

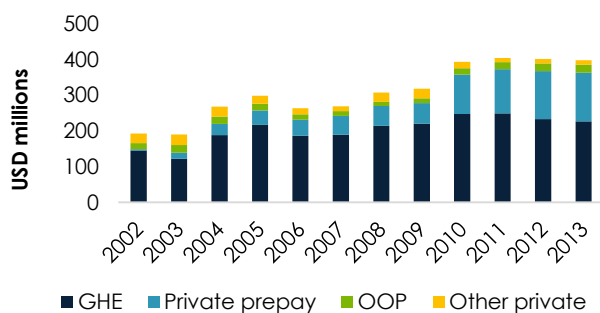


Key Indicators	
Population (2014)	2.2 million
GDP per capita (2014, current USD)	\$7,123
Income classification	Upper-middle
Health Financing (2013)	
THE per capita (USD)	\$397
THE as % of GDP	5.4%
GHE as % of THE	57.1%
GHE as % of GGE	8.8%
OOP as % of THE	5.4%
DAH as % of THE	7.4%
Pooled private as % of THE	39%
HIV Financing	
Adult HIV/AIDS prevalence (2014)	25.2%
DAH for HIV as % of TAE (FY 2006/07)	32%
TAE per PLHIV (current USD, 2007)	\$118
GAE as % of GGE (FY 2006/07)	1.2%
GAE as % of TAE (FY 2006/07)	66%

Source: WHO, 2015; Amico et al., 2010.

THE = total health expenditure, GDP = gross domestic product, GHE = government health expenditure, GGE = general government expenditure, OOP = out-of-pocket, DAH = development assistance for health, TAE = total AIDS expenditure, PLHIV = people living with HIV, GAE = government AIDS expenditure.

Figure 1: Shares of Total Health Expenditures (THE)



Source: WHO, 2015.

Overview

In the 50 years since independence, the government of Botswana has made it a priority to ensure equitable access to healthcare for its citizens. Total health expenditure (THE) in Botswana was US\$397 per capita in 2013, with government health expenditure (GHE) per capita amounting to US\$227. Although GHE per capita has remained relatively constant since 2005, financing for health has been boosted by the growth of private health insurance. Private prepay expenditure per capita in Botswana grew from US\$3 in 2003 to US\$136 in 2013.

Despite the increase in private health insurance expenditure on health, Botswana's health system remains dominated by the public sector. Public care is based on a primary healthcare model, with health posts and clinics making up 95% of government health facilities. Many clinics are supported by donor funding as part of the response to HIV; however, international donors are beginning to reduce this funding. PEPFAR funding fell from more than US\$90 million in 2010 to US\$40 million in 2015. The strengthening of the private sector has offset much of this reduction in funding, but Botswana will need to continue identifying new resources to ensure the sustainability of its HIV response and the health sector as a whole.

Universal health coverage (UHC) is a real possibility for Botswana. The government has encouraged the growth of private health insurance providers. The greatest challenge to UHC remains in rural areas, where improved access has not necessarily translated to utilization of high-quality services. As Botswana's health system continues to move toward UHC, it can take additional steps to ensure equitable access to such services through partnerships with the private sector. Despite broad access to health facilities, there is potential for improving utilization of services and high-quality interventions.

Health Financing Functions

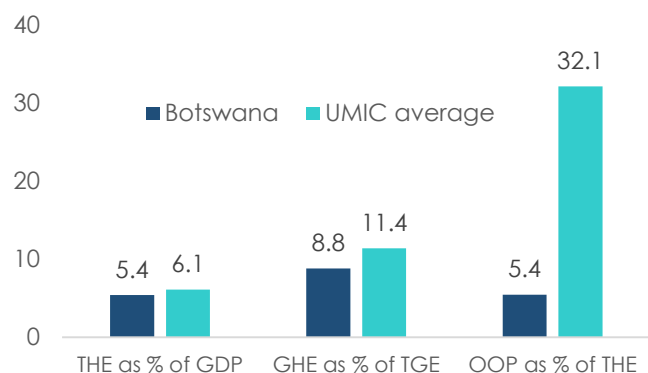
Revenue contribution and collection

The government funds the majority (57%) of health expenditure (Figure 1); 54% of government spending is from domestic sources. The government gets most of its revenue from mineral resources. Currently, no taxes are earmarked for health. Companies and individuals contribute approximately 39% of health funding; donors account for 7%, including on- and off-budget support. There is low out-of-pocket expenditure on health (Figure 2).

Pooling

A large portion (39%) of Botswana's health expenditure is pooled through private insurance schemes.

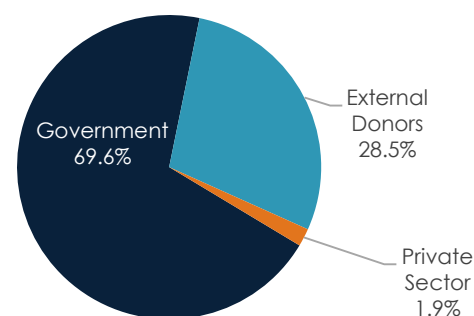
Figure 2: Comparative Health Expenditure (2013)



Source: WHO, 2015.

UMIC = Upper middle-income country

Figure 3: Sources of HIV Expenditure (2007)



Source: PEPFAR, 2015.

Although these schemes cover just 17% of the population, they have grown rapidly as a source of health expenditure. There are nine insurance schemes in the country; the largest three cover 88% of the beneficiaries, so a number of the pools are insufficiently large to effectively spread risk or lower operational costs. The government recognizes the importance of private health insurance providers and is considering ways to expand coverage through the private sector, including compulsory enrollment of public employees in these schemes and contracting out. Employers in both the public and private sectors already heavily subsidize employees' health insurance, so mandating enrollment for private companies is likely to face resistance. Botswana has made strong efforts to extend coverage under the public system to rural areas through mobile services. The current system of tax-financed health services has been successful in pooling risk, contributing to reductions in catastrophic expenditure and promotion of equity in health.

Purchasing

Private insurers make fee-for-service payments to private clinics and hospitals for patients covered by their schemes. The government pays for services in the public sector through budget line items. Although reproductive health and antiretroviral treatment (ART) services are free to all citizens, there is a nominal fee of about US\$0.45 for consultations for other services in the public health sector. However, very few facilities actually collect this fee, and no one is denied service due to an inability to pay. Donor-supported nongovernmental organizations represent only a small proportion of health expenditure.

HIV Financing

Data on recent HIV expenditure in Botswana are limited. The National AIDS Spending Assessment (NASA) conducted in 2007 calculated total HIV and AIDS expenditure (TAE) per capita at US\$118, or 44% of THE. This number is generally in line with the disease burden; HIV accounts for the biggest share (32%) of disability-adjusted life years. According to preliminary results from the 2012 NASA, government and donor HIV spending accounted for 70% and 29% of TAE, respectively; private sources accounted for nearly 2% (Figure 3). However, the rapid increase in private insurance coverage in Botswana suggests that the private sector contribution to HIV is much larger than previously calculated. Over the last five years, PEPFAR has contributed over US\$700 million to Botswana's HIV response. In 2014, PEPFAR expenditure per person living with HIV (PLHIV) ranged from US\$23 to US\$225, depending on the district.

Botswana is likely to achieve universal access to ART at the current eligibility of CD4 <500 by 2017. Approximately 73% of all PLHIV are on ART, according to a recent population-based survey (Gaolathe et al., 2016). The commodity costs of implementing a test and treat model for ART would be US\$21.5 million by 2020 (Lang and Menon, 2015).

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The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. The project's HIV activities are supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). HPP is implemented by Futures Group, in collaboration with Plan International USA, Avenir Health (formerly Futures Institute), Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WRA).

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