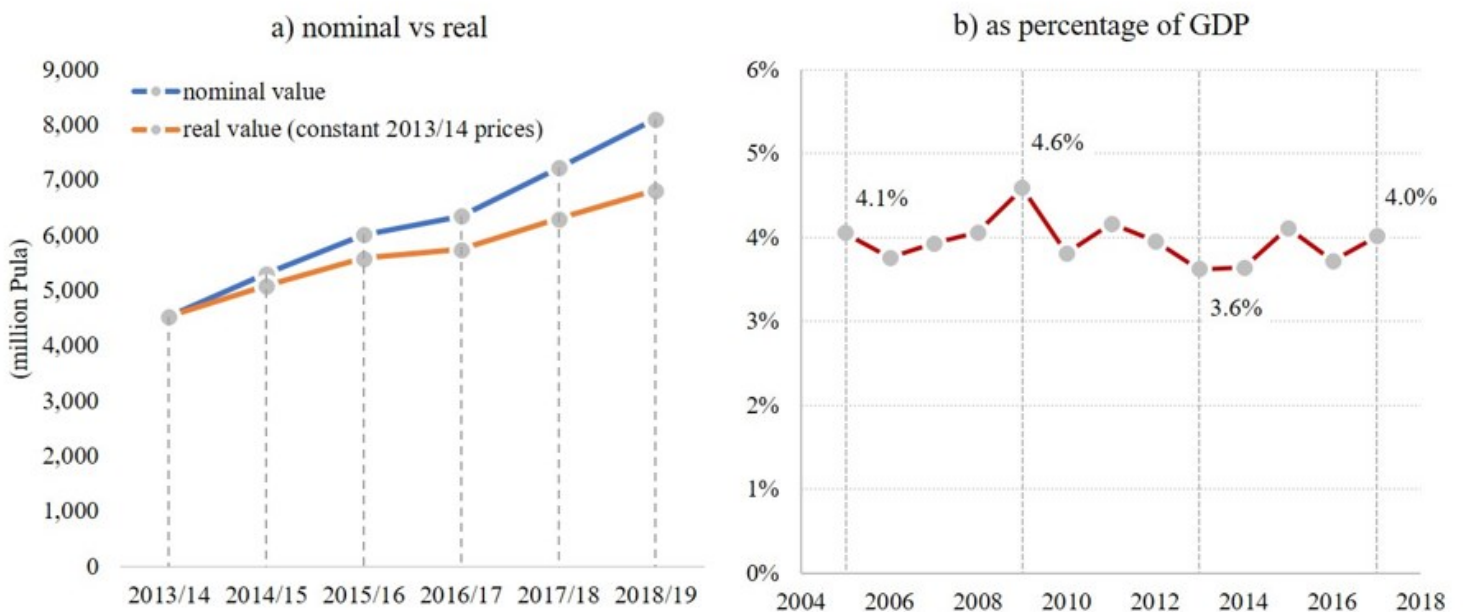
Figure 3: Prevalence of stunting among children under-five years in selected sub-Saharan Africa



Source: UNICEF "The State of the World's Children 2016."

³ CEA is a type of economic evaluation that compares costs and health outcomes of alternative intervention strategies in a systematic way.

Figure 4: National health expenditure trends



Source: MFED, Financial Statements, Tables and Estimates of Expenditure for various years. Inflation estimates the IMF's World Economic Outlook Database (April 2018).

2. Health spending trends

The budgetary allocations in the health sector have been increasing steadily over the years in both nominal and real terms. In nominal terms, total spending increased by an average of 12.4 per cent between 2013/14 and 2018/19 (Figure 4-a). When adjusting for inflation, the increase in spending remains within the same range, increasing by 8.6 per cent over the same period. Historically, aggregate health expenditures as a share of gross domestic product (GDP) remained stable, around 4.1 per cent, with recurrent expenditures being most benefited (Figure 4-b). Planned spending on health in the current fiscal year suggests continuation of a positive trend, which is expected to rise by 0.1 percentage points as a share of GDP. However, this current level of government spending as a proportion of general government expenditure puts Botswana below the Abuja target of 15 per cent.

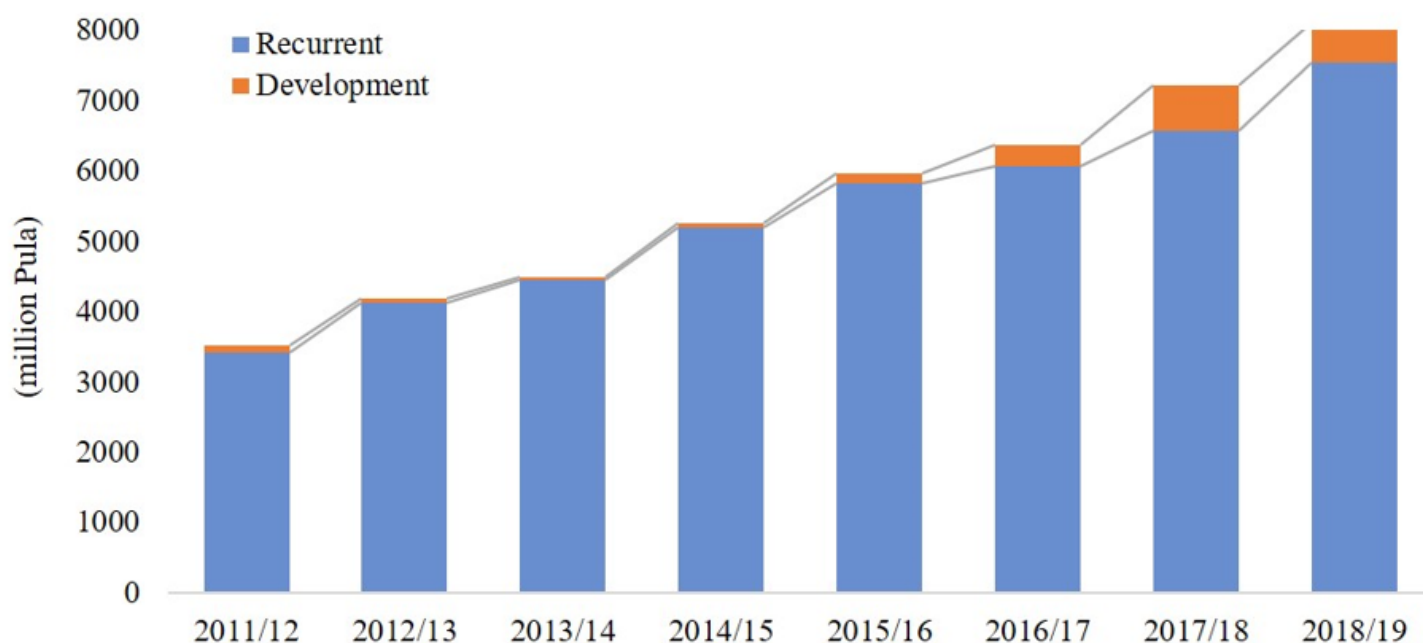
In fiscal year 2018/19, the MOHW's share of the total health budget remained roughly constant (around 90 per cent), while the ministerial budget slightly declined compared to the previous year. In the current year, it accounted for 9.8 per cent, which is less than the 10

per cent allocated in fiscal year 2017/18. In total, the MOHW is expected to receive more than P8.1 billion (Figure 5). At the department level, clinical services and headquarters together represent close to 94 per cent of the ministry's recurrent funding. Human resources expenditures grew by 14 per cent in current prices, including salaries and allowances, overtime, temporary assistance and specialized medical services contracted under non-wage expenses (e.g. Chinese Medical Teams). The MOHW's total annual payroll shows gradual reduction as a percentage of total expenditures from 47 per cent in 2013/14 to 45 per cent in 2018/19. Similarly, the development budget – although quite small – is trending upward.

Takeaways:

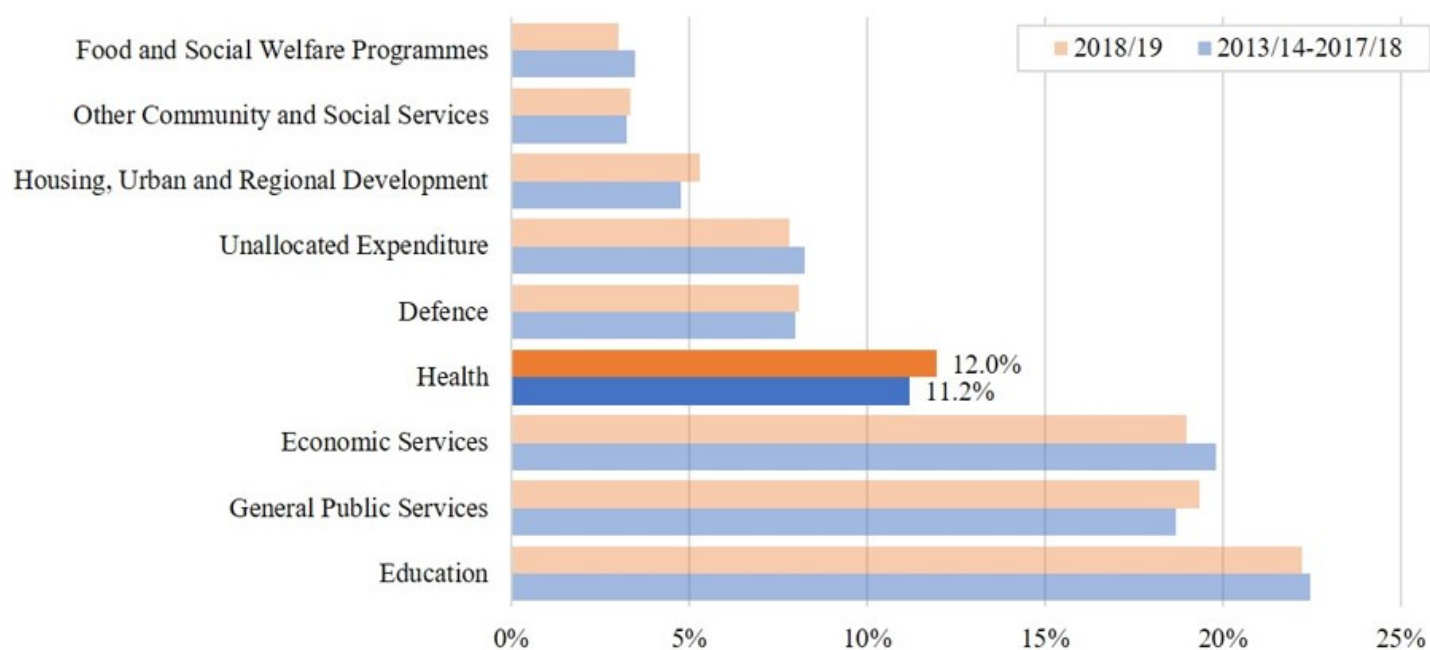
- ⇒ Botswana is doing well in terms of prioritising public resources to both expanding provision of health services and enhancing public health infrastructure.
- ⇒ The government may consider maintaining public spending on health above the five-year average of 3.8 per cent of GDP (2013/14-2017/18), as one of the priorities in the coming years, with specific focus on public expenditure on service delivery targeting children (e.g. on vaccines, essential medicines, etc.).

Figure 5: Ministry of Health & Wellness expenditures



Source: MFED, Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds: 2011/12 to 2016/17 (actual), 2017/18 (revised) and 2018/19 (planned).

Figure 6: Composition of the national budget by functional areas



Source: MFED, Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds: 2013/14 to 2016/17 (actual), 2017/18 (revised) and 2018/19 (planned).

3. Composition of health spending

The government took concrete actions towards achieving the IHSP health-financing goal of raising sufficient resources to deliver services efficiently with a focus on the needs of vulnerable groups. After education and general administration, the health sector receives the third largest share of government spending, averaging 11 per cent of total spending over the five years from 2013/14 to 2017/18.⁴ In the current fiscal year, total health spending rose by 12.3 per cent to P8.1 billion, up from P7.2 billion in 2017/18 (Figure 6). The share of spending allocated to health has been increasing over the years, due, in part, to the costs of addressing HIV/AIDS.

The high level of recurrent health expenditure is largely on clinical services, which is under the remit of MOHW's Department of Clinical Services. Primary hospitals and some district hospitals are the first referral point in the system, which provide clinical services to clients. Clinical Services Department accounts for an average share of 81 per cent of recurrent expenditure based on fiscal years 2017/18 and 2018/19 (Figure 7). Meanwhile, the other two departments – Public Health and AIDS Prevention and Care – together receive about 2 per cent of available resources. Meeting the costs of staffing, medicines

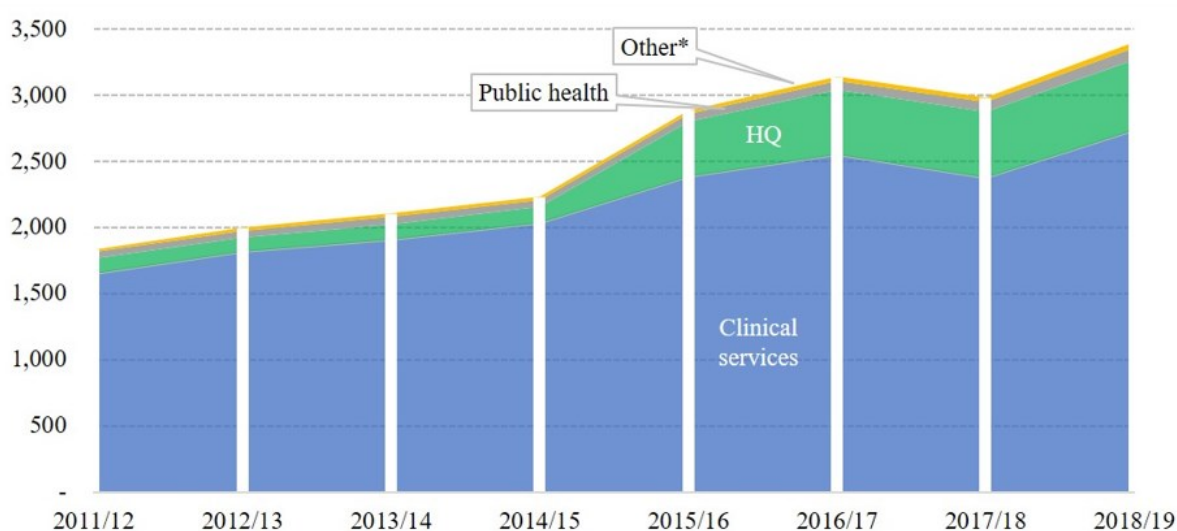
and maintenance is a major investment, which absorbs on average 45 per cent of the MOHW's recurrent budget, and wages and salaries amount to P3.4 billion in the 2018/19 budget.

Over the past three years, the MOHW invested above P1.5 billion in capital expenditures, which is four times the total over the 2011/12-2015/16 period. The 2017/18 fiscal year presented the largest development spending, with 8.8 per cent of the Ministry's consolidated expenditures (Figure 8). In the 2018/19 budget, however, it reduced from P639 million to P570 million, with capital funds for HIV/AIDS programmes (44 per cent) and primary healthcare services (18 per cent) being negatively affected, at the main expense of hospital services (36 per cent increase).

Takeaways:

- ⇒ The continued increase in recurrent health expenditure reflects government's response to availability of skilled labour resources and a large variety of drugs and supplies.
- ⇒ Botswana should continue addressing inefficiencies in the health system through optimising recurrent spending, which is extremely high by international comparison.

Figure 7: Ministry of Health & Wellness annual payroll



Source: MFED, Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds: 2011/12 to 2016/17 (actual), 2017/18 (revised) and 2018/19 (planned).

* Department of AIDS Prevention & Care, Policy, Planning, M&E Relations & Partnership, and Health Inspectorate.

⁴ MFED, Tables and Estimates of Expenditure from the Consolidated and Development Funds and Functional Classification of Expenditure and Net Lending.

Figure 8: MOHW Development Expenditure, million Pula



Source: MFED, Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds: 2013/14 to 2016/17 (actual), 2017/18 (revised) and 2018/19 (planned).

4. Budget Credibility and Execution

At the aggregate level, public health recurrent spending performs strongly while development spending is marked by significant budget credibility and execution⁵ challenges. In general, the health sector is successfully implementing good budget planning practices and translating government policies into on-the-ground activities (Figure 9). The MOHW's recurrent budget performed well and overspent 2.4 per cent, on average, over the past four fiscal years. This suggests that rigorous decisions on allocations of available resources led to aggregate expenditure credibility. High budget execution rates, in the sense of deviation between authorized and actual spending, point out strong absorption capacities within the health sector.

On the other hand, recurrent budget trends raise concern about the persistent misalignment between policy planning and budgeting. The MFED has addressed this issue by introducing the Baseline Budgeting Projections (BBPs) of which the key objective is to determine the budgetary consequences of current policies on expenditure and revenue levels in the medium term. The exercise also seeks to align the national policy priorities with the budget allocation. The ministries and departments

(including the MOHW) are required to submit their BBPs in line with the NDP 11 Performance Framework at the commencement of each budget cycle.

In contrast, the performance of development spending is characterized by chronic underspending. The difference between MOHW's planned and actual expenditure varied between 38 and 63 per cent (Figure 10). This could be partly explained by structural changes in the health system since 2010. With the relocation of primary health care from the Ministry of Local Government, the MOHW became the principal public sector health care provider.

These changes may have created some challenges for implementation of the development budget. It worth noting some improvements in credibility over the past two fiscal years. There are considerable deviations between planned and budgeted development expenditures at the sub-vote level. For example, in 2017/18, Department of Clinical Services largely underspent (8 per cent) having almost 71 per cent of the Ministry's total development budget. This indicates that poor credibility is mainly linked with the shortfall in spending on clinical services area. In terms of programmes, "Primary Health Care Services" underspent 24 per cent of the authorized development budget, while "Hospital Services" overspent by more than 13 per cent.

⁵ The budget is realistic and is implemented as intended.

Figure 9: MOHW recurrent budget utilization trends



Note: Budget credibility – difference between planned and actual expenditure. Budget execution – difference between authorized and actual expenditure. Source: MFED, “Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds”.

Figure 10: MOHW development budget utilization trends



Note: Budget credibility – difference between planned and actual expenditure. Budget execution – difference between authorized and actual expenditure. Source: MFED, “Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds”.

Takeaways:

- ⇒ Seemingly, distinct trends in the recurrent (high) and development (low) health budget credibility are not driven by capacity considerations but by aggregate revenue shortfalls and over-optimistic revenue forecasts.
- ⇒ In the MOHW recurrent budget, some critical programmatic areas (e.g. public health, AIDS prevention and care) fall behind administrative areas and significantly overspent their budgets.

5. Financing the health sector

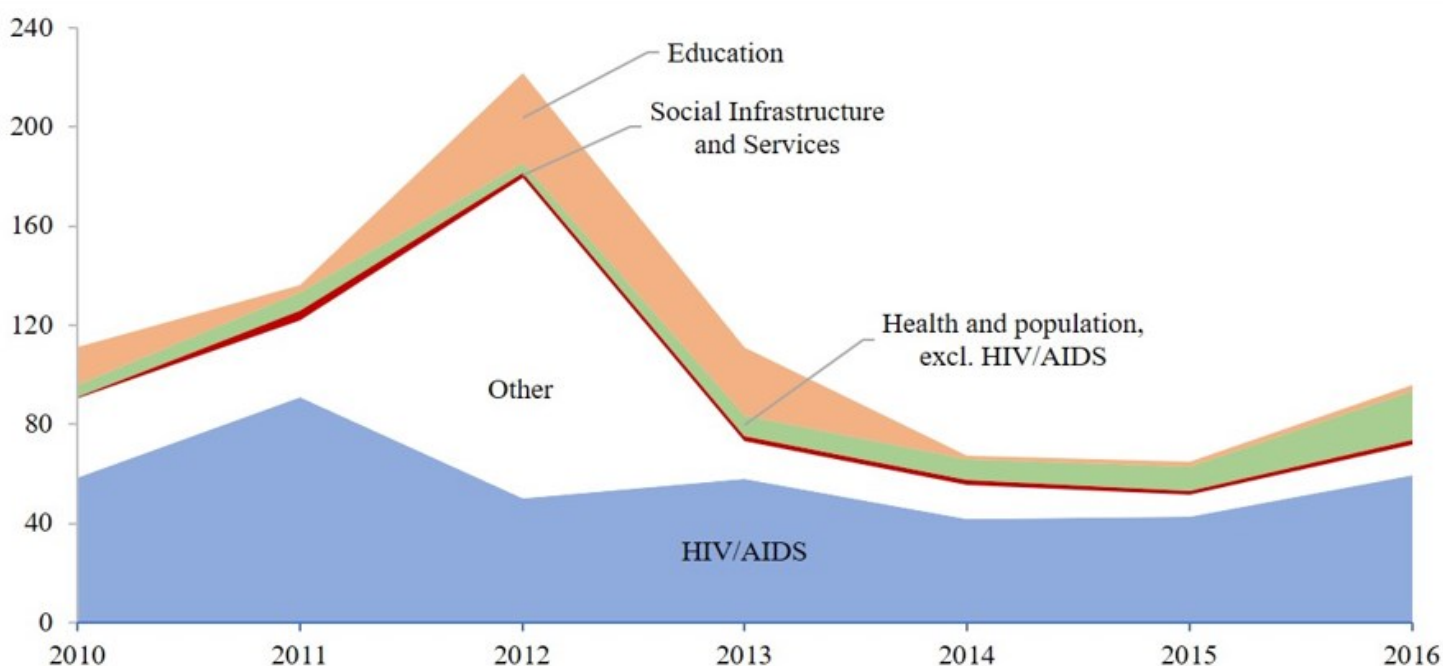
Since the 2016/17 fiscal year, the MOHW has been part of the Medium-Term Expenditure Framework (MTEF). The MOH with support of the MFED developed three-year budget estimates in line with the IHSP.⁶ This multiyear perspective budget planning allows to establish stronger links between the sector-specific policies and budgets. Besides, more realistic/accurate resource allocation scenarios and adequate costing of healthcare services/packages significantly contribute to improved decision-making and budget performance in term of credibility and execution.

Public resources allocated to the health sector are not aligned with the sector-specific strategies and programmes, including the IHSP. This situation presents difficulties to separate budget and expenditures by functional categories; for example,

Primary health care and In-patient care. All health facilities salaries are aggregated under the Clinical Services. Therefore, resource allocation is based on incremental line items and respective votes and is not programmatically oriented.⁷

In Botswana, health care programmes are financed mainly from public sources, with a modest donor contribution, mainly in the area of HIV/AIDS. In the 2018/19 budget, P8.1 billion is proposed for the health sector to finance various programmes, including the HIV/AIDS interventions. Figure 11 shows that HIV/AIDS has been receiving the bulk of Botswana's declining foreign aid budget in recent years, accounting for 55 per cent of the total foreign assistance, on average. Data from the OECD data suggest that 97 per cent of HIV/AIDS-related international assistance were provided by the U.S. Government between 2010 and 2016.

Figure 11: External aid disbursements, million USD



Source: OECD Creditor Reporting System (CRS), 2018. Figures summarize aid disbursement, excluding debt operations. "HIV/AIDS" corresponds to CRS sectors 120 and 130; "social infrastructure and services" comprises CRS sector 160; and "other" includes all aid disbursements not included elsewhere (website: <https://stats.oecd.org/index.aspx?DataSetCode=CRS1>).

⁶ Botswana Health and HIV/AIDS Public Expenditure Review, The World Bank, 15 June 2016, page 31.

⁷ Ibid, page 30.

Takeaways:

- ⇒ An evaluation of the MOH's MTEF for 2016/17-2018/19 allows to understand the impact of funding policies on achievement of the IHSP goals and objectives. It would be also helpful in assessing the accuracy/reliability of forward estimates of the costs of existing policies and programmes.
- ⇒ The government may consider introducing "performance-based budgeting" in the health system, which is in line with international best practice.
- ⇒ Increasing recurrent costs associated with combatting HIV/AIDS and other diseases call for the government to establish a sustainable financing model and to develop new revenue streams. For example, considering earmarking (earmarked taxes) as a mechanism to increase fiscal space for the health sector.
- ⇒ Availability of comprehensive HIV/AIDS expenditure information would reveal underlying trends and issues and allow for better informed decisions on feasible options to scale up public investment in this area.

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