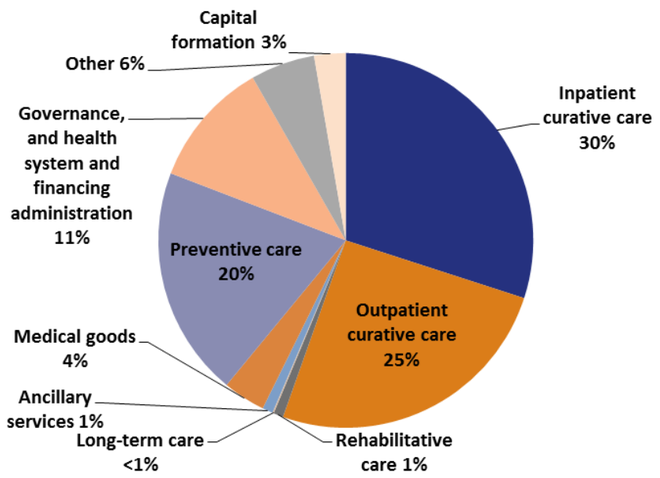
How is spending allocated among type of service?

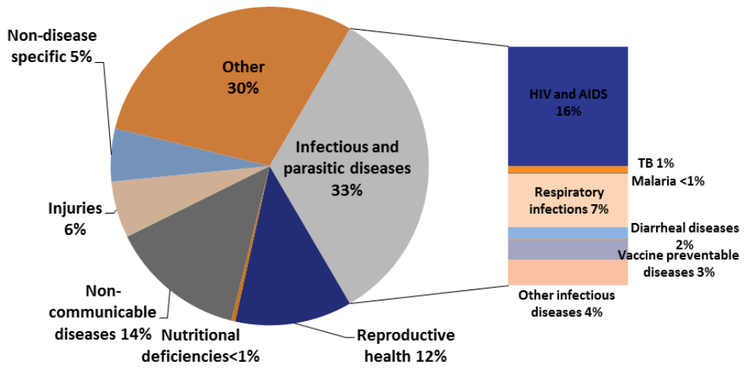
Health expenditures by type of service, 2013/14



A total of 55 percent of the health care spending goes to provision of curative care, of which 25 percent was outpatient and 30 percent was inpatient. Curative care is followed by preventive care, which takes 20 percent of funding and has more than doubled since 2009/2010.

What is the breakdown of spending by disease?

Health Expenditures by disease/condition, 2013/14



One-third of health care funds were spent on treating infectious and parasitic diseases in Botswana. Within this category, spending is highest on HIV/AIDS at 16 percent of THE, followed by respiratory infections at 7 percent. Fourteen percent of THE is spent on Non-communicable diseases and 12 percent on reproductive health.

Policy Implications & Recommendations

- Increase government health expenditure to achieve the Abuja target and explore alternative sources of funding for health. This can be achieved by reducing high reliance on mineral revenues, strengthening public-private partnerships in financing and provision of health services, and raising additional revenues for health through earmarked sin taxes.
- Retain low levels of out-of-pocket (OOP) expenditure on health.
- Continue to increase allocation of resources to preventive care to improve quality, accessibility, and allocative efficiency.
- Allocate more resources to primary care instead of secondary and tertiary care to improve allocative efficiency. This can be achieved through introducing gatekeeper clinics within hospital premises and contractual agreements between the government and private sector.
- Increase spending on Non-communicable diseases as they contribute significantly to overall mortality but only receive 14 percent of THE.
- Develop sustainable financing options for donor-funded HIV programming.

The Botswana Health Accounts 2013/14 exercise was undertaken by Government of Botswana with support from the United States Agency for International Development (USAID) Botswana Mission. Program management and support and funding for the Health Accounts estimation were provided by USAID through the Health Finance and Governance (HFG) project, implemented by Abt Associates Inc. under cooperative agreement AID-OAA-A-12-00080.

Botswana Health Accounts 2013/14

Key Findings and Policy Implications

REPUBLIC OF BOTSWANA

MINISTRY of HEALTH
REPUBLIC OF BOTSWANA

Ministry of Health and Wellness

This brochure presents health expenditure data by households, public and private institutions for the 2013/14 fiscal year.

What is the Health Accounts methodology?

Health Accounts is an internationally standardized methodology utilized by countries to track funding flows through the health sector in a given year. More specifically, Health Accounts measures how a country's total health expenditure (THE) flows from financing sources to financing agents, health care providers, and health functions. As the globally recognized methodology for tracking health resources, Health Accounts allows cross-comparisons with data from other countries.

Health Accounts data measure financial performance and answer key policy questions, which makes it a critical tool for policy analysis and strategic planning for: *Sustainability*: Is health financing too donor dependent? *Equity*: Are households bearing too heavy a burden? *Efficiency*: Does spending favor inpatient care?

Health Accounts in Botswana

The current exercise is Botswana's third round of Health Accounts for FY 2013/2014. The first round results were published in 2006 and covered financial years 2001/2002–2002/03; the second round was published in 2012 and covered FY 2007/2008–2009/2010. Earlier Health Accounts helped the country to understand major health spending flows and magnitude of funds across different actors in the health care system. They also highlighted trends in the share of contribution by each actor in the health care system, such as the government, donors, nonprofit institutions, and employers. Multiple years of Health Accounts data have enabled Botswana to visualize changes in key trends such as per capita spending, health spending as a percentage of GDP, and resource allocation across major health programs. The availability of such information supports the Government of Botswana's ambitions to constantly improve health systems' performance, allocate resources to key health programs and to progress towards providing universal health coverage to its entire population.

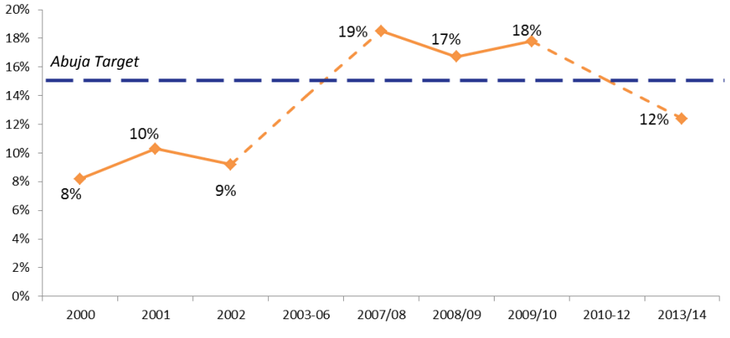
Data Sources

Health Expenditure data was collected from a wide range of primary and secondary sources:

- Donors (both bilateral and multilateral donors)
- NGOs involved in health
- Private employers
- Medical aid schemes
- Ministry of Health and Wellness; Ministry of Education; Ministry of Local Government and Rural Development; Ministry of Defense, Justice, and Security (including the Defense Force, Police Service, and Prison Service); and the National AIDS Coordinating Agency
- 2010 Botswana Core Welfare Indicator Survey
- Botswana's Health Information System
- WHO CHOICE database
- Statistics Botswana 2013/2014 Annual Report

Trends in Health Spending

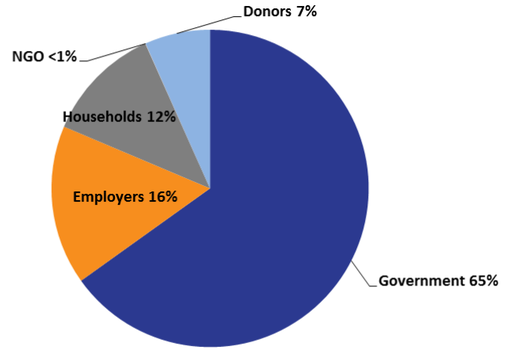
Share of Total Government Health Expenditure out of Total Government Expenditure (GGE), 2000 to 2013/2014



Total government health expenditure as a percentage of GGE declined from 19 percent to 18 percent from 2007/2008 to 2009/2010, sustaining an average of 18 percent during this period. As of 2013/2014, government expenditure on health as a percentage of GGE was 12 percent. This current level of government spending as a proportion of GGE puts Botswana below the Abuja target of 15 percent.

Who Financed Health?

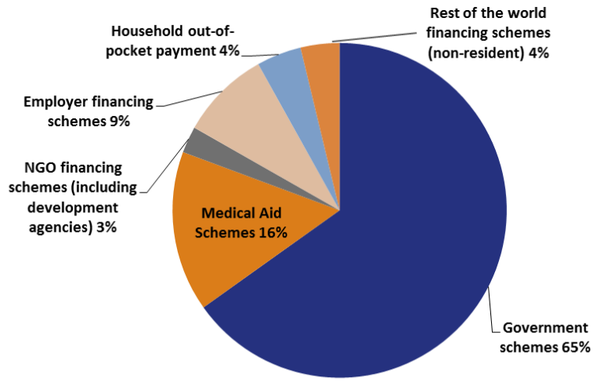
Health expenditures by financing source, 2013/14



The government is the biggest contributor to health spending in the country; it represents over half of total health spending (65 percent).

To what extent are funds pooled to minimize risk?

Health expenditures by financing scheme, 2013/14



THE is predominantly managed through government schemes (65 percent), followed by a significant contribution (16 percent) from medical aid schemes. Employers and NGOs together constitute 12 percent of total spending, whereas household OOP payment is only 4 percent. The OOP share is well below the 15–20 percent threshold .

At least 90 percent of health spending is managed through schemes with some element of risk pooling, where financial contributions are spread among a group of the population, and the provision of health services is based on need.