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Strengthening Health Outcomes  
through the Private Sector

# Botswana

## Private Health Sector Assessment



**BRIEF**

**Summary:** This brief is a summary of the Botswana private health sector assessment conducted by the SHOPS project in May 2013. Sean Callahan prepared the brief, which discusses the assessment methods and findings, and presents recommendations to further leverage the private sector to sustain Botswana's national HIV response and expand on the achievements of the past 10 years.

**Note:** The Botswana private health sector assessment brief presents a snapshot of the country's private health sector landscape at the time of the assessment, and does not address any changes in the health sector since that time.

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**Keywords:** AIDS, Botswana, health financing, HIV, NGO sustainability, private sector assessment, private sector health, public-private partnerships, sustainability

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**Cover Photo:** Thierry van Bastelaer, Abt Associates

**Project Description:** The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV and AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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# Botswana Private Health Sector Assessment

**Botswana faces regionally unique** circumstances as it continues to develop and sustain its national HIV response. Partly due to the country's success in scaling up the delivery of HIV and AIDS services, many international donors plan to reduce their financial support. As part of this transition planning, the United States Agency for International Development (USAID) mission in Botswana asked the Strengthening Health Outcomes through the Private Sector (SHOPS) project to conduct a private health sector assessment.<sup>1</sup> The assessment was intended to assist USAID, Botswana's Ministry of Health (MOH), and other health system stakeholders in developing strategies that leverage private health sector resources—including financing, personnel, and pharmaceutical commodities and supplies—to sustain Botswana's HIV and AIDS programs. This brief is a summary of the assessment's methods, findings, and recommendations.

Decades of stability, good governance, and sound fiscal management have helped the government of Botswana translate its natural resource wealth into improved health outcomes. However, the country struggles with a high HIV prevalence rate. Partnerships with the private sector and international donors, including the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the African Comprehensive HIV/AIDS Partnerships (ACHAP) funded by Merck and the Bill and Melinda Gates Foundation, have helped increase access to HIV and AIDS services. With many partnerships set to end or transition to full country ownership in the next few years, the government faces challenges as it implements its Vision 2016 strategic plan, which emphasizes HIV treatment and prevention. Botswana aims to achieve zero new infections by 2016. The private health sector is an important source of health services, commodities, and financing for the national HIV response, although significant barriers to its growth exist. This assessment makes recommendations to create new opportunities for the private health sector.



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*Bokamoso, a private for-profit hospital in Gaborone, was co-financed by the Botswana Public Officers' Medical Aid Scheme.*

## Background

Located in southern Africa, Botswana is a regional leader in its HIV response. The country of two million people has experienced decades of economic growth due to a history of stability, good governance, and sound fiscal management of its diamond resources. The economic growth has resulted in a per capita gross domestic product of \$16,300. Despite this improvement, 17.8 percent of the workforce is unemployed and 20.7 percent of the population lives in poverty (Statistics Botswana, 2011).

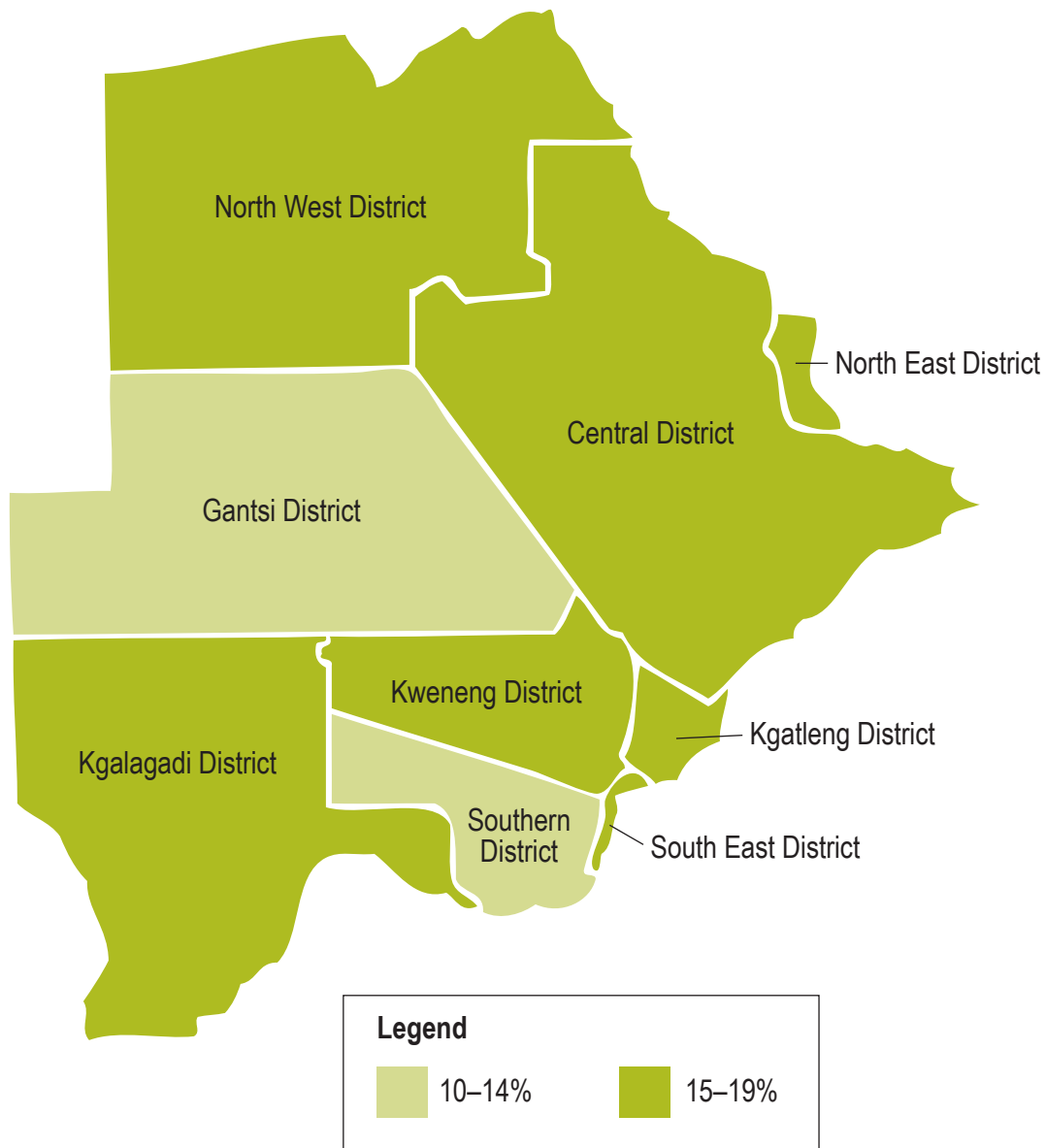
Botswana has made remarkable achievements in its health sector. Its maternal and child health indicators, while slightly below the average for upper-middle-income countries, are better than the regional average and those of neighboring countries (World Bank, 2013). In addition to a recent rise in non-communicable diseases, Botswana's main health challenge is its persistently high HIV prevalence. Between 1985 and 2001, HIV prevalence in the country peaked at 27 percent of the adult population. It has since declined to 23 percent of the adult population, or 18 percent

<sup>1</sup> Callahan, Sean, Tanvi Pandit-Rajani, Ilana Ron Levey, and Thierry van Bastelaer. 2014. *Botswana Private Health Sector Assessment*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates.

of the total population (UNAIDS, 2013; Central Statistics Office and National AIDS Coordinating Agency, 2009). As shown in Figure 1, prevalence varies across the country, with the highest rates in

the Central and North East districts and the lowest rates in the Gantsi and Southern districts (Central Statistics Office and National AIDS Coordinating Agency, 2009).

**Figure 1. HIV Prevalence by District (Percent of Total Population, 2008)**



The government has committed to ensuring that all citizens can access affordable and quality health care services. As HIV prevalence increased, life expectancy declined from 64 years in 1990 to 49 years in 2003, before slightly increasing to 53 years in 2011 (World Bank, 2013). Botswana's HIV strategy has largely driven this improvement. The country's efforts have been primarily channeled through the MOH and the National AIDS Coordinating Agency (NACA), and supported by partnerships with PEPFAR and ACHAP. These partnerships have helped expand access to free or subsidized antiretroviral (ARV) drugs. In 2010, there were 300,000 people living with HIV in Botswana. Of those eligible for antiretroviral therapy (ART), 95 percent received treatment, and 94 percent of pregnant women received care for prevention of mother-to-child transmission (UNAIDS, 2013). As Botswana has scaled up treatment and prevention

interventions, its HIV effort has transitioned from an emergency response to one addressing a chronic health issue requiring a sustained strategy. To accomplish this, the MOH has invested in tertiary care facilities and strong primary health care and preventive services (HLSP, 2009).

The successes in HIV treatment have partially been the result of foreign assistance. Bilateral and multilateral donors, as well as private foundations and companies, increased funding and the provision of donated resources in the early 2000s. According to recent analysis, in 2010 international donors accounted for about 8 percent of total health spending in Botswana (Ministry of Health, 2012) and about 52 percent of HIV spending (HSLP, 2009). The size and scope of donor contributions vary (see table), but together they have played a significant role in Botswana's health sector.

## Donor Contributions to Botswana's Health System

| Donor                                       | Contribution  |
|---|---|
| African Comprehensive HIV/AIDS Partnerships | <ul style="list-style-type: none"> <li>In 2000, partnership formed between the government of Botswana, the Gates Foundation, and the Merck Company Foundation; Merck donates two ARV drugs for the duration of the partnership</li> <li>Phase I: a five-year, \$100 million program (later extended to nine years and \$106 million) focused on building infrastructure, training health workers, and strengthening the health system</li> <li>Phase II (began in 2010): a five-year, \$60 million extension focused on HIV prevention, tuberculosis and HIV integration, and sustainability efforts (African Comprehensive HIV/AIDS Partnerships, 2013)</li> </ul> |
| European Union                              | <ul style="list-style-type: none"> <li>In 2013, announced a \$11.4 million contribution to Botswana to meet the health-related Millennium Development Goals (Government of Botswana, 2013)</li> <li>Focused on family and community-oriented health services to reduce maternal, infant, and child mortality rates (Government of Botswana, 2013)</li> </ul>  |
| United States                               | <ul style="list-style-type: none"> <li>Largest bilateral donor, with \$556.8 million in commitments since the launch of PEPFAR in 2004 (PEPFAR, 2013)</li> <li>Largest Botswana recipients are the Botswana government and the Partnership for Supply Chain Management (PEPFAR, 2011)</li> <li>Focus on prevention efforts, care and treatment, and health systems strengthening (PEPFAR, 2011)</li> </ul>  |
| World Bank                                  | <ul style="list-style-type: none"> <li>In 2008, announced a five-year, \$50 million loan to the government of Botswana to improve treatment coverage, efficiency, and sustainability of the country's HIV response (World Bank, 2008)</li> <li>Funding channeled through NACA, public sector ministries, civil society organizations, and private sector partners (HLSP, 2009)</li> </ul>   |



Thierry van Bastelaer, Abt Associates

*Diagnofirm, Botswana's largest private laboratory. The country's robust private laboratory and pharmacy infrastructure is capable of providing more HIV counseling and testing.*

Many of these donor programs will end or transition from financial contributions to technical assistance in the near future. Due to Botswana's strong economic indicators and government commitment to financing HIV costs, as well as its small population, PEPFAR funding is expected to significantly decline by 2016 as part of a transition to solely provide technical assistance (Stash et al., 2012). This creates a need for USAID to develop short-term strategies to inform the direction and type of PEPFAR assistance.

More effort has been spent exploring ways to improve public sector HIV services than looking at the role of the private health sector in sustaining the HIV response. Analyzing the role of the private sector was necessary, given the explicit calls for developing public-private partnerships in multiple government strategic and policy documents. The SHOPS project assembled an assessment team to obtain information on the private sector.

## Scope

After a discussion with USAID/Botswana, the USAID Office of HIV/AIDS, the MOH, and NACA, the assessment team focused on the following objectives:

1. Provide an overview of private health sector stakeholders and their respective roles.
2. Analyze private health sector growth prospects and challenges.
3. Describe private sector contributions to and opportunities for growth in health financing.
4. Identify innovative ways to sustain priority investments in HIV services through the private sector.
5. Provide recommendations on how to implement public-private partnerships (PPPs) in the health sector.

## METHODS

The assessment team collected data in two stages. First, it reviewed formally and informally published literature. Then, the team conducted interviews with stakeholders in Botswana. Team members met with representatives from public, private for-profit, private nonprofit, and development entities to (1) understand attitudes toward private sector engagement and (2) identify opportunities, challenges, and solutions for sustaining achievements in the country's HIV and AIDS response.

# Findings

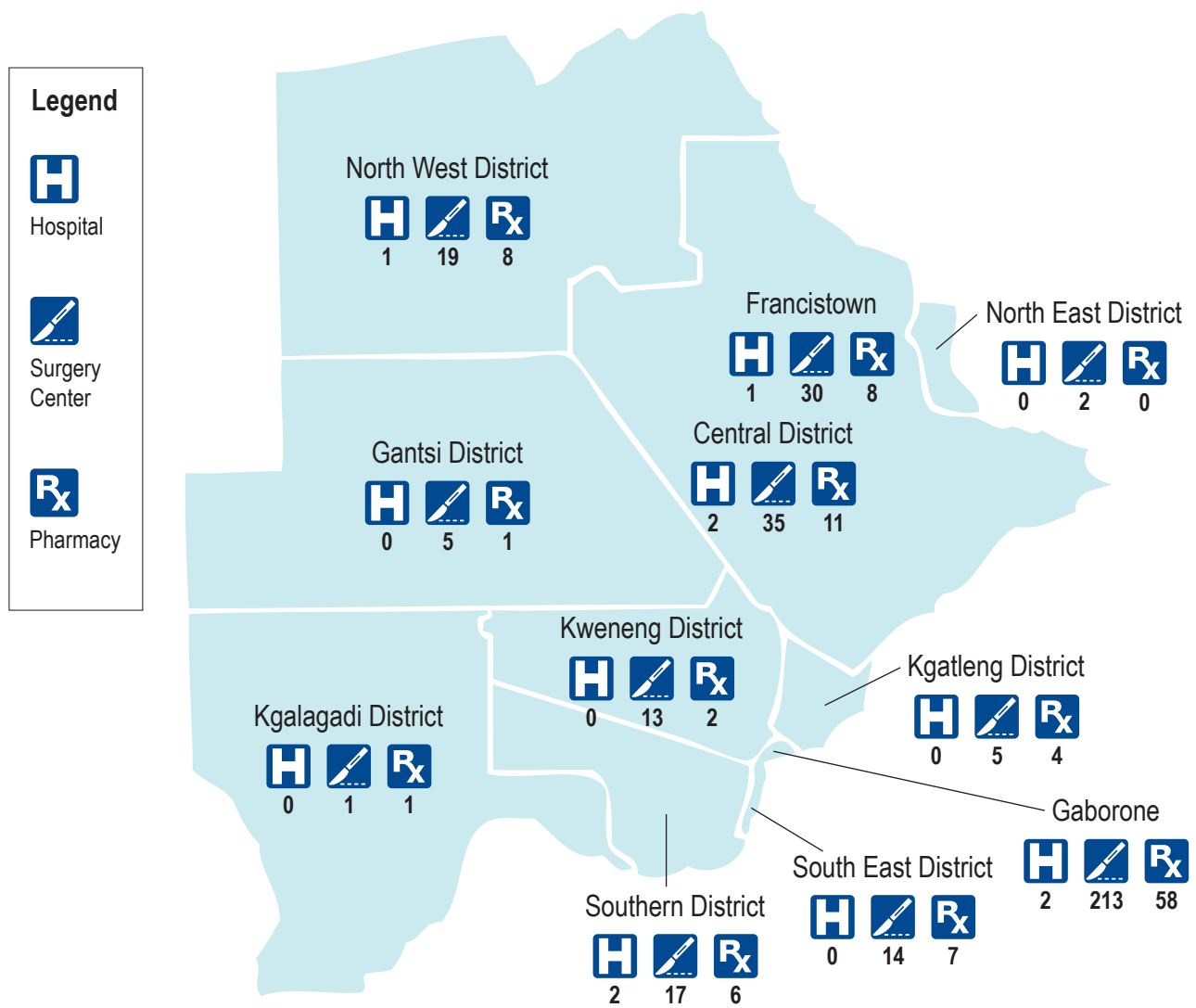


## The Private Health Sector and Botswana's HIV Response

The private health sector has evolved over the last 20 years and currently serves as an important source for general and specialized health care. However, many factors that facilitated its growth are threatened by increased public sector investments, urban saturation, and limited growth of new medical aid scheme subscribers. The government's commitment to ensuring free essential health

services for all citizens has led to public sector dominance in Botswana's health market, with the vast majority of the population living within an eight-kilometer reach of a health facility (Government of Botswana, 2011). Excluding public mobile clinics, about 40 percent of health facilities in the country are in the private sector. Most are private surgery centers or independent pharmacies located in urban areas like Gaborone or Francistown, where 60 percent of the population resides (see Figure 2).

Figure 2. Distribution of Private Facilities by District



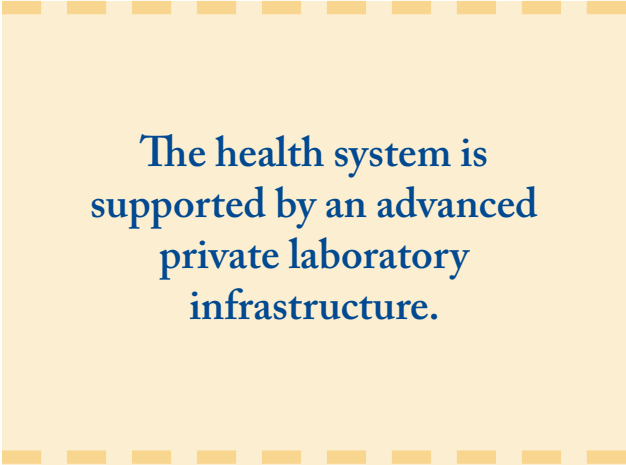
Note: Francistown and Gaborone are urban districts that are independent from Central District and the South East districts that surround them, respectively.



Although there are over three times as many public hospitals as private ones (Central Statistics Office, 2012; AFA, 2013), the health system is supported by an advanced private laboratory infrastructure. There has been a steady growth in the number of private facilities over the past 12 years (Associated Fund Administrators, 2013). During this period, the concentration of private facilities in urban areas has increased, resulting in fewer patients at private facilities. This has led some providers—particularly in Gaborone—to close their practices. Private providers are represented by the Medical Practitioners Association, which has largely focused on negotiating tariff rates with the country’s medical aid administrations and has generally not engaged in policy dialogue with the public sector.

The Botswana Health Professions Council (BHPC) registers all health workers and the MOH is responsible for licensing private practices and enforcing clinical standards. Lenient registration and licensing requirements have enabled physicians to establish private practices or join private group practices. Medical aid administrators and some medical aid

schemes separately inspect registered private facilities to ensure the quality of covered services, creating a dual inspection and enforcement system between the MOH and the medical aid industry. This adds costs to the government and the industry. The MOH is generally approachable and non-punitive, inspecting private facilities annually and, in the case of an infraction, creating an action plan for the facility rather than closing the facility. The MOH inspectorate is understaffed, and not all annual enforcement and post-action plan visits occur as planned. Within the next year, the MOH aims to transfer licensure and enforcement responsibilities to the BHPC. However, there are significant capacity gaps around BHPC staff training and numbers, as well as its data management abilities. These gaps threaten the ability of the BHPC to effectively enforce quality in the private sector, and will diminish



**The health system is supported by an advanced private laboratory infrastructure.**

prospects for a singular, unified enforcement system that the medical aid industry can trust.

Botswana’s economic growth has created a small market for private providers. These providers present an alternative for patients concerned with HIV-related stigma or who perceive the public sector to offer lower-quality care. Over the past few years, private spending on health has steadily increased. Household spending on health combined with spending by employers equals about 25 percent of total health expenditures (Ministry of Health, 2012). This growth could be due to increased prices in the private sector or increased demand for private sector goods and services. Higher incomes are enabling more individuals to pay for services through a medical aid scheme (which covers 17 percent of the population) or out-of-pocket payments.

#### **Improving the supply chain**

The HIV epidemic brought supply chain issues to the forefront due to the complexities of ART management. Botswana has three types of supply systems: public and commercial supply chains that provide a broad range of medicines and other products, and a PPP model that extends ART services to 14,000 uninsured HIV patients through private sector channels. Donors and the MOH have heavily invested in various aspects of these three supply systems to ensure uninterrupted access to ARVs. Since ARVs became available in Botswana, the MOH has actively sought to build local capacity and leverage the private sector to help strengthen its supply chain.

The private health sector supply chain is efficient and reliable. Local manufacturing capacity is limited, so wholesalers purchase most products from registered international suppliers and manufacturers based in South Africa. Unlike many countries in sub-Saharan Africa, Botswana has implemented a policy that exempts prescription medications from a value-added tax typically placed on imported goods.

## Healthy competition appears to exist among private wholesalers, creating incentive to deliver high quality products.

This policy supports the importation of pharmaceuticals and helps reduce the cost of products. Medical aid scheme reimbursement caps limit markups throughout the

supply chain, which also helps keep costs down. Healthy competition appears to exist among private wholesalers, creating incentive to deliver high quality products.

The public sector supply chain that serves the vast majority of Botswana's ART patients will face multiple changes over the next few years. Such changes include:

- PEPFAR support to Central Medical Stores (the government agency responsible for procuring and distributing health products) is shifting to greater country ownership.
- The MOH will soon contract out warehousing and distribution of medical products.
- The MOH contracts out to the BOMaid medical aid scheme on the PPP ART model, expected to end in early 2014.
- Merck ARV donations through ACHAP are expected to end in late 2014.

Exploring how these changes will affect the public sector supply chain is crucial to understanding future prospects for the ART PPP model. Central Medical Stores is the most important entity in Botswana's public sector supply chain. Since 2009, PEPFAR's Supply Chain Management System project has managed all Central Medical Stores operations to ensure timely procurement and delivery of essential medicines. System inefficiencies have improved, but stockouts and shortages persist for non-ARV commodities. Although the project has improved operational capacity and mitigated supply disruptions, system bottlenecks limit the ability of Central Medical Stores to be more effective.

## Managing human resources for health

The private health sector faces a number of challenges. Recent MOH efforts have begun expanding access to high quality specialty health services in the public sector, with increased investment in health infrastructure, including four new state-of-the-art district hospitals. Since the government has had difficulty staffing these facilities, the MOH initiated the Specialists Health Services Program to bring physician specialists to the four new hospitals through a contract with an India-based private hospital group. However, many Botswana private physicians are underemployed. Oversaturation of private doctors in Gaborone has led to the closure of some practices and left others unable to obtain licenses. New registration requirements take into account the geographic distribution of providers and discourage too many private facilities in one area. A widespread nursing shortage is also preventing some facilities from operating at full capacity. Many nurses who were once employed through donor programs are now being released from externally supported employment. A country-wide hiring freeze is preventing new graduates and trained, experienced nurses from obtaining employment within the public health system, leading many nurses to retire or seek jobs outside of Botswana.

## Expanding access to HIV services

The government has a history of partnering with the private sector to expand access to essential HIV services. Since 2005, selected private providers have been trained by the MOH in ART, and the first ART providers in Botswana were from the private sector. Currently, private providers in Botswana offer the full range of HIV services from prevention to treatment. Both private and public health facilities focus heavily on HIV treatment, and NGOs play a leading role in the provision of HIV prevention services, including HIV counseling and testing (HCT) and voluntary medical male circumcision (VMMC). As presented in Figure 3, various government and donor initiatives have shaped the role of the private sector not only in the HIV response, but also in Botswana's overall health system. These include:

- **ACHAP provides access to lifesaving ARVs.** When ACHAP began in 2000, the annual per-person cost for HIV treatment was approximately \$10,000, largely due to a lack of generic options (Global

Fund, 2012). Through ACHAP, the Merck Company Foundation donated the latest ARV medications, helping expand access to lifesaving drugs and setting up one of the first national ART programs in Africa.

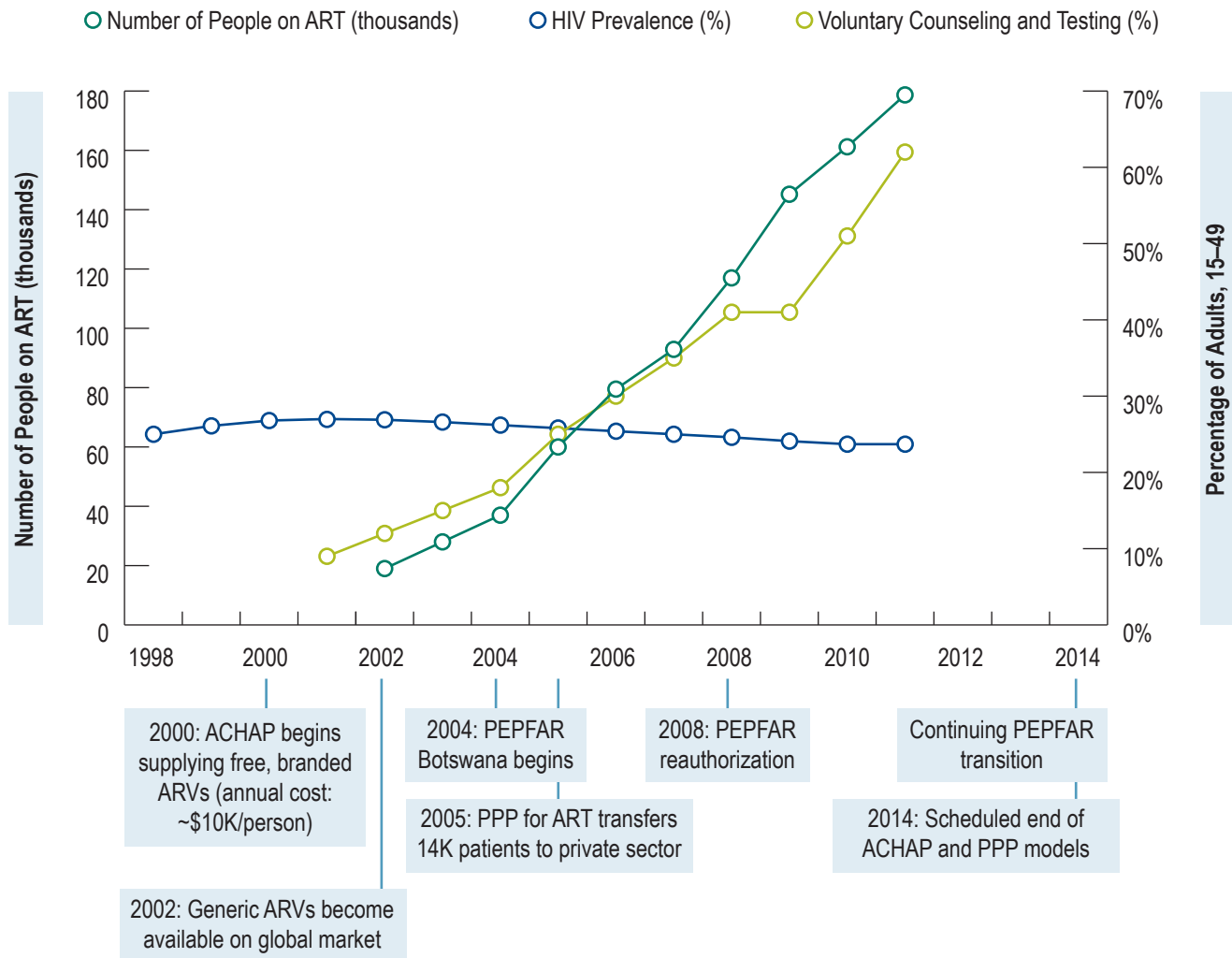
- **New efforts help scale up ART provision.** Between 2002 and 2004, global advocacy efforts helped make generic ARVs available in the global market, drastically lowering the cost of treatment. In 2004, the government of Botswana initiated a new policy to provide HIV testing as part of all medical visits to increase enrollment in ART programs. As a result, enrollment in the national ART program more than doubled within two years (Weiser et al., 2006; World Health Organization, 2005). This increase, combined with an influx of PEPFAR resources, placed additional pressures on a public health system that had chronic human resource shortages. In response, the MOH developed new strategies for partnering with the private sector to meet the growing demand for ART.

- **The private sector role evolves through the HIV scale-up response.** Through the establishment of the Botswana Business Coalition on AIDS to coordinate the private sector HIV response and the decision of Debswana, the large diamond mining company, to expand medical aid coverage from only employees to include family members, the private sector has helped expand coverage of HIV services. In 2005, the government implemented an innovative arrangement to contract out ART delivery to the Associated Fund Administrators, a private medical aid administrator. This allowed 14,000 uninsured public sector patients to access ART through private providers, relieving some of the patient load from the overburdened public sector. Under this model, the government provided free medications that were then packaged, distributed, and accessed through the private sector.

*Private companies such as MRI Botswana, which specializes in medical transportation, are an important source for health care.*



**Figure 3. Evolution of Botswana's HIV Response**



These partnerships have helped strengthen Botswana's HIV response, and provided a strong historical basis for making further investment to sustain HIV programs. Further leveraging the private health sector's capacity and resources will require implementing reforms.

### Leveraging the Private Sector for Health Financing

In light of an expected tapering off of mineral revenues and announced reductions in donor funding, Botswana is developing strategies to close the anticipated revenue gap for health care. Strategies to use public sector resources are being examined (Lee et al., 2012), but the private sector

can also contribute. Options for leveraging private financial resources include asking users to pay more for health care out of pocket, asking employers to cover a larger share of employees' health care costs, and expanding participation in medical aid schemes. Out-of-pocket spending is the lowest in sub-Saharan Africa—comprising 13 percent of total health expenditures. However, increasing spending is not a viable solution for the poorest groups, because they may not be able to cover health care costs. Similarly, as the private sector is likely to see its profits shrink due to the global economic slowdown, asking private companies to cover an increased amount of their employees' health care costs may not be feasible.

While large numbers of Batswana are unable to cover the full cost of their health care, many have sufficient resources to purchase affordable health insurance products. The health finance environment in Botswana is characterized by a relatively large number of medical aid schemes. An estimated 140,000 employees are covered by a scheme, amounting to 340,000 lives covered (including family members), or about 17 percent of the total population. There are nine schemes in the country. The Botswana Public Officers' Medical Aid Scheme (BPOMAS) serves public sector employees, covering about 70,000, or 55 percent, of these employees. The remaining eight schemes serve about 70,000 employees in the formal private sector and their families. These schemes range in size from around 300 members for the smaller schemes to 35,000 members (BOMaid). This coverage level equals 34 percent of the private sector workforce, meaning about 66 percent of private sector workers are not covered by a medical aid scheme.

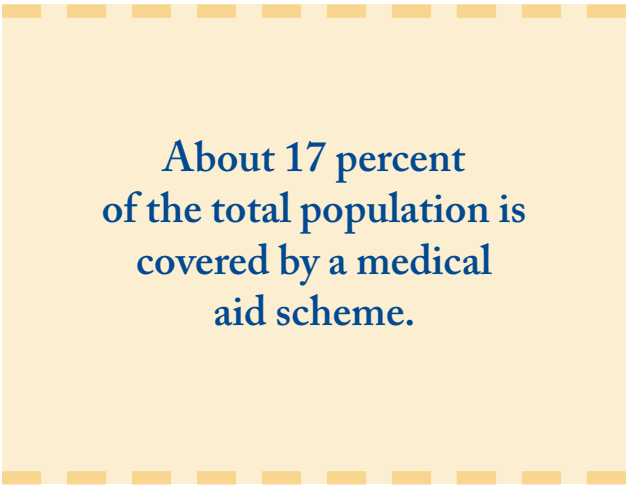
It is believed that very few of the country's estimated 70,000 informal workers are covered by a medical aid scheme. Expanding coverage of medical aid scheme products is perhaps the most feasible approach to use private resources to bridge the expected health financing gap. This goal will require increasing the attractiveness of medical aid schemes by developing a broader choice of insurance products and reducing their cost.

### **The Private Health Sector and Key PEPFAR Investments**

Botswana has made tremendous strides in its HIV response through substantial and effective investments by the government, PEPFAR, and ACHAP. As the health system faces decreasing donor resources, the private sector could play a greater role in sustaining these investments—particularly for HCT, VMMC, and HIV treatment.

### **PEPFAR-funded NGOs and HIV counseling and testing services**

Botswana has more than 300 health-focused NGOs. Many were created during the peak of the HIV epidemic and are focused on HIV prevention, especially HCT. These NGOs mainly receive funding through donor contributions (especially PEPFAR and ACHAP), and to a lesser degree through MOH contracting or small-scale grants from umbrella organizations. Many of these NGOs will face uncertainty in their funding as they seek to sustain and expand their health and independent HCT services.



Registered in 1995, the Botswana Council of Non-Governmental Organizations helps coordinate and advocate on behalf of more than 200 NGOs. The organization receives funding through the \$5.3 million Maatla project (PEPFAR's key NGO-strengthening initiative in Botswana) to help sustain and strengthen civil society capacity to support HIV

and AIDS and other health service delivery. Maatla and the Botswana Council of Non-Governmental Organizations have aimed to help Batswana NGOs seek additional sources of revenue. To date, they have had limited experience brokering sustainable NGO-commercial sector linkages. Most NGOs have focused outreach efforts to corporations mainly for one-time corporate donations.

As donor funding declines, the MOH may choose to scale up contracting arrangements with NGOs to provide HCT in remote areas. In addition, the private health sector has a robust laboratory and pharmacy infrastructure that is capable of increasing HCT provision. Many private laboratories and pharmacies in Botswana have the private counseling rooms required for high quality HCT. However, without a medical aid scheme tariff to cover the counseling component, many private pharmacists and laboratory technicians are hesitant to provide the service.

### **Voluntary medical male circumcision**

The MOH, ACHAP, and PEPFAR have invested heavily in scaling up VMMC since 2007 as a key HIV preventive service, with the goal of circumcising 80 percent of adult males by 2016. The VMMC program is led by the MOH, and ACHAP supports VMMC coverage in 10 districts. PEPFAR supports the scale-up of VMMC through clinical trainings for public health care sites and providers, direct provision of services, and technical assistance for quality assurance, monitoring, and evaluation. Unlike neighboring Namibia and South Africa, Botswana has a long history of private sector involvement in its VMMC response. Private providers are trained, contracted in for three annual VMMC outreach campaigns, and reimbursed per procedure in all 10 ACHAP-supported districts.

In Botswana, medical aid schemes can individually elect to cover VMMC as an HIV preventive benefit, and only BPOMAS, Pula, and BOMaid do so. About 47,000 Botswana men enrolled with these three medical aid schemes are in the target VMMC age range (ages 15 to 49), representing approximately 10 percent of the total Botswana 2016 target. Although Botswana (like most southern African countries) is behind in meeting its targets, these 47,000 men may be an important group for the expansion of VMMC. Leveraging the private health sector to deliver VMMC for those men relieves the public and NGO sectors of these clients, and provides men who are used to the private health sector with a more familiar service delivery point. However, due to concerns over collusion and lack of actuarial analysis regarding medical aid scheme tariffs, many private providers believe that the current VMMC reimbursement rate is too low. This discontent has led to a relatively low uptake of VMMC in private facilities, as well as donor perceptions that private providers are not interested in providing the VMMC service.

### **HIV treatment**

Through multi-sectoral strategies, Botswana has developed strong platforms for partnering with the commercial sector to help achieve universal ART coverage and expand HIV services. However, the combination of anticipated funding transitions in PEPFAR, ACHAP, and the ART PPP delivery model could weaken the country's effective HIV program. For example, as PEPFAR technical assistance phases out, Central Medical Stores is

expected to take on full ownership of PEPFAR's procurement process. Managing and implementing these complex functions requires greater capacity than what currently exists in the public sector. Additionally, when the current ACHAP funding arrangement ends in December 2014, it is expected that ARV donations from Merck could end as well. As Merck's drug donations through the partnership have decreased, the MOH has taken increasing responsibility to procure generic ARVs. However, in 2012, the estimated value of Merck's medicine donations was still approximately \$25 million. Although generic ARVs cost less than the donated branded medicines, the MOH will have to assume this additional responsibility at a time when concurrent transitions are already placing strains on limited financial resources. These costs could weigh on the MOH's decision about the future of the ART PPP model. Although the ART PPP delivery program has successfully extended ART provision to 14,000 patients, many stakeholders perceive it to be too costly to continue past its scheduled end date in 2014 in light of budgetary strains. Plans for its continuation after 2014 remain unclear as the MOH considers transferring these patients back into the public health system. New WHO guidelines expand ART eligibility requirements from CD4 250 to 350 for HIV-positive adults (and even newer guidelines recommend initiating ART at CD4 500). More people will be eligible for treatment at an earlier stage of infection, increasing the HIV patient load at public health facilities. A recent costing study revealed that with the change to CD4 350, it may take three to four years for the additional pool of patients entering the health system to level off.

# Recommendations



The recommendations in this assessment are grouped into three general categories. The first focuses on better leveraging existing resources in the private health sector to strengthen Botswana's health system, the second focuses on options for increasing private financing through Botswana's medical aid industry, and the third focuses on opportunities for the private health sector to help sustain PEPFAR investments.

## Recommendations to Better Leverage the Private Health Sector

### Strengthen private sector representation.

Strong and effective private sector representatives are needed to strengthen dialogue with the MOH on critical issues of registration, licensure, and enforcement. The Medical Practitioners Association needs a broader mandate and a vision that goes beyond medical aid negotiations. It needs to be able to adequately represent private providers outside of Gaborone. The medical aid industry is the primary point of contact with the MOH on discussions around new contracting options and regulatory decisions. This arrangement leaves individual private providers fragmented and with little ability to give input into important items affecting their practices. If sufficiently strengthened, the Medical Practitioners Association could present a more unified voice.

*A midwife draws blood to determine the CD4 count of a patient with HIV. About 23 percent of adults in Botswana are living with HIV.*



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### Support the ability of the Botswana Health Professions Council to effectively implement private sector enforcement functions.

PEPFAR already provides support to the BHPC. Once private practice enforcement functions are fully transferred to the council, extensive training and technical assistance will be needed to give the BHPC sufficient capabilities in terms of staff, training, and data management to support accurate and efficient reporting on private sector quality. Because the private sector receives little clinical support from professional associations, private providers in Botswana are particularly in need of a strong supportive supervision system. Moving toward one high quality, trusted enforcement system can reduce the need for the medical aid industry to operate its own parallel inspection system, which may bring down administrative costs.

### Consider partnerships, including mobile, to strengthen primary health care.

Both national policy documents and longstanding experience in partnering with the private health sector for ART provision suggest a strong government commitment to PPPs for service delivery. Recent MOH investments in tertiary and specialist care have helped increase reliance on PEPFAR-supported NGOs for the provision of HIV prevention services. To focus on primary health care in remote areas, the MOH can pursue innovative PPPs such as mobile outreach clinics, which have been used successfully in Namibia and South Africa. Typically, these clinics focus on primary health care and prevention services that include HCT. In Botswana, medical aid schemes and administrators may be interested in partnering with the MOH to outfit and administer mobile clinics. As part of this PPP, the public sector could supply commodities to the mobile clinics free of charge, while the medical aid scheme could charge a small monthly subscription fee per user. In addition, private corporations in Botswana could consider donating vehicles or medical equipment to spur the creation of these clinics, while private employers could purchase mobile clinic access for their employees at a cost considerably lower than medical aid coverage.



### **Build on MOH contracting experience to maximize the use of existing human resources in the private sector.**

In Gaborone, there is an oversaturation of private general practitioners, a large number of underemployed nurses, and many understaffed state-of-the-art public health facilities. As donor support declines, retention of human resources in Botswana is crucial to sustaining achievements in health care coverage. Contracting locally based private health providers to work in public facilities is one option to help improve private provider compensation, maximize the use of existing human resources, and encourage workforce retention in the country. Existing mechanisms in the MOH for outsourcing may offer a platform for contracting in private physicians and nurses to work at public health facilities around the country. One such option would have private general practitioners that face market limitations on the growth of their practices work in public facilities outside normal operating hours. Extending services to evenings and weekends would provide patients with greater access to health services and would help reduce pressures placed on overcrowded facilities. Another option would use the Specialists Health Services Program to help attract, train, and retain much-needed nursing staff within Botswana. Pairing nurses with specialized physicians would help nurses receive clinical exposure and build specialized skills, while foreign physicians would have the appropriate nursing support to deliver high quality, efficient care.

### **Options for Increasing Private Financing through Medical Aid**

#### **Support efforts to build fewer, larger, stronger medical aid schemes.**

Nine medical aid schemes cover about 140,000 employees (300,000 lives) in Botswana, averaging 16,000 principal members per scheme. The three largest schemes (BPOMAS, BOMaid, and Pula) provide about 88 percent of this coverage, resulting in a number of small risk pools that individually are not large enough to spread risk sufficiently and lower operational costs. A smaller number of larger and well-managed schemes would lower the risk exposure of each scheme's portfolio while leveraging economies of scale. Both of these strategies would result in lower operational costs, and, if these cost reductions are passed on to members, more affordable premiums. Any increase in medical aid

scheme coverage is more likely to be sustainable if it is based on lower costs and more attractive products, which are difficult to attain under the current industry structure.

Merging medical aid schemes in Botswana is likely to have both proponents and detractors, but it has significant potential for increasing overall market growth.

**Merging medical aid schemes could increase overall market growth.**

#### **Develop lower-cost insurance products and distribution channels.**

Lowering the cost of insurance products, and increasing outreach to youth and low-income populations are essential to expanding medical aid scheme coverage. To attract low-income clients and be sustainable for the scheme, insurance products should:

- Cover essential primary care services with a working referral system in place.
- Rely on wide service provider networks contracted to provide health services, which helps limit the risk that providers face by guaranteeing a portion of their income.
- Use a capitation reimbursement model by actively encouraging beneficiaries to register with specific primary care practitioners or facilities.
- Allow coverage of chronic conditions (including HIV and AIDS) and use cost-effective generic medicines.
- As volumes increase, negotiate medicine pricing throughout the supply chain.
- Explore and test hybrid insurance-savings products in which outpatient care is financed through savings, resulting in less expensive inpatient-only products.

Three medical aid scheme products combine some of the elements listed above. Although these schemes feature high loss ratios, no current data in Botswana show that low-income products are

necessarily less profitable, suggesting that the losses may have more to do with low volumes and cost control issues. An additional four schemes offer products that are somewhat similar to low-income products, but none of these schemes have made serious outreach efforts to low-income workers.

Additionally, small risk pools are sensitive to the aging of their members. Attracting young, healthy people is one way these risk pools can avoid worsening their collective risk as members age, and thereby reduce the cost of their insurance products. Reaching this population requires a deliberate design, pricing, and marketing strategy that takes into account the needs and preferences of the target population.

Lower-cost distribution and payment channels are also important for reaching uninsured groups. For example, new efforts to sell insurance outside of the workplace may help increase enrollment. This approach means that premium payments through direct payroll deductions likely are not an option, requiring alternative methods for automatic premium payments, including direct debit from bank accounts. Selling insurance to the informal sector through grassroots organizations such as microfinance institutions and cooperatives does not appear to hold much potential in Botswana, since these organizations have limited reach, and their members generally appear satisfied with the public health system.

### **Create modified plan choices in the public and private sectors.**

Two options for increasing health insurance coverage are increasing the affordability and attractiveness of insurance products, and making enrollment a condition or a benefit of formal employment. The government of Botswana is in a particularly favorable position to use both of these options to boost scheme coverage for public sector employees. Public sector employees have BPOMAS as their main scheme choice, although they can purchase coverage for their families from any of the other eight schemes. Increasing the choice of benefit

plans for public sector employees may increase net enrollment in medical aid schemes.

The second option at the government's disposal is to make scheme coverage compulsory for all public sector employees—either under one BPOMAS administrator or through competition among scheme administrators. Since the government subsidizes at least half of the premiums of all public sector employees with BPOMAS coverage, this option would represent a significant financial burden on the government.

**Reaching young, healthy people requires a deliberate design, pricing, and marketing strategy that takes into account their needs and preferences.**

Making health coverage compulsory for employees in the private sector would most likely meet resistance from private companies, as it would place significant financial burden on companies in the form of scheme subsidies. Private sector stakeholders and employers would need to be consulted to gauge the private sector's interest in this solution.

### **Develop a supportive regulatory environment, enhancing impartiality.**

A well-designed and impartially enforced regulatory framework can help strengthen a country's health insurance industry by improving schemes' financial stability, strengthening client protections, and facilitating greater accumulation of financial reserves. All of these outcomes can affect the solidity and cost structure of the industry, preparing it to expand coverage. If the insurance regulator has legislative backing and the administrative tools to ensure that medical aid schemes are financially sound, then it can also protect the medical aid scheme members' contributions and their access to care. At the same time, involving insurance regulators in the setting of premiums and reimbursement rates can limit increases in member contributions and medical inflation.

A close monitoring of the medical aid schemes' reserve accumulation show potential for lower premiums. The Non-Bank Financial Institution Regulatory Authority (NBFIRA) Act of 2008 put the supervision of medical aid schemes under the

purview of NBFIRA, but specific legislation to deal with financial soundness, consumer choice, and consumer protection has yet to be written. While most schemes see the value of an enabling and progressive regulatory environment, NBFIRA does not have much experience with the health sector, raising questions about its ability to effectively regulate medical aid schemes. If done correctly, NBFIRA regulation can help improve Botswana's medical aid scheme industry.

The Competition Authority, established in April 2011, has indicated concerns about what it sees as potentially damaging collusion in the medical aid industry, especially among providers while negotiating reimbursement rates with schemes. As a result, the Authority has ruled that medical aid schemes can only negotiate with providers on an individual basis. This raises administrative costs, damages trust between schemes and providers, and does not necessarily result in lower rates. The Authority also expressed concern over the enrollment of providers into networks tied to a specific scheme. Since this type of enrollment provides some level of financial predictability and security to providers, they generally agree to lower reimbursement rates, which can translate into lower member contributions. The Authority has expressed concern that such practice increases the risk of collusion between providers. While such concerns are rational, the Authority may want to explore ways that it can loosen some of the regulations in a way that translates into financial benefits for consumers.

### **Implement stronger risk-sharing arrangements among all parties.**

Balanced risk sharing is essential to a well-functioning health insurance system, as it affects incentives, behaviors, investments, and access to care. If providers cannot cover their costs with insurance reimbursement, they might ask policyholders to make up the difference or give priority to cash-paying patients. If reimbursement rates are higher than the costs of treatment, providers may be tempted to provide too many services. From the insurer side, if reimbursement payments are too high compared to premium income, the sustainability of the scheme will be weakened. If reimbursement payments are low compared to premium income, premiums could be lowered—and coverage increased—without affecting the financial health of the industry.

Providers and medical aid schemes have different views on the acceptability of current reimbursement levels and their effect on the quality of care and insurance coverage. This situation is complicated by multiple factors, including the restrictions on collective negotiations on reimbursement between provider associations and schemes. Another factor is the lack of costing information from an impartial source, although recent efforts to cost a package of essential services will help.

The patient's share of risk is another element that affects access to care. Copayments are a well-established means of controlling risk and costs in health insurance by forcing policyholders to cover a small portion of their health care costs. Copayments in Botswana range from 0 to 22 percent, depending on the medical aid scheme. Some copayments that include a 12-percent value-added tax on medical services appear to be high enough to serve as a barrier to care and to medical aid scheme coverage. Some medical aid scheme members may choose to go to public facilities for more expensive treatments because they cannot afford the copayment, and thus crowd out uninsured patients in these facilities. Switching to a lump sum copayment, advocating that medical aid schemes reduce their copayment amounts, and lobbying the Ministry of Finance to remove the value-added tax on health care services can help address these issues.

*Botswana's maternal and child health indicators are slightly below the average for upper-middle-income countries, but better than those of its neighboring countries.*



Joanjo Aguar Matoses

## Recommendations for Sustaining Key PEPFAR Investments

### Explore additional opportunities for PEPFAR-funded NGOs to provide health, wellness, and HIV services.

Many larger private corporations in Botswana contract out health and wellness services, including HIV prevention, to for-profit peer education and training firms, and to a few large NGOs. Although these corporations have provided robust HIV preventive services, more employees are interested in holistic health and wellness services. In response, some companies have chosen to contract multiple for-profit providers that have a wide range of health and non-health expertise, creating a multitude of contracts that are difficult to manage and cost a great deal of time and money. Some traditional HIV-focused NGOs with extensive HCT experience may be able to offer a broad array of services to corporations if they repackage and reframe their services, and receive adequate skills-building assistance in additional health and wellness topics. There may be other market opportunities for NGOs, such as providing disease management or low-cost health services. To deliver these services to corporations, NGOs need an urban presence and

reach, marketing skills to pitch their services, and adequate management skills, which could require targeted USAID-supported technical assistance. Stakeholders should conduct a market analysis for these types of health and wellness services. Cost-effective ways to obtain market information include working through the Maatla project to survey its partner NGOs, holding a consultation event through the Botswana Council of Non-Governmental Organizations' PPP forum, and working through the PPP forum of the Botswana Business Coalition on AIDS to survey and understand the health and wellness needs of its member corporations.

Contracting arrangements for wellness services will not likely make up for the anticipated reduction in donor funding. Exploring further contracting arrangements between NGOs and the MOH is important for sustaining HIV prevention investments, particularly given the MOH's focus on tertiary care in urban areas at the expense of preventive care in rural areas. The MOH has begun to pursue contracts with a select number of NGOs for HIV prevention—a strategy that is likely to be important for NGO sustainability. Additionally, independent actuarial analysis and medical aid scheme advocacy



could support the development of an accurate tariff to cover the full costs of HCT through the private sector. Finally, more private pharmacists could be trained in HCT using donor support to ensure quality in the private sector.

### **Develop a more accurate reimbursement for voluntary medical male circumcision.**

Efforts to facilitate more accurate reimbursement rates for VMMC that reflect perceived higher costs should focus on three areas. First, donors and stakeholders should advocate for more medical aid schemes to cover the procedure as an HIV preventive benefit. Donors could subsidize the cost of marketing materials that would introduce scheme members to the new service. Second, robust actuarial analysis should be conducted to develop a more accurate VMMC tariff. This will help mitigate the risk that private providers might not want to perform the service under medical aid scheme coverage, or that they may cut back on the more time-consuming aspects of the service that are needed to maintain quality. Third, stakeholders should consider networking and reinforcement mechanisms for private providers offering the procedure. In addition to the financing challenges, counseling and post-procedure follow-up visits make VMMC a time-consuming service. Private providers also need a critical mass of VMMC clients to build and retain their clinical skills post-training and to make the service financially viable within their practice. Overall, it could be more effective to have a smaller number of private general practitioners offering the procedure in Botswana at higher volumes than the current larger pool of fragmented general practitioners. Networking and branding trained providers could build a trusted base for private sector provision of VMMC and ensure the necessary critical mass of clients for private providers. Medical aid scheme marketing materials could help publicize those branded VMMC service delivery points.

### **Leverage private sector procurement and distribution capabilities to sustain HIV treatment gains.**

As Central Medical Stores take on greater responsibility for Botswana's supply chain, PEPFAR should ensure that its technical assistance supports efforts to explore and cost various options for the MOH to contract out to third parties for procurement and distribution of essential

commodities. For example, Central Medical Stores own 15 vehicles for distribution of its products, but major bottlenecks within the Central Transport Authority create delays when these vehicles need repairs. Options to contract out the management of the entire government-owned fleet to a local private courier service are under discussion and would extend to warehousing and distribution under Central Medical Stores. If implemented, contracting out these functions could help mitigate some of the inefficiencies in the current distribution system, although the contractor would have to be carefully monitored to ensure adherence to special requirements for handling, stocking, and packaging pharmaceuticals and medical products. Contracting out procurement may lead to more flexible and favorable terms of purchase for the government. It could also improve efficiency in the system, as third-party agents should have built-in capacity and expertise to carry out essential procurement functions.

**It could be more effective to have a smaller number of private general practitioners offering VMMC.**

Before a decision is made on whether to transfer patients served through the ART PPP model back to the public sector, stakeholders should consider the capacity of the public distribution system to manage and deliver necessary medicines for these additional patients. To reach an informed decision on the future of the ART PPP model, stakeholders should conduct a cost analysis to better understand its prospects for scalability and expansion. The model offers prospects for scaling up ART, and other health services and products, through private sector delivery channels. One of the major criticisms of the program is that it is too expensive. A cost-benefit analysis would determine whether the MOH is receiving the best value for its money, and would help identify improvements that could better maximize program benefits. PEPFAR could potentially build on this effort by costing the PPP model. Cost data would inform future budget decisions for sustaining and scaling up the PPP to deliver other essential health services.

## CONCLUSION

The private health sector assessment aimed to assist the government of Botswana, USAID, PEPFAR and the private sector in further strengthening Botswana's vibrant health care system to prepare for a country-led and self-sufficient future. This brief provides recommendations to better leverage the private health sector in expanding essential health services; increasing private health financing and medical aid scheme coverage; and sustaining the tremendous achievements in HIV services made by the government of Botswana, private providers, and PEPFAR over the last 10 years. The MOH, USAID, and PEPFAR can pursue many of these recommendations to help ensure shared responsibility for national health goals between the public and private sectors. Botswana's position as a frontrunner in the PEPFAR transition offers an opportunity to understand how private sector strategies can help sustain investments made by donors, and may offer ideas for other countries

at various stages of private sector development and at higher levels of PEPFAR dependence. Some recommendations in the assessment require broad-based consultation and senior political buy-in. Other recommendations may be easier to implement at a small scale, but will have less impact on national implications. Although Botswana's small population and its saturation of health care facilities in urban centers represent a market barrier to private health sector growth, the private sector will remain an important provider of health care services. Through effective stewardship by the MOH, targeted investments by donors, and strong representation by the private sector, the contributions of private providers will likely expand. Through creative thinking, planning for the impact of multiple transitions, and an effective use of evidence to consider the future of public-private engagement, Botswana's health care system will continue to serve the evolving needs of its citizens.

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**For more information about the SHOPS project, visit: [www.shopsproject.org](http://www.shopsproject.org)**



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