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District Control and Accountability in Botswana's Health Care System

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Health care financing reform is currently a top priority on the development agendas of many countries, donors, and financial institutions across the world. Although the reasons and the urgency for health care financing reform differ from one country to another, the trend and objectives are the same. All countries recognize that public financing, traditionally the main source of health care financing, is proving both inadequate and unsustainable.

Developing countries, in particular, are in danger of losing the impressive achievements in health and education they made in years past when they were experiencing better economic growth rates. In the face of shrinking public budgets, many countries must find additional sources of health care financing. A number of countries are diversifying their sources of health care financing to include individuals, communities, local authorities, nongovernmental organizations, and the private sector. Botswana has followed the trend by undertaking significant health care financing reforms since the beginning of the 1990s (Government of Botswana 1991; Moalosi 1991).

The concepts of user fees, community participation, and medical aid are currently receiving more emphasis than in the past. This chapter addresses a number of health care financing reforms with specific reference to district-level health care financing and control in Botswana.

Health Care Development

Botswana has performed impressively in the social sector in the three decades since independence. For instance, the number of rural health posts increased from 244 to 302 and rural clinics from 51 to 131 between 1984 and 1990 (Moalosi 1991). The number of primary and district hospitals also increased from 20 to 24 during this period. This trend has continued in the 1990s, though at a much slower rate, because emphasis in the health sector has shifted from infrastructure development to manpower training and management issues (Government of Botswana 1991). On the whole, Botswana's 1.5 million people enjoy good health care, although the benefits have been distributed unequally (Government of Botswana 1991; Lauglo and

Molutsi 1994). Public funding through central government grants has dominated health care financing, even at the district or local authority level.

Unintended Consequences of Centralized Health Care Financing

The extended period of centralized health care financing in Botswana over the last two decades has had far reaching negative consequences. These can be summarized as follows:

- Massive central government financing pushed out private, nongovernmental, and local authority funding. Most mission hospitals and clinics became reliant on grant-in-aid from the central government. The annual grant increased proportionately over time from around 30 percent from the government and 70 percent from missions or donors to the current ratio of 90 to 10 percent.
- Self-reliance and self-help by communities, an important health care strategy, was undermined. Facilities built and managed by communities were of low quality both in structural terms and in service provision. These facilities have since been upgraded or replaced by modern purpose-built ones. Even where communities were involved in selecting family welfare educators and where village health committees were established to oversee and supervise health care programs and health workers at a facility level, the community's role remained minimal. The family welfare educators had greater allegiance to their employer, the central government, than to the communities they served, and village health committees were weak as health program supervisors at the village level.
- User fees were increasingly neglected and irrelevant as determinants of health care quality. Between 1975 and 1993 the consultation fee at public health facilities remained at P 0.40, or around US$0.20. Other charges for beds and operating theaters also remained exceptionally low in government health facilities. There were even attempts in the early 1980s to do away with most of the charges because of high collection costs (Moalosi 1991).

The overall effects on the health sector were major improvements in quality, but not necessarily in efficiency.

In the early years of independence, between 1966 and 1975, a shortage of public resources in general, particularly for the health sector, encouraged the diversification of health care financing. The government lacked funds, but the population's health was poor. The country had few health facilities of any significance. In addition, the roads were bad; most of the population depended on polluted surface drinking water; and the general level of hygiene of homes and their surroundings was poor, because most households lacked toilets or any other method of hygienic disposal of different types of waste. At this time the main health care financiers were the government, Christian missions, and local communities. Across the country, church organizations and communities established mission hospitals, clinics, and health posts. Poverty-stricken communities—especially following a devastating drought between 1964 and 1966—contributed labor and management services to health facilities, while mission agencies raised funds for construction, drug procurement, and salaries of health personnel. The government focused its limited resources on upgrading the country's few hospitals and constructing some clinics in densely populated areas.

In short, this early period was characterized by a strong ethos of community self-help and self-reliance; by limited, but diversified, sources of health care funding; and by relatively high user fees. However, the quality and efficiency of health care delivery remained major concerns. Hence, both infant and maternal mortality remained high and communicable diseases went uncontrolled. It was under these circumstances that Botswana adopted elements of the primary health care approach much before its formal introduction and international sanctioning in 1978. Community participation, intersectoral collaboration, and preventive health care were central to the country's health care system during the late 1960s and early 1970s.

Management of the Health System

Before 1986 when regional health teams were transferred to the districts, Botswana operated two parallel health care systems, one at the local or district level and the other at the central government level. The

system was cumbersome and expensive. Hence following the reorganization of the Ministry of Health in 1984, regional health teams were integrated into district health teams. On the whole, the process has gone smoothly except for constraints noted by Lauglo and Molutsi (1994), which include the following:

- Financial decentralization has not yet occurred. This hinders the work and management decisions of district health personnel, local leaders, and community health committees.
- Human resources staff have also remained largely centralized at the Ministry of Local Government, Lands, and Housing (MLGLH). Thus local authorities have no influence over the transfer and promotion of staff.
- Coordination of activities between the Ministry of Health and the MLGLH (which is responsible for administering local authorities) remains problematic.
- Conditions of service for central government staff seconded to local authorities differ significantly from those for local authority employees, which results in poor working relationships.

However, decentralization is proving to be more efficient in the use of scarce human and financial resources. The following section draws heavily on empirical studies of five districts in Botswana conducted by Lauglo and Molutsi (1994) for the Ministry of Health between 1992 and 1994.

Resource Allocation at the District Level

Financial resources are allocated within the framework of national development plans (NDPs). The process for preparing a NDP, which is the responsibility of the Ministry of Finance and Development Planning, is long and complex. The ministry circulates copies of the NDP before it is finalized to ensure that its priorities match those of other ministries. Changes are seldom made before the NDP is sent to parliament.

The current NDP exhibits some lack of coordination between the MLGLH and the Ministry of Health in relation to health. The MLGLH continues its commitment to build more health facilities. Its target is 10 more clinics, 25 more health posts, and 5 more maternity wards at an estimated cost of P 30 million in 1994. However, the Ministry of Health's main priorities are developing manpower, developing a good health information system, improving organization and management, and expanding the National Health Institute.

All district council development grants are channeled through the MLGLH, where they are administered by planning officers. All planning officers in the central ministries are Ministry of Finance and Development Planning officers seconded to the ministries. All central government planning officers interviewed for the study (Lauglo and Molutsi 1994) said that they identified with the ministry in which they were placed and not with the Ministry of Finance and Development Planning, which one planning officer viewed as "the enemy…we have to fight with them for our money."

Local authority officers manage funds allocated for development. Additional requests for money need to be justified by a project memorandum to the senior planning officer at the MLGLH. Experienced planning officers noted that the ministry had never turned down one of their project memoranda. The MLGLH confirmed that it never refuses to accept a well-justified project memorandum.

The ethos of planning is firmly based in a bottom-up approach. Local authorities are responsible for village development committees, which the central government established in 1968. Development proposals are brought to the district level, where district development committees consolidate them into district development plans, which the NDP is supposed to take into account. In reality the processes that produce the district development plans and the NDP are not synchronized in a way that allows the district development plans to contribute to the NDP. Senior planners in the central ministries openly acknowledge this situation.

Annual Budgets for Development Projects

Senior planning officers and desk officers at the MLGLH who have been granted project money control development funds. For the first time, the current planning period allows districts to change the amount of money they spend each year on a project as long as the total at the end of the plan period stays within the project budget.

Recurrent Estimated Expenditures

Preparations for the recurrent budget commence when the Ministry of Finance and Development Planning sets the ceilings on recurrent spending. The personnel ceilings are given first, which according to one senior planner allows no room for deviation. A ceiling on finances and personnel is given to each ministry and is passed on to the district councils. Council departments are asked to prepare their own recurrent budget proposals, which are consolidated by senior officers for approval by the Council Finance Committee.

The MLGLH then begins a round of annual discussions on recurrent budgets with each district. The ministry tries to visit each district, although district teams from remote areas sometimes meet ministry staff at a local town. The district teams usually consist of the council secretary, council planning officer, treasurer, principal personnel and training officer, and the district administration. Heads of departments do not normally participate in budget discussions.

The MLGLH considers its visits to the districts as an important part of involving the districts in decisions about recurrent budget allocations and prides itself on these discussions as an example of its bottom-up decisionmaking philosophy. The districts perceive things differently. The local authorities view these discussions as times when they must present their requests and be prepared to argue for them. Local authority officers have commented on being treated roughly during the talks and being abruptly cut off during discussions.

Public officials acknowledge that the link between capital expenditures and the recurrent cost ramifications of development projects has been weak in the past, which carries implications for later recurrent budgets. To some extent this has not been an insurmountable obstacle, because councils have been able to overspend by applying to parliament for supplementary funds. However, since 1993 supplementary funds have been severely curtailed.

Financial Planning at the District Level

District administration officers see their role as preparing, monitoring, and implementing development activities, but have little, if anything, to do with preparing councils' recurrent budgets. They are responsible for preparing recurrent budgets for district administrations. In addition, each district prepares an annual district development plan. The chairs and secretaries of the district development committees are actively involved in preparing the plans. In some districts, they share these responsibilities with the council secretary and CPO.

The council chairs described their role in planning in different ways. One suggested that they were bringing their communities' views, as expressed at the village development committees and village health committees, to the council. Another said that his planning role was fulfilled in council committees, a third saw his role as linking the community and the council.

Chairs do not play an active role in the recurrent budget, but limit their contributions to work on council committees. They do not normally participate in discussions with the MLGLH about ceilings, although in 1992 they were invited to participate. This has not been repeated, perhaps because the ministry did not perceive their participation as successful.

Our original assumption was that CPOs were key informants about the planning of health services. However, during the study we found that they limit their role to development planning, that is, the use of the capital budget. Seminars and workshops are financed under the development budget and can fall within the scope of the CPOs' work, although their main health work has been the development planning of new facilities. CPOs are also responsible for advising on the recurrent cost implications of planned development projects, but as one noted, "This is the weakest link in the planning process."

Most district medical officers interviewed participated to some degree in preparing the council health department's budget estimates, although one subdistrict district medical officer left it to the section heads, who took it to their respective heads at district headquarters to be consolidated there.

The Management of Primary Health Care Services at the Local Level

Given Botswana's commitment to decentralization, an examination of issues concerning primary health care management at the local level is important. This section focuses on the influence of local politicians and on how councils manage the health services they are expected to provide.

Financial Resource Allocation

The authorities generally see health services as a priority sector, although in a few instances they give priority to water, education, or roads. A senior planning officer at the central level commented that districts are not expected to be able to prioritize among social services, which reflects what happens at the central level. All the district medical officers felt that health did not get special priority or the attention it deserved.

Financial Control

Council officers were asked about how much scope they had for making line item changes in the recurrent budget and the development budget. The perceived scope for making individual decisions varied widely. Some chief executive officers thought they had no room for making changes to the recurrent budget. Another was unable to make any changes other than those affecting salaries and wages. Their perceived scope for decisionmaking did not seem to depend on whether they were at subdistrict or district headquarters.

Once the budget is agreed, the chief executive officers can approve all items within the budget, or at least to a high limit, without central approval. No changes in salaries and wages can be made at the local council level. Two officers noted the availability of supplementary funds if they overspent their budgets.

Some staff were aware that they only make recommendations to the central government, which then approves their estimates. Others perceive the same process as being decided at the local level. Senior health managers felt they had considerably less leeway than the chief executive officers in spending from the recurrent budget once it had been approved. A number noted that the council secretary had to decide everything. Some heads of department have commitment control, in that they have the authority to spend within their approved budgets, while others find that even after their budgets have been agreed, they must get permission from the council secretary to make purchases. One subdistrict had to have all purchases approved by senior health managers at the district headquarters. One staff member summed up the situation saying: "We are dealing with two ministries, in Gaborone and at district headquarters." Matrons and chief health inspectors do not necessarily feel that they need to go to their district medical officers for approval to spend. Some noted that everything they do is with the approval of the district medical officer, indicating that they have never encountered problems.

Control over the development budget at the district level is more limited. Most chief executive officers felt that they could not make any changes in line items without MLGLH approval. However, at least one CPO was aware that changes could be made during project reviews and through project memoranda.

Similarly, approval of items in the development budget are more difficult to obtain at the district level. Some chief executive officers can approve items up to a certain limit, but most nonhealth officers said that everything had to be applied for through a project memorandum to the MLGLH. One experienced CPO noted that he had never been refused the use of money if funds were left over after a project and were within the same sector. The MLGLH planning unit confirmed this, and said that it rarely turned down a well-justified project memorandum. The role of donors is significant here, in that one CPO has found that changes are possible between sectors if a donor is not involved.

Council health staff also find it difficult to influence the development budget, although changes can be made in the seminar plan, which is partially financed by development funds.

Personnel Management

The overall vacancy level of staff deployed by district local government (DLG) in established posts is 8 percent, but levels are higher among certain technical grades. According to DLG records, vacancy levels for districts in the study ranged from 5 to 9 percent, which does not support the contention that vacancy levels are higher in remote districts. One possibility is that more expatriates are filling posts in the remote districts, thereby hiding recruitment difficulty differences between districts.

As council chairs are not generally involved in recurrent budget discussions with the MLGLH, they are not normally party to discussions on personnel ceilings. Neither are they involved in the allocation of staff at the district level. As noted earlier, the personnel ceilings are set by the Ministry of Finance and Development Planning and given to the MLGLH, which in turn sets them for each district. At the district level, this means that each post requested must be well justified, that is, based on known and accepted criteria. The DLG notes that in the past three years, districts have usually been given the staff they requested, because they have become better at justifying their requests.

Until recently, local councils were able to recruit staff up to salary grade B4, which includes family welfare educators. In an effort to decentralize further, some of the personnel functions are being transferred to the council level A government paper on decentralization (Government of Botswana 1993) recommends that districts should be able to recruit and appoint staff up to the C3 salary grade within five years.

Once staff have been allocated, DLG personnel, matrons, and chief health inspectors can deploy and transfer them within their districts. They usually take into account distances between facilities, attendance figures, and the remoteness factor. Some districts have a policy of rotating staff within the district to share the burden of covering remote facilities. However, transferring staff requires paying a substantial transfer allowance, which hinders the systematic implementation of such a policy. District medical officers seldom play an active role in intradistrict transfers although they could, theoretically, refuse to approve a transfer should they so desire.

Just as matrons and chief health inspectors can freely deploy the staff allocated to them around the district, they can also either use staff with specialized surveillance skills appropriately or decide that they are needed for other duties. Even though a number of community health nurses are deployed in the districts, apparently many are not in positions to use their community health skills, but have been given responsibilities in clinics.

Lessons Learned

Several useful lessons can be drawn from Botswana's experience at the district level, namely:

- Botswana's highly developed and well-functioning planning culture allocates resources efficiently at all levels based on clearly defined needs and priorities.
- Accountability and control are emphasized and exercised through the system of annual plans, budgets, and local auditing.
- Relatively rigid administrative procedures limit political interference and promote planned expenditure.
- District authorities operate at comparable levels with the central government, thereby ensuring consistency and understanding.

However, there are also a number of constraints to be noted here. These include the following:

- Centralized funding limits local priority setting and flexibility.
- Insistence on rigid procedures centralizes the process and limits diversification of funding sources.
- Genuine local autonomy is compromised.
- Community participation is reduced and local expertise required by the primary health care approach is lost.

- Planning and resource allocation dominated by development is limited.
- Operational and contingency planning opportunities are lost.

Conclusion

Botswana has embarked on a major health policy reform that may have some lessons for other countries in a similar situation. The reform is in line with world trends, and focuses on diversification of health care financing, efficient use of resources, and equity issues. To date this reform is progressing well. The decentralization strategy adopted in 1984 has helped efforts to increase the efficient use of scarce resources, even though a number of constraints remain.

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