BotswanaBudgetBrief

HEALTH

FISCAL YEAR 2019|20

Highlights

The Botswana health system is characterised by ambitious and well-thought-out health plans, including a central role for the public health system that is fundamental to the delivery of quality health care to the general population.

Budget allocations to public healthcare have increased steadily over the years, with an increasing share of total government spending and a stable share of around 4 percent of GDP.

Government health spending per capita reached an estimated P3,500 (US$350) per capita in 2018/19.

Demands on the health system have been increasing, due to HIV and AIDS from the 1990s onwards, and more recently due to non-communicable diseases (cancer, diabetes etc.).

Although achievements related to HIV and AIDS have been good, other health outcomes – particularly for children - have not been commensurate with the level of spending.

Child malnutrition remains high for an upper-middle income country, as does infant and maternal mortality.

There are major problems with health system efficiency, implementation of projects and ability to spend budgeted funds.

Overall there are capacity constraints in the public health system, which go beyond issues related to the availability of funding.

In Botswana, there is a need to maintain health budgets as fiscal resources come under pressure, along with a need to spend those budgets more effectively, with better management, implementation, and evidence-based prioritisation

Key Policy Issues

- Defining the Essential Health Services Package (EHSP) and ensuring that it is adequately resourced.
- Decentralisation of health service provision, control of budgets, decision-making and accountability.
- Improving the incentives and ability to deliver public health services efficiently, including the provision of high quality information regarding service costs and effectiveness, and introducing proper monitoring and evaluation systems.
- Introducing a purchaser-provider split through the establishment of a (largely tax funded) national health fund (NHF).
- Making decisions regarding the future financing of public health care within and outside of the EHSP, from general taxation, earmarked taxation, insurance, and user fees.
- Clarifying the relationships between public and private health service providers.
- Ensuring that as government budgets come under pressure with declining fiscal revenues, allocations to health are maintained; however, this will only be possible if greater efficiency can be demonstrated in spending, and with evidence that financial resources are being devoted to the most important needs, on the basis of evidence.

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.

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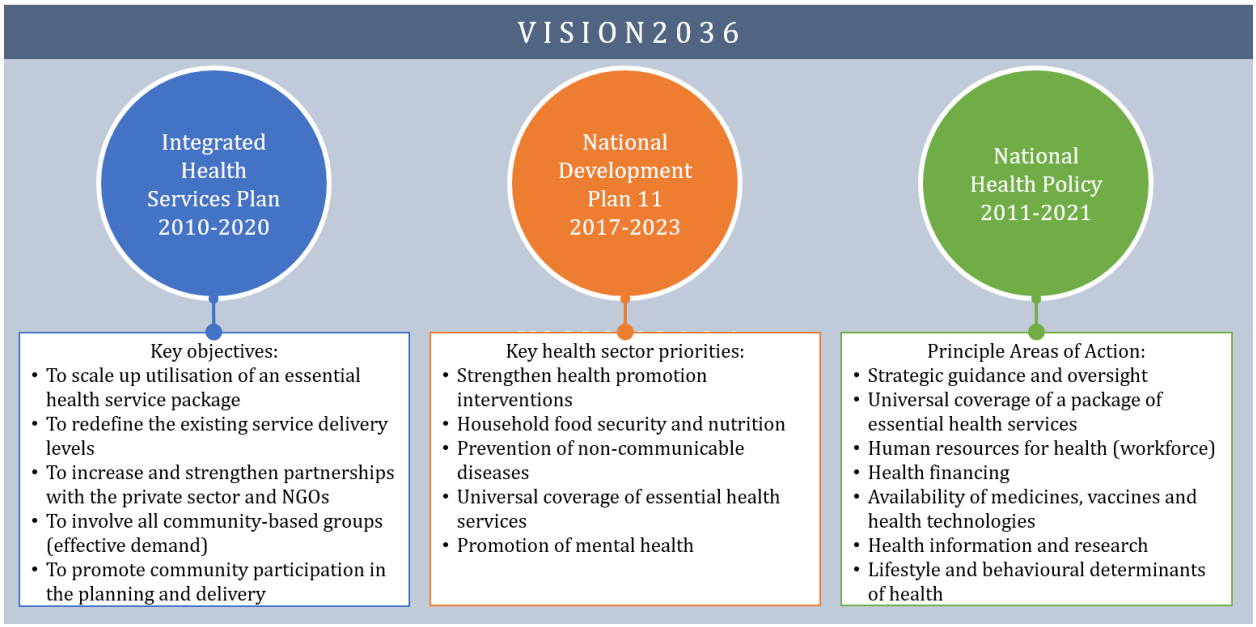
Section 1. Introduction

National Development Plans (NDPs) and strategic sector plans guide Botswana's health sector (Figure 1). The overarching plan, the National Vision 2036, is implemented through a series of medium term National Development Plans (NDPs). 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. NDP 11 is currently going through a Mid-Term Review, which may provide a revision to health sector projects included in the NDP 11 Development Programme.

The Integrated Health Services Plan for 2010-2020 (IHSP) also guides health sector strategic priorities. The 2011 revised National Health Policy (NHP) proposes adopting sector-wide approaches to harmonise and align planning, financing, implementation, monitoring and evaluation of the health sector over a 10 year period.[1] Particularly, the Ministry of Health and Wellness (MOHW) 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 1: Botswana's Health Sector Policies and Plans



Source: Adapted from Botswana's NDP 11, NHP 2011-2021 and IHSP 2010-2020.

A key component of the IHSP is the delivery of an essential health service package (EHSP), which is an integrated set of health interventions that the Government is committed to making accessible to the entire population, mostly (although not entirely) through the

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

public health service. Although first proposed in 2010, and subject to considerable discussion, design work and costing since then, the EHSP is still not finalised.

Botswana's health sector provisions fall under the 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. 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 and mobile stops to tertiary hospitals. There are public, private for-profit, private non-profit and traditional medicine practices in the country. An estimated 84 percent of Botswana's population lives within 5 kilometres of a health facility, while 95 percent 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. This suggests that malnutrition is not merely a function of income.

With regards to UNICEF's "The State of the World's Children 2017," the prevalence of stunting among Botswana children stood at 31 percent, while 11 percent and 7 percent 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 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 lifestyles, creating an enabling 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.

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

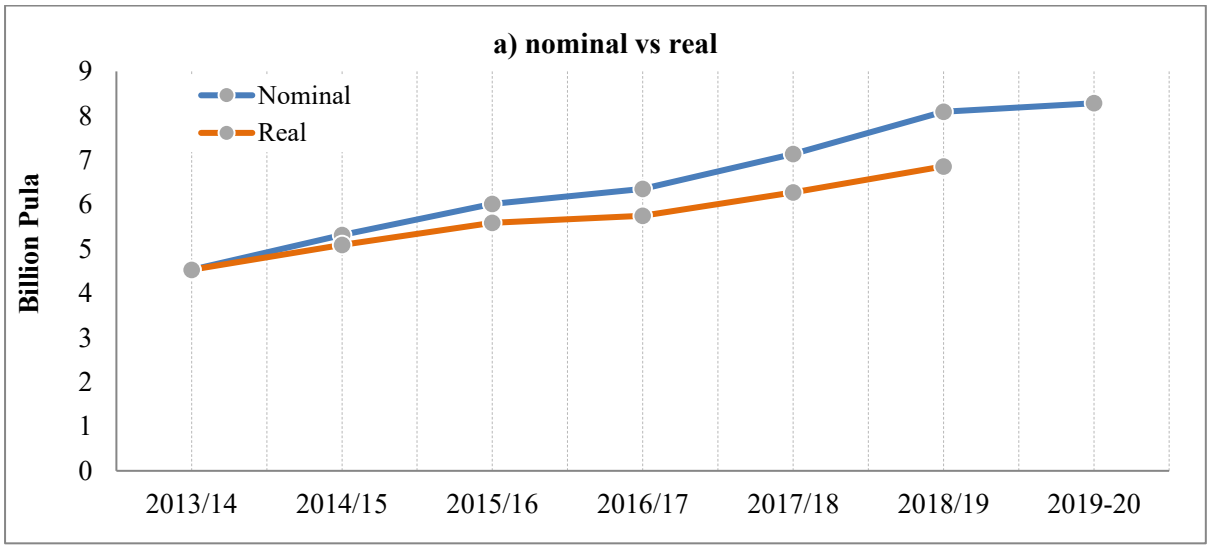
Takeaways:

- 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.

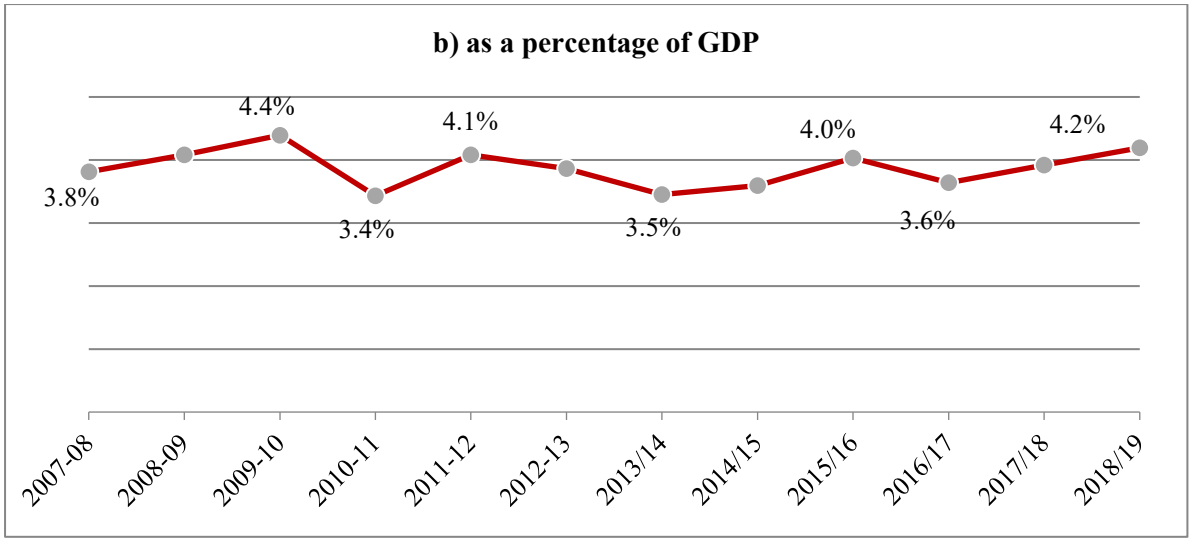
Section 2. Health spending trends

Budgetary allocations to the health sector have been increasing steadily over the years in both nominal and real terms. In nominal terms, total spending increased by 78 percent from 2013/14 to 2018/19. (**Figure 2-a**). When adjusting for inflation, the annual average increase in spending is 8.6 percent over this period, indicating significant real growth. Historically, total health expenditures as a share of gross domestic product (GDP) remained stable, around 4 percent (**Figure 2-b**). In 2019/20, health spending amounts to 12 percent of general government expenditure, which puts Botswana below the Abuja Declaration target of 15 percent.

Figure 2: National health expenditure trends



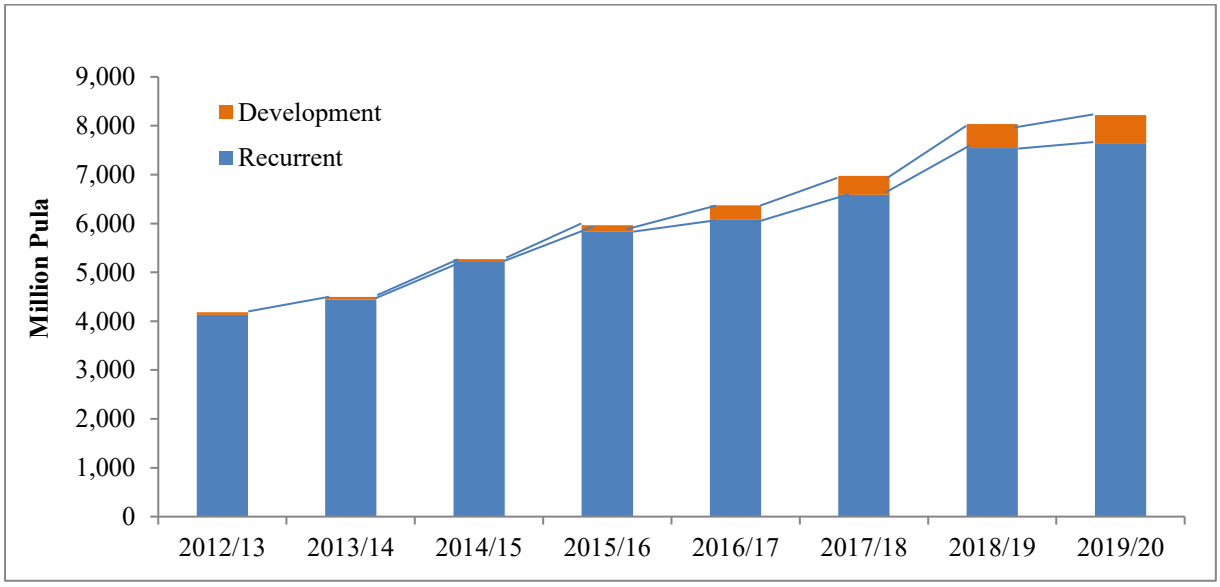
[3] Cost-effectiveness analysis is a type of economic evaluation that compares costs and health outcomes of alternative intervention strategies in a systematic way.



Source: Ministry of Finance and Economic Development, Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds for various years. Inflation figures based on data from Statistics Botswana.

In fiscal year 2019/20, the MOHW's projected share of the total government budget was around 10.8 percent, which is slightly more than the 10.3 percent allocated in fiscal year 2018/19. In total, the MOHW is expected to receive more than P8.1 billion (**Figure 3**). At the department level, clinical services and headquarters together represent more than 93 percent of the Ministry's recurrent funding. Human resources expenditures grew by 2.4 percent in current prices, including salaries and allowances, overtime, temporary assistance and specialized services contracted under non-wage expenses (e.g. Chinese Medical Teams). The MOHW's total annual payroll shows a slight increase as a percentage of total expenditures from 45.8 percent in 2018/19 to 46.4 percent in 2019/20. Similarly, the development budget – although quite small – is trending upward.

Figure 3: Ministry of Health & Wellness expenditures



Source: Ministry of Finance and Economic Development, Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds: 2011/12 to 2017/18 (actual), 2018/19 (revised) and 2019/20 (planned).

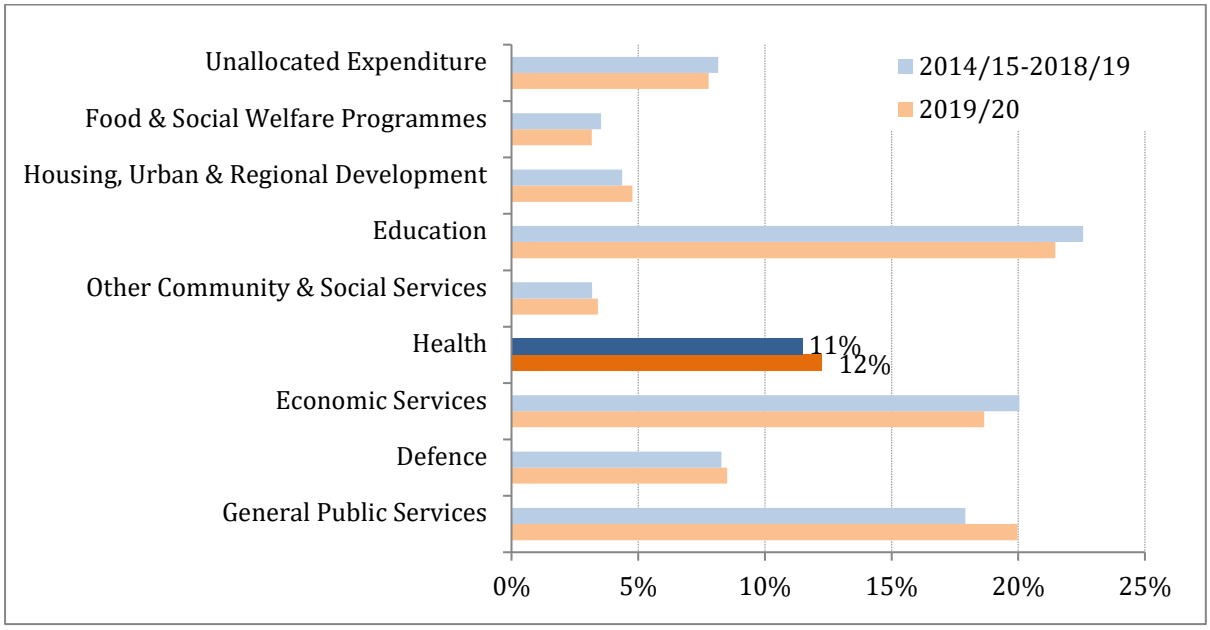
Takeaways:

- Botswana is doing well in terms of prioritising public resources to both expanding provision of health services and enhancing public health infrastructure.
- The government should maintain public spending on health at least at the five-year average of 3.9 percent of GDP (2014/15-2018/19), as one of the priorities in the coming years, even as overall spending is reduced as a share of GDP, with a specific focus on public expenditure on service delivery targeting children (e.g. on vaccines, essential medicines, etc.).

Section 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 percent of total spending over the five years from 2014/15 to 2018/19.[4] In the current fiscal year, total health spending is budgeted to rise by 2.4 percent to P 8.3 billion, up from P8.1 billion in 2018/19 (**Figure 4**). The share of spending allocated to health has been increasing over the years, due, in part, to the costs of addressing HIV/AIDS.

Figure 4: Composition of the national budget by functional areas

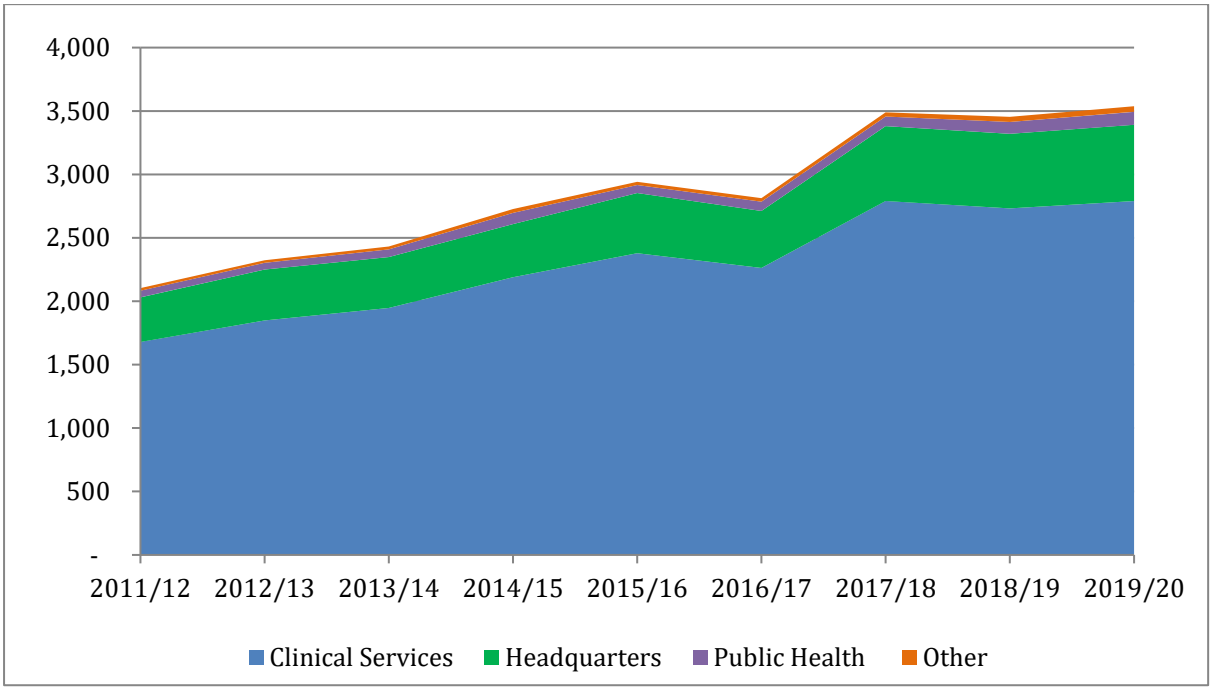


Source: Ministry of Finance and Economic Development, Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds

[4] Ministry of Finance and Economic Development, Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds 2018/19, Functional Classification of Expenditure and Net Lending, which is based on the IMF's Manual on Government Finance Statistics.

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. The Clinical Services Department accounts for an average share of 83 percent of recurrent expenditure based on fiscal year 2019/20 (**Figure 5**). Meanwhile, the other two departments – Public Health and AIDS Prevention and Care – together receive about 3.5 percent of available resources. In the 2019 budget, and wages and salaries amount to P4.3 billion.

Figure 5: Ministry of Health & Wellness annual payroll expenditure

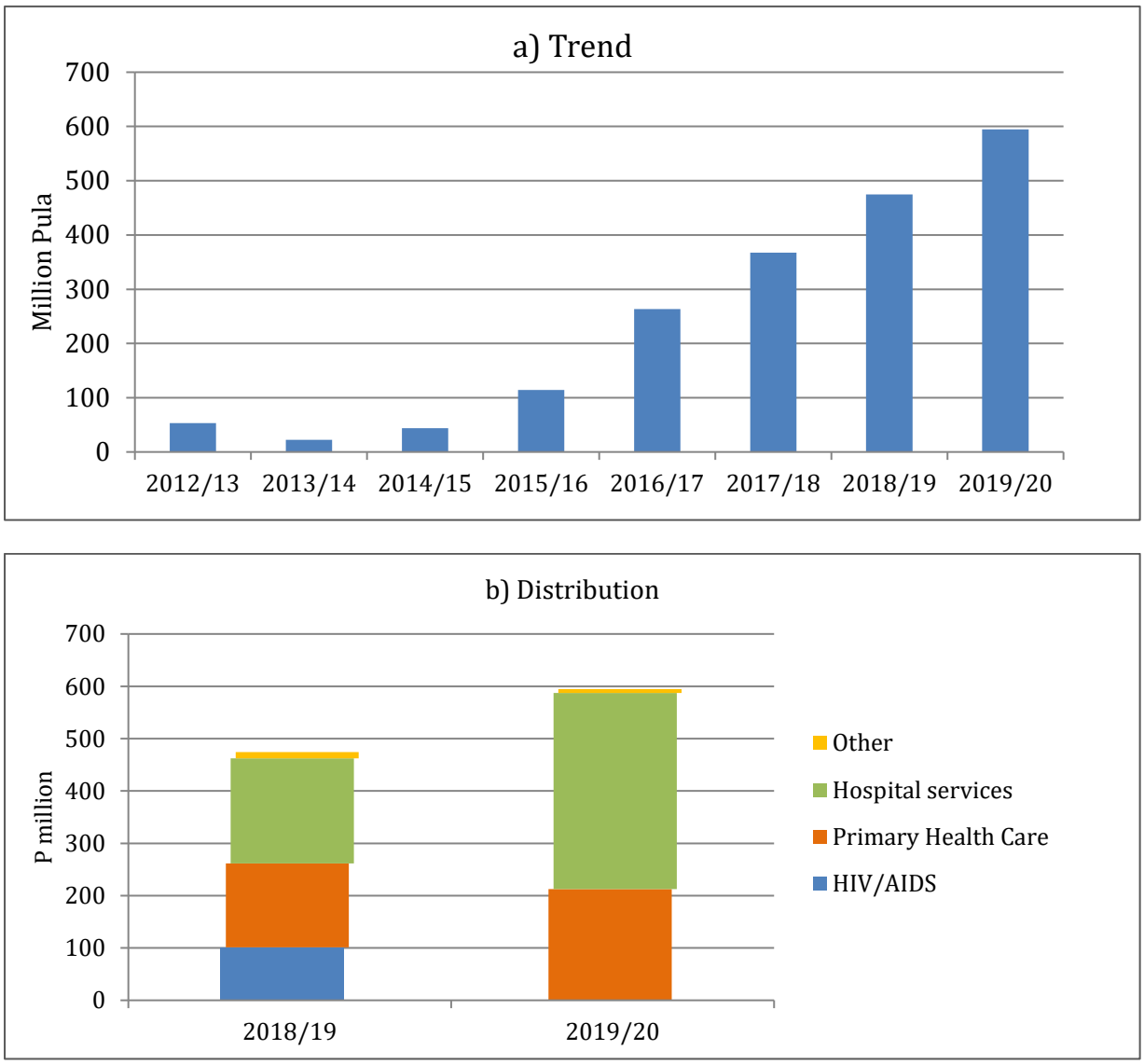


Source: Ministry of Finance and Economic Development, Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds: 2011/12 to 2017/18 (actual), 2018/19 (revised) and 2019/20 (planned). * Department of AIDS Prevention & Care, Policy, Planning, M&E Relations & Partnership, and Health Inspectorate.

Over the past three years, the MOHW invested more than P1.5 billion in capital expenditures, which is four times the total over the 2011/12-2015/16 period. The MOHW development expenditures have increased steadily since 2013/14 (Effectively, therefore, the increase in capital spending is greater than the overall figures indicate, Figure 6). In the 2019/20 budget, capital expenditures increased from P475 million to P594 million, with capital funds for primary healthcare services (36 percent) and hospital services (63 percent). This shows an 87 percent increase in the capital funds for hospital services between 2018/19 and 2019/20.

The overall picture is complicated by the fact that responsibility for some aspects of HIV/AIDS programmes and health promotion has been moved from the MOHW to the Ministry of Presidential Affairs, Governance and Public Administration (MOPAGPA), and hence is no longer in MOHW's development expenditure. Effectively, therefore, the increase in capital spending is greater than the overall figures indicate.

Figure 6: Ministry of Health & Wellness Development Expenditure, million Pula



Source: Ministry of Finance and Economic Development, Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds

Takeaways:

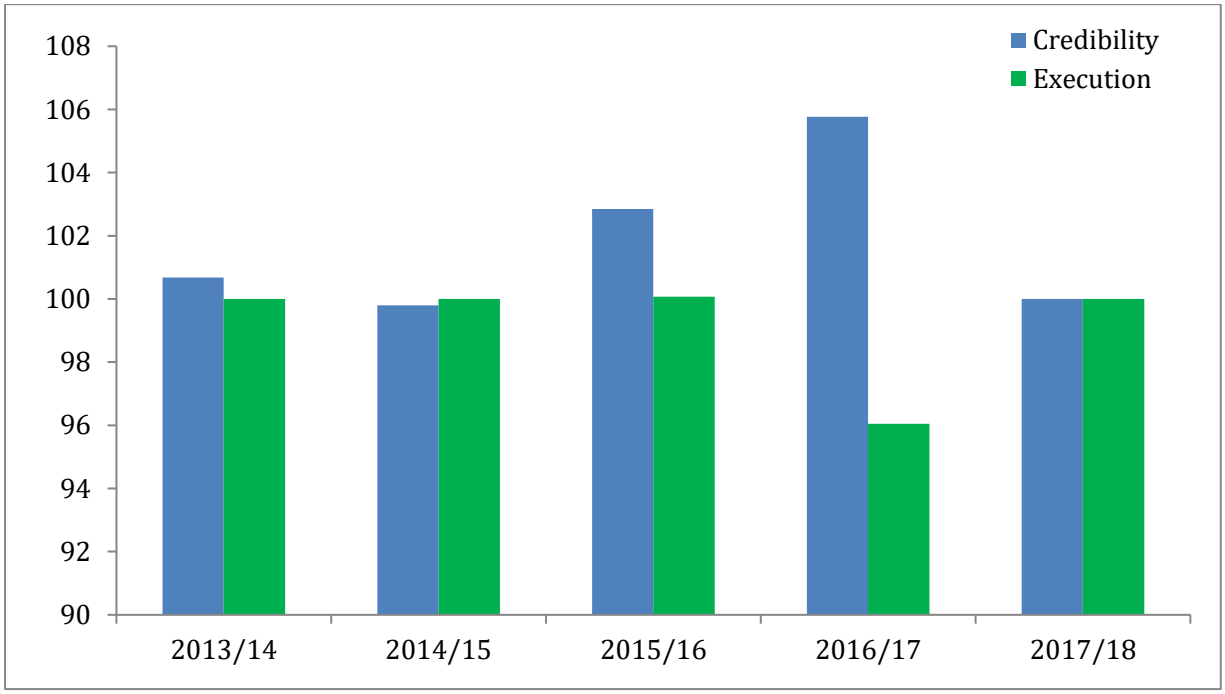
- The share of total government spending allocated to health has been increasing over the years, with the recurrent budget accounting for the large majority of spending. Recurrent spending is mainly for salaries and drug costs.
- Development spending has increased sharply in the current budget year (2019/20). However, the MOHW may face constraints in being able to spend this effectively.
- HIV/AIDS development expenditure is now budgeted in the National Aids and Health Promotion Agency (previously known as National Aids Coordination Agency) under the Ministry of Presidential Affairs, Governance and Public Administration (MOPAGPA).

Section 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 execution[5] challenges. In general, the health sector is successfully implementing good budget planning practices and translating government policies into on-the-ground activities (**Figure 7**). The MOHW's recurrent budget performed well, 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 low deviation between authorized and actual spending, point out strong absorption capacities within the health sector.

However, there are concerns about the misalignment between policy planning and budgeting, whereby the recurrent budget implications of development spending are not well predicted. 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.

Figure 7: MOHW recurrent budget utilization trends

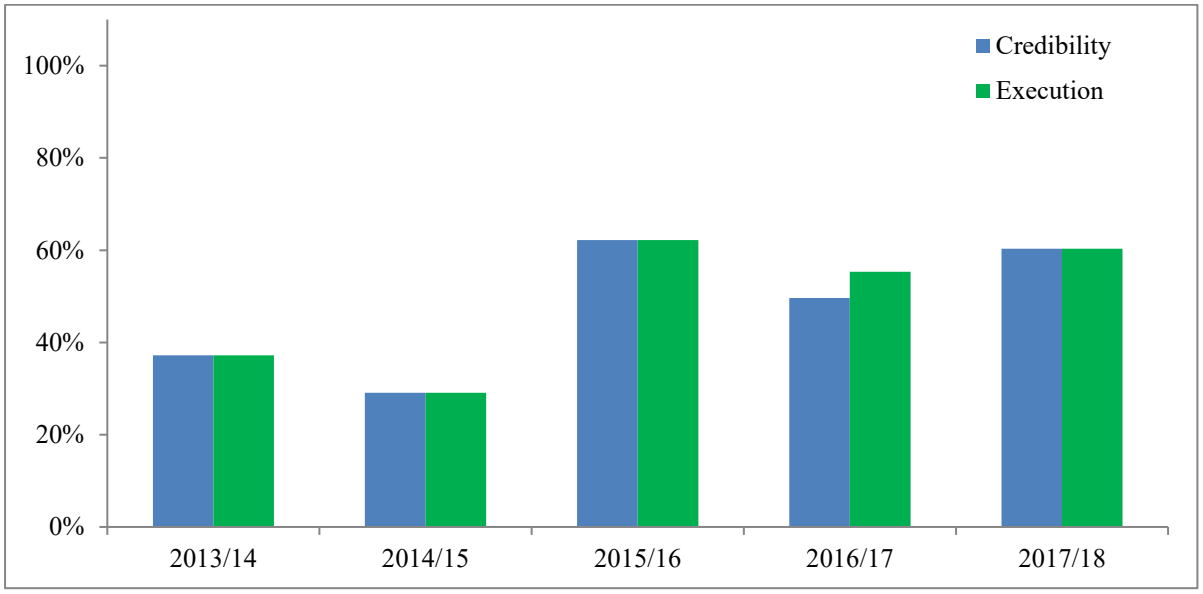


Note: Budget credibility – difference between planned and actual expenditure. Budget execution – difference between authorized and actual expenditure. Source: Ministry of Finance and Economic Development, "Financial Statements, Tables and Estimates of Expenditure from the Consolidated and Development Funds".

[5]The budget is realistic and is implemented as intended.

In contrast to the recurrent budget, the performance of the development budget is characterized by chronic underspending. The difference between MOHW's planned and actual expenditure varied between 38 and 63 percent. However, it also reflects very rapid increases in the development budget allocation (**Figure 6**); this illustrates that the planned development projects are well beyond the implementation capacity of the MOHW. As an example, the new Sir Ketumile Masire Teaching Hospital in Gaborone is still not operational, six years after it was handed over to the Ministry by the contractor **Figure 8**).

Figure 8: MOHW development budget utilization trends



Note: Budget credibility – difference between planned and actual expenditure. Budget execution – difference between authorized and actual expenditure. Source: Ministry of Finance and Economic Development, "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 illustrate that there are capacity constraints in project implementation in the MOHW.

Section 5. Financing the health sector

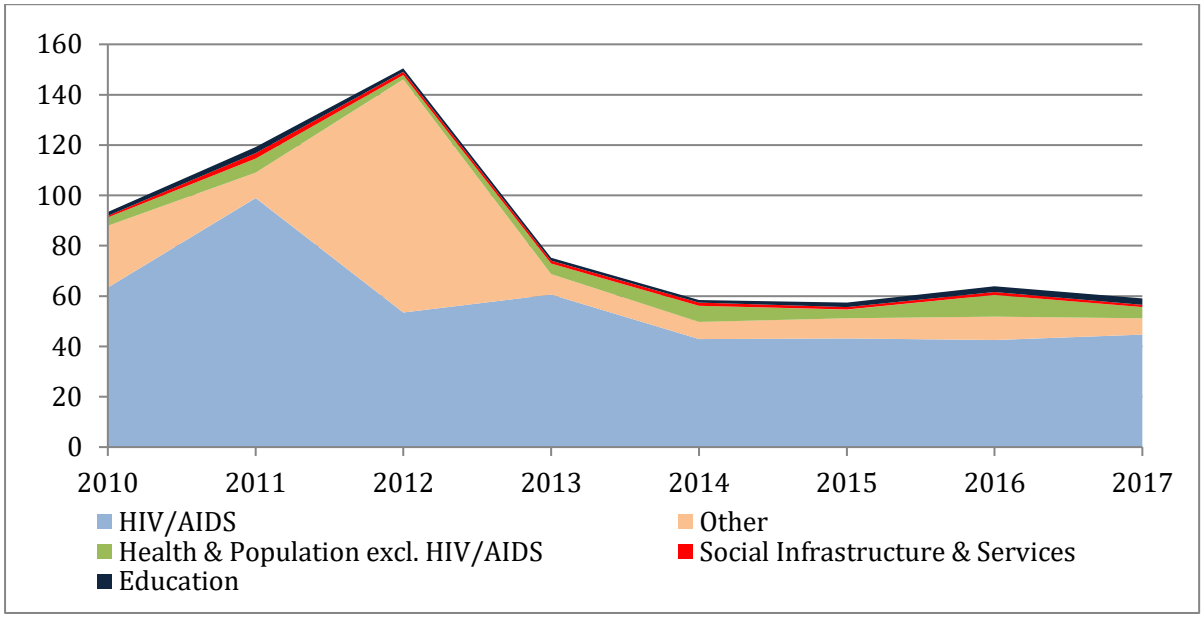
Since the 2016/17 fiscal year, the MOHW has been part of the Medium-Term Expenditure Framework (MTEF). The MOH, with support of the MFED, developed three-year budget estimates in line with the IHSP.[6] This multiyear budget and planning perspective allows stronger links between the sector-specific policies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

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

It is not possible to determine, on the basis of public data, whether public resources allocated to the health sector are aligned with 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 Clinical Services. Therefore, resource allocation is based on incremental line items and respective votes and is not programmatically oriented.[7]

In Botswana, public health care programmes are financed mainly from domestic sources, with a modest donor contribution, mainly in the area of HIV/AIDS. In the 2019/20 budget, P8.3 billion is proposed for the health sector to finance various programmes, including the HIV/AIDS interventions. Figure 9 shows that HIV/AIDS has been receiving the bulk of Botswana's declining foreign aid budget in recent years, accounting for 55 percent of the total foreign assistance, on average. Overall aid receipts have been on a declining trend and accounted for less than one percent of government receipts since 2013/14. Data from the OECD suggests that 97 percent of HIV/AIDS-related international assistance were provided by the U.S. Government between 2010 and 2016.

Figure 9: 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).

The private sector plays a significant role in healthcare provision. Services are provided by private hospitals and clinics, private specialists and general practitioners, and the traditional sector. There are no comprehensive data on the provision of healthcare services by non-government service providers. However, rough estimates

[7]Ibid, page 30.

indicate that approximately 15 percent of the population is covered by private medical aid schemes.

Overall health spending comprises spending by government and non-government sources. The latter includes household contributions through out-of-pocket spending (e.g. on travel, medication, traditional healers etc.); private sector spending through medical aid (insurance) schemes, usually financed by contributions from individuals and employers; health care directly financed by employers; spending by NGOs; spending by donors and development partners (not through government, including their contributions to the costs of running government-aided hospitals – mainly from churches). Information on overall health spending is captured in the National Health Accounts (NHA), the most recent set of which covers the period from 2013/14. The NHA concluded that of total healthcare expenditure over this period, 65.4 percent was financed by government, 6.7 percent by external parties (donors), and 16.3 percent by private sector companies and 11.5 percent by households[8].

A modest fee – P5 – is, in principle, charged to users of public health facilities. However, the fee is waived for those on low incomes, and is not generally enforced. Furthermore, it is set at such a low level that it unlikely to cover the costs of collection and administration. Revenue from health service fees is not clearly identified in the government accounts, but it is possible that the health service is made worse off financially by the imposition of fees, if the costs of collection are greater than the revenue raised. However, the imposition of user-fees for health services is not generally to raise funding but to reduce moral hazard and signal the value of the service to the user.

One barrier to improved efficiency in healthcare is a lack of information on the costs of service provision. The MOHW does not have good information on the costs of providing different types of healthcare services. This is in part due to the way in which expenditures are budgeted, and too high a level of aggregation that makes it difficult to identify where and how key expenditures – such as staff and drug costs – are used. Improvements in financial information are needed to identify the real costs of providing different types of healthcare services, which would in turn underpin a more efficient allocation of resources.

A health financing strategy is being developed, with various forms of funding being considered besides subventions from general revenue, including consideration of a national health insurance (NHI) scheme. However, projections indicate that this would not raise a significant amount of money and would face other difficulties. The cost would fall mainly on people who are already members of medical aid schemes and hence users of private healthcare services, and would therefore be analogous to an additional tax, rather than payment for a service received (public healthcare). For a universal scheme, there would be challenges in collecting premiums from the informal sector, and most likely political constraints to enforcing compliance. Alternative tax-based financing schemes, such as an additional earmarked 1 percent on VAT, may be more effective.

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[8] Botswana 2013/14 Health Accounts, Statistical Report (MOHW, 2016). A new NHA for the period since 2013/14 is being prepared but was not available at the time of preparation of this report.

The real financing problem facing the public health service is not lack of funding, but inefficient spending. The level of recurrent healthcare spending per capita (around P3,500 – P4,000 or USD350-400 in 2019/20) should be more than sufficient to provide a comprehensive universal healthcare package to the entire population. Greater efficiencies need to be sought in public healthcare spending, which requires (1) data to identify the true costs of service provision and (2) organisational reforms, such as introducing a purchaser-provider split, to help improve efficiency and resource allocation.

The Mid-Term Review of NDP 11 shows that overall government financial resources are expected to decline in the short- to medium-term. Hence competition for limited budgets will become more acute. Pressure to increase public sector wages will impact heavily on the health sector, given the magnitude of its wage & salary bill, and may constrain the availability of funds for other recurrent and investment needs. In supporting claims for sustained or increased budget allocations, the health sector will need to demonstrate that resources are being efficiently used and also that spending can be prioritised based on projected impact, all of which requires better health sector information and impact analysis.

Takeaways:

- An evaluation of the MOH's medium-term expenditure and financing projections for 2016/17-2018/19 would permit an understanding of the impact of funding policies on the achievement of the IHSP goals and objectives, as long as data could be made available in a manner that relates spending to IHSP categories. 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.
- Improved data on non-government healthcare provision and healthcare spending would help to provide a more comprehensive picture of overall healthcare provision and financing.
- 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.
- In the context of the anticipated squeeze on fiscal resources in the years ahead, for structural reasons, it will be important to maintain allocations to healthcare, in real per capita terms.
- Improved efficiency and better value-for-money is the key to improving the quality of healthcare and achieving better health outcomes in the context of resource constraints.

Section 6. Policy Issues

The key policy challenges and objectives have been well laid out in the National Health Policy and the Integrated Health Services Plan. As is often the case in Botswana, the challenge is not devising a good policy, but implementing it in a timely manner. Much of the delay involves moving from policy principles to the details of implementation, making hard choices about trade-offs, and introducing accountability mechanisms. Amongst the key policy challenges are:

Defining the EHSP and ensuring that it is adequately resourced. This of course also means defining what is outside of the EHSP. Government undertakes to provide the EHSP as a social right to all citizens. The tendency is to make the EHSP as broad as possible, so as to minimise possible conflict around services that are not included – and which may therefore not be at low or no cost. But the broader it is, the higher the cost of delivery.

Decentralisation of health service provision, control of budgets and decision-making. The provision of many health services is already decentralised to DHMTs; however, there is a need to match this with decentralising autonomy over decision-making and budgets.

Improving the incentives to deliver public health services efficiently. At present, health service providers (DHMTs) have little incentive to improve efficiency, or the ability to do so. Effective decentralisation will help to provide these incentives, as will the provision of effective information (e.g. on costs).

Introducing a purchaser-provider split through the establishment of a national health fund (NHF). This is one of the major recommendations of the HFG project. The NHF would be the purchaser of health services provided by the DHMTs. This would allow funding to follow health needs, as well as providing incentives for greater efficiency.

Decisions regarding the future financing of public health care within and outside of the EHSP. It is likely that the EHSP will be provided free at the point of delivery and funded by the NHF. It is likely that the bulk of the funding for the EHSP will be provided from tax revenues. However, decisions are needed regarding the possible establishment of a national health insurance scheme, how it should be designed, whether membership would be mandatory, and how membership and premium payments would be enforced. Another decision is how the provision of health services outside of the EHSP by public health facilities will be financed. A decision is also needed as to whether to continue the (largely unobserved) P5 fee for the use of public health facilities.

Relationships between the public health service and private health insurers and service providers. At present the two are largely independent of each other. However, introduction of the EHSP, a NHF, and a possible NHI all have implications for this relationship and the role and financing of private health providers, and whether they can provide services to public patients in competition to DHMTs.