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A REVIEW OF HEALTH FINANCING IN NAMIBIA

June 2016

This publication was produced for review by the United States Agency for International Development.

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The Health Finance and Governance Project

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June 2016

Cooperative Agreement No: AID-OAA-A-12-00080

Submitted to: Scott Stewart, AOR
Office of Health Systems
Bureau for Global Health

Recommended Citation: Ohadi, Elizabeth; Claire Jones; Carlos Avila. June 2016. *A Review of Health Financing in Namibia*. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.



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ACRONYMS

AfDB	African Development Bank
AFRO	African Regional Office of the World Health Organization
AIDS	Acquired Immunodeficiency Syndrome
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
MoHSS	Namibia Ministry of Health and Social Services
MSD	Maternity Leave, Sickness Leave, and Death Benefit (Fund)
MTEF	Medium Term Expenditure Framework
MVA	Motor Vehicle Accident (Fund)
NAMAF	Namibian Association of Medical Aid Funds
NAMFISA	Namibia Financial Institutions Supervisory Authority
NMBF	National Medical Benefits Fund
NPC	National Planning Commission
OOP	Out-of-Pocket (Expenditure)
PPP	Purchasing Power Parity
PSEMAS	Public Service Employee Medical Aid Scheme
SACU	South African Customs Union
SSC	Social Security Commission
THE	Total Health Expenditure
UHC	Universal Health Coverage
UHCAN	Universal Health Coverage Advisory Committee of Namibia
USAID	United States Agency for International Development
WHO	World Health Organization

ACKNOWLEDGMENTS

This study was financed by the U.S. Government, through the United States Agency for International Development (USAID)-funded Health Finance and Governance project.

The authors thank all those who contributed to this report. We would like to recognize the support and commitment of Namibia's Social Security Commission and, specifically, the members of the Universal Health Coverage Advisory Committee of Namibia and its Technical Working Group for providing key input and feedback on the structure and content of this health financing review. We are also grateful to the Ministry of Health and Social Services for providing the data and other sources of essential information critical to the foundation of this study.

We would also like to thank Mr. Stephen Musau and Mr. Michael Rodriguez, who provided valuable support to this work.



EXECUTIVE SUMMARY

The goals for Universal Health Coverage (UHC) as defined by the World Health Organization (WHO) include equity in use of health services, quality of care, and financial protection. Therefore, key factors to consider in the development of approaches to UHC include expanding coverage of the population in terms of access to and quality of health service; equitable distribution of services; the types of services to be provided in the benefits package¹; and the proportion of costs covered in terms of the affordability and the sustainability of the financing sources. Namibia's Ministry of Health and Social Services (MoHSS) and Social Security Commission (SSC) are working in close collaboration to explore the way forward toward achieving UHC and have established the Universal Health Coverage Advisory Committee of Namibia (UHCAN) for this purpose. The objective of this Advisory Committee is to guide the MoHSS in the development of sustainable systems and policies for achieving UHC in Namibia with a focus on compiling evidence and developing alternative policy approaches specific to the Namibian context. The goals of UHC cannot be achieved without a well-functioning and sustainable health financing system, and therefore the Government of the Republic of Namibia has prioritized the identification of sustainable health financing options in order to ensure timely and equitable access of quality health services.

Fiscal Context

The fiscal capacity of a country refers to the government's ability and willingness to mobilize public revenues, which in turn allows it to spend money on public services and programs, including health. The greater the fiscal capacity of a country, the greater the potential for public spending on health. Fiscal capacity is largely driven government spending which is, in turn, influenced by the government's ability to generate revenue. GDP growth strongly influences the government's ability to generate revenue which is critical to understanding the government's capacity to increase health sector spending (McIntyre 2014a).

Namibia's GDP growth remained relatively stable between 2011 and 2013 with annual growth rates of 5.2 percent in 2011 and 2012, and 5.1 percent in 2013. However, in 2014 and 2015 the annual GDP growth rate decreased slightly to 4.5 percent. In 2016, real annual GDP growth is expected to remain under 5.0 percent and possibly decrease further to 4.3 percent (Chamwe 2016). While Namibia's real GDP growth is projected to slow down in 2015 and 2016, economic growth is expected to improve again in 2017 with a rise in GDP growth rate to 5.9 percent.

The magnitude of the fiscal deficit and long-term debt are also critical when determining the government's ability to increase spending, including spending on health, as these factors have an influence on economic growth (McIntyre 2014a). From 2012 to 2014, Namibia's budget deficit grew from 1.4 percent to an estimated 6 percent of GDP, but then decreased slightly to 5.2 percent of GDP in 2015/16. As per the 2016/17 budget of the Ministry of Finance, the budget deficit is expected to decrease further to 4.3 percent in 2016 and 2.7 percent in 2017 (PricewaterhouseCoopers 2016). The estimated gross government debt to GDP ratio was 24.7 percent in 2014 and 25.8 percent in 2015. As a result of increasing financing needs particularly for infrastructural projects, the government debt to GDP

¹ Benefits package is defined in the broader context of the WHO UHC cube. The specific health services to be included in the Namibian essential benefits package still need to be defined by the UHCAN as part of the process of achieving UHC in the country.

ratio is expected to stand at about 37 percent in 2016/17. While these estimates remain well below the International Monetary Fund recommendation of a “prudent” debt to GDP ratio threshold of less than or equal to 40 percent for developing and emerging economies (McIntyre 2014a) and being well below the median of 40 percent for Namibia’s sovereign rating peer group of BBB-, the debt to GDP ratio has exceeded the national cap of 35 percent. The Government of Namibia is committed to fiscal consolidation measures aimed at stabilizing the growth in public debt and bringing the proportion of public debt within the threshold level (Ministry of Finance 2016).

Based on the above fiscal indicators, it can be expected that Namibia’s real GDP growth remain positive and increase slightly in the medium-term (Bank of Namibia 2015); however, a rising fiscal deficit, debt burden, and volatile exchange rate may impact economic growth and, therefore, the potential availability of additional resources for the health sector.

The government’s revenue sources include indirect (44 percent) and direct taxes (52 percent) as well as non-tax income (4 percent). The South African Customs Union (SACU) revenues are the greatest contributor to indirect taxes. The largest share of direct tax revenue is from individual income taxes, comprising 61 percent of direct tax revenue, while company taxes amount to 37 percent of direct tax revenue (PricewaterhouseCoopers 2015). Individual income tax rates in Namibia are staggered based on the individual’s income level, including 6 income brackets with progressively higher tax rates ranging from 18 to 37 percent and tax exemptions for individuals earning a taxable income of less than N\$50,000. High reliance on indirect or consumption taxes in relation to direct taxes has equity implications, since indirect taxes tend to be less progressive than direct taxes (Inchauste G 2015). Furthermore, Namibia’s high reliance on SACU revenue as a source of government revenue poses a key risk to Namibia’s medium-term growth due to this revenue source’s volatility and vulnerability to fluctuations in the global economy, and expected reductions in SACU revenues due to the economic slowdown in South Africa (AfDB 2014).

While Namibia’s poverty rates have declined, the country remains one of the most inequitable countries in the world. Such severe inequities contribute to a higher incidence of poverty thereby impeding progress in health outcomes. Furthermore, the high, broad unemployment rate of 28.1 percent (Namibia Statistics Agency 2015) continues to be a significant challenge for the economy. According to a study by the 2014 Labour Force Survey, 58.8 percent of individuals were employed in the formal sector while the remaining 41.1 percent were employed in the informal sector. With the high proportion of the population working in the informal sector, Namibia faces challenges such as a lack of legislation regulating employment in this sector, irregular and low wages, and little to no access to social security and medical aid benefits (Brockmeyer and Ebert-Stiftung 2012). The proportion of Namibia’s working age population, who are largely responsible for revenue generation, remains low relative to other countries. However, the size of this population is gradually increasing while the proportion of the population ages 0 to 14, who rely heavily on social programs, is gradually decreasing.

In conclusion, the fiscal space of Namibia indicates that there is potential for increasing financial resources for the health sector in the medium term. In the short term, various factors including the exchange rate volatilities, reduction of indirect tax revenues and repayment of SACU revenues, high fiscal deficit and debt burden, high unemployment, expected increasing inflation and the current drought, are likely to limit the ability of the government to secure and allocate significant additional resources for health. However, the anticipated increase GDP growth from 2017 onward is due to factors –increased mining output from new mines, recovery in agriculture, and sustained growth in wholesale and retail trade, combined with the expansion and deepening of the domestic revenue base, acceleration of the tax administration reform agenda and improving efficiencies in government expenditure – that are expected to have a positive impact on the country’s fiscal space for health in the medium term.

Public Administration

The MoHSS carries the main responsibility for the provision and regulation of health services in Namibia. Namibia also has a well-established private health sector, which is mainly financed through medical aid funds that are regulated by the Medical Aid Funds Act of 1995. A number of laws have been promulgated to regulate both the public and private health sectors, while additional regulations, policies and guidelines have been developed by the MoHSS for implementation by all health care providers. The SSC has also to some extent been mandated to secure the health and well-being of Namibians through the establishment of the National Medical Benefits Fund (NMBF), which aims to provide for the payment of medical benefits to employees and essentially serves as a Social Health Insurance mechanism. The NMBF has not yet been established and is not operational.

In terms of public sector financial management, the legal framework for transparency and accountability in the budget process is quite comprehensive in Namibia with the regulations to the process being provided in the Constitution and the State Finance Act of 1991. Namibia's executive branch has the overall responsibility for the preparation and execution of the national budget and involves active cooperation between the key institutions. In terms of the Open Budget Initiative of the International Budget Partnership, Namibia achieved a score of 46 points out of a possible 100 points for transparency, indicating that the Government of Namibia provides the public with limited budget information. In terms of public participation, Namibia scored 15 out of 100 points as the Government of Namibia is deemed weak in providing the public with opportunities to engage in the budget process. Finally, budget oversight by legislature is rated weak with 17 out of 100 points and oversight by auditor adequate at 75 out of 100 points (International Budget Partnership 2015). While there have been efforts to move toward program-based budgeting and strengthening budgeting processes, there are serious systems weaknesses in the budgeting process, which have resulted in an urgent need to curb and effectively manage overspending.

The annual MoHSS budget is prepared by the ministry's Directorate of Finance and submitted to the Ministry of Finance. It contains detailed budgets for each MoHSS directorate. Decisions relating to the actual allocation of resources to the various regions and tertiary hospitals included in the budget submission are made by the Directorate of Finance. All revenues collected at district- and regional-level health facilities are submitted to the Ministry of Finance via the central-level MoHSS. Any purchasing decisions made at the regional level need to follow the overall government's procurement guidelines, with many of the major purchases made at central level and distributed to the regions. The MoHSS has made concerted efforts to move away from the historical budgeting practices and toward program-based budgeting with a revised resource allocation formula that will allocate resources to the regions on more relevant factors such as regional population sizes, poverty levels, disease burden, and differences in costs of service provision. Such a budgeting approach would more effectively take into account the regional priorities and financing requirements. However, shortfalls and limitations within the current version of the financial management information system of the Ministry of Finance have prevented the MoHSS to fully move toward program-based budgeting and no final decisions have been made regarding the implementation of the revised resource allocation formula.

Directorates of MoHSS are responsible for the operational budget execution and management of expenditures. Money not spent by the end of the fiscal year at all levels of the MoHSS is returned to the Ministry of Finance. The funding unspent by the MoHSS during the 2012/13 fiscal year amounted to N\$202,940,778, which amounts to 5.1 percent of the total MoHSS budget allocation (Government of the Republic of Namibia 2015a). The main reasons noted as reasons for underexpenditure included delays in the recruitment and procurement procedures.

Health Expenditures

Total health expenditure is the sum of all public and private expenditures on health, including external resource expenditures. Total health expenditure as a percentage of GDP indicates the level of health care expenditure relative to the country's economic development. In 2013, Namibia's total health expenditure was 9 percent of GDP. This represents a 2.2 percentage point increase over the past 10 years (2004-2013). While Namibia's total health expenditure as a percentage of GDP is high in relation to all countries in WHO's AFRO region classified as upper-middle income, its total health expenditure per capita is below the average.

Also over the last 10 years, Namibia's general government expenditure on health as a percentage of GDP increased 1.4 percent, while the average increase for the AFRO region was 0.7 percent. In 2013, Namibia's general government expenditure on health as a percentage of GDP, at 4.6 percent, exceeded that of all WHO/AFRO countries classified as upper-middle income, with the exception of Algeria (4.9 percent).

However, over the 10-year period, Namibia's total health expenditure as a percentage of GDP has increased more than general government expenditure on health as a percentage of GDP. This indicates a negative trend in government spending on health – general government expenditure on health as a percentage of total government expenditure reflects how much government funding is raised for health relative to total government resources and is an indicator of the priority that government gives to funding health relative to other public expenditures. The Abuja target recommends that 15 percent of total government expenditures should be allocated to health. While Namibia's 13 percent falls slightly below the Abuja target, it does reflect a strong government commitment to health. In 2013, Namibia's spending on health as a proportion of all government expenditures exceeded that of all other countries in WHO's AFRO region, with the exception of South Africa.

Another measure of the government's commitment to spending on health is per capita government expenditure on health, which measures the total resources expended on health relative to the benefit population (WHO 2010b). Similar to Namibia's total health expenditure and general government expenditure on health as percentages of GDP being at the top of all upper-middle-income WHO/AFRO countries in 2013, its per capita government expenditure on health (US\$452.60), was above the mean for the group (US\$445.51).²

In addition to indicating the priority the government gives to health spending, general government expenditure on health as a percentage of total health expenditure indicates the sustainability of health financing. An increase in the government contribution relative to donor or household contributions indicates more sustainable financing for health (HFG 2014). While Namibia's 2013 general government expenditure on health as a percentage of total health expenditure of 54.0 percent falls around the middle of the range for all WHO/AFRO upper-middle-income countries – 3.7 percent below the 57.7 percent average and 0.4 percent below the 54.4 percent median – its spending has increased by 4.5 percent over the last 10 years whereas the average increase for the region was 4.1 percent.

² Adjusted for purchasing power.

External resources for health as a percentage of total health expenditure is an indicator that tracks financing flows from external sources to public and private financing agents. It measures the health sector's dependency on external resources to purchase health services. Data from the last five years (2009-2013) show Namibia's dependence on external resources for health has decreased by 13.7 percent whereas the average decrease in the region was 3.5 percent. However, in 2013, 8 percent of Namibia's health expenditures were still from external resources – the highest dependency in the region – which leaves the country's health response and subject to external factors dictating the availability of external resources.

Dependency on external resources specifically for HIV funding is even more worrisome. HIV currently ranks highest on Namibia's Burden of Disease, and spending on HIV/AIDS is currently 13 percent of total health expenditure (MoHSS 2015). In 2013, 51 percent of expenditures for HIV/AIDS were provided by donors and 37 percent by government. Only 2 percent of HIV/AIDS expenditures came from households meaning that people living with HIV/AIDS are financially protected when seeking care and treatment for this disease, but there is nonetheless a substantial risk to sustainability of the response due to the high donor reliance (MoHSS 2015).

Regarding private expenditure on health, Namibia is in the middle of the range for all upper-middle-income countries in WHO's AFRO region. The trend of the private expenditures as a share of total health expenditures decreased by 12.5 percent over the past 10 years (2004-2013), but over the past five years (2009-2013), it increased by 15.7 percent, while general government expenditures increased by only 0.2 percent. Over the 10-year period, the share of private expenditures that are out-of-pocket (OOP) payments has increased by 10.5 percent, while the share of voluntary insurance payments has decreased by 12.5 percent. Looked at for the past five years alone, there has been little change in the proportion. Decreasing the share of OOP health expenditures by increasing expenditures from other sources, such as government or compulsory prepaid medical insurance schemes, will increase financial protection.

The apparent trend of increasing government expenditures over the last 10 years, with relatively stable private expenditures, indicates some level of sustainability for financing health care in Namibia. However, it is expected that the external resources for health will decrease further in future, placing greater pressure on sustainability. Furthermore, if the drop in government expenditures in 2013 becomes a trend, which can be expected in the medium term as the government is pressed to reduce its budget deficit, the sustainability of the health response will become an even greater concern.

OOP expenditures can have a critical impact on health care choices made by the population, and they have the potential to cause financial catastrophe for individual households (HFG 2014). Therefore, OOP expenditure as a percentage of total health expenditure is a critical indicator for assessing financial protection. A higher percentage of OOP expenditures generally suggests limited financial protection and in any case is an inefficient way to finance the health system (MoHSS 2015). Over the last 10 years, Namibia's OOP expenditures have been substantially lower than the regional mean. Over the past five years, government expenditure per capita has increased by 39 percent while OOP expenditure per capita has increased only 11 percent. Therefore, despite the OOP expenditure having increased in recent years, the increase remains less than the additional financial burden that was picked up by the government.

Private prepaid plans as a percentage of total health expenditure indicates the extent to which voluntary prepayment mechanisms are used within a country. Figure 15 shows that in 2013, Namibia's proportion of health expenditures from private prepaid plans, 23.4 percent, was on the high end of all WHO/AFRO upper-middle-income countries; they were 5.5 percent higher than the average 18.0 percent and 8.9 percent higher than median 14.6 percent.



Health Financing Arrangements

Public resources have consistently been the main source of financing for health in Namibia. Public financing as a percentage of total health expenditure was 53.8 percent in 2008/09 and 54 percent in 2012/13. In 2012/13, the main source of MoHSS funding (97 percent) was the central government, using primarily tax-based revenue. The remaining 3 percent came from donors and development agencies. Donor funding in 2012/13 decreased significantly to only 8 percent as donors began to withdraw financial support as Namibia transitions to an upper-middle-income country status.

Health facilities in Namibia are expected to charge some form of user fees, which were introduced to increase efficiency and lessen congestion at secondary- and tertiary-level facilities by encouraging patients and clients to enter the health system at lower-level facilities. All user fees collected at all levels of health facilities are returned to the Treasury; they cannot be retained and used by the MoHSS. Actual revenue collected by the MoHSS facilities for the provision of health services was N\$44,439,677 in 2012/13 (approximately 0.48 percent of the MoHSS budget in that year) and estimated revenue for 2014/15 is N\$35,700,000 (0.68 percent of the ministry's budget).

The MoHSS follows a primary health care approach and has developed primary health care guidelines that set out the minimum packages of health services to be provided at each level of health facility. Despite the government's policy to follow such an approach, only 11 percent of total government health expenditure is spent on provision of primary health care services. Close to three-quarters (71 percent) of government funding for health is spent on secondary and tertiary health services, and 14 percent is spent on administration. In 2012/13 just over two-thirds (67 percent) of government spending went to curative care services, divided about equally between inpatient and outpatient care, 7 percent to prevention, and 9 percent to capital formation.

Fund Pooling Arrangements

Namibia's private health insurance industry is relatively well-established with a total of 10 medical aid funds operating in the country. Medical aid funds in Namibia are regulated by the Medical Aid Funds Act 23 of 1995 and overseen by the Namibia Financial Institutions Supervisory Authority. Despite this industry being well-established, the total population covered through these funds is quite limited compared with international trends toward national health insurance. In 2014, there were 181,378 private medical aid members including dependents and pensioners and the total membership contributions collected amounted to N\$2.5 billion (NAMFISA 2015). This equates to approximately N\$13,964 per beneficiary per annum. Claims paid out by medical aid funds in 2014 totaled nearly N\$2.2 billion, equivalent to 86.7 percent of the medical aid funds' contributions received, and an average claims amount of N\$12,102 per beneficiary. The Namibian Association of Medical Aid Funds (NAMAF) is a juristic body established by the Medical Aid Funds Act to control, promote, encourage, and coordinate the establishment, development, and functioning of medical aid funds in Namibia. One of NAMAF's functions is to bring together health care providers and medical aid funds on an annual basis to determine NAMAF benchmark tariffs, guideline amounts that medical aid funds contribute to defray the health care costs of members. As Namibia is a free market economy, health care providers are free to set their own prices and a substantial percentage of them charge more than the NAMAF tariffs. Among the reasons for this free market pricing, the primary is the limited pool of private sector health care skills: many services are provided only by visiting specialists or foreign providers. Most medical aid funds have also introduced low-cost options in an attempt to increase their market size and potential for risk pooling and generally all funds provide for cross-subsidization across the different benefit package options, but each medical aid fund has its own funding pool. However, with the promulgation of the Financial Institutions and Markets Act, expected to be in 2016, medical aid funds will need to ensure that

each of their medical aid options is financially sound, which implies that cross-subsidization between options will no longer be allowed.

The Public Employee Medical Aid Scheme (PSEMAS), which covers the public service employees of Namibia, is run on a different financial basis to other medical aid funds; it does not have to adhere to the same solvency requirements since the balance of expenditures that exceed the employee contributions are covered by the Treasury. PSEMAS is a voluntary condition of employment arrangement, whereby standard contributions are payable by the public service employees and are deducted off their salaries, while the remainder of the claim expenses are covered by the Ministry of Finance. The total contributions deducted for 2012/13 was N\$196 million and the balance covered by government was N\$1.112 billion. This implies that only 15 percent of the total funds required for PSEMAS are paid by the employees, while the remaining 85 percent is subsidized by the government. The total claims amount of N\$1.307 billion is equivalent to N\$5,681 per beneficiary (based on 230,248 beneficiaries including principal and dependent members). While PSEMAS has a larger beneficiary base than the combined private medical aid sector, there is a lack of proper risk pooling, since the premiums contributed by the members are not based on their risk profile or ability to pay and the government has to provide the additional funds to ensure full coverage of all claims. The contributions are based on a flat rate regardless of salary level, which makes the contributions highly regressive.

The SSC administers the Employees' Compensation Fund, which serves as an employees' compensation insurance on a collective liability basis for accidents. The fund pays benefits to an employee injured as a result of a work-related accident. Compensation is paid for temporary disablement, permanent disablement (according to the degree of disablement), and death. Reasonable medical expenses are paid for a period of two years, or longer if further medical or surgical treatment may reduce the extent of the disablement. Every employer who employs one or more employees in Namibia is required to register with the SSC and to pay annual contributions to the Compensation Fund. In 2012/13, the SSC generated a total revenue of N\$135,671,000, including annual employer contributions of N\$86,802,000. The total amount paid out specifically for the provision of health care benefits was N\$6,719,331, approximately 5 percent of total revenue.

The Motor Vehicle Accident (MVA) Fund of Namibia is mandated to provide assistance and benefits to all people injured and the dependents of those killed in motor vehicle crashes in accordance with the MVA Fund Act No.10 of 2007. The fund operates on a hybrid system in which all people injured in motor vehicle crashes, regardless of who caused the crash, receive fair and reasonable benefits (subject to some limitations and exclusions). The main source of fund revenue is a fuel levy system, a compulsory third-party insurance payable by every driver/owner of a motor vehicle when purchasing fuel. The most recent audited financial statements of the fund, for the financial year ending March 31, 2014, show that total fund revenue amounted to N\$469,848,174, of which 95 percent was collected from fuel levies. The total amount paid out in claims in the same year amounted to N\$213,339,144, approximately 45 percent of total revenue.

Financial Protection and Equity in Health Financing

A health system should ensure financial protection of the population by funding health services in a manner that protects individuals and households from financial ruin or adverse effects on their livelihood as a consequence of paying for health care, typically through high OOP payments. Protecting people from catastrophic health expenditures is widely accepted as a desirable objective of health policy. Such financial protection for all is a key goal of UHC; a related goal is how equitably health services are financed. Equity in health system financing refers to the distribution of health spending rather than the level of health spending across socio-economic groups. It is generally accepted that the burden of health financing should be distributed according to an individual's ability to pay, that is, the burden should increase as household income increases. Signs of equity in Namibia's health financing are mixed, as the following paragraphs show.

An analysis of Namibia's OOP payments for health shows that slight increases in these payments and total health expenditure, along with high poverty and low government expenditures on health as a percentage of GDP, signal that the incidence of households with catastrophic health expenditures has likely increased since the 0.11 percent estimated in 1994. However, even if a slight increase occurred, catastrophic health expenditures likely remain relatively low.

Namibia's 10-year trends of increasing public and decreasing private funding for health, comparatively low OOP payments, and dependence on direct tax revenue over VAT (indirect) tax revenue suggest proportional to progressive financing mechanisms in the health system.

An analysis of medical aid coverage in Windhoek shows that while only 5 percent of individuals in the poorest quintile are enrolled in medical aid, 70 percent of individuals in the richest quintile have medical aid benefits. The primary reason individuals lack health insurance in Namibia is the inability to pay health insurance premiums, even for the low-cost coverage options. Insurance coverage was also found to have had an effect on health seeking behavior and health care utilization. Analysis findings show that the uninsured were more likely to forgo care for acute illness over 20 percent of the time compared with 14 percent for the insured, a finding that highlights the inequitable and potentially harmful health consequences for individuals lacking health insurance (Gustafsson-Wright et al. 2011). Furthermore, the uninsured are also disproportionately impacted by OOP health expenditures relative to the insured.

Health Service Quality

The 2013 Presidential Commission Inquiry described the quality of patient care in public health facilities as below acceptable standards. Indications of poor quality of patient care cited in the report include overcrowding at outpatient departments, long waiting times, an inadequate number of health professionals, equipment, and supplies, and poor infrastructure (Government of the Republic of Namibia 2013).

Among key health indicators, Namibia performs more poorly than the average for all upper-middle-income countries in WHO's AFRO region on life expectancy, health-adjusted life expectancy, and HIV prevalence. However, Namibia performs better than the average on maternal and under-five mortality.

Equity in Service Use and Distribution of Resources

"Namibia's vast distances and relatively low population densities create considerable challenges for MoHSS efforts to balance health care equity, efficiency and quality" (McQuide et al. 2013). There are significant differences in per capita budgetary allocations between regions, even after taking into account the percentage of services provided by referral hospitals as part of the region-specific health services.

While a comparison of the per capita allocations with the needs based on poverty incidence did not show a clear trend, there is some evidence that Namibia does not conform to the so-called “inverse care law” under which regions with the greatest needs tend to receive the least resources (MoHSS 2012). Further comparisons of the resource inputs to the health outputs show that there is no direct relationship between the two, which can be attributed to the fact that resources are not appropriately allocated according to health needs or to the fact that there are inefficiencies in specific regions. The MoHSS has drafted a resource allocation formula based on factors including population size, burden of disease, poverty, and cost differences, but no final policy decision has been made on this matter.

An analysis of staffing in public health facilities found significant disparities between and within regions. A ranking of nurse staffing shortages in health centers by region found Ohangwena, Omusati, Otjozondjupa, Caprivi, and Khomas lack the number of nurses needed to deliver quality health services. Similarly, a ranking of nurse staff shortages in clinics found Ohangwena, Omusati, Kavango, Kunene, Oshikoto, Omaheke, and Oshana lack sufficient staff (McQuide 2013).

Another study found regional differences in the use of skilled providers during delivery, resulting in differences in maternal health outcomes. Kavango, Kunene, and Ohangwena ranked far below the national average on this indicator. The study concluded that the regions with a greater need for scarce maternal health resources are not appropriately targeted through the current methods of resource allocation (Zere 2011).

Health System Efficiency

Resources for health are limited in any country; therefore, the efficient use of resources is critical in moving toward UHC. Identifying and measuring inefficiencies is a large and complex undertaking, and a study is proposed under the UHCAN to review the performance of the Namibia health system within the public and private sectors.

Public sector

A 2006 study by Zere et al. assessed the technical efficiency of Namibia’s 30 district hospitals and quantified the potential efficiency gains. The results of the study indicate that many of the district hospitals operate at technical efficiency levels well below the efficient frontier, concluding that if the inefficient hospitals were to operate more efficiently, the health system could reduce the total resources for hospitals by an estimated 26 to 37 percent (Zere et al. 2006).

Another study, by Low et al. (2001) found that intermediate hospitals are being used heavily by patients within their local districts as a first point of contact with the health system or first referral point. It also found that first-level referral hospitals are often used as the initial point of contact with the health system. Several district hospitals refer directly to Windhoek Central rather than their appropriate intermediate hospitals. If patients bypass the referral system, they are treated at higher cost than necessary; the higher-level systems become overburdened by the workload, while lower-level and less costly facilities become underutilized, resulting in inefficiencies.

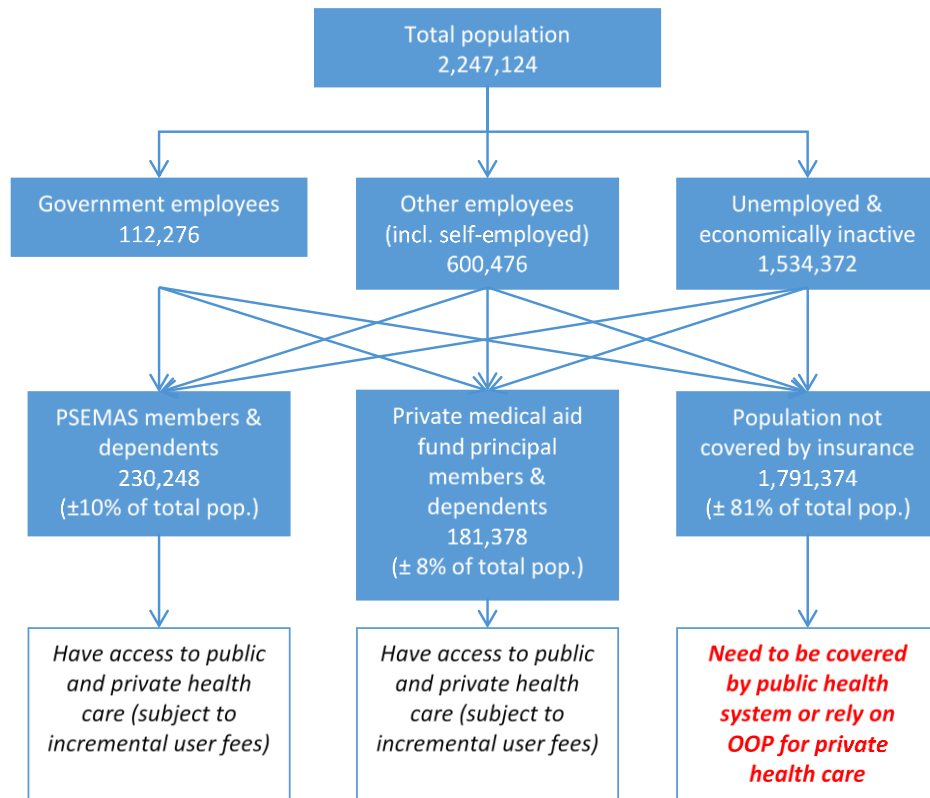
A comparison of efficiency scores among sub-Saharan countries, comparing health outcomes to inputs, shows that Namibia’s relatively high score represents one of the better performing health systems, significantly better than the majority of sub-Saharan Africa, with regards to efficiency (Novignon and Lawanson 2014).

Private sector

There are serious concerns about the escalating costs of health care in the private sector. The 2012/13 health accounts results show that approximately 37 percent of total health expenditures were paid by medical aid funds, while in 2008/09 this figure was approximately 28 percent. Conversely, the percentage of the population covered by health insurance increased only by approximately 1 percent over the same five-year period. While no comprehensive studies have been performed on the cost-effectiveness of the Namibian private health sector and the specific reasons for the escalating costs are not known, there are many hypotheses for these increasing costs such as lack of price-competitiveness, over-servicing, waste, direct patient access to higher-level services without referral, and absence of outcome measurement.

Namibia's UHC Status

Despite the government's strong commitment to the achievement of UHC, challenges remain in terms of ensuring equity in access, adequate health benefits coverage, and financial protection particularly for the poor. The figure below illustrates how the Namibian population is currently covered in terms of health services. Namibia has an estimated population of approximately 2.25 million, of which 112,276 are employed by the government (Government of the Republic of Namibia 2015) and are thus entitled to health benefits through PSEMAS. It is noted that enrollment in PSEMAS is voluntary; however, approximately 92 percent of government employees are enrolled as principal members (MoHSS 2015). The 2014 Labour Force Survey (Namibia Statistics Agency 2015) estimates that approximately 1.53 million people in Namibia are either unemployed, economically inactive, or below the age of 15, thus leaving 600,476 persons who are employed outside of the public sector. Even within the employed population, affordability of private medical aid is an issue, resulting in only 76,522 principal members and a total of 181,378 persons including dependents, being covered by private medical aid funds.



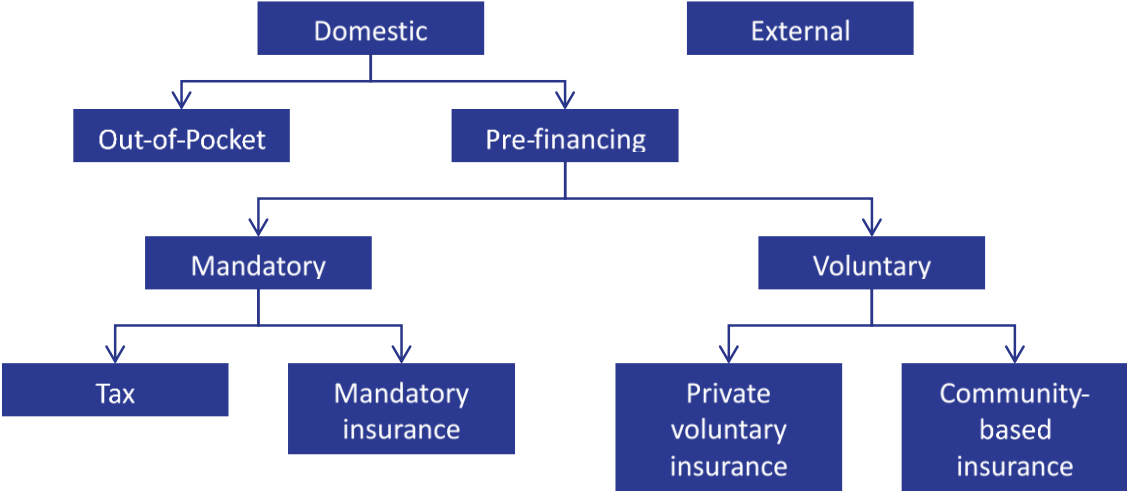
The figure highlights one of the greatest challenges of the health system, which is its fragmentation and differences in health coverage between those who are covered by PSEMAS, those who can afford private medical aid, and those who have neither. Specifically, an estimated total population of 1.79 million or approximately 81 percent of the Namibian population remains uncovered by a medical aid fund and thus is reliant on either the public health system for access to health services or on OOP payments for private health care. As a result, the distribution of health resources among the population is largely unequal. Annual health spending for the 81 percent of the population without medical aid coverage is US\$209.00 per person, while it is more than three times greater for those with medical aid at US\$700.00 per person. Similarly, the 2012/13 health accounts (MoHSS 2015) show that approximately 44 percent of total health expenditure is used to provide health services to 19 percent of the population, while the remaining 56 percent of total health expenditure had to cover the remaining 81 percent. As such, within the sphere of health financing, the major UHC principles Namibia needs to work on are equity and financial risk protection.

Decisions on the Health System Design

While the public and private health sectors in Namibia are well-established and some progress has been made on the establishment of the NMBF, the Government of Namibia, with the advice of the UHCAN, still needs to decide on the ultimate structure of the health system, revenue collection mechanisms, pooling of funds, purchasing mechanisms, and the population coverage and benefits package.

Revenue collection

The figure below shows options for revenue collection. To ensure the sustainability of revenue for health and to achieve the goal of financial risk protection, the WHO recommends that health care financing be secured through mandatory prepayments, which implies either a mandatory health insurance system or government spending through taxation.



Namibia has already made provision for the establishment of a mandatory health insurance fund in the form of the SSC's NMBF, which is envisioned to serve as social health insurance providing medical benefits to employees. The SSC currently has 602,983 employees registered under the Maternity leave, Sickness leave, and Death benefit (MSD) fund. Assuming that all of these employees would also be eligible for registration under the NMBF and persons already covered through PSEMAS (230,248) or a private medical aid fund (181,378) would be exempted, the minimum number of persons to be enrolled under the NMBF is potentially 191,357. This number is likely to be higher, since not all persons covered by PSEMAS or private medical aid funds are employed or registered with the SSC. Mechanisms to ensure that the informal sector can contribute to the NMBF would substantially increase the membership and result in greater benefits of risk pooling; however, revenue collection mechanisms are likely to be difficult to implement.

Assuming that the NMBF is established, the challenge in terms of UHC will be to effectively provide quality health benefits to the population that remains uncovered by prepaid health insurance or medical aid, even after the introduction of the NMBF. In terms of the WHO recommendation for sustainable health financing sources, the remaining population should be covered either through an expansion of the mandatory NMBF or through government spending raised from taxation. Currently, the MoHSS is mandated to provide health benefits to this sizeable population, primarily through financing from taxation.

The aim of mandatory health insurance would be to improve equity and financial risk protection. Thus, it is important to ensure that the health insurance mechanism is progressive rather than regressive so that the health insurance contributions do not further burden the poor. The implications of introducing the NMBF need to be fully analyzed and considered in terms of affordability, effect of introducing additional taxation on the economy and employment levels, impact on the health system and its capacity to supply health services, implications and continued affordability of medical aid funds, and roles of private health care providers.

In order to effectively reduce the inequalities in resources between the public and private sectors, there is a need to generate more resources for public health services through taxation and ensuring the effective use of these resources. Therefore, the UHCAN in collaboration with the MoHSS and the Ministry of Finance should explore options of resource mobilization to improve equity in health, quality of health services, and financial protection of the poor. The emphasis should be on increasing revenue through the most progressive means possible, since the purpose of raising government spending for health is to meet human rights obligations, which would be defeated if that spending were funded by increasing the relative tax burden of those who are meant to benefit (McIntyre 2014a). The key options of mobilizing additional resources for health domestically include:

1. Increasing the efficiency of revenue collection
2. Reprioritizing government budgets
3. Implementing innovative financing mechanisms

While there is a need in Namibia for additional funds for health, it is also critical that the resources are used as efficiently as possible and that the absorptive capacity of the MoHSS is improved. Focus should be placed on improving the quality of care provided in public facilities, ensuring health services are accessible, and appropriate benefits packages are offered.

Risk pooling

Equity in Namibia can be improved by pooling resources and risk sharing across wealth and income levels. Risk pooling is based upon the premise that contributions from the healthy pay for the care of the sick, and thus, those suffering from disease are not struck by the double burden of sickness and financial costs of health care. These principles represent the basis of moving toward preventing catastrophic expenditures related to high-cost medical conditions.

Pooling resources can be implicit, as in the case of tax revenues used to provide public health services, or explicit, as in the case of insurance. Currently, resource pooling in Namibia is primarily done through the MOHSS in providing public services, medical aid funds, PSEMAS, the MVA Fund, and SSC employee compensation fund. Various pooling options have been implemented in other countries and essentially there are four options in terms of risk pooling: no risk pool, unitary risk pool, fragmented risk pools, and integrated risk pools.

Purchasing mechanisms

Purchasing mechanisms for health services represent a major lever to achieve desired health goals. Paying for results and value for money are therefore relevant objectives of a well-functioning purchasing system. Active purchasing considers aspects of population health needs including regional health need variances and the interventions and services required to meet the health needs taking into consideration the optimum mix of promotion, prevention, treatment, and rehabilitation. Purchasing arrangements should further consider the availability of providers and their levels of quality and efficiency. The different purchasing models include the following:

- Capitation is a payment arrangement whereby health care providers are paid a set amount for each enrolled person assigned to them for a specified period of time. The capitation payment is made to the provider regardless of whether or not that person seeks care.
- Fee-for-service purchasing is where health service providers are reimbursed for each service provided. Payments on this basis are made retrospectively.
- A pay-for-performance purchasing system gives financial incentives to health care providers to produce better health outcomes. Also known as “value-based purchasing,” this payment model rewards physicians, hospitals, medical groups, and other providers for meeting certain performance measures for quality and efficiency.

The current payment mechanisms in Namibia need to be revisited, specifically, fee-for-service tariffs to establish payments to private providers and historical budgets for public providers. The experience with traditional budgets as well as fee for service is that they produce overutilization of resources and lack of accountability resulting in high costs and poor health outcomes. Controls for health care costs should be developed in parallel to any initiative to expand population as well as service coverage. Monitoring and controlling cost are integral to improving technical efficiency. The increasing cost to provide health services is a major concern among public and private health systems around the globe.

Population coverage

Clearly one of the key objectives of any policy reform for UHC should include measures to improve population coverage with the ultimate goal of achieving close to 100 percent coverage. As depicted in Figure 22 in Section 6.1, in Namibia there are key concerns in terms of population coverage with many of the poor and unemployed being reliant on health services through the public sectors, where the quality of services requires substantial improvement. Furthermore, with Namibia's significant disparities in income distribution, it is critical that the resulting health inequities in terms of population coverage are addressed. The key inequities are found in coverage differences between the rich and the poor, employed and unemployed, and urban and rural populations, with 46 percent of rural women reporting having serious problems in accessing health care services due to the distances to health facilities versus 18.6 percent of urban women reporting the same problem (MoHSS 2013).

Package of services

Namibia, like every country, needs to determine its own benefit package of health services and service model. The package of services should be based on criteria including health needs, cost-effectiveness, affordability, financial and social protection, demand and supply, opinion of the scientific community, and social acceptance. It may decide to have one package of benefits for the entire population or different packages for different population groups based on specific criteria and determinants.

The Way Forward

Namibia needs to develop and implement innovative health financing reforms; to do this, it should conduct a comprehensive assessment of funding options as part of the feasibility study that will be implemented through the UHCAN. Furthermore, one of the most critical aspects of health financing is the relationship between pooling and purchasing. Pooling is needed to obtain improvements in equity and financial risk protection. It is hard to attain efficiency gains and improve access and quality without good pooling arrangements even though health purchasing mechanisms are flexible with many instruments and tools that can be used to overcome pooling deficiencies in the short term.

Strategies to successfully implement UHC need significant political commitment and support from decision makers, service implementers, and civil society. An effective communication strategy will inform the aims, expectations, and results achieved. A health care financing strategy will produce a health financing model that, integrated with other health system building blocks, will provide accountability and long-term sustainability, and better health for Namibia.

I. INTRODUCTION

Ensuring timely and equitable access to quality health services is essential for improving health outcomes, especially in priority areas as defined in the Ministry of Health and Social Services (MoHSS) Health Policy Framework; these include HIV/AIDS, sexually transmitted infections, maternal, neonatal and child health, adolescent and school health, endemic diseases, and non-communicable diseases. Progress in these areas cannot be achieved without a well-functioning and sustainable health financing system. The identification of sustainable health financing options, specifically in the context of universal health coverage (UHC), is a priority for the Government of the Republic of Namibia – the MoHSS and Social Security Commission (SSC) are working together closely to explore ways to achieve UHC. To this end, they established the Universal Health Coverage Advisory Committee of Namibia (UHCAN), which will provide guidance to the MoHSS on the development of sustainable systems and policies for achieving UHC. In particular, the UHCAN will focus on compiling evidence and developing policy options specific to the Namibian context. It will also advise on: approaches to expanding coverage of the population in terms of access to and quality of health service; equitable distribution of services; the types of services to be provided in the benefits package³; as well as the proportion of costs covered in terms of the affordability and the sustainability of the financing sources.

The World Health Organization (WHO) defines UHC as:

“...providing financial protection from the costs of using health services for all people of a country as well as enabling them to obtain the health services that they need (of sufficient quality to be effective)”

(McIntyre 2014a).

The WHO goes on to define the goals of UHC as: equity in the use of health services; quality of care; and financial protection (McIntyre 2014a).

- *Equity in the use of health services.* When there are barriers to accessing health services, there will be a gap between individuals' need for a health service and the actual use of that service. Reducing this gap leads to greater equity in the use of health services.
- *Quality of care.* Delivering high-quality health services means that those services are effectively achieving the desired health outcomes.
- *Financial protection* refers to protecting individuals and households from catastrophic health expenditures or 'financial ruin' as a consequence of paying for health services.

This report will analyze the elements and variables of Namibia's existing health financing system and their relationship to the goals of UHC to assess the strengths and challenges of the current system and where improvements should be considered on the path to UHC. The structure of this report largely followed the framework in WHO's *Guidance on conducting a situation analysis of health financing for universal health coverage* (McIntyre and Kutzin 2014). The data used for this report are primarily from

³ Benefits package is defined in the broader context of the WHO UHC cube. The specific health services to be included in the Namibian essential benefits package still need to be defined by the UHCAN as part of the development of UHC in the country.



publicly available sources. In assessing some elements of the health financing system, comparisons with other upper-middle-income countries in WHO's Africa region (AFRO) are offered as a means of analysis.

The findings in this report will include detailed descriptions of the current health financing system, benefits and disadvantages of alternative health financing options, and criteria that the UHCAN could use to evaluate options for improving the financial sustainability of health services.

Summary of key strategic objectives:

- ◆ Namibia aims to achieve UHC and is committed to identifying sustainable funding options.
- ◆ MoHSS and SSC are working together on the UHC agenda and have established the UHCAN to provide guidance to the MoHSS on the development of systems and policies on UHC.
- ◆ Goals of UHC include equity in use of health services, quality of care, and financial protection.

2. BACKGROUND

2.1 Fiscal Context

A review of Namibia's fiscal context is critical to understand the government's ability to allocate additional resources for health. Global trends indicate that increases in government spending overall generally result in increases in government spending on health. "Fiscal capacity" denotes a country's potential to spend. It is largely influenced by the government's ability to generate revenue, which is driven by the overall health of the economy as indicated by growth in the gross domestic product (GDP), deficit spending, debt, unemployment, the size of the working age population, the sources of government revenue, and other factors. The WHO defines fiscal capacity and its relationship to health financing as follows:

The fiscal capacity of a country refers to the government's ability and willingness to mobilize public revenues, which in turn allows it to spend money on public services and programs, including health. The greater the fiscal capacity of a country, the greater the potential for public spending on health

(McIntyre and Kutzin 2014).

Analysis of Namibia's fiscal context will tell us if the country can expect an increase in government revenue in the next few years, which would result in a general increase in government spending and in turn an increase in health expenditures, or if additional government spending for health must come from mobilizing additional resources through innovative financing mechanisms, advocacy to increase the health allocation, or improving the effectiveness of health spending through increased efficiencies and reduced waste – that is, achieving greater health outcomes with the same or even less financial resources.

A country's government spending to GDP ratio indicates the size of the public sector – or level of public spending – relative to the overall economy and serves as an indicator of fiscal capacity. In Namibia in 2015, the estimated government spending to GDP ratio was 38.5 percent (IMF 2015). This reflects a medium to high level of fiscal capacity. (Less than 15 percent is considered very low and greater than 45 percent is considered very high (McIntyre and Kutzin 2014).)

Table 1 shows Namibia's government spending to GDP ratio relative to ratios for the other WHO/AFRO countries classified as upper-middle income. As the table shows, the size of Namibia's public sector within the overall economy is relatively large. Specifically, Namibia's level of spending is 5.2 percent greater than the mean (33.3 percent) and 5.3 percent greater than the median (33.2 percent) spending levels for the region. Furthermore, its rate of government spending per capita surpasses all countries with the exception of Mauritius.

While **Namibia's fiscal capacity is medium to high**, an analysis of the government's 2013/14 budget found that fiscal space was "approaching the limits, and allocation to priority sectors [such as health] still need improvement..." (NPC 2014). The IMF defines fiscal space as the "...room in a government's budget that allows it to provide resources for a desired purpose without jeopardizing the sustainability of its financial position or the stability of the economy" (Heller 2005).

Table I: Estimated general government expenditure as a percentage of GDP and per capita, GDP per capita, and population, 2015

Country	Gov't Spending as % of GDP	Gov't Spending per Capita (USD)	GDP per Capita (USD)	Population (millions)
Algeria	43.3	1,882	4,345	40.3
Angola	30.9	1,256	4,062	25.1
Botswana	34.8	2,186	6,150	2.1
Gabon	25.1	2,155	8,581	1.6
Mauritius	27.4	2,516	9,186	1.3
Namibia	38.5	2,294	5,787	2.2
South Africa	33.2	1,921	5,783	54.9

Source: IMF (2015)

Note: 2015 General government total expenditure data , GDP data and population data are based on IMF estimates.

GDP growth strongly influences the government's ability to generate revenue, which is critical to understanding the government's capacity to increase health sector spending (McIntyre 2014a). Namibia's GDP growth remained relatively stable between 2011 and 2013 with annual growth rates of 5.2 percent in 2011 and 2012, and 5.1 percent in 2013. In 2014 and 2015, the rate decreased slightly to 4.5 percent. Nonetheless, this showed that **the growth in the Namibian economy remained greater than the average annual growth in WHO/AFRO upper-middle-income countries of 4.5 percent in 2012, 5.1 percent in 2013, and 3.6 percent in 2014**. While Namibia's real GDP growth is projected to slow in 2015 and 2016 – Chamwe (2016) predicted real annual GDP growth to remain under 5.0 percent and possibly decrease further to 4.3 percent in 2016 – economic growth is expected to improve again in 2017 and the GDP growth rate to rise to 5.9 percent. This growth is expected to be mainly supported by increased mining output from new mines, recovery in agriculture, and sustained growth in the wholesale and retail trade. Increasing uncertainties in the South African economy, mainly in the form of low growth and drought conditions, are likely to increase exchange rate volatility further, with consequential effects on inflation. The negative impact of the decline in oil prices on the Angolan economy is also likely to limit Namibia's growth, mainly through the wholesale and retail trade (Bank of Namibia 2015).

The magnitude of the fiscal deficit and long-term debt are also critical when determining the government's ability to increase spending, including spending on health, as its capacity to do so is largely effected by overall economic growth (McIntyre 2014a). From 2012 to 2014, Namibia's budget deficit grew from 1.4 percent of GDP to an estimated 6 percent, but then decreased again slightly to 5.2 percent of GDP in 2015/16. As per the 2016/17 budget of the Ministry of Finance, the budget deficit is expected to decrease further to 4.3 percent in 2016 and 2.7 percent in 2017 (PricewaterhouseCoopers 2016). In line with this projection, the International Monetary Fund (IMF) projects a 1.8 percent decrease in the deficit from 2014 to 2016. This expected reduction in the fiscal deficit is attributed to higher economic growth, initiatives aimed at improving tax administration, and additional tax proposals (PricewaterhouseCoopers 2016).

The **estimated gross government debt to GDP ratio was 24.7 percent in 2014 and 25.8 percent in 2015**. This represents an estimated 2 percent increase from 2013. As a result of increasing financing needs particularly for infrastructural projects, the total debt stock has risen further, from N\$35.95 billion in 2014/15, to an estimated N\$59.79 billion by the end of 2015/16, about 37 percent of GDP. The IMF forecasts further annual increases in the debt burden of 1 percent and 1.2 percent in 2016 and 2017 respectively, after which the debt burden is expected to decrease again to 24.1 percent in 2020 (IMF 2015). These estimates remain well below the **IMF recommendation of a “prudent” debt to GDP ratio threshold of less than or equal to 40 percent for developing and emerging economies** (McIntyre 2014a). Despite the debt level remaining below the median of 40 percent for Namibia’s sovereign rating peer group of BBB-, it has exceeded the national cap of 35 percent. The fiscal consolidation stance proposed in the 2016/17 budget and Medium Term Expenditure Framework (MTEF) is aimed at stabilizing this growth in public debt and bringing the proportion of public debt within the threshold level (Ministry of Finance 2016).

Based on the above fiscal indicators, it can be concluded that **Namibia’s real GDP growth is expected to remain positive and increase slightly in the medium term** (Bank of Namibia 2015); **however, a rising fiscal deficit, debt burden, and volatile exchange rate may impact economic growth and, therefore, the potential availability of additional resources for the health sector.**

Namibia has significantly reduced its incidence of poverty over the past few years. In 2013, the incidence of poverty was estimated at 26 percent – a reduction from 29 percent in 2010. Moreover, reductions in poverty have been found in both urban and rural areas, as well as across regions (NPC 2014). The proportion of the population living in severe poverty in 2013 was estimated at 14 percent. While **poverty rates have declined**, Namibia’s Gini Coefficient, a measure of income inequality, has remained relatively stagnant since 2004. It decreased from 0.74 in 1993 to 0.64 in 2004, and has remained close to 0.6 since then. With the current Gini Coefficient of 0.58 in 2013 (NPC 2014), **Namibia remains one of the most inequitable countries in the world. Such severe inequities contribute to a high incidence of poverty thereby impeding progress in health outcomes.** The World Bank suggests that decreasing income inequality could accelerate both economic and human development (Soubotina and Sheram 2000).

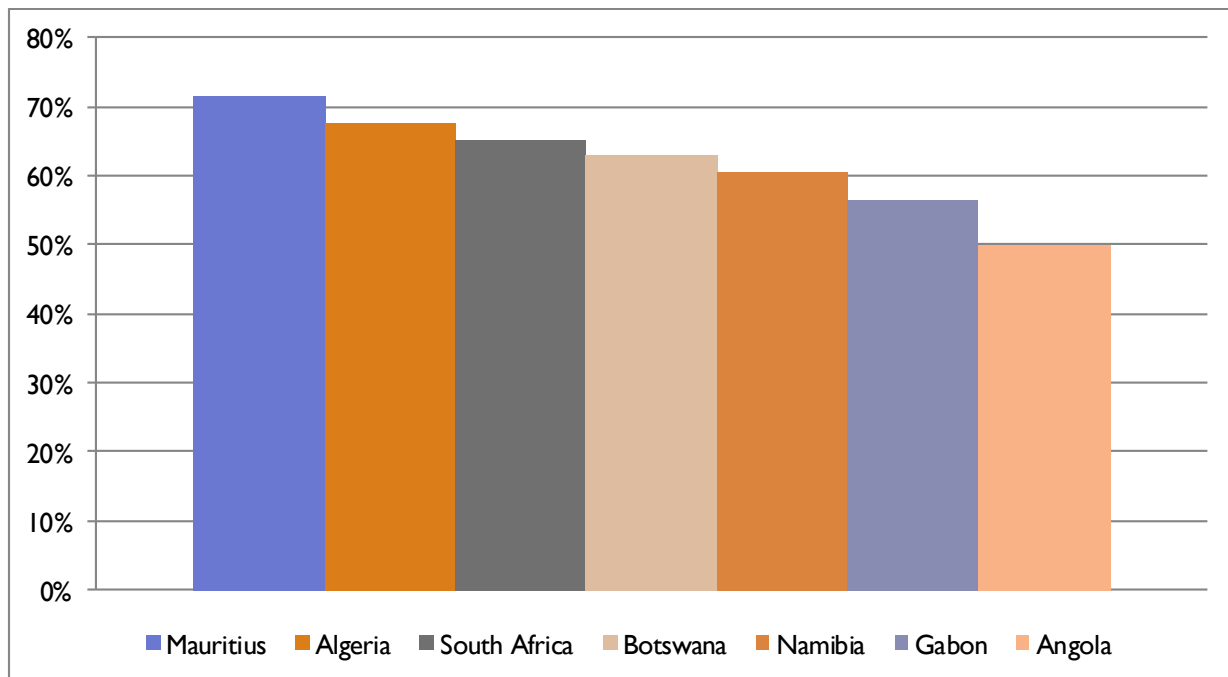
The high unemployment rate continues to be a significant challenge for the economy. The size of a country’s working-age population indicates the number of potential workers in the economy, which, in turn, indicates potential for revenue generation.

Namibia is a sparsely populated country with approximately 2.2 million people (IMF 2015) over a land area of 824,000 Km². The 2014 Namibia Labour Force Survey (Namibia Statistics Agency 2015) indicates that, in 2013, 60 percent of the population was considered to be of working age, defined as 15 to 64 years; 58.8 percent of working individuals were employed in the formal sector, 41.1 percent in the informal sector. The unemployment rate was high, 28.1 percent, albeit down 1.5 percent from 2013 (NPC 2015). This rate includes all people of the economically active workforce, irrespective of whether they are seeking jobs or not. According to the African Development Bank (AfDB), a majority of the unemployed are youth – 56 percent are 15 to 19 year olds and 49 percent are 20 to 24 year olds – followed by unskilled workers and women. The AfDB links the country’s high income inequality to its high rate of unemployment (AfDB 2014). A high unemployment rate like Namibia’s is an obstacle to the government’s ability to generate revenue and to grow the economy.

The 2014 Labour Force Survey includes other relevant findings: 54 percent of the individuals are employed in urban areas while 46 percent are employed in rural areas. Fifty-nine percent of individuals employed in urban areas work in the informal sector while 19.3 percent of individuals employed in rural areas work in the informal sector. Approximately 20.5 percent of those employed in the informal sector work in the wholesale and retail sector, 15 percent in agriculture forestry and fishing, 15 percent in private households, and 12 percent in construction. **With the high proportion of the population working in the informal sector, Namibia faces challenges such as a lack of legislation regulating employment in this sector, irregular and low wages, and little to no access to social security and medical aid benefits** (Brockmeyer and Ebert-Stiftung 2012).

Figure 1 shows Namibia’s working age population relative to those all upper-middle-income countries in WHO’s Africa region. The proportion of Namibia’s working age population is 1.5 percent below the average and 2.4 percent below the median.

Figure 1: Population ages 15-64 as a percentage of the total population, 2013



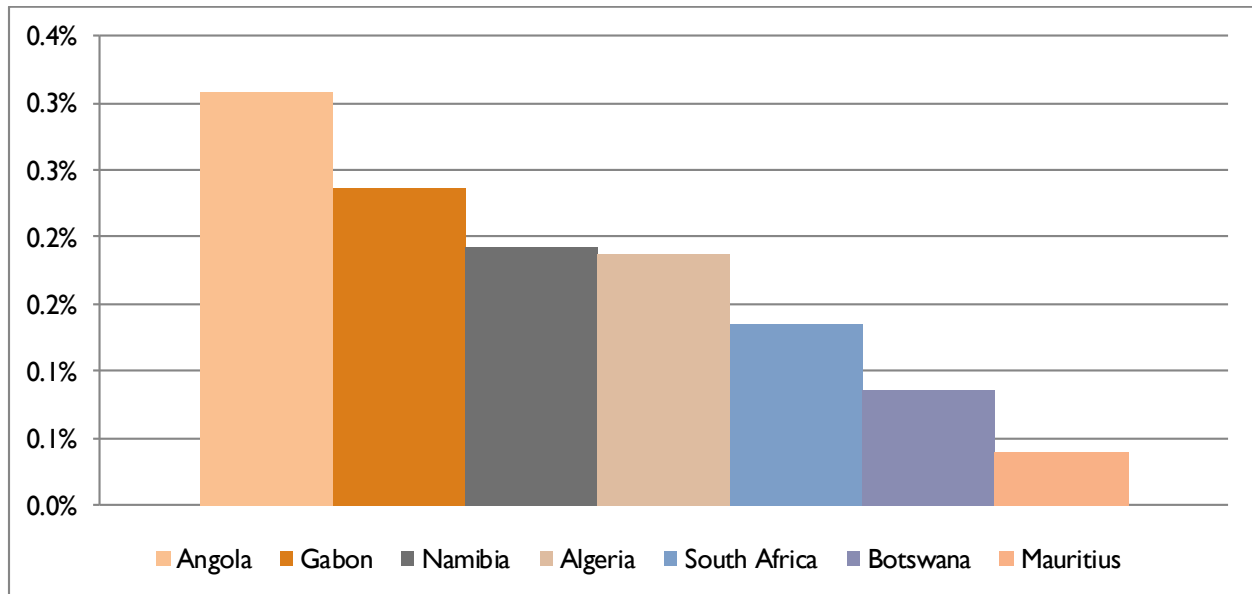
Source: World Bank (2014)

Note: 2013 population data for Namibia are based on World Bank estimates.

The relative size of the youth and elderly populations is also important as these populations generally rely heavily on social programs, including health programs, and increases in the working age population can expand productive potential and output (NPC 2014). Outside of the working age population, 36 percent are between the ages of 0 and 14 years and only 3.5 percent of the population is 65 and older. However, over the past decade, the trend indicates an average annual decrease of 1.1 percent in the proportion of the population ages 0 to 14, and an average annual increase of 0.7 percent for both the 15 to 64 and 65 and older populations (World Bank 2014).

The annual growth rate for the Namibian population was 1.9 percent in 2013 (World Bank 2014). Figure 2 shows Namibia’s growth rate relative to those of all WHO/AFRO upper-middle-income countries. Among these countries, Namibia’s annual growth rate in 2013 is surpassed only by Angola and Gabon. The country’s annual growth rate is 0.2 and 0.1 percent higher than mean and median growth rates (1.7 and 1.9 percent, respectively) (World Bank 2014).

Figure 2: Annual population growth rate, 2013 (percent)



Source: World Bank (2014)

Note: 2013 population data for Namibia is based on World Bank estimates.

High population growth with a low dependency ratio can contribute to positive economic growth, and reductions in the dependency ratio allow households to increase investments. The National Planning Commission's Annual Report 2013/2014 states:

Currently, Namibia is experiencing a population growth with a high dependency ratio of 73.4 per 100 working age population. Of this ratio, 64.4 is child dependency ratio.

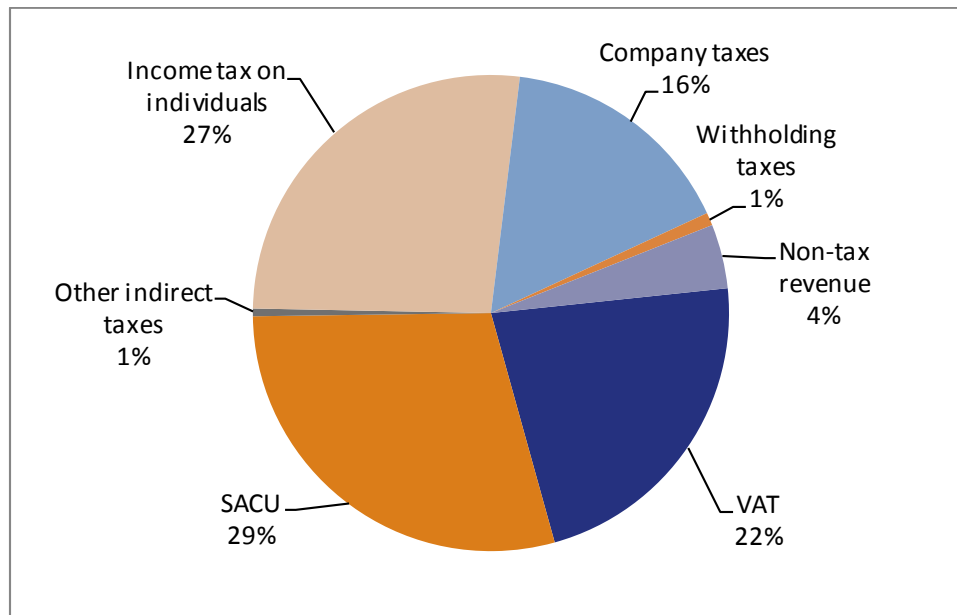
The report also states that Namibia can, in the long term, benefit from the demographic dividend, a term used to describe a period of 20 to 30 years when fertility rates decline due to significant reductions in child and infant mortality rates and increases in life expectancy. As women realize that fewer children will die during infancy or childhood, they begin to have fewer children thereby reducing the number of dependents in the population. When this is accompanied by extensions of average life expectancy, the proportion of the working-age population increases and leads to accelerated economic growth, assuming that there are corresponding employment opportunities. To benefit from this effect, Namibia must sustain the reduction in fertility rates, further reduce infant mortality, and reduce the number of unproductive youth (NPC 2014).

In summary, the proportion of Namibia's working-age population, who are largely responsible for revenue generation, remains low relative to other countries. However, the size of this population is gradually increasing while the proportion of the population ages 0 to 14, who rely heavily on social programs, is gradually decreasing.

The government's revenue sources include direct and indirect taxes as well as non-tax income. Figure 3 shows the proportion of revenue from each source. The largest source of the government's income is indirect tax revenue, which includes customs revenue from the South African Customs Union (SACU).

The largest share of direct tax revenue is from individual income taxes, which constitute 61 percent of direct tax revenue, while company taxes amount to 37 percent of direct tax revenue (PricewaterhouseCoopers 2015). Individual income tax rates in Namibia are staggered based on the individual's income level, including six income brackets with progressively higher tax rates, ranging from 18 to 37 percent. Individuals earning a taxable income of less than N\$50,000 are exempt from paying individual income taxes.

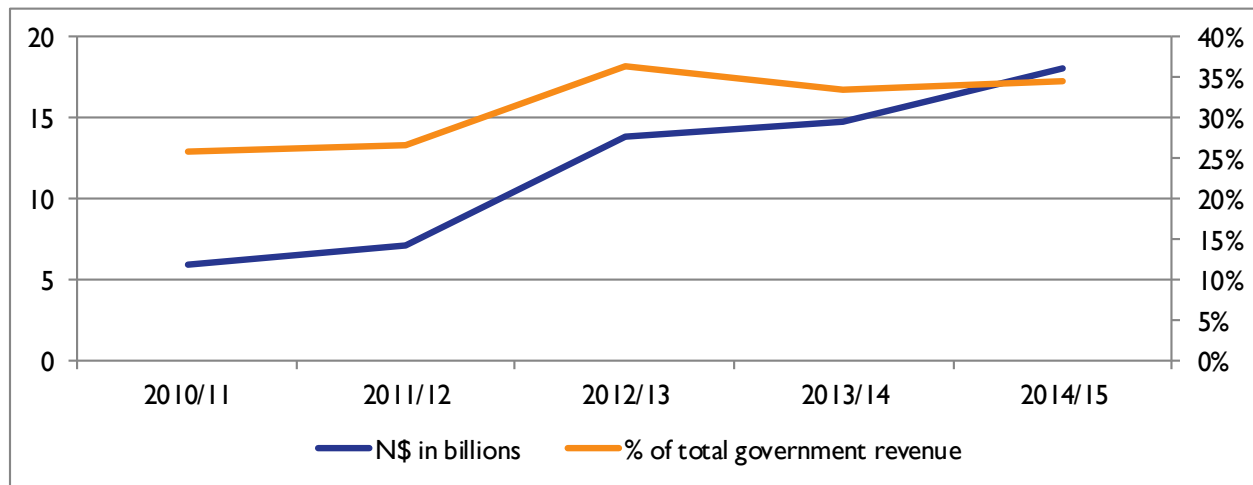
Figure 3: Revenue by source, in percent, 2015/2016



Source: PricewaterhouseCoopers (2015)

Within the indirect tax revenue category, SACU revenues are the largest source of revenue for the Namibian government. High reliance on indirect or consumption taxes in relation to direct taxes has equity implications, since indirect taxes tend to be less progressive than direct taxes (World Bank 2015). Furthermore, Namibia's high reliance on SACU revenue as a source of government revenue poses a key risk to Namibia's medium-term growth due to this revenue source's volatility and vulnerability to fluctuations in the global economy, and expected reductions in SACU revenues due to the economic slowdown in South Africa (AfDB 2014). Figure 4 shows the trends of the SACU revenues over the last five years. The analysis shows that the value of the SACU revenue for Namibia has been consistently increasing over time; however, there has been some fluctuation in terms of the SACU revenue as a percentage of total government revenue. The SACU revenue as a percentage of total government revenue increased from 26 percent in 2011/12 to 36 percent in 2012/13, and decreased slightly, to 34 percent, in 2014/15.

Figure 4: Trends in Namibian SACU revenue, in N\$ billions and percent of total government revenue



Source: SACU annual reports from 2010/11 to 2014/15

Despite the apparent increasing trends of SACU revenues over the last five years, Namibia is currently experiencing significant volatilities in this revenue source. Namibia has to repay a total of N\$2.96 billion back to the SACU Common Revenue Pool due to the deficit experienced in the Pool in 2015. It is expected that SACU revenues will further decrease substantially in the next two financial years on account of lower growth outlook for the South African economy (Ministry of Finance 2016). The Minister of Finance is planning to navigate through the volatility in this revenue base by expanding and deepening the domestic revenue base, accelerating the tax administration reform agenda, and adjusting expenditure levels in line with the changing revenue and macroeconomic environment (Ministry of Finance 2015).

In conclusion, the fiscal space of Namibia indicates that there is potential for increasing financial resources for the health sector in the medium term. In the short term, various factors including the exchange rate volatilities, reduction of indirect tax revenues and repayment of SACU revenues, high fiscal deficit and debt burden, expected increasing inflation and the current drought are likely to limit the ability of the government to secure and allocate significant additional resources for health. However, the anticipated increase in GDP growth from 2017 onward, mainly supported by factors such as increased mining output from new mines, recovery in agriculture and sustained growth in wholesale and retail trade, combined with the expansion and deepening of the domestic revenue base, acceleration of the tax administration reform agenda and improving efficiencies in government expenditure that are expected to have a positive impact on the country's fiscal space for health in the medium term.

2.2 The Structure of Public Administration

The Republic of Namibia became independent as a sovereign, secular, democratic, and unitary state on March 21, 1990. The government is divided into three organs in accordance with the doctrine of separation of powers with each organ being responsible for a different function of the government. These organs include the legislative branch, which is responsible for making laws; the executive, which is responsible for the implementation of those laws; and finally the judiciary branch, which is responsible for the interpretation of law.

2.2.1 Legislative Branch

The legislative branch of government is responsible for making laws in Namibia. The main law-making body is the Parliament, which consists of two chambers – the National Assembly and the National Council.

The National Assembly is the highest law-making body of Namibia and has the power to pass laws to the National Council with the consent of the President. The National Assembly comprises 104 members, including 96 members elected on a proportional representation system and not more than eight members appointed by the President by virtue of their special expertise, status, skill, or experience. These appointed members do not vote in the National Assembly.

The National Council is the second house of Parliament and consists of 30 members representing the 14 regions of Namibia (Government of the Republic of Namibia 2015b). These members are elected from among the members of the Regional Council for each region. In addition to considering all bills passed by the National Assembly, the National Council recommends legislation on matters of regional concern for submission to and consideration by the National Assembly.

There are a number of laws regulating the health care sector including:

- Allied Health Professions Act of 2004
- Hospital and Health Facilities Act of 1994
- Medical and Dental Act of 2004
- Medical Funds Act of 1995
- Medicines and related substances Control Act of 2003
- National Disability Council Act of 2004
- Nursing Act of 2004
- Pharmacy Act of 2004
- Public Service Act of 1995
- Social Security Act of 1994
- Social Work and Psychology Act of 2004

These laws regulate both the public and private health sectors, while additional regulations, policies, and guidelines have been developed by the MoHSS for implementation by all health care providers. In addition to being regulated by the Hospital and Health Facilities Act of 1994, all private health facilities need to be licensed by the MoHSS to provide health services to private patients. Furthermore, the private sectors are also guided by MoHSS policies and guidelines. However, private sector adherence to these policies and guidelines has been limited (Government of the Republic of Namibia 2015). In addition to the laws regulating the provision of health services, the MoHSS is also required to adhere to the State Finance Act of 1991, which regulates the management of public financial resources. The Act regulates the allocation, receipt, custody, and expenditure of financial resources by the State.

The private health sector in Namibia is mainly financed through medical aid funds, which are regulated by the Medical Aid Funds Act of 1995. This Act defines how medical aid funds need to be registered, administered, and managed, as well as the mandate of the Namibian Association of Medical Aid Funds (NAMAF). Medical aid funds are regulated by the Namibia Financial Supervisory Authority (NAMFISA), particularly in terms of the liquidity and solvency of the funds.

While the MoHSS carries the main responsibility for the provision and regulation of health services in Namibia, the SSC has also to some extent been mandated to secure the health and well-being of Namibians. Under the Social Security Act No. 34 of 1994, the SSC is responsible for the establishment and management of the following funds:

- Maternity leave, Sickness leave and Death Benefit Fund (MSD fund): to provide for the payment of maternity leave benefits to female employee members, sick leave benefits to all employee members, and death benefits to dependents of all employees, subject to the provisions of the fund.
- Development Fund: to provide for the funding of training schemes for disadvantaged persons, employment schemes for unemployed persons, bursaries, and other forms of financial aid.
- National Pension Fund: to provide for the payment of pension benefits to retired employees, subject to the rules of the fund.
- National Medical Benefit Fund (NMBF): to provide for the payment of medical benefits to employees.

Neither the National Pension Fund or the NMBF have been formally established and are thus not operational. **While the MSD fund serves as a form of income protection, the concept of the NMBF is to essentially serve as a social health insurance mechanism.** The NMBF requires that every employee of every employer be registered with the Fund, except if he or she is a member of another medical aid fund approved by the Minister on recommendation of the SSC.

In addition to having the mandate for the NMBF, the SSC has agreed to work in close collaboration with the MoHSS to explore the way forward toward achieving UHC. For this purpose, they have established the UHCAN as a sub-committee to the SSC's board of directors. The UHCAN is composed of representatives from the SSC, Office of the Prime Minister, Ministry of Finance, Ministry of Labour, and MoHSS, along with Namibian medical aid funds, health insurers, trade unions, employers' federations, and provider associations. The objective of UHCAN is to provide guidance to the MoHSS on the development of sustainable systems and policies to achieving UHC in Namibia. Its primary focus is on compiling evidence and developing alternative policy approaches specific to the Namibian context with the ultimate aim of ensuring equity, access, and financial protection in the provision of health services.

2.2.2 Executive Branch

The executive power of Namibia is vested in the President and the Cabinet, who are charged with ensuring that the laws passed by the National Assembly and National Council are carried out. The President is the Head of State and of the Government and is elected by direct, universal, and equal suffrage in a national election held every five years, in which he/she must win more than 50 percent of the votes. After an amendment to the Constitution in December 1998, the President is limited to a maximum of three terms.



The Cabinet consists of the President, the Prime Minister, Deputy Prime Minister and Ministers, including the Minister of Health and Social Services, appointed by the President from the National Assembly. Together, they implement the policies guided by the constitution and acts of Parliament. The Prime Minister is the Chief Advisor to the President and the overall coordinator of the Government Offices, Ministries, and Agencies.

While the Ministers represent their line Ministries on the Cabinet, the **Permanent Secretaries are appointed as accounting officers of the Ministries as per the State Finance Act**, which means that the Permanent Secretaries are responsible for the financial administration and affairs of the Ministry.

2.2.3 Judiciary Branch

The judicial powers are vested in the Supreme Court, High Court, and Lower Courts. This third branch of government is responsible for the interpretation of the laws and behavior of State and Government officials. The Courts are independent and subject only to the Constitution and the law.

2.2.4 Local Government

In accordance with the Constitution and the Regional Councils and Local Authorities Acts, Namibia has been divided into 14 administrative regions and many other local authorities. In terms of Namibian policies, Regional and Local Authority Councils both have substantial fiscal powers, although the **implementation of these decentralization policies remains limited**. All regional and local bodies have the power to legislate regarding their own affairs as long as their acts and conduct do not conflict with the overall guidelines in the Constitution. Each region has several local governments elected by the community to take care of the community matters. Cities and urban centers have their own municipal or town bodies that make ordinances to deal with their local issues and have the powers to enforce these ordinances.

2.2.5 Decentralization in Namibia

The reform of local government to move toward decentralization was initiated in Namibia in 1990 after gaining independence from the apartheid rule of South Africa. The official *Decentralization Policy of Namibia* was launched in 1998, which was preceded in 1992 by the passing of both the *Regional Councils Act* and the *Local Authority Councils Act* providing the legislative framework for the institutionalization of the decentralized government.

The *Decentralization Policy of Namibia* specifies the functions to be decentralized and provides implementation guidelines, resource strategies, and the choice of the form of decentralization. The stated aim of decentralization in Namibia is to ensure economic, cultural, and socio-economic development; to provide people at grassroots level with the opportunity to participate in decision making; and to extend democracy as a right based on Namibia's national ideals and values.

The implementation of the decentralization policy aims to decentralize functions from the line ministries to the regional councils and local authorities first by delegation, and ultimately by devolution of the political and administrative responsibility of the service provision to the regional councils and local authorities. In general terms, delegation refers to the transfer of responsibility for decision making and administration of public functions from central government to semi-autonomous organizations, which are accountable on these functions to the central government. Devolution is a more comprehensive type of decentralization, and generally refers to the transfer of authority for decision making, finance, and management from central government to local authorities with corporate status and considerable degree of autonomy from the central government.

The implementation of the decentralization policy has been slower than anticipated. The government has also acknowledged that the magnitude and complexity of the decentralization process has been grossly underestimated since the introduction of the decentralization policy.

The decentralization of primary health care services has been identified as a specific function that is to be decentralized to the regions immediately in the decentralization policy. However, the decentralization of key public services, including health, to local authorities as planned in the decentralization policy of Namibia has progressed particularly slowly. Nonetheless, the **MoHSS has established regional directorates in each of the regions**, which, per the decentralization policy, are classified as major directorates with their own administrative, financial, and personnel management capacity where only some of its operations are to be delegated. Furthermore, these regions have also established Regional Health Advisory Committees within their regional councils. The responsibility for policy decisions and treatment guidelines remains with the Ministry at the central level.

2.3 Public Sector Financial Management

The legal framework for transparency and accountability in the budget process is quite comprehensive in Namibia with the regulations to the process being provided in the Constitution and the State Finance Act of 1991. These documents clearly set out the relevant powers and duties of the various government entities in the budget process, which include the Ministry of Finance, the National Assembly, the Treasury, the Accounting Officers of the Ministries, and the Auditor General.

Namibia's executive branch has the overall responsibility for the preparation and execution of the national budget and involves active cooperation between the key institutions including the Ministry of Finance, National Planning Commission, the Bank of Namibia, and the Office of the Prime Minister. The budget drafting process is informed by the National Development Plan, which is a policy framework document covering a period five years. Furthermore, the development of the annual government budget is informed by the MTEF and the Performance Effectiveness Management Programme (PEMP) in order to strengthen the transparency of the budgeting process. Both of these policy tools have been formally adopted by Cabinet. **The budget drafting phase is implemented as relatively closed process with limited public consultations around budget priorities and little or no participation on the part of civil society, the legislatures, or the broad public during budget planning** (Motinga and Sherbourne 2015). The Ministry of Finance does not publish a pre-budget statement for stakeholder input. The National Assembly and the National Council oversee the budget process and review the final budget proposal. The legislatures have the clear authority to approve, reject, or amend the executive's budget proposals.

In terms of the Open Budget Initiative of the International Budget Partnership, Namibia achieved a score of 46 points out of a possible 100 points for transparency, indicating that the **Government of Namibia provides the public with limited budget information**. In terms of public participation, Namibia scored 15 out of 100 points as the Government of Namibia is deemed **weak in providing the public with opportunities to engage in the budget process**. Finally, **budget oversight by the legislature is rated weak** with 17 out of 100 points **and adequate by auditor** with a rating of 75 out of 100 points (International Budget Partnership 2015).

The implementation of the budget is the sole responsibility of the executive branch and the roles and responsibilities for financial management, procurement, and reporting of the various role-players in budget execution are clearly defined in the legal framework.

There is a general shortage of adequately trained and skilled technical staff to undertake budget planning and auditing in Namibia, which implies limited human resource capacity within both the Ministry of Finance and the Office of the Auditor General. **While there have been efforts to move toward program-based budgeting and strengthening budgeting processes, there are serious systems weaknesses in the budgeting process, which have resulted in an urgent need to curb and effectively manage overspending.** The Ministry of Finance is working on improving the government financial management information system in order to improve monitoring and internal control mechanisms for better budget adherence.

The Auditor General operates independently as provided for in the Constitution and the powers and duties of this office are defined in the State Finance Act. Audit reports typically lag significantly behind, which adversely impacts the accountability cycle and reduces their usefulness and relevance of such information to current budget debates.

2.3.1 Financial management within the MoHSS

The responsibility of the financial management within the MoHSS lies with the Directorate of Finance, which is responsible for overseeing all aspects of financial management.

The annual budget is prepared by the MoHSS Directorate of Finance for submission to the Ministry of Finance and is divided into detailed budgets for each directorate of the MoHSS. The regional directorates are consulted in the Ministry's budgeting process by being requested to prepare budgets for their respective regions, which are consolidated in the sub-budget for regional health and social welfare services. Tertiary hospitals in Namibia are treated separately from the regions in which they are located and are required to make their own budget submissions to the central MoHSS under the main division of referral hospital services. While the Finance Directorate communicates to the regions and tertiary health facilities general guidelines and the overall ministerial budget ceiling (including the change in ceiling in comparison to the previous year), the regions and tertiary health facilities are not provided with specific budget limits and are instead requested to budget for their actual needs. Decisions relating to the actual allocation of resources to the various regions and tertiary hospitals as included in the budget submission are made by the Directorate of Finance. All revenues collected at the district and regional level through the health facilities are returned to the Ministry of Finance via the central-level MoHSS. Any purchasing decisions made at regional level need to follow the overall government's procurement guidelines, with many of the major purchases made at the central level and distributed to the regions.

The MoHSS has made concerted efforts to move away from the historical budgeting practices that have been in place for many years toward program-based budgeting, which also more effectively takes into account the regional priorities and financing requirements. However, shortfalls and limitations within the current version of the financial management information system of the Ministry of Finance has prevented the MoHSS from fully moving toward program-based budgeting as the system does not facilitate the monitoring of the execution of the budgets on this basis.

For a number of years, the MoHSS has also been considering the implementation of a revised resource allocation formula in order to move away from its traditional historical budgeting approach and to consider more relevant factors in the allocation of resources to the regions. Factors that have been considered for inclusion in the resource allocation formula include regional population sizes, poverty levels, disease burden, and differences in costs of service provision. This approach would allow for a more equitable distribution of health resources taking into account the need for health services. **No final decisions on the implementation of this resource allocation formula have been reached and as a result the Ministry still uses a historical budgeting approach.**

Directorates, including the regional directorates, are responsible for the operational budget execution and management of expenditures. Information on actual expenditures by the directorates is obtained by the

Directorate of Finance on a regular basis for monitoring purposes. Budget shortfalls and reallocations of funding need to be managed through the MoHSS Directorate of Finance, which is responsible for coordination with the Ministry of Finance. **Money not spent by the end of the fiscal year at all levels of the MoHSS is returned to the Ministry of Finance.** The funding unspent by the MoHSS during 2012/13 amounted to N\$202,940,778, 5.1 percent of the total MoHSS budget allocation (Government of the Republic of Namibia 2015). The poor absorption of funds by the MoHSS has been noted as an issue for a number of years. Furthermore, the public sector uses a cash basis of accounting, which is based on payments and receipts instead of income and expenditure. This implies that the MoHSS does not have comprehensive financial statements including an adequate balance sheet and income statement, which has adversely affected the MoHSS' ability to plan, budget, and account effectively.

Summary of key findings:

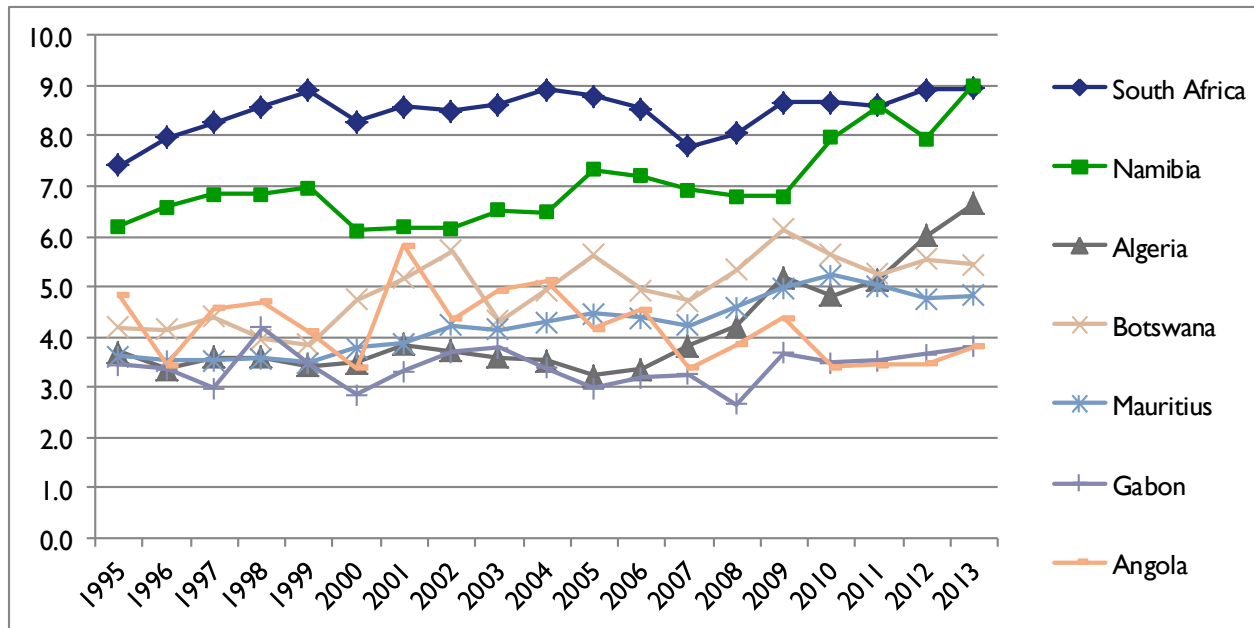
- ◆ While Namibia's fiscal capacity is medium to high, the fiscal space available to expand overall government spending is limited.
- ◆ Namibia has positive economic growth and prudent fiscal management, but high unemployment, inequality, poverty, and potential volatility in government revenue streams continue to pose significant obstacles and risk for the economy.
- ◆ Nearly half of the Namibian population is economically active in the largely unregulated informal sector with limited access to medical aid benefits and accordingly are dependent on the state health facilities for medical treatment.
- ◆ Decentralization has been limited and slow to progress in Namibia, including the decentralization of primary health care services. Within the MoHSS, regional directorates and regional health advisory committees have been established but with limited impact on the provision of services.
- ◆ Namibia's budgeting process is not very transparent and allows only for limited public participation. Its budget oversight by legislature is weak, but adequate by the auditor.
- ◆ Government budgeting processes need to be improved and overspending needs to be managed more effectively.
- ◆ Public Financial Management for health care, on an accrual basis with full income statement and balance sheet accounting, would enhance ability to plan, budget, and account for public funds.
- ◆ The MoHSS is considering a resource allocation formula that would more effectively address the needs of the regional population in terms of the allocation of financial resources
- ◆ The MoHSS failed to absorb 5.1 percent of its budget allocation in 2012/13; incomplete execution resulted in some funds being returned to the Treasury.

3. HEALTH EXPENDITURES

The most recent Namibia Health Accounts Report, for 2012/13, indicates that the absolute dollar value of both total health expenditures and government health expenditures have steadily increased since 2001 (MoHSS 2015). Health expenditure data allow for a disaggregation of the sources of financing the current health system. The data also allow us to see trends in health expenditures and better understand the factors that explain the level of government spending on health, specifically distinguishing the impact of the fiscal context from the extent to which the government prioritizes health in its resource allocation decisions. Health expenditure data are critical for understanding the extent to which the current financing system depends on external sources of financing and private contributions from individuals, either in the form of insurance or out-of-pocket (OOP) expenditure for health.

In 2013, Namibia’s total health expenditure was 9 percent of GDP. This represents a 2.2 percentage point increase over the past 10 years while the average and median for the region was an increase of 0.7 percent. Total health expenditure reflects the sum of all public and private expenditures on health, including external resource expenditures, and total health expenditure as a percentage of GDP indicates the level of health care expenditure relative to the country’s economic development. A WHO study found that increases in GDP lead to increases in total health expenditure across all income groups (Xu et al. 2011); however, higher-income countries generally expend a greater proportion of their GDP on health care than lower-income countries (McIntyre and Kutzin 2014). Figure 5 shows total health expenditure as a percentage of GDP over time for all countries in WHO’s AFRO region that are classified as upper-middle income. Namibia’s total health expenditure of 9 percent of GDP in 2013 is 2.9 percent higher than the average of 6.1 percent and 3.6 percent higher than the median of 5.4 percent for all upper-middle-income countries in the region.

Figure 5: Total health expenditure as a percentage of GDP, 1995-2013



Source: WHO Global Health Expenditure Database: <http://apps.who.int/nha/database/Home/Index/en> and Namibia NHA Reports from 2007/2008, 2008/2009, and 2012/2013

While Namibia's total health expenditure as a percentage of GDP was relatively high for this group of comparable countries, its total health expenditure per capita was below the average. Table 2 shows total health expenditure per capita alongside total health expenditure as a percentage of GDP in 2013. In that year, Namibia's total health expenditure per capita, at \$749, was US\$30 below the average of US\$779 and US\$29 below the median of US\$778. Over the past five years (2009-2013), the average increase in total health expenditure per capita was US\$131, while Namibia's total expenditure per capita increased by only US\$118.

Table 2: Total health expenditure per capita, US\$ adjusted for PPP, and total health expenditure as a percentage of GDP, 2013

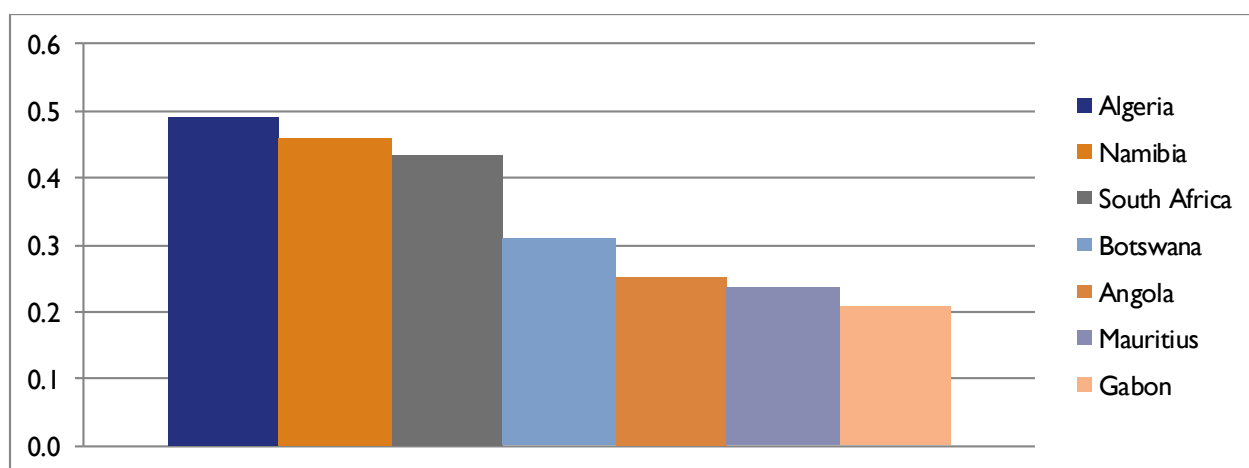
Country	THE per capita	THE as % of GDP
South Africa	1,121	8.9
Mauritius	864	4.8
Botswana	851	5.4
Algeria	778	6.6
Namibia	749	9.0
Gabon	735	3.8
Angola	355	3.8

Source: WHO Global Health Expenditure Database: <http://apps.who.int/nha/database/Home/Index/en>

Note: PPP=purchasing power parity

General government expenditure on health as a percentage of GDP is an indicator that “provides insights into the combination of the fiscal capacity of the government and its commitment to health relative to other uses of public spending” (McIntyre and Kutzin 2014). The indicator provides information on the overall availability of health funds and is considered a strong predictor of the extent to which the health system depends on OOP spending on health (McIntyre and Kutzin 2014). Over the last 10 years, Namibia's general government expenditure on health as a percentage of GDP has increased 1.4 percent while the average increase for this region was 0.7 percent. Figure 6 shows that, **in 2013, Namibia's general government expenditure on health as a percentage of GDP at 4.6 percent exceeded that of all upper-middle-income countries in WHO's AFRO region, with the exception of Algeria (4.9 percent).**

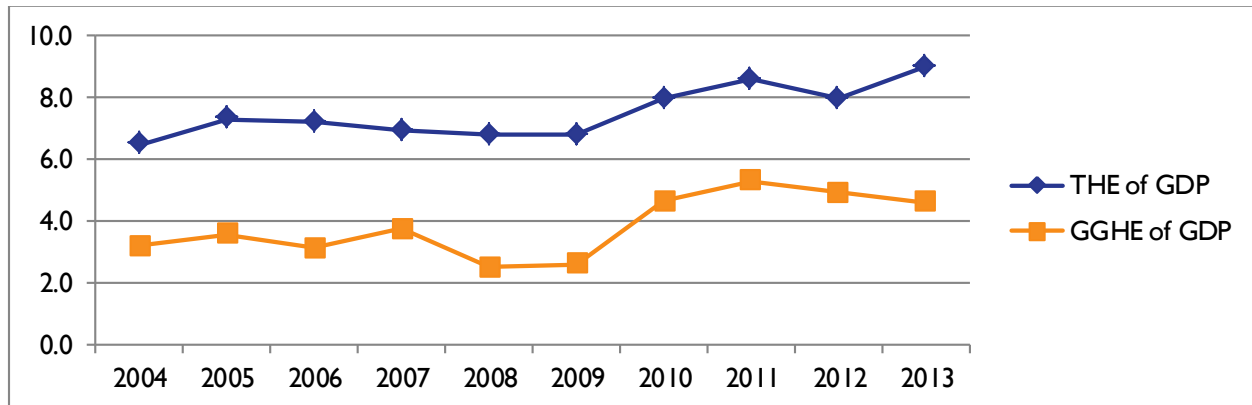
Figure 6: General government expenditure on health as a percentage of GDP, 2013



Sources: MoHSS (2015) and WHO Global Health Expenditure Database: <http://apps.who.int/nha/database/Home/Index/en>

Over the last 10 years, total health expenditure as a percentage of GDP has increased more than general government expenditure on health as a percentage of GDP indicating a negative trend in government spending on health. Figure 7 shows that from 2004 to 2013, Namibia's general government expenditure on health and total health expenditure as percentages of GDP have trended in the same general direction, but there is a slightly greater increase in total increase in health expenditure. Since 2004, Namibia's total expenditure on health has increased 2.5 percent while government health expenditure as a percentage of GDP increased 1.4 percent.

Figure 7: Total expenditure on health and general government expenditure on health, as a percentage of GDP, 2004-2013

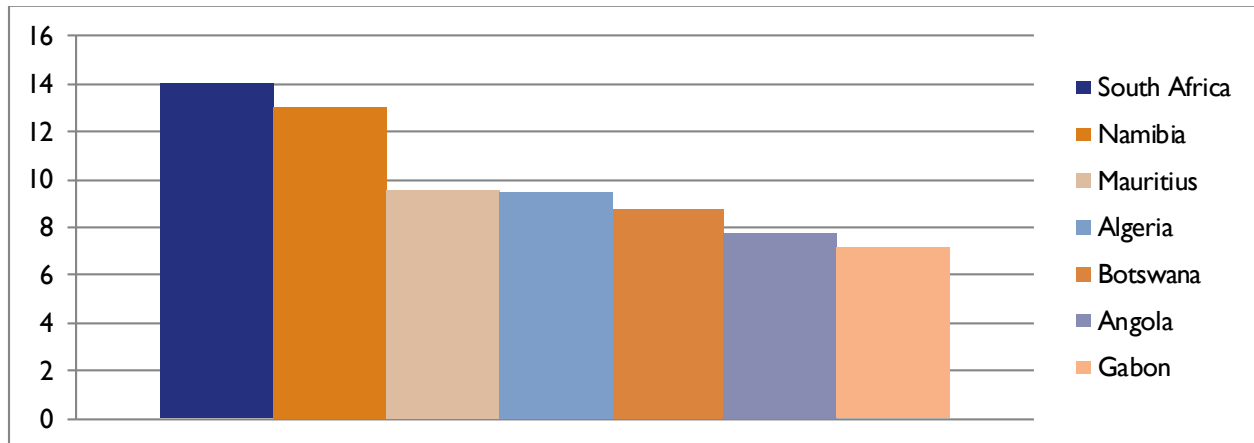


Source: WHO Global Health Expenditure Database and Namibia NHA Reports from 2007/2008, 2008/2009, and 2012/2013

General government expenditure on health as a percentage of total government expenditure reflects how much government funding is raised for health, relative to total government resources and is an indicator of the priority that government gives to funding health relative to other public expenditures. The Abuja target recommends that 15 percent of total government expenditures should be allocated to health. **While the level of the government's expenditure on health at 13 percent falls slightly below the Abuja target of 15 percent, it does reflect the government's strong commitment to health.**

Figure 8 shows that, in 2013, Namibia’s spending on health as a proportion of all government expenditures nearly exceeded that of all other countries in WHO’s AFRO region, with the exception of South Africa. However, its level of spending still falls below the Abuja target. Over the last 10 years, Namibia’s general government expenditure on health as a percentage of total government expenditure has increased 1.8 percent while the average increase for this region was 0.8 percent. In 2013, Namibia’s general government expenditure on health as a percentage of total government expenditure was 13 percent, which is 3.1 percent higher than the regional average of 9.9 percent.

Figure 8: General government expenditure on health as a percentage of total government expenditure, 2013

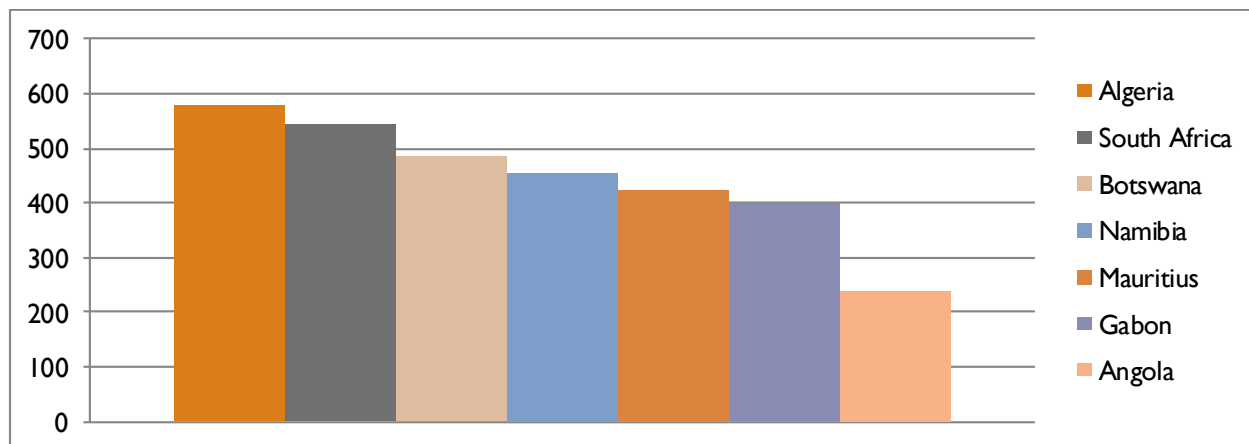


Source: WHO Global Health Expenditure Database and Namibia NHA Reports from 2007/2008, 2008/2009, and 2012/2013

Per capita government expenditure on health is another measure of the government’s commitment to spending on health, as it measures the total resources expended on health relative to the benefit population (WHO 2010a). Similar to general government expenditure on health as a percentage of GDP, this indicator is a determinant of the dependence of the health system on OOP spending on health (McIntyre 2014a).

Figure 9 shows Namibia's per capita government expenditure on health in 2013 relative to all upper-middle-income countries in WHO's AFRO region. **Namibia's total health expenditure and general government expenditure on health as percentages of GDP were at the top of all upper-middle-income countries in WHO's AFRO region, and similarly in 2013, its per capita government expenditure on health, at US\$452.60, was above the mean expenditure for the same group of countries at US\$445.51.**⁴

Figure 9: Per capita government expenditure on health, 2013 (US\$ adjusted for PPP)



Source: WHO Global Health Expenditure Database: <http://apps.who.int/nha/database/Home/Index/en>

General government expenditure on health as a percentage of total health expenditure measures the contribution of government spending on health within the total value of expenditure on health. This includes central government tax-funded health spending, payroll tax-funded mandatory health insurance, and external revenues reflected in the government budget (loans and grants). Expenditures from these sources encompass mandatory pre-payment for health care and are therefore an important indicator of UHC (McIntyre and Kutzin 2014). An increase in this indicator relative to donor or household contributions to total health expenditure indicates more sustainable financing for health (HFG 2014). Table 3 shows the general government expenditure on health as a percentage of total health expenditure for all upper-middle-income countries in WHO's AFRO region in 2013. **While Namibia's general government expenditure on health as a percentage of total health expenditure of 54.0 percent in 2013 falls around the middle of the range for all upper-middle-income countries in WHO's AFRO region – 3.7 percent below the average of 57.7 percent and 0.4 percent below the median of 54.4 percent – its spending has increased by 4.5 percent over the last 10 years (2004–2013), whereas the average increase for the region was 4.1 percent.**

Table 3: General government expenditure as a percentage of total health expenditure, 2013

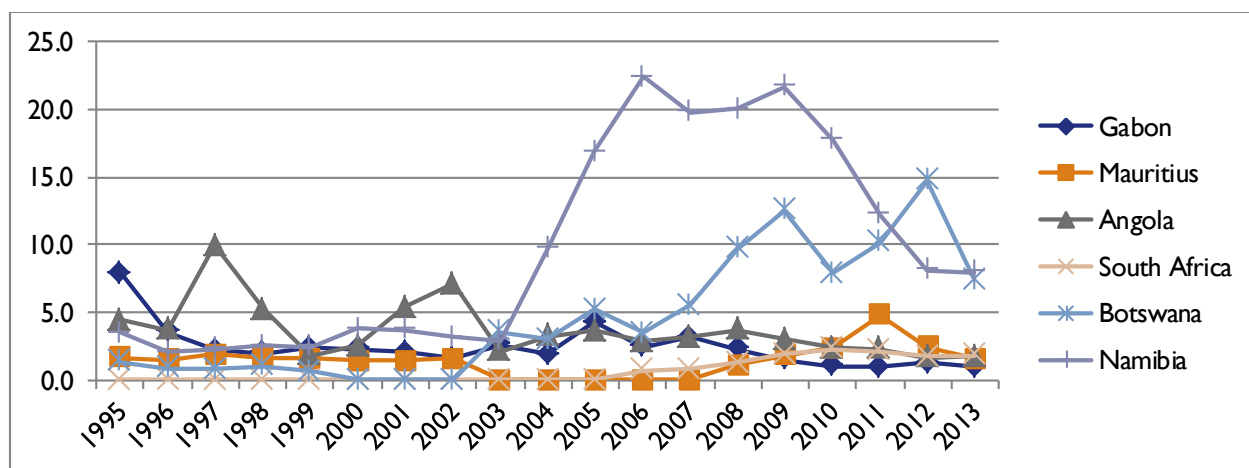
Country	%
Algeria	74.2
Angola	66.7
Botswana	57.1
Gabon	54.4
Namibia	54.0
Mauritius	49.1
South Africa	48.4

Sources: MoHSS (2015) and WHO Global Health Expenditure Database: <http://apps.who.int/nha/database/Home/Index/en>

⁴ Adjusted for purchasing power.

External resources for health as a percentage of total health expenditure is an indicator that traces the financing flows from external sources that provide funds to public and private financing agents. It measures the health sector's dependency on external resources to purchase health services. A high percentage indicates a situation in which a country is unable to perform many of the core functions of government, such as operations and maintenance, or the delivery of basic public services, without foreign aid funding and expertise (Brautigam 2000). It is important to gauge the changes in this indicator over time. In Figure 10, significant actual and relative increases in the proportion of external funding for health can be seen in 2004 (9.7 percent), 2005 (16.9 percent), and 2006 (22.4 percent) followed by the noteworthy decreasing trend from 2009 to 2013. **Over the last five years of data (2009-2013), Namibia's dependence on external resources for health has decreased by 13.7 percent whereas the average decrease in the region was 3.5 percent. However, in 2013, 8 percent of Namibia's health expenditures were still from external resources – this was the highest dependency on external resources in the region, which leaves the country's health response at risk to external factors and subject to the availability of external resources.**

Figure 10: External resources for health as a percentage of total health expenditure, 1995-2013



Sources: WHO Global Health Expenditure Database and Namibia NHA Reports from 2007/2008, 2008/2009, and 2012/2013

Note: Data for Algeria (1995-2013), Botswana (2000-2002), Mauritius (2003-2007, 2012), Seychelles (1997, 2007-2008), and South Africa (1996-2005) were unavailable.

The funding dependency on external resources specifically for HIV is even more worrisome. HIV currently ranks highest on Namibia's Burden of Disease, and spending on HIV/AIDS is currently 13 percent of total health expenditure (MoHSS 2015). In 2013, 51 percent of expenditures for HIV/AIDS were provided by donors with government expenditures at 37 percent. Only 2 percent of HIV/AIDS expenditures came from households meaning that people living with HIV/AIDS are financially protected when seeking care and treatment for this disease, but there is nonetheless a substantial risk to the response in terms of sustainability due to the high donor reliance (MoHSS 2015).

As seen in Table 4, **Namibia is again in the middle of the range for all upper-middle-income countries in WHO's AFRO region with the share of private expenditures.** Private expenditures for health as a percentage of total health expenditure have increased over the last five years as the proportion of government expenditures remains relatively stable over the same period. However, over a 10-year period, the share of private expenditures has decreased, while the proportion of government expenditures has increased. Private expenditure on health as a percentage of total health expenditure indicates the share of expenditures on health financed through sources such as OOP payments and voluntary insurance payments (equivalent in Namibia to medical aid fund contributions). When comparing this indicator to the previous indicators of general government expenditure on health as a percentage of total health expenditure, the dynamic relationship of public-private health expenditures is evident. Namibia's private expenditures on health were 3.2 percent lower than the average of 41.2 percent and 4.9 percent below the median of 42.9

percent in 2013. Private expenditures have increased by 15.7 percent over the last five years (2009-2013), while general government expenditures increased by only 0.2 percent. The average decrease in private expenditures as a percentage of total health expenditure for the region was 0.1 percent.

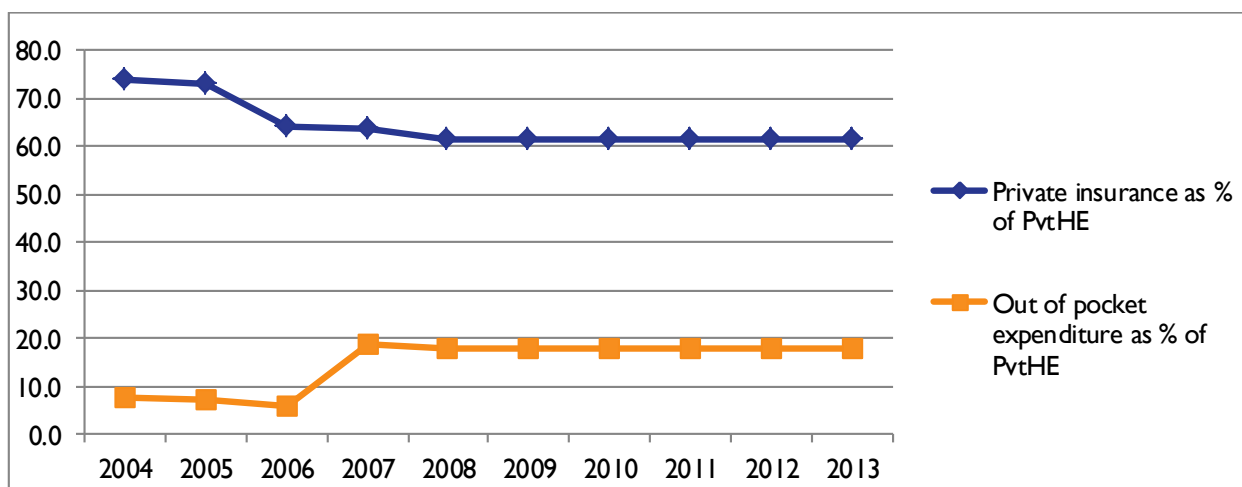
Table 4: Private expenditure on health as a percentage of total health expenditure, 2013

Country	%
Algeria	25.8
Angola	33.3
Namibia	38.0
Botswana	42.9
Gabon	45.6
Mauritius	50.9
South Africa	51.6

Source: MoHSS (2015) and WHO Global Health Expenditure Database: <http://apps.who.int/nha/database/Home/Index/en>

Figure 11 shows the breakdown of private expenditures on health over time, including OOP payments and private insurance payments. While the private expenditures as a share of total health expenditures decreased 12.5 percent over the past 10 years (2004-2013) and increased 15.7 percent over the past five years (2009-2013), the share of private expenditures that are OOP payments has increased by 10.5 percent over the past 10 years while the share of voluntary insurance payments has decreased by 12.5 percent. Over the past five years, there has been little change in the proportion of OOP payments versus voluntary insurance payments, but prepaid insurance mechanisms provide greater financial protection against catastrophic health expenditures. **Decreasing the share of private health expenditures that are OOP payments by increasing expenditures from other sources, such as government or compulsory prepaid medical insurance schemes, will increase financial protection.**

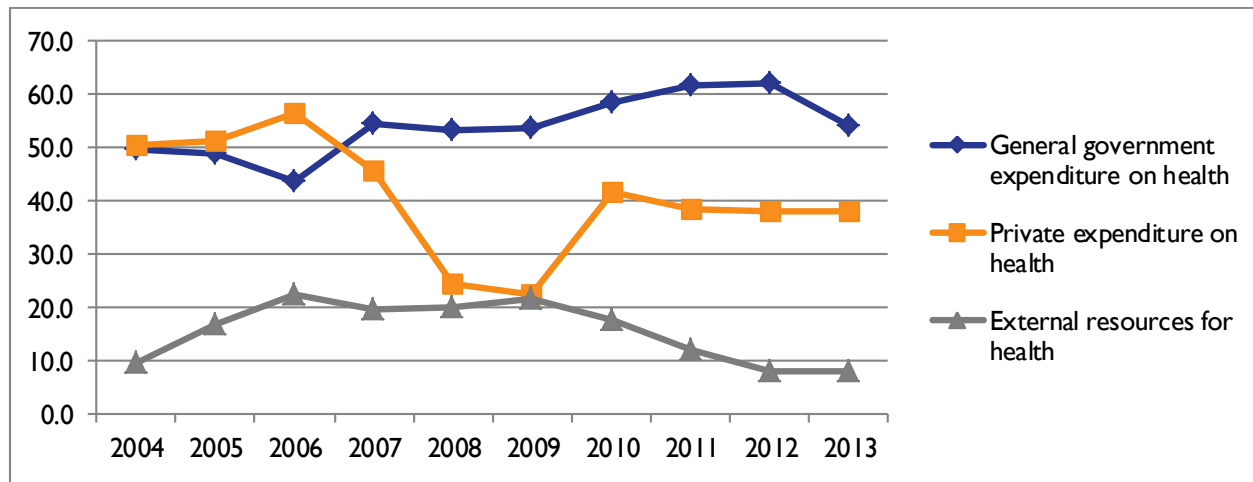
Figure 11: Breakdown of private health expenditures in Namibia, 2004-2013 (%)



Source: WHO Global Health Expenditure Database: <http://apps.who.int/nha/database/Home/Index/en>

Figure 12 shows the breakdown of several key components of total health expenditure in Namibia over time, including general government expenditures, private expenditures, and external resources. **The steady increase in government expenditures since 2007, with relatively stable private expenditures, indicates some sustainability for the financing health care. However, if the expected continuation of decreases in external resources for health happens, the government – already under pressure to reduce its budget deficit – will be hard pressed to make up the difference, and this will jeopardize sustainability.**

Figure 12: Breakdown of total health expenditure in Namibia, 2004-2013 (%)

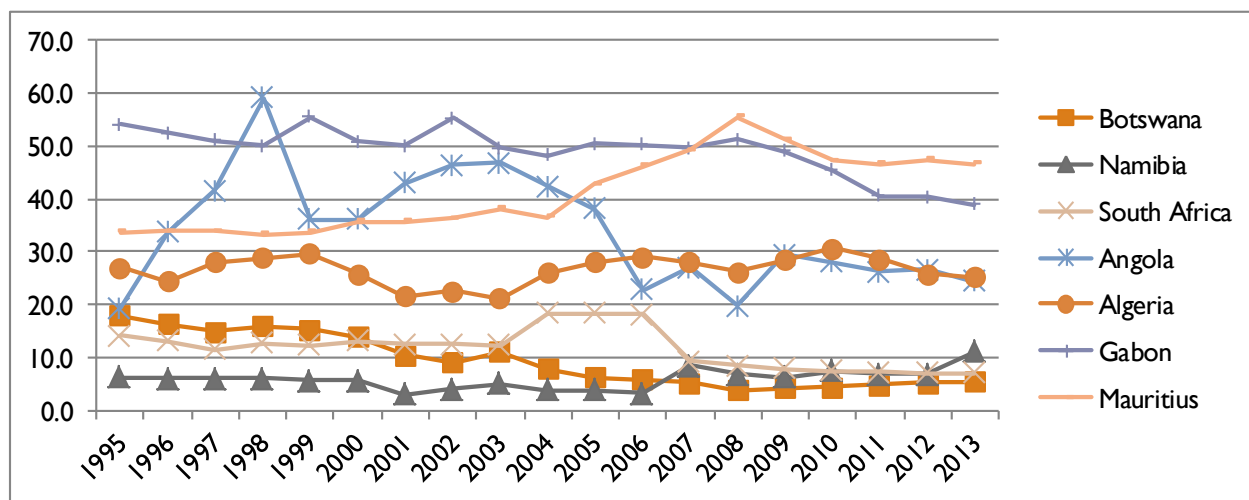


Source: WHO Global Health Expenditure Database: <http://apps.who.int/nha/database/Home/Index/en>

It follows from the past decade of increasing public funding and decreasing private funding for health that Namibia’s OOP expenditures have remained relatively low; then again, historically, Namibia’s OOP expenditures have been substantially less than the regional mean. As has been discussed in this report, OOP expenditure as a percentage of total health expenditure is a critical indicator for assessing the extent of financial protection within a country. A high percentage of OOP expenditures generally suggests limited financial protection – to the point where these expenditures force people to avoid seeking care or face financial hardship or catastrophe (HFG 2014). It also is an inefficient means of financing the health system (MoHSS 2015). As the last 10 years of data (2004-2013) show, Namibia’s OOP expenditures have been on average 18.1 percent lower than the mean for all upper-middle-income countries in WHO’s AFRO region. In 2013, Namibia’s OOP expenditures, at 11 percent of total health expenditure, were 7.3 percent higher than they were in 2004 (3.8 percent), whereas average OOP expenditures across the region had decreased 3.5 percent. Over the period, Namibia’s average OOP expenditures were 6.5 percent of total health expenditure; the regional average was 24.6 percent.

Figure 13 illustrates OOP spending for seven countries in the region over the past 19 years (1995-2013); the spending in Namibia has been low relative to the other countries.

Figure 13: OOP expenditures as a percentage of total health expenditure, 1995-2013



Source: WHO Global Health Expenditure Database and Namibia NHA Reports from 2007/2008, 2008/2009, and 2012/2013

In contrast to the relatively stable OOP expenditures of the population as a whole, indicated by the health accounts data of 2012/13 presented above, payment data from NAMAf specifically for medical aid fund members show consistently high increases in OOP spending over the three-year period 2013-2015. Table 5 shows amounts claimed by fund members and the amounts paid out by the funds; the difference is the members' OOP payments for health services. The increases in these payments over the three-year period substantially exceeded the inflation rate.

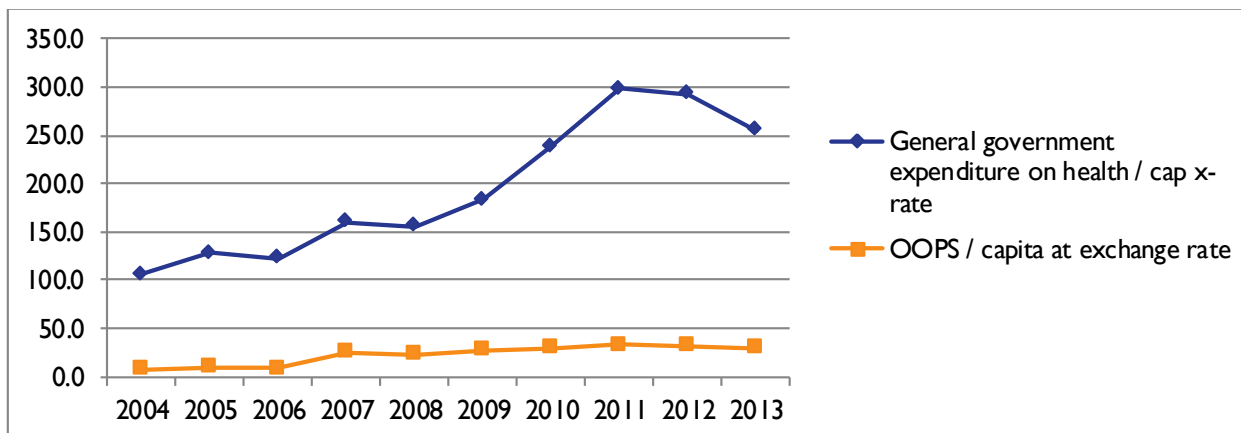
Table 5: OOP payments by medical aid fund members, 2013-2015 (N\$)

	2013	2014	2015
Total amount claimed	2,409,611,212	2,679,015,832	3,124,411,803
Total amount paid	1,943,497,643	2,167,612,475	2,516,882,821
Difference payable by member	466,113,569	511,403,357	607,528,982
Annual percentage increase in OOP by member		10%	19%

Source: NAMAf data

Figure 14 shows Namibia's general government expenditure and OOP expenditure per capita over the past 10 years. **Over the past five years (2009-2013), government expenditure per capita increased by 39 percent while OOP expenditure per capita increased only 11 percent.** That is, while OOP expenditures have increased, the increase is less than the additional financial burden assumed by the government.

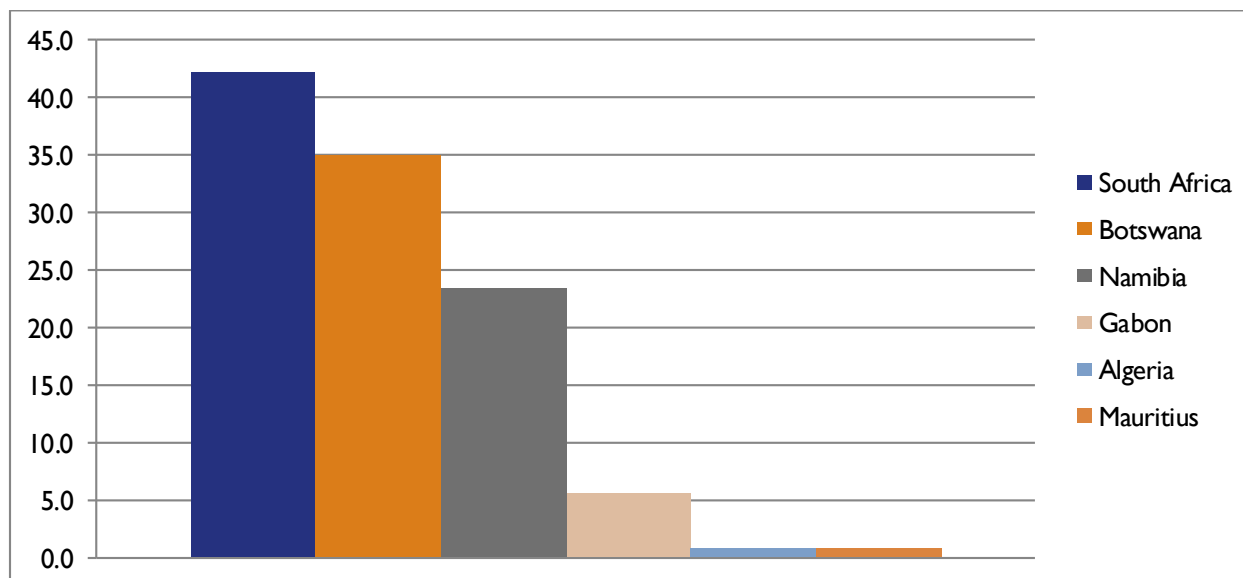
Figure 14: General government expenditure and OOP expenditure per capita, 1995-2013 (US\$ adjusted for PPP)



Source: WHO Global Health Expenditure Database: <http://apps.who.int/nha/database/Home/Index/en>

Spending on private prepaid plans as a percentage of total health expenditure indicates the extent to which voluntary prepayment mechanisms are used within the country. Figure 15 shows that **in Namibia in 2013, almost a quarter (23.4 percent) of total health expenditure came from private prepaid plans, putting the country well above the WHO/AFRO upper-middle-income country average of 18 percent and median of 14.6 percent.**

Figure 15: Private prepaid plans as a percentage of total health expenditure, 2013



Source: WHO Global Health Expenditure Database: <http://apps.who.int/nha/database/Home/Index/en>

Summary of key findings:

- ◆ While government spending on health, at 13 percent of all government spending, is still below the Abuja target, it shows a strong government commitment to invest in health.
- ◆ Over the last 10 years, government expenditures on health have increased while private expenditures and external resources decreased, indicating improved sustainability for financing Namibia's health care system.
- ◆ Namibia still relies on external resources to finance health care, notably for HIV/AIDS for which over half of funding comes from donors.

4. ANALYSIS/REVIEW OF HEALTH FINANCING ARRANGEMENTS

4.1 Revenue Contribution and Collection Mechanisms

4.1.1 The current health financing arrangements

Per 2012/13 health accounts findings, the main financing sources for health expenditure were public funds (54 percent),⁵ private funds including corporations and households (38 percent), and donor funds (8 percent) (MOH 2015). Within the private funds category, household spending, via OOP payments and contributions to prepaid/insurance plans, amounted to 16 percent of total health expenditure; OOP payments amounted to 11 percent.

This funding is mainly managed by government (44 percent) and medical aid funds and other insurance providers (37 percent), while the remaining funds are managed by households (11 percent), NGOs (6 percent), donors (1 percent), and corporations (1 percent). The sections below investigate in more detail the financing arrangements of the government, the medical aid funds (including private medical aid funds and the Public Service Employee Medical Aid Scheme, or PSEMAS) and other health funds (including the Motor Vehicle Accident (MVA) Fund and SSC Employee Compensation Fund).

4.1.2 Public health sector

Public resources have consistently been the main source of financing for health in Namibia. The percentage of total health expenditure coming from public financing decreased from a high of 64.1 percent in 2002/03 to 44 percent in 2006/07, reflecting a substantial influx of donor funding in the period. Between 2007/08 and 2008/09, donor funding decreased slightly, from 22.4 percent to 21.7 percent; since then, it has fallen more significantly as **Namibia transitions to upper-middle-income country status**, to where in 2012/13 it was only 8 percent. As the proportion of donor financing decreased, the proportion of public financing increased, reaching 53.4 percent in 2008/09 and 53.8 percent in 2012/13. In 2012/13, the main source of MoHSS funding (97 percent) was the central government; most of the funding came from tax-based income. The remaining 3 percent came from donors and development agencies.

Since 2001, government health expenditure as a percentage of total government expenditure has remained relatively consistent, ranging between 11.3 percent in 2006/07 and 14.7 percent in 2007/08. While **Namibia was close to meeting the Abuja target** in 2007/08, the **percentage allocation to health has decreased again slightly in recent years**, to 13 percent in 2012/13.

⁵ Percentage includes expenditure through PSEMAS, as it forms part of the government payroll and is subsidized by the Government of the Republic of Namibia

Table 6 shows the budget estimates for the MoHSS for 2014/15 as allocated to the various directorates/offices.

Table 6: Budget estimates by MoHSS directorate/office, 2013/14-2016/17 (N\$)

Directorate/office	2013/14	2014/15	2015/16	2016/17
Office of the Minister	4,587,000	12,520,000	13,138,000	14,072,000
Human Resources Management	144,016,000	176,987,000	188,156,000	200,880,000
Referral Hospitals	1,290,899,000	1,570,568,000	1,581,921,000	1,962,488,000
Regional Hhealth	3,395,389,000	3,668,358,000	3,546,029,000	4,227,148,000
Primary Health Care	27,034,000	81,406,000	74,112,000	76,061,000
Social Welfare Services	38,311,000	43,881,000	40,384,000	43,027,000
Tertiary Health Care	29,565,000	63,229,000	52,901,000	62,965,000
Policy Planning and Human Resource Development	99,245,000	171,435,000	144,864,000	165,425,000
Finance and Logistics	88,784,000	193,145,000	115,416,000	97,845,000
Special Programs	123,198,000	77,838,000	80,980,000	86,649,000
Atomic Energy	4,470,000	7,436,000	7,958,000	8,514,000
Total	5,245,498,000	6,066,803,000	5,845,859,000	6,945,074,000

Health facilities in Namibia are expected to charge some form of user fees, which were introduced to enhance efficiency by encouraging patients and clients to enter the health services at lower-level facilities, thereby contributing to the decongestion of secondary- and tertiary-level facilities. All user fees collected at the various levels of health facilities are returned to the Treasury; they cannot be retained and used by the MoHSS. The actual revenue collected by the MoHSS for the provision of health services in 2012/13 was N\$44,439,677, approximately 0.48 percent of the total health expenditure. Estimated revenue for 2014/15 is N\$35,700,000, 0.68 percent of the total ministerial budget.

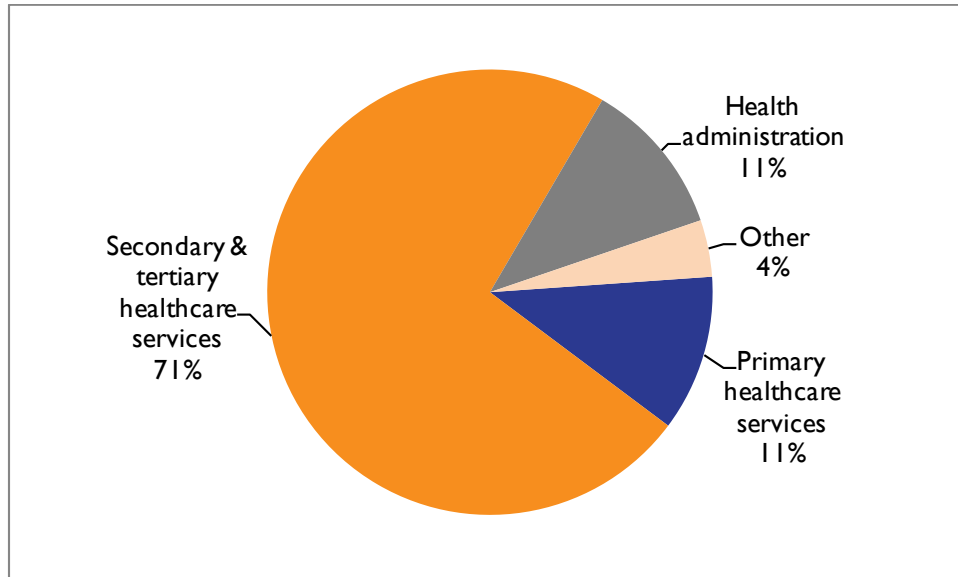
The MoHSS has in place stringent procurement and tender procedures that are closely monitored by its Finance Directorate. All significant purchases need to be completed using the government's tender board; exceptions from tender board procedures must be specifically requested. Furthermore, the Central Medical Stores is responsible for the procurement of all pharmaceuticals and health products with quality assurance requirements and standards in place.

The MoHSS follows a primary health care approach and has developed primary health care guidelines that set out the minimum packages health services to be provided at each level of health facility. The guidelines comprise directions for implementation and selection of primary health care service packages for disease prevention and health promotion, rehabilitation, and curative services that address priority health problems, integrated in a way that makes care accessible at appropriate levels and at affordable cost. The key health intervention initiatives include the following:

- Integrated Sexual and Reproductive Health Care
- Integrated Essential Child Health Care/Integrated Management of Neonatal and Childhood Illnesses (IMNCI)
- Community Based Health and Nutrition Care that include primary eye care, injury and disability prevention, and oral and mental health
- Health Education and Promotion

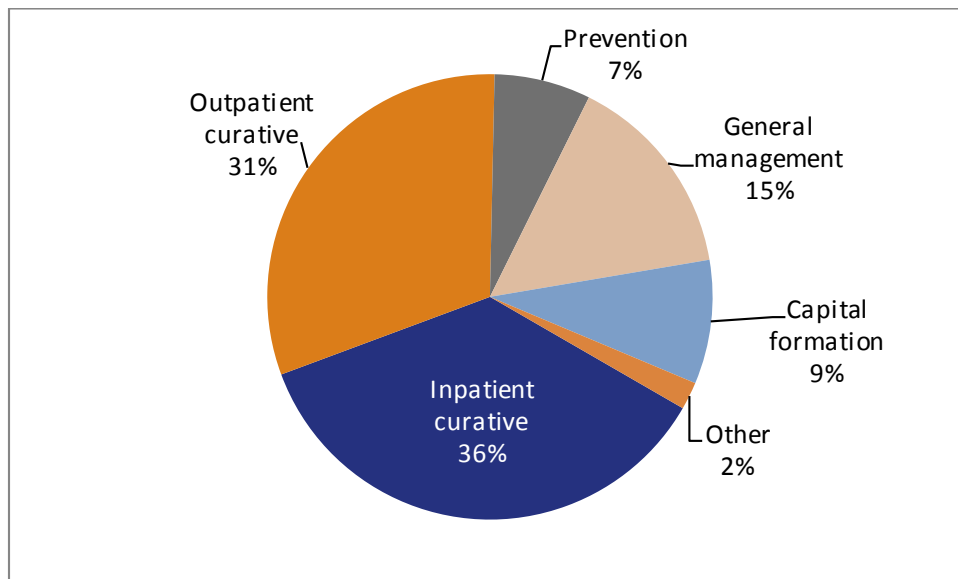
Despite the government's policy to follow a primary health care approach, only 11 percent of total government health expenditure is spent on the provision of primary health care services. As Figure 16 shows, close to three-quarters (71 percent) of government funding for health is spent on secondary and tertiary health services, and 14 percent is spent on administration.

Figure 16: Government health expenditure by level, 2012/13



Further understanding of the breakdown of government health expenditure by service provision is critical. As Figure 17 shows, in 2012/13, **just over two-thirds (67 percent) of government spending went to curative health care services with an approximately equal breakdown between inpatient and outpatient care, 7 percent to prevention**, and 9 percent to capital formation, the long-term investment on items such as buildings, machines, vehicles, and equipment. Health system administration and general management accounted for 15 percent of government spending.

Figure 17: Government health expenditure by service provision, 2012/13



In addition to the health services provided by the public sector as per the minimum package of services, the MoHSS has a special fund available for the treatment of special cases by health services outside of the minimum package or beyond the capacity of the public health care system.

Funds not spent by the MoHSS by the end of the fiscal year are returned to the Ministry of Finance. In 2012/13 unspent funds amounted to N\$202,940,778, equivalent to 2.2 percent of total health expenditure and 4.1 percent of the total government health expenditure. As this shows, a significant portion of funding available for health goes unused due to absorption limitations of the MoHSS. MoHSS directorates/offices responsible for the largest underexpenditures included the Office of the Minister (22 percent of budget), Development Welfare Services (22 percent of budget), Policy Planning and Human Resources Development (16 percent), and Human Resources Management and General Services (13 percent). The main reasons for underexpenditure were delays stemming from recruitment and procurement procedures. Directorates responsible for health service provision showed better absorption rates including referral hospitals (with only 0.6 percent underexpenditure), primary health care services (2 percent), tertiary health care services (7 percent), and special programs (1 percent).

4.2 Fund Pooling Arrangements

4.2.1 Private medical aid funds

Namibia's private health insurance industry is relatively well-established with 10 medical aid funds operating in the country. Medical aid funds in Namibia are regulated by the Medical Aid Funds Act 23 of 1995 and overseen by the NAMFISA. The funds are required to submit quarterly and annual financial reports, which are reviewed by NAMFISA to ensure that the funds are adhering to solvency and liquidity requirements. Furthermore, all products provided by the medical aid funds need to be reviewed and approved by NAMFISA before they can be offered to the public.

Despite this industry being well-established, the total population coverage through these medical aid funds is quite limited compared with international trends of moving toward national health insurance. In 2014, there were 181,378 private medical aid members including dependents and pensioners, and the total membership contributions collected during the same year amounted to N\$2.5 billion (NAMFISA 2015). This is equivalent to approximately N\$13,964 per beneficiary per annum. In addition to the contributions received, the medical aid funds also generated an income from investments of N\$145 million. The information obtained from the NAMFISA annual report of 2015 and from the medical aid funds for the recent health accounts (2012/13) (MoHSS 2015) was unfortunately not consistently split between employer contributions and individual contributions. The health accounts 2012/13 data show that approximately 49 percent of reported contributions were paid by employers, 7 percent was paid by individuals, while the remainder was not specifically allocated, which means that it cannot be determined whether the contributions were paid by employers or individuals. Claims paid out by medical aid funds in 2014 amounted to close to N\$2.2 billion, which is equivalent to 86.7 percent of the medical aid funds' contributions received, and an average claim amounted to N\$12,102.

NAMAF is a juristic body, established by the Medical Aid Funds Act, 1995 (Act 23 of 1995) to control, promote, encourage, and co-ordinate the establishment, development, and functioning of medical aid funds in Namibia. This body is also responsible for registering practice numbers of health care providers to facilitate their claims directly from the medical aid funds. NAMAF brings together health care providers and medical aid funds on an annual basis to determine NAMAF tariffs, which are the guideline amounts that medical aid funds to defray health care costs of members.

That said, as Namibia is a free market economy, health care providers can set their own prices, and a substantial percentage of providers do charge more than the NAMAFA benchmark tariffs. The primary reason for this is the limited pool of private sector health care skills, with many services only provided by visiting specialists or foreign health care providers. When health care providers charge fees higher than the NAMAFA tariffs, the difference is paid by the member out of pocket.

An investigation into the NAMAFA tariffs was initiated in 2011 by the Namibian Competition Commission, since the setting of tariffs that are used as guidance for provider payments for all medical aid funds may be regarded as contravening the principles of fair market competition. The Competition Commission found that there was a clear infringement of section 23 of the Competition Act in that NAMAFA and its member funds had conspired to fix prices. The initial hearing on this matter took place on November 26, 2015 in the High Court in Windhoek and the case is ongoing. The importance and value of the benchmark tariffs was supported by both NAMFISA and the MoHSS in their contributions to the case.

Each medical aid fund offers multiple benefit packages, each targeting different markets and health risk profiles. **Most medical aid funds have introduced low-cost options in an attempt to increase their market size and potential for risk pooling. While most medical aid funds provide for cross-subsidization across their own benefit package options, each fund has its own funding pool.** However, the Financial Institutions and Markets Act, expected to be promulgated in 2016, will require medical aid funds to ensure that each of their medical aid options are financially sound, which implies that cross-subsidization between options will no longer be allowed. The monthly contribution amounts paid by the members are determined by the scope and value of the benefits coverage as well as the age of the members. Most medical aid options manage the claim payouts by imposing overall limits on annual payouts as well as sub-limits on specific services. The limits on specific services can be both in terms of the cost of the services as well as the number of services (e.g., physician consultations limited to 40 consultations and NAD 15,000). Different limits are usually imposed for the principal member and his/her dependents. Policies also vary in the extent to which they cover services beyond hospital care, physicians, and drugs. Limiting or excluding services such as dentistry or opticians lowers the premium.

In addition to the specified maximum claim amounts set out for each condition, special consideration can be given for *ex gratia* claims that are paid out in excess of the maximum claim limits. These *ex gratia* claims are reviewed and approved by the boards of trustees (elected by the members) of the medical aid funds.

All new medical aid fund products are subject to prior approval by NAMFISA, which reviews both the benefits of the plan and the proposed price to assure that the premium is fair and does not endanger the solvency of the fund.

4.2.2 Public Service Employees Medical Aid Scheme

PSEMAS, which covers the public service employees of Namibia, operates on a different financial basis to other medical aid funds: it does not have to adhere to the same solvency requirements since expenditures that exceed the employee contributions are covered by the Treasury. PSEMAS is a voluntary condition of employment arrangement, whereby standard contributions are payable by the public service employees and are deducted from their salaries, while the remainder of the claim expenses are covered by the Ministry of Finance. The total contributions deducted for 2012/13 amounted to N\$ 196 million and the balance covered by government was N\$ 1.112 billion. This implies that **only 15 percent of the total funds required for PSEMAS are paid by employees, while 85 percent is subsidized by the government.** The total claims amount of N\$ 1.307 billion is equivalent to N\$5,681 per beneficiary (based on 230,248 beneficiaries including principal and dependent members).

While PSEMAS has a larger beneficiary base than the combined private medical aid sector, **there is a lack of proper risk pooling: the premiums paid by members are not based on the risk profile of the members or their ability to pay and, as described above, the government provides the additional funds to ensure full coverage of all claims.** The contributions are based on a flat rate regardless of salary level, which makes the contributions highly regressive.

PSEMAS has made different benefit options available to its members. The standard option (N\$ 120/month per main member and N\$60 per dependent) generally provides for private health services, but limits hospitalization to the private wards of the public health facilities unless the required services are not available in a public hospital. The higher benefits option (N\$240/month per main member and N\$ 120 per dependent) provides hospitalization and other health service provision through private providers. Neither option has any overall limits in terms of claims or day-to-day benefits, but sub-limits exist for specific services. PSEMAS uses the NAMAF benchmark tariffs in setting their own tariff structures.

4.2.3 Social Security Commission Employee Compensation Fund

The SSC administers the Employees' Compensation Fund, which is an employees' compensation insurance on a collective liability basis for accidents. The fund pays benefits to an employee injured as a result of an accident arising out of and in the course of his/her employment. Compensation is paid for temporary disablement, permanent disablement (according to the degree of disablement), and death. Reasonable medical expenses are payable for a period of two years, or longer if further medical or surgical treatment might reduce the extent of the disablement.

Every employer who employs one or more employees in Namibia is required to register with the SSC and to pay annual contributions to the Accident Fund. In 2012/13, the SSC generated a total revenue of N\$ 135,671,000 including annual contributions from employers of N\$86,802,000. The fund paid out N\$6,719,331 specifically for the provision of health care benefits, approximately 5 percent of its total revenue.

4.2.4 Motor Vehicle Accident Fund

The MVA Fund is mandated to provide assistance and benefits to all people injured and the dependents of those killed in motor vehicle crashes in accordance with the MVA Fund Act No. 10 of 2007. The fund operates on a non-fault system in which all people injured in motor vehicle crashes, regardless of who caused the crash, receive fair and reasonable benefits (subject to some limitations and exclusions).

The following are the benefits offered by the MVA Fund, in accordance with the MVA Fund Act 10 of 2007:

- **Medical Benefits:** A person involved in a motor vehicle crash is eligible for up to N\$ 1,500,000.00 for medical treatment, injury management, rehabilitation, and life enhancement.
- **Injury Grant:** The cash grant provides to any injured person up to N\$ 100,000.00 as compensation for the injury.
- **Funeral Grant:** The fund provides a funeral benefit up to the value of N\$7,000.00 for any person who dies in a road crash in Namibia.
- **Loss of Income:** Loss of income may be claimed by a survivor of a road crash; this benefit is limited to N\$ 100,000.00, with certain limitations and exclusions.
- **Loss of Support:** Loss of support may be claimed by a dependent of a deceased and is limited to N\$ 100,000.00, with certain limitations and exclusions.

The main source of MVA Fund revenue is the fuel levy system, which was introduced as a compulsory third-party insurance payable by every driver/owner of a motor vehicle when purchasing fuel. The most recent audited financial statements of the MVA Fund for the financial year ending March 31, 2014, show that total revenue of the fund was N\$469,848,174, of which 95 percent was collected from the fuel levy. The total amount paid out in claims in the same financial year was N\$213,339,144, equivalent to approximately 45 percent of total revenue.

It is noted that as a result of the MVA policies and protocols of transporting vehicle accident patients by State ambulance to the nearest public health facility, many private medical aid members do not report vehicle accidents to the MVA in order to be evacuated and hospitalized at private hospitals. In this way, health care costs that should be carried by the MVA Fund are instead being financed by the medical aid funds.

Summary of key findings:

- ◆ The majority of health financing in Namibia is managed through the government, medical aid funds, and other health funds including the SSC Employee Compensation Fund and the MVA Fund.
- ◆ The main source of health financing remains the public sector. Donor resources have decreased significantly over the last five years, in line with the transitioning of donors due to Namibia's upper-middle-income status.
- ◆ Government health expenditure in relation to total government expenditure has remained stable, approaching the Abuja target of 15 percent, but showing a decrease in 2012/13.
- ◆ Despite the MoHSS primary health care approach, only 11 percent of total government health expenditure is spent on primary health care services. The majority of funds are spent on secondary and tertiary health care.
- ◆ Over 67 percent of government health expenditure is spent on curative care and only 7 percent is spent on prevention.
- ◆ Most medical aid funds have introduced low-cost options in an attempt to increase their market size and potential for risk pooling and generally all funds provide for cross-subsidization across the different benefit package options, but each medical aid fund has its own funding pool.
- ◆ With PSEMAS, there is a lack of proper risk pooling as premiums are not based on members' risk profile or ability to pay and government subsidies amount to 85 percent of the total required funds.

5. ANALYZING UHC GOALS AND INTERMEDIATE OBJECTIVES

5.1 Financial Protection and Equity in Finance

A health system should ensure financial protection of the population by funding health services in a manner that protects individuals and households from ‘financial ruin’ or adverse effects on their livelihood as a consequence of paying for health care, typically due to OOP payments. Protecting people from these catastrophic health expenditures is widely accepted as a desirable objective of health policy. Catastrophic health expenditures are not always caused by high health care costs. Even small costs for common illnesses can be financially disastrous for low-income households with no insurance coverage (Xu et al. 2003).

Financial protection for all is a key UHC goal, and a related goal is how equitably health services are financed. Equity in financing the health system refers to the distribution across different socio-economic groups. It is generally accepted that the burden of health financing should be distributed according to an individual’s ability to pay. Therefore, the burden should increase as household income increases.

5.1.1 Financial risk protection for health

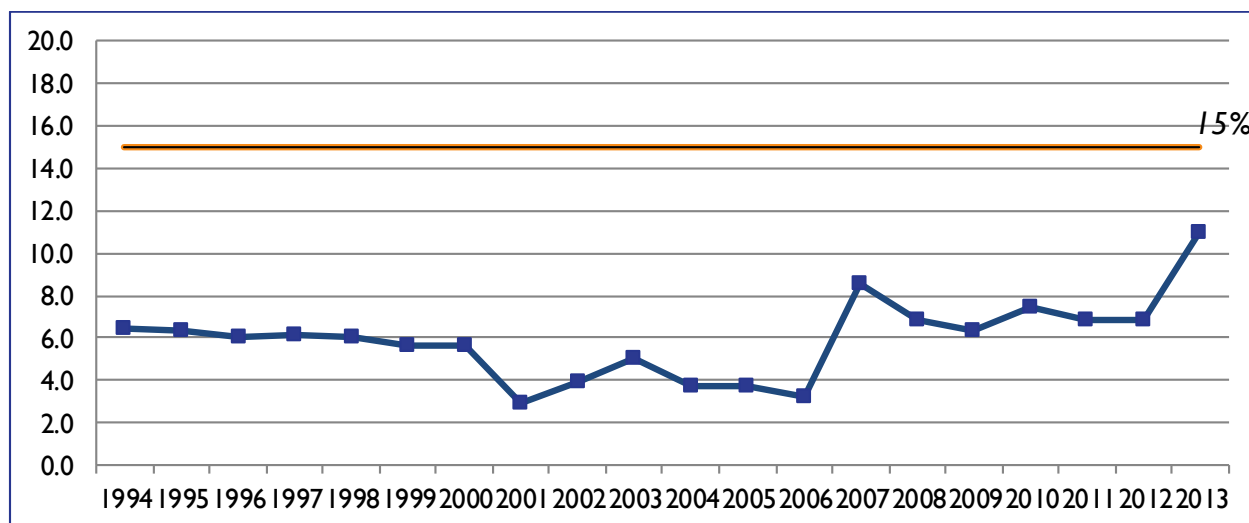
Financial risk protection and access to care are markedly effected by the relative size of public and private health expenditures, notably households’ OOP payments for health. WHO defines OOP expenditure as:

“...direct outlays of households including gratuities and payments in-kind made to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or to the enhancement of the health status of individuals or population groups. These outlays include the payments made to public services, non-profit institutions or non-governmental organizations by households”

(Poullier et al. 2002).

Xu et al. (2010) found it well-documented in the literature that households experience financial catastrophe and impoverishment as a result of OOP spending – there is a positive correlation between a country’s proportion of OOP expenditure relative to total health expenditure and the number of households facing financial catastrophe. As a definition of catastrophic expenditure, the two most commonly used thresholds are expenditure on health care of (1) 10 percent or more of total household expenditure or (2) 40 percent or more of non-food household expenditure (McIntyre 2014a). Using the latter threshold for catastrophic expenditure, Xu et al. (2010) observed that “catastrophic health expenditure and impoverishment remain low in countries where OOP expenditure represent less than 15-20 percent of total national health expenditure.” Figure 18 shows that Namibia’s OOP expenditure has remained well below that 15 percent threshold of total health expenditure. From 1995 to 2013, Namibia’s OOP expenditure as a percentage of total health expenditure ranged from 3 to 11 percent, with an average of 5.9 percent.

Figure 18: Namibia's OOP expenditures as a percentage of total health expenditure, 1995-2013



Source: WHO Global Health Expenditure Database and Namibia NHA Reports from 2007/2008, 2008/2009, and 2012/2013

In a multi-country analysis, Xu et al. (2003) used the 1994 Household Income and Expenditure Survey to conclude that 0.11 percent of households in Namibia faced catastrophic health expenditures. Table 7 shows the proportion of households with catastrophic expenditures for the upper-middle-income countries included in the study. At 0.11, Namibia is on the lower end.

Table 7: Proportion of households with catastrophic health expenditures (%)

Country	%	Year
Brazil	10.27	1996
Azerbaijan	7.15	1995
Colombia	6.26	1997
Argentina	5.77	1996/97
Lebanon	5.17	1999
Peru	3.21	1994
Panama	2.35	1997
Bulgaria	2.00	2000
Jamaica	1.86	1997
Mexico	1.54	1996
Mauritius	1.28	1996/97
Thailand	0.80	1998
Hungary	0.20	1993
Costa Rica	0.12	1992
Namibia	0.11	1994
South Africa	0.03	1995

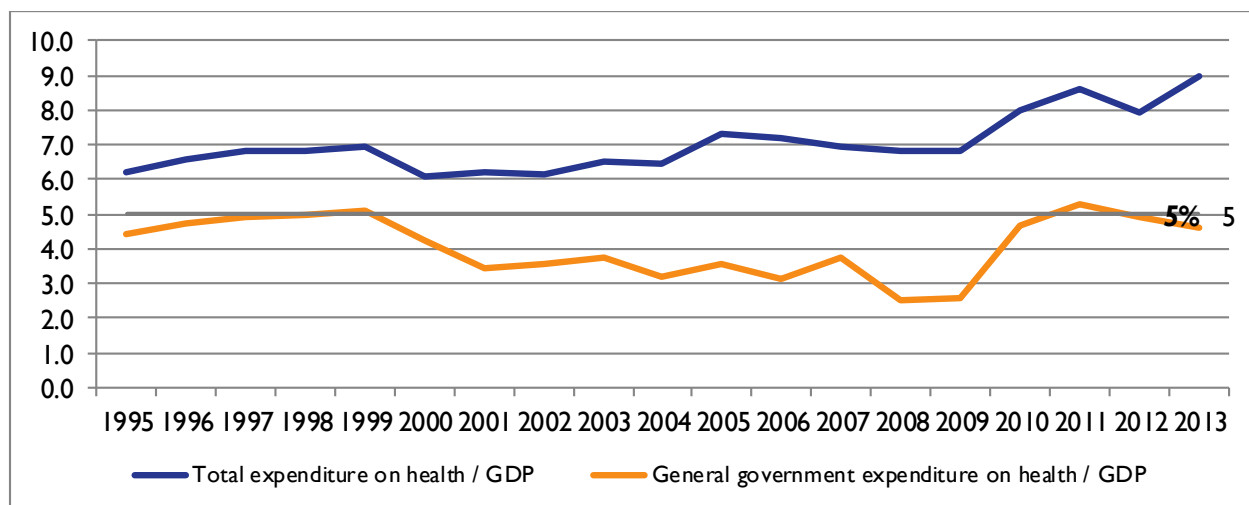
Source: Xu et al. (2003)

Note: "Year" represents the year of the household income and expenditure survey meeting the analysis criteria.

This analysis found that a 1 percent increase in the proportion of OOP expenditure relative to total health expenditure was associated with an average increase of 2.2 percent in the proportion of households facing catastrophic payments (Xu et al. 2003). While this analysis used factors in addition to OOP expenditure to determine the proportion of the population facing catastrophic health expenditure, and because we do not have access to the underlying data used in this analysis, we can use a linear extrapolation⁶ to estimate that Namibia's OOP expenditure as a percentage of total health expenditure was likely around 6.4 percent in 1994. From 1995 to 2006, OOP spending remained below 6.4 percent until a significant increase from 3.2 percent in 2006 to 8.5 percent in 2007. However, a period of steady decline followed this initial spike, and then, in 2013, another spike in OOP expenditure, to 11.0 percent of total health expenditure. If we compare only the initial estimated OOP expenditure of 6.4 percent in 1994 to the 11.0 percent in 2013, this slight increase in OOP expenditure may have contributed to a slight increase in catastrophic health expenditures since the estimate of 0.11 percent in 1994.

As was previously noted, OOP expenditure is not the only notable determinant of catastrophic payments. Other significant variables positively correlated with catastrophic payments are the proportion of the population living below the poverty line – a 1 percent increase in poverty will increase catastrophic payments by 0.2 percent – and the share of total health expenditure in the GDP, an indirect measure of the level of health care access and use – a 1 percent increase in the share of the GDP spent on health will increase catastrophic payment by 1.6 percent. The rationale for this is that as government increases health spending, more individuals will be able to access care, which may then lead to increases in OOP expenditure on user fees, medications, tests, etc. (Xu et al. 2010). Figure 19 shows that total health expenditure as a proportion of GDP has trended upward. In 2013, total health expenditure had increased 2.8 percent to 9.0 percent from 6.2 percent in 1995 with an average annual increase of 0.2 percent. Xu et al. (2010) also found that “when government expenditure on health is greater than 5-6 percent of GDP, fewer households face financial difficulties in paying for health services.” Figure 19 also shows that government expenditure on health only met or slightly exceeded the lower end of the threshold where the incidence of financial catastrophe is estimated to be reduced, 5 percent, in 1998, 1999, 2011, and 2012. Another important determinant of catastrophic health expenditures is the failure of social mechanisms to pool financial risks (Xu et al. 2003).

Figure 19: Namibia's total health expenditure and government expenditure on health as a percentage of GDP, 1995-2013



Source: WHO Global Health Expenditure Database and Namibia NHA Reports from 2007/2008, 2008/2009, and 2012/2013

⁶ Note: The linear extrapolation applied the average change over the values of the five preceding years, 1995-2000, to estimate the 1994 value.

Table 8 shows the available data on poverty in Namibia. The proportion living in poverty has remained close to one-third of the population. Without data on the interim years, it is impossible to definitively conclude that there is an increasing trend; however, the poverty rate remains disconcertingly high in 2011.

Table 8: Proportion of the population living in poverty

Year	%
2001	28.0
2004	27.6
2009	29.0
2011	33.0

Source: 2001: 2001-2003 African Development Bank Country Strategy Paper; 2004: Review of Poverty and Inequity in Namibia. 2008: From the Government of Namibia, National Planning Commission, Central Bureau of Statistics; 2009: World Bank Development Database; 2011: Namibia 2011 Population and Housing Census Preliminary Results cited in "BLC and NANASO Mapping and Capacity Assessment of HIV and AIDS Civil Society Organizations in Namibia."

Slight increases in OOP expenditure and total health expenditure, along with high poverty and government expenditures on health as a percentage of GDP that only barely surpass the 5 percent threshold, signal that the incidence of households with catastrophic health expenditures also has likely increased slightly since the 0.11 percent estimated in 1994. However, even if this occurred, catastrophic health expenditures likely remain relatively low.

5.1.2 Equity in finance

The concept of equitable financing of the health system explores the distribution of health spending rather than the level of health spending. On equity in health finance, Murray et al. (2000), writing for the WHO, state the following:

A health system is fairly financed if the ratio of total health system contribution of each household through all payment mechanisms to that household's capacity to pay (effective non-subsistence income) is identical for all households, independent of the household's health status or use of the health system.

WHO created a measure and an index of fairness in financial contribution to the health system. Underlying its concept of fairness are the following objectives: avoiding catastrophic expenditures for health by households, horizontal equity, and, to some extent, the progressivity of the financial contribution (Murray et al. 2000). Horizontal equity means that households with the same ability to pay will make the same contribution to financing the health system (Wagstaff 1999). Progressive financing is a mechanism whereby higher-income groups contribute a higher percentage of their income to health care payments than do lower-income groups. The progressivity of financing the health system is largely related to the sources of revenue and the structure of funding contributions (McIntyre 2014a). Table 9 includes WHO's fairness of financial contribution index estimates for all upper-middle-income countries in WHO's AFRO region. As the index value approaches 1.0, the fairness of financial contribution to the health system and the equity in financing improves. ***Based on data from 1997, Namibia's fairness of financial contribution index value of 0.915 was on the lower end and surpassed only South Africa with an index value of 0.904. Namibia was 0.02 below the average and median values of 0.93.***

Table 9: Fairness of financial contribution, 1997 estimates

Country	Index Value
Algeria	0.941
Gabon	0.937
Botswana	0.934
Angola	0.928
Mauritius	0.916
Namibia	0.915
South Africa	0.904

Source: WHO (2001)

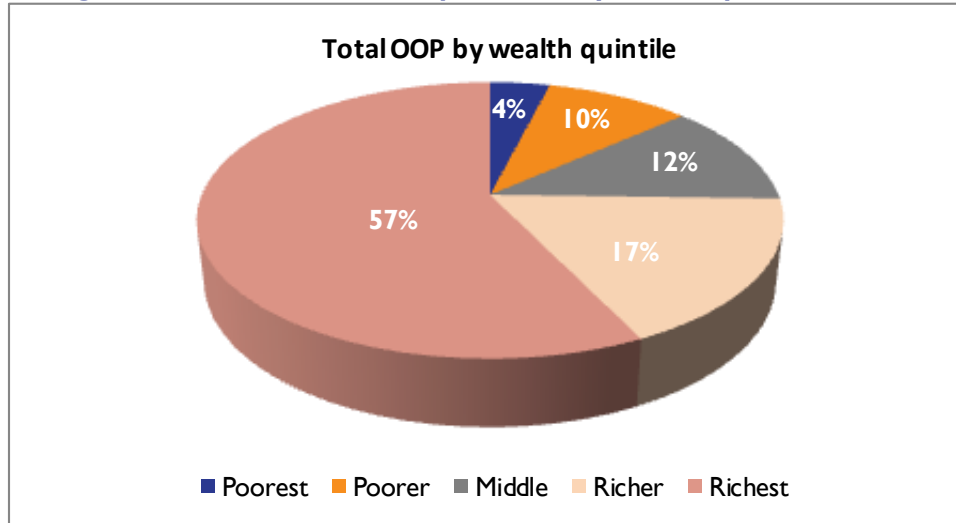
Another measure, the Kakwani index, assesses equity in health finance solely through an analysis of the progressivity of each mechanism used to finance the health system. Findings show that direct taxes are generally progressive while indirect taxes are generally regressive, meaning lower-income groups are contributing a higher percentage of their income to health care payments than higher-income groups. As discussed in Section 2.1 (see Figure 3), Namibia's government revenues rely heavily on indirect taxes, 52 percent of revenue, as compared to direct taxes, 44 percent of revenue. Fifty-six percent of Namibia's indirect tax revenue comes from customs and excise taxes, and 43 percent comes from VAT taxes. In monetary values, direct tax revenue from income, company, and withholding taxes still accounts for almost twice the revenue from VAT taxes.

Application of the Kakwani index also found that OOP expenditure is generally regressive (Murray et al. 2000). As previously noted, Namibia's OOP expenditure as a proportion of total health expenditure is, and has historically been, comparatively low.

Broadly, findings from the Kakwani index indicate that when the health system is predominantly financed by the private contributions – private insurance or OOP expenditure – it is most regressive. When the system is financed by social insurance, whether or not higher-income groups are allowed to opt out determines the progressivity of the insurance program; if they are allowed to opt out, the system is more regressive. Finally, when the system is largely financed through taxation, it is proportional or mildly progressive (Murray et al. 2000). **Namibia's trends over the last 10 years of increasing public and decreasing private funding for health, comparatively low OOP expenditure, and dependence on direct tax revenue over VAT (indirect) tax revenue suggest proportional to progressive financing mechanisms in the health system.**

An analysis of the relationship between OOP expenditure and wealth in Namibia for 2012/13 shows that the majority of OOP expenditures are incurred by the richest quintile with progressively decreasing OOP expenditure toward the poorest quintile. The amount of OOP cost incurred by the richest quintile is more than three times the amount incurred by the richer quintile and more than 14 times the amount incurred by the poorest quintile. While caution should be noted in analyzing this information due to limited sample sizes and outliers in the data, the results indicate that the burden of OOP costs are incurred mainly by the wealthier population, for whom affordability becomes less of a risk.

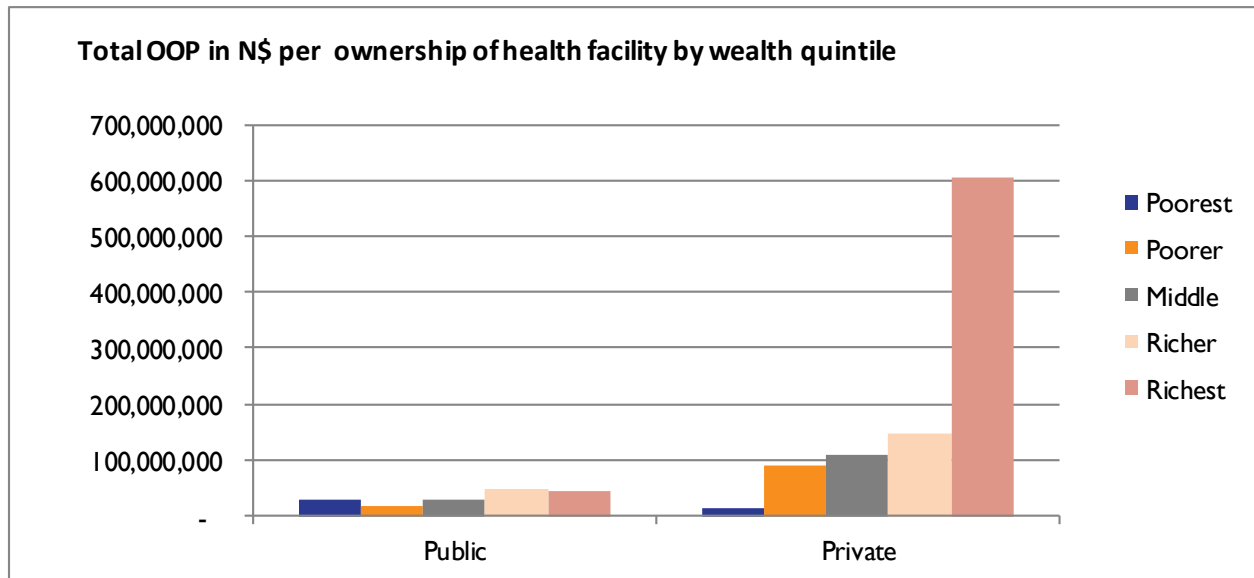
Figure 20: Namibia's OOP expenditure by wealth quintile, 2012/13



Source: WHO Global Health Expenditure Database and Namibia NHA Reports from 2007/2008, 2008/2009, and 2012/2013

The breakdown of OOP expenditure by wealth quintile per ownership of the health facilities providing health services shows that 85 percent of OOP cost is incurred in private health facilities and only 15 percent is incurred in public health facilities. Furthermore, within each wealth quintile, the amount of OOP spending at private facilities exceeds the amount of OOP spent at public facilities, except for the poorest wealth quintile, where the expenditure at public facilities exceeds the expenditure at private facilities. These OOP expenditures were estimated as part of the 2012/13 health accounts based on the results of the Demographic and Health Survey of 2013. While these figures are the best available estimates of the breakdown of the OOP spending by wealth quintile, caution is noted as these estimates were subject to small sample sizes and that may not be representative of the entire population.

Figure 21: Namibia's OOP expenditure by wealth quintile, 2012/13



Source: WHO Global Health Expenditure Database and Namibia NHA Reports from 2007/2008, 2008/2009, and 2012/2013

Gustafsson-Wright et al. (2011) used a unique combination of household survey data and a biomedical survey with HIV test data from the Windhoek area to analyze the extent to which the Namibian public sector protects uninsured households from health shocks. Table 10 shows their findings, based on the 2006 Okambilimbili Survey, on the number of individuals and households insured by quintile. **While only 5 percent of individuals in the poorest quintile are enrolled in medical aid, 70 percent of individuals in the richest quintile have medical aid benefits.** Overall, in the Windhoek area, 47 percent of households have at least one individual with medical insurance. Because this percentage is much larger than individual enrollment rates, enrollment within households is unevenly distributed. The authors did note that having one household member with insurance can be helpful in protecting household against health shocks.

Table 10: Percentage of individual and households enrolled in medical aid, by consumption quintile

Consumption quintile	% of individuals insured	% of households insured
1 (poorest)	5.27	14.29
2	13.61	28.42
3	25.93	40.43
4	44.03	55.31
5 (richest)	69.14	81.31

Source: Gustafsson-Wright et al. (2011)

The primary reason individuals lack health insurance in Namibia is the inability to pay health insurance premiums. Despite the range of insurance options available, including low-cost products with limited coverage, Gustafsson-Wright et al. (2011) found that these are still too expensive for many households and individuals to afford. **The majority of the insured are in the high-income quintile or middle-income and receiving an employee subsidy.**

Gustafsson-Wright et al. (2011) also found that insurance coverage had an effect on health seeking behavior and health care utilization. **The uninsured were more likely to forgo care for acute illness over 20 percent of time compared with 14 percent for the insured – a finding that highlights the inequitable and potentially harmful health consequences for individuals lacking health insurance.**

The uninsured are also disproportionately impacted by OOP health expenditures relative to the insured in the geographical area of this study. While the insured pay more out of pocket in absolute terms, the uninsured pay a higher percentage per capita consumption for both chronic and acute illness (Gustafsson-Wright et al. 2011). Table 11 shows the average percent per capita of annual OOP health expenditure by insured status.

Table 11: Average percent per capita of annual OOP health expenditure, by insured status

Type of illness/care	Insured	Uninsured
Chronic	2.72	3.95
Acute	3.48	7.78
Hospitalization	3.05	1.82

Source: Gustafsson-Wright et al. (2011)

Table 12 shows the percentage of per capita income spent on chronic and acute care and hospitalization for the uninsured by quintile. The findings of Gustafsson-Wright et al. (2011) also indicate that **uninsured individuals in the lower three quintiles spend up to 14 percent of their per capita income on acute illness**. Individuals in the highest income quintile spend the most on hospitalization. The authors note that this is most likely due to either the choice or ability to pay for expensive procedures or better knowledge of health.

Table 12: Percent of per capita spent on care for the uninsured, by consumption quintile

Consumption quintile	Chronic	Acute	Hospitalization
1 (poorest)	5.36	11.11	1.90
2	4.30	13.88	0.94
3	3.93	8.18	3.52
4	5.63	4.90	0.91
5 (richest)	1.93	7.19	6.73

Source: Gustafsson-Wright et al. (2011)

From this analysis, we understand that **individuals in the lower quintiles are less likely to be insured. While the uninsured are less likely to seek care, when they do seek care, typically for chronic or acute illnesses, they are disproportionately impacted by OOP expenditures. The finding that uninsured individuals in the lower three quintiles are spending 14 percent of their per capita income on acute illness is significant as it reduces the income available to spend on other basic needs.**

For health services within the public sector, the MoHSS has made provision for the equity and financial protection of the poor within its regulations on user fees, whereby no person shall be refused treatment on the basis that he/she is unable to pay the user fees. Furthermore, there are specific user fee exemptions for the treatment of communicable diseases and other key conditions, for pensioners and persons with disabilities, and for orphans and vulnerable children. Through these provisions, the poor are to some extent protected from experiencing catastrophic health expenditures and therefore improved equitable access to health care services is achieved.

5.2 Health Service Quality

The 2013 Presidential Commission Inquiry described the quality of patient care in public health facilities as below acceptable standards (Government of the Republic of Namibia 2013). Indications of poor quality of patient care cited in the report include overcrowding at outpatient departments, long waiting times, inadequate numbers of health professionals, inadequate equipment and supplies, and poor infrastructure.

Among key health indicators, Namibia performs more poorly than the average for all upper-middle-income countries in WHO's AFRO region on life expectancy, health-adjusted life expectancy, and HIV prevalence. However, Namibia performs better than the average on maternal and under-five mortality. The table in Annex A shows Namibia's performance alongside that of all upper-middle-income countries in WHO's AFRO region across a few key health indicators. With a life expectancy of 62 years, Namibia falls below the average (65 years), but is on par with the median (62 years). Similarly, with a health-adjusted life expectancy of 53 years, Namibia again falls below the regional average (56 years). Namibia's HIV prevalence of 14.3 percent in 2013 is the third highest among these countries, surpassed only by South Africa (19.1 percent) and Botswana (21.9 percent).

Namibia performs better on maternal and under-five mortality. Its under-five mortality rate of 40 deaths per 1,000 births is below the median (48 deaths) for the countries. Similarly, Namibia's maternal mortality ratio of 130 deaths per 100,000 births is below the average (181 deaths) and median (140 deaths) among the countries.

“...In most health facilities, the ratio of health professionals to patients per day is so low that provision of good quality patient care is almost impossible” (Government of the Republic of Namibia 2013). Application of the WHO’s Workload Indicators of Staffing Need (WISN) in Namibia in 2013 revealed significant shortages and inequities in the distribution of human resources for health in the public sector. While the shortages were most profound for doctors and pharmacists, there was a sufficient number of nurses; however, they are inequitably distributed across the facility types with hospitals more likely to have the number of nurses needed and sometimes more. Hospitals have only one-third of the doctors required based on workload, and there are no doctors at health centers or clinics. Health centers have 85 percent and clinics have only 77 percent of the nurses required (McQuide et al. 2013). Even as the supply of nurses exceeds that of doctors and pharmacists, nurses are often performing non-nurse duties to compensate for the shortages of other cadres, thereby increasing their workload and reducing their time available to attend to patients (Government of the Republic of Namibia 2013).

The quality of patient care will be affected by findings of inadequate equipment and supplies. The 2013 Presidential Commission of Inquiry noted:

“...There is generally inadequate supply or total absence of essential life support equipment like ECG monitors, blood-gas machines, glucometers, defibrillators, incubators, cardiocograph, suction machines, blood pressure machines, and incubators in facilities that should have them.”

In some cases, district hospitals were found not to have functioning essential equipment in areas such as operating theaters, casualty departments, and maternity wards. Some district hospitals are unable to provide Comprehensive Emergency Obstetric Care due to unavailability of essential equipment. Some ambulances were not adequately equipped with the necessary life support equipment. Further compounding the problem, when the equipment was available, it was often found to be inadequate or not functioning properly. The public health sector’s current system for maintaining available equipment and replacing obsolete equipment was found to be unable to keep up with demand (Government of the Republic of Namibia 2013).

Findings suggest an adequate distribution of medicines and vaccines in public health facilities.

“To achieve its aims, a health system should ensure equitable access to essential medical products, vaccines and technology or assured quality, safety, efficacy and cost-effectiveness and their sound and cost-effective use.”

While there were occasional reports of stock-outs, most facilities maintained above 90 percent of the essential medicines and vaccines included in the Namibian Essential Medicines List, or NemList. However, the NemList does not provide for all essential medicines and vaccines at *all* facility levels. Only certain medications, and the authorization to prescribe, are allowed at the clinic, health center, and district hospital levels. It should also be noted that misoprostol, a drug commonly used worldwide and in Namibia’s private sector to prevent and treat post-partum hemorrhage, is not on NemList (Government of the Republic of Namibia 2013).

5.3 Equity in Service Use and in the Distribution of Resources

“Namibia’s vast distances and relatively low population densities create considerable challenges for MoHSS efforts to balance health care equity, efficiency and quality” (McQuide et al. 2013). Concerns have been expressed about the allocations of health resources across the different regions of Namibia and whether the distribution of the health infrastructure and health spending is appropriately aligned with the needs of the population. A 2012 paper on the need for a resource allocation formula by the MoHSS indicated that there are significant differences in per capita budgetary allocations between regions, even after taking into account the percentage of services provided by referral hospitals as part of the region-specific health services. While a comparison of the per capita allocations with the needs based on poverty incidence did not show a clear trend, there is some evidence that Namibia does not seem to conform to the so-called “inverse care law” under which regions with the greatest needs tend to receive the least resources (MoHSS 2012). Further comparisons of the resource inputs to the health outputs show that there is no direct relationship between the two, which can either be attributed to the fact that resources are not appropriately allocated according to health needs or to issues of inefficiencies in specific regions. While the MoHSS produced the paper on the need for the introduction of a resource allocation formula based on factors including population size, burden of disease, poverty and cost differences, no final policy decision has been made on this matter.

The 2011 analysis of staffing in public health facilities found significant disparities between and within regions. A ranking of nurse staffing shortages in health centers by region found Ohangwena, Omusati, Otjozondjupa, Caprivi, and Khomas lacking the number of nurses needed to deliver quality health services. Similarly, a ranking of nurse staff shortages in clinics found Ohangwena, Omusati, Kavango, Kunene, Oshikoto, Omaheke, and Oshana lacking sufficient staff. In contrast, while Otjozondjupa and Caprivi lacked sufficient staffing in health centers, their clinic staffing was adequate (McQuide et al. 2013). Inequities in maternal health outcomes and access to maternal health interventions is of great concern in Namibia as its maternal mortality ratio increased from 271 per 100,000 live births in the period 1991-2000 to 449 per 100,000 live births in the period 1998-2007. This increase was seen despite increasing coverage of good maternal health interventions such as antenatal care and delivery by skilled health workers. A 2010 study by Zere et al. examined the socio-economic inequalities in access to maternal health services. The study found regional differences in the use of skilled providers during delivery. Kavango, Kunene, and Ohangwena ranked far below the national average on this indicator. Four other regions also ranked below the average and only six of 13 regions at or above the national average. The study concluded that the regions with a greater need for scarce maternal health resources are not appropriately targeted through the current methods of resource allocation. It recommended that all efforts and interventions should be focused on those regions with the greatest need in terms of access to maternal health interventions.

Zere et al. (2010) also found that the regions with the lowest coverage of maternal health interventions were also scoring lowest on the human development index, a composite indicator measuring income per capita, life expectancy at birth, adult literacy, and gross school enrollment ratio. Inequities in the use and access to maternal health interventions, like many health services, can be explained by both demand and supply side factors: (i) delay in deciding to seek care; (ii) delay in getting to the facility; and (iii) delay in getting the appropriate care once at the facility. The first two are demand-side barriers, largely influenced by the level of the mother’s education, household income levels, and poverty. Therefore, it is not surprising that improvements in health outcomes and equity require a multi-sectoral approach to address all of the social determinants of health such as poverty and educational attainment.

Namibia's MoHSS considers equity fundamental in its allocation of health care resources, and the country's Poverty Reduction Strategy reaffirms its commitment to reducing disparities in health expenditure across regions by developing an appropriate resource allocation formula. However, significant progress has not been made on this front and resources continue to be allocated on the basis of historical budget allocations leaving historically disadvantaged regions with a higher disease burden with an inequitably small share of the resources for health. Similar to what was recommended by Zere et al. (2010), an earlier (2007) Zere et al. study sought to provide evidence on how an improved resource allocation methodology to target health resources to where there is the greatest need could contribute to improvements in health among traditionally disadvantaged populations. The study reaffirmed that the current mode of distributing health resources has only perpetuated past inequities between regions. "The regions with more need for health care currently get a lower share of the public sector resources, while those with relatively less need are allocated a greater share of resources" (Zere et al. 2007).

5.4 Health System Efficiency

Resources for health are limited in any country; therefore the efficient use of resources is critical in moving toward universal health coverage. Essentially, providing a health service with the minimum level of resources required, without compromising quality, allows the health system to provide more services for more people with greater cost coverage (McIntyre 2014a). *The World Health Report 2010* (WHO 2010b) identified 10 leading sources of inefficiency in the health system. These include: **Medicines**, (i) underuse of generics and high prices, (ii) use of substandard medicines, (iii) inappropriate and ineffective use; **Health care products and services**, (iv) overuse or supply; **Health workers**, (v) inappropriate staff mix; **Health care services**, (vi) inappropriate hospital admissions and length of stay, (vii) inappropriate hospital size, (viii) medical errors and suboptimal quality of care; **Health system leakages**, (ix) waste, corruption, and fraud; and **Health interventions**, (x) inefficient or inappropriate strategies.

Identifying and measuring inefficiencies is a large and complex undertaking, but we identified several studies of the Namibian health system's efficiency. Another study is proposed under the UHCAN to review the performance of the Namibia health system within the public and private sectors.

5.4.1 Public health sector

Expenditures in Namibia echo the findings for sub-Saharan Africa as a whole in which the greatest proportion of total health expenditure, 45 to 69 percent of government health expenditure, is absorbed by hospitals. Therefore, understanding the efficiency of the country's hospitals is critical to reducing the waste of scarce health system resources, and evidence suggests a wide prevalence of technical inefficiency in hospitals and other health facilities in Africa. A 2006 study assessed the technical efficiency of Namibia's 30 district hospitals and quantified the potential efficiency gains. The study measured technical efficiency from both an input and output orientation. Output-oriented technical efficiency seeks to maximize outputs with the inputs available while input-oriented efficiency seeks to minimize inputs without changing the quantity of outputs produced. Using data envelope analysis, the study model used three inputs (total recurrent expenditure, beds, and nursing staff) and two outputs (total outpatient visits and inpatient days) (Zere et al. 2006).

The results of the study indicate that **many of the district hospitals operate at technical efficiency levels well below the efficient frontier**. The study found inefficiencies due to pure technical inefficiency and inappropriate hospital size (e.g., hospitals are too large) leading to inefficiencies of scale. The inefficiency levels observed in the study ranged from 26 to 37 percent meaning that **if the inefficient hospitals were to operate more efficiently, the health system could reduce the total resources for hospitals by an estimated 26 to 37 percent**. For the inefficiency of scale, an increasing return to scale would be achieved if output increased by a greater proportion than the increase in inputs. However, this is not happening in district hospitals in Namibia because increasing outputs would require an increase in demand for health

services at the hospitals. The study concluded that improving the efficiency of hospitals could go a long way to addressing inequities in the health system and/or improving the quality of the available health care. For example, the efficiency savings that could have been realized in 2000/01 equal the amount needed to construct 50 clinics (Zere et al. 2006).

Another means of examining efficiency in the health system is determining whether patients are treated at the appropriate level. If patients bypass the referral system, for example going directly to the hospital for care, patients are treated at higher cost than necessary and higher-level systems become over-burdened by the workload and lower level, less costly, facilities become underutilized. It was estimated that in developing countries, government hospital expenditures could be reduced by 10 percent if just 33 percent of patients were shifted from upper to lower-level hospitals. Low et al. (2001) conducted a study of Namibia's referral system to understand the extent to which designated secondary hospitals were being bypassed both by health workers making referrals and by patients self-referring. **The study found that intermediate hospitals are being used heavily as district facilities by patients within their local districts as a first point of contact with the health system or first referral point. It also found that first-level referral hospitals are often used as the initial point of contact with the health system. Several district hospitals refer directly to Windhoek Central rather than their appropriate intermediate hospitals** (Low et al. 2001).

A 2014 comparative study of models analyzing the efficiency of health systems in sub-Saharan African estimated efficiency using infant survival rate as the output variable and per-capita health expenditure as the input variable. Other indirect input variables include HIV/AIDS, education, and per capita gross domestic product. The study used data from the World Bank World Development Indicators from 1995 to 2011 across 45 countries. Table 13 shows the preferred true random effect model's results for the available upper-middle-income countries in the AFRO region. The table shows both the estimated mean efficiency score and the country rank across all 45 countries (Novignon and Lawanson 2014).

Table 13: Rank and estimated mean efficiency score, 2005-2011

Country	Estimated Mean Efficiency Score	Overall Efficiency Ranking
Mauritius	0.9993186	1
Botswana	0.999087	3
Namibia	0.9985626	8
South Africa	0.9894383	17
Gabon	0.7547606	27
Angola	0.3128233	42

Source: Novignon and Lawanson (2014)

A higher mean efficiency score represents greater efficiency. The mean efficiency score across the sub-Saharan countries included in the study was .80 representing 80 percent efficiency and 20 percent wastage. **Namibia's relatively high score represents one of the better performing health systems, significantly better than the majority of sub-Saharan Africa, with regards to efficiency** using this method of measurement (Novignon and Lawanson 2014).

5.4.2 Private health sector

There are concerns about escalating costs of health care in the private sector. The 2012/13 health accounts results show that approximately 37 percent of total health expenditures were paid by medical aid funds, while in 2008/09 this figure was approximately 28 percent. Conversely, the percentage of the population covered by health insurance increased only by approximately 1 percent over the same five-year period. Currently very limited documented evidence exists on the cost drivers and efficiencies within private sector, and the UHCAN has commissioned a unit cost study that is to review the unit costs of specified services as well as the quality of services provided at different levels of health facilities both in the private and public sectors. This study is expected to provide insight into whether quality of health services is the key cost driver within the private health sector in Namibia.

While no comprehensive studies have been performed on the cost-effectiveness of the Namibian private health sector and the specific reasons for the escalating costs are not known, there are many hypotheses for these increasing costs such as over-servicing, waste, and absence of outcome measurement. Within the private health sector, the private providers generally do not compete on price, since, in an environment where most medical expenses are covered by a third-party payer (medical aid funds), patients are not likely to choose a service provider based on cost as they do not have to pay the bill themselves. As a result, there is very little incentive for health care providers to lower fees to compete with others. This lack of price competition in the absence of appropriate regulation or tariff setting is a factor in explaining escalating costs (Edmeston and Francis).

Furthermore, there may also be issues of over-servicing, which means that health services are provided to patients over and above what is truly required. This issue can be caused from both a supply and a demand side. From a supply-side perspective, the health service providers often recommend additional tests and treatment that may not be necessary. For example, the C-section rate in private hospitals in Namibia is above 78 percent while WHO recommends a C-section rate of 10 percent. Various arguments have been raised against the hypothesis that the high C-section rate in the Namibian private sector is mostly being driven by the providers' financial motivations, but instead that it is a direct result of the scarcity of qualified obstetricians in the industry. The scarcity of qualified health care providers has been noted as a major issue in Namibia for a number of years, and it may be considered as a reason for providers preferring C-sections as they are generally a shorter procedure than a natural delivery and they simply do not have the time to attend the lengthier natural births.

From the demand side, concerns have often been noted in terms of the high demand for specialist services. For example, many patients go to pediatricians for routine infant and child monitoring, which are services that can easily be handled at lower levels of the health system. This problem can also be related to the lack of a proper referral system within the private sector as there is often no need for referrals to access specialist services.

The model applied in the private health care sector in Namibia is a further challenge that leads to significant inefficiencies as it does not implement a primary health care approach. In contrast to the WHO model, there are very limited primary health care providers and instead GPs or even specialists tend to be the first point of consultation, even for minor illnesses and regular check-ups. This results in high service-delivery costs, which in turn increases medical aid fund contributions and makes them unaffordable to a large portion of the population.

Summary of key findings:

- ◆ Namibia's OOP spending on health has consistently been low, which means there is a limited risk of catastrophic health expenditures despite increases in poverty and relatively low government expenditures on health.
- ◆ Namibia's health financing mechanisms are proportional to progressive given increases in public and decreases in private funding for health, the comparatively low OOP expenditure, and dependence on direct tax revenue over VAT.
- ◆ Medical aid enrollment is low nationally and is highest among the richest quintile. Poor quintiles are less likely to be insured and less likely to seek care, particularly for chronic or acute illnesses.
- ◆ Namibia performs more poorly than average on key health indicators, implying poor-quality health services.
- ◆ Health resources in public sector are not equitably distributed across and within regions.
- ◆ While the Namibia health system as a whole is more efficient than its peers, there are opportunities to improve efficiency and maximize the use of resources, specifically in hospitals, which absorb a significant portion of government health expenditures.
- ◆ Increasing costs in the private health sector are indicative of potential prevailing private sector inefficiencies, which need to be further investigated to assess their nature and causes.

6. DISCUSSION AND CONCLUSIONS

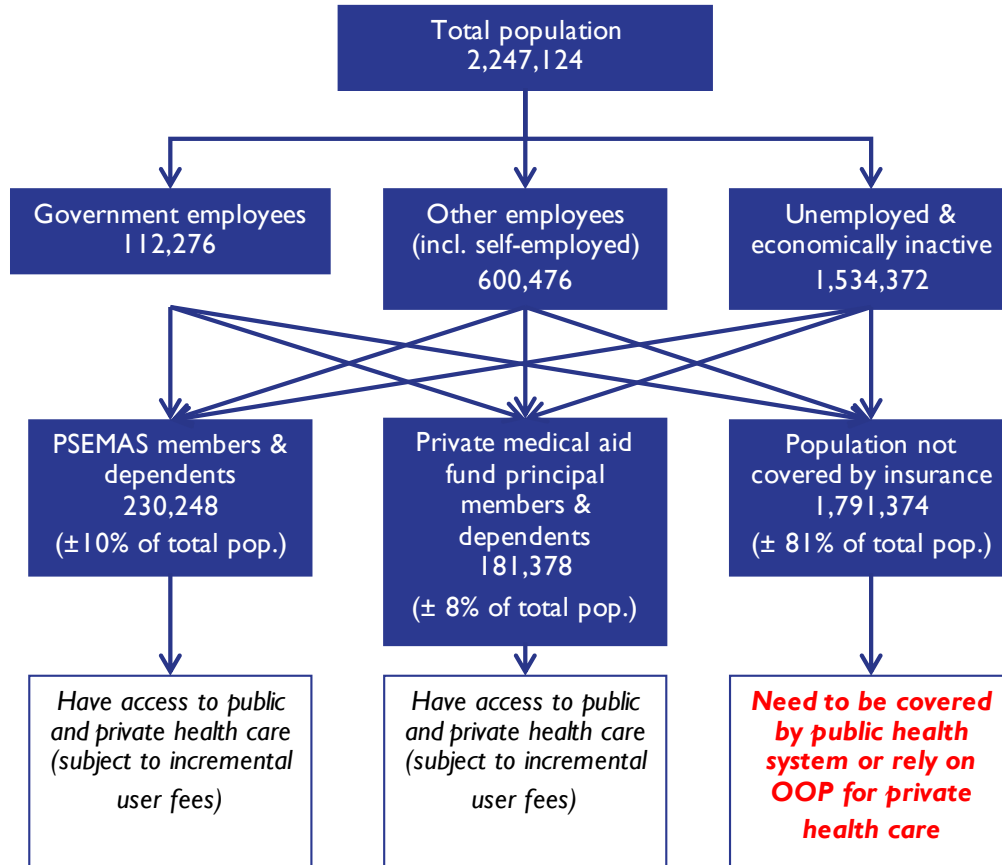
6.1 Namibia's UHC status

In creating UHCAN, Namibia has shown strong political commitment to expand health services and develop a health system guided by the principles of universality, equity, quality, and efficiency. The achievement of these goals relies on stable economic growth over the next decade. Namibia's political commitment, social stability, and economic growth create an environment conducive to improving the functioning of the health system, improving the quality of care, improving efficiency, and reducing inequalities in the provision of services. The government is fully committed to reducing inequalities in the access and delivery of health services.

Despite the government's strong commitment, there remain challenges in terms of ensuring equity in access, adequate health benefits coverage, as well as financial protection particularly for the poor. Figure 22 illustrates how the Namibian population is currently covered in terms of health services. Namibia has a total population estimated at approximately 2.25 million, of which 112,276 are employed by the Government of the Republic of Namibia (Government of the Republic of Namibia 2015) and are thus entitled to health benefits through PSEMAS. It is noted that while enrollment in PSEMAS is voluntary, approximately 92 percent of government employees are enrolled as principal members (MoHSS 2015). The 2014 Labour Force Survey (Namibia Statistical Agency 2015) estimates that approximately 1.53 million people in Namibia are either unemployed, economically inactive, or below the age of 15, leaving 600,476 persons who are employed outside of the public sector. Even within the employed population, affordability of private medical aid is an issue, resulting in only 76,522 principal members and a total of 181,378 persons including dependents being covered by private medical aid funds. There may be some coverage across the categories whereby, for example, non-government employees or the unemployed and economically inactive are covered through PSEMAS as dependents, or the economically inactive may still be able to afford private medical aid. For example, there were 6,769 pensioners covered by private medical aid funds in 2014, who no longer form part of the employed population but are still covered by the benefits.

Figure 22 highlights one of the greatest challenges of the health system, which is its fragmentation and differences in health coverage between those who are covered by PSEMAS, those who can afford private medical aid, and those who have neither. Specifically, an estimated total population of 1.79 million or approximately 81 percent of the Namibian population remains uncovered by a medical aid fund and thus is reliant on either the public health system for access to health services or must pay out of pocket for private health care. As a result, the distribution of health resources among the population is largely unequal. Annual health spending for approximately 81 percent of the population without medical aid coverage is US\$209.00 per person, while it is more than three times greater for those with medical aid at US\$700.00 per person. Similarly, the 2012/13 health accounts show that approximately 44 percent of total health expenditure is used to provide health services to 19 percent of the population, while the remaining 56 percent of total health expenditure must cover the remaining 81 percent. As such, within the sphere of health financing, the major UHC principles Namibia needs to work on are equity and financial risk protection.

Figure 22: Namibia's UHC situation



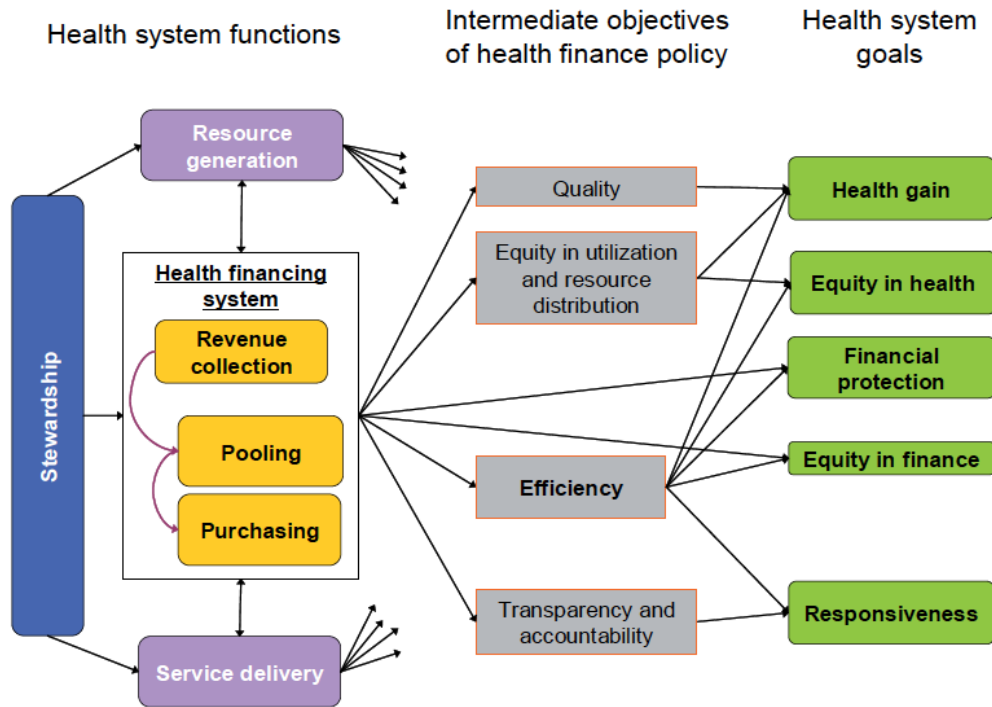
As discussed in Section 4.2, each of the private medical aid funds, PSEMAS, and the public health service offer different benefit packages to their members. For the private medical aid funds and PSEMAS, the options with higher premiums offer a greater range and value of benefits coverage. The MoHSS follows a primary health care approach using primary health care guidelines that set out the minimum packages health services to be provided at each level of health facility. Referrals to higher-level facilities are required to access additional services and user fees at these facilities are generally higher to ensure adherence to the referral system.

Further contributing to the fragmentation of the health system is the fact that the prepaid financing mechanisms, including medical aid funds and PSEMAS, are overseen by institutions external to the MoHSS, NAMFISA, and the Ministry of Finance, respectively, which makes the coordination, management, and oversight of the health system as a whole even more complex.

6.2 Decisions on the Health System Design for the Achievement of UHC

While the public and private health sectors in Namibia are well-established and some progress has been made on the establishment of the NMBF, the Government of Namibia, with the advice of UHCAN, still needs to make a final decision on the ultimate structure of the health system, financing mechanisms, pooling of funds, purchasing mechanisms, as well as the population coverage and benefits package. These decisions should aim to achieve the intermediate objectives of health finance policy and the ultimate health system goals as outlined in Figure 23.

Figure 23: Health Financing System Framework



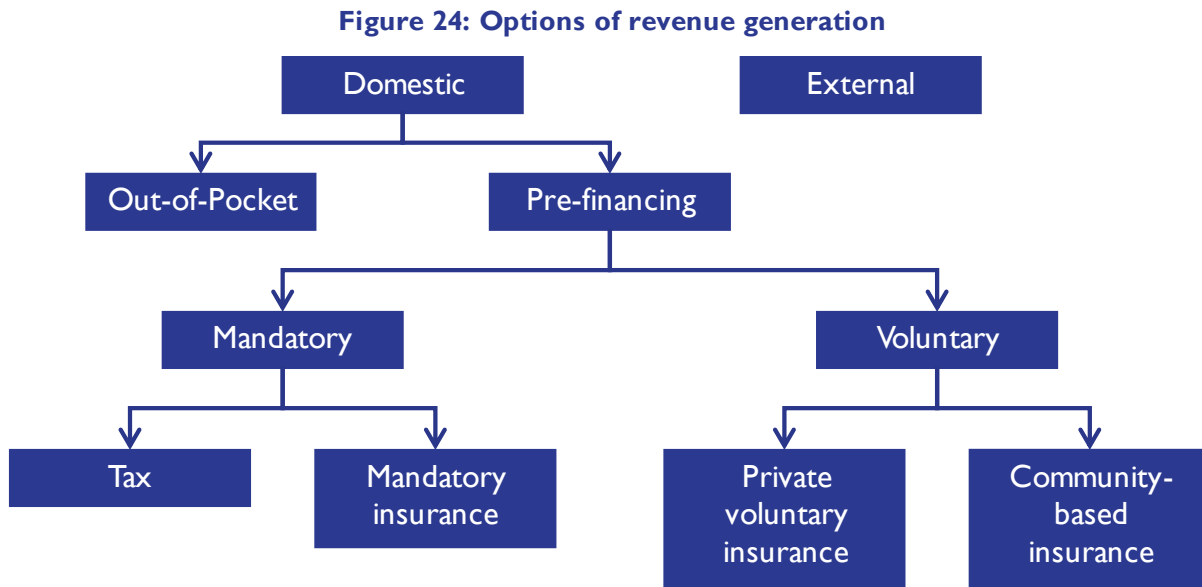
Source: WHO (20010a)

Therefore, the above objectives of the health financing policy and goals of the overall health system should be used as key guiding factors and criteria for decision making on the revised health financing system that will lead Namibia to the achievement of UHC. The UHCAN will need to prioritize the various objectives and goals in order to determine their respective weightings in the development of evaluation criteria.

6.2.1 Health financing decisions

6.2.1.1 Revenue collection

Various models of health financing have been adopted by other countries to achieve the goal of UHC, specifically to improve financial risk protection, while also expanding health services and population coverage. In order to expand health services and population coverage, while limiting the financial burden on the population, additional revenue needs to be generated for health. Figure 24 illustrates the options of revenue generation.



In order to ensure the sustainability of revenue for health and to achieve the goal of financial risk protection, the WHO recommends that health care financing is secured through mandatory prepayment schemes, which implies either a mandatory health insurance system or government spending through taxation.

Mandatory health insurance

As discussed in Section 2.2, provision has already been made for the establishment of a mandatory health insurance fund in the form of the SSC's National Medical Benefits Fund, which is envisioned to serve as social health insurance providing medical benefits to employees. Currently, the SSC has finalized the actuarial analyses, projections, and costing of the benefits package, and recommendations have been submitted to the Ministry of Labour for consideration. The final model of the fund will need to be approved by Cabinet before implementation can commence.

The SSC currently has 602,983 employees registered under the MSD Fund. Assuming that all of these employees would also be eligible for registration under the NMBF and persons already covered through PSEMAS (230,248) or a private medical aid fund (181,378) would be exempted, the minimum number of persons to be potentially enrolled under the NMBF would be 191,357. This number is likely to be higher, since not all persons covered by PSEMAS or private medical aid funds are employed or registered with the SSC. Applying this logic, the number of persons receiving exemptions due to alternate coverage can already be reduced by 6,769 for the number of pensioners, because they are not part of the working population registered with the SSC. As such, the total number of potential NMBF enrolled persons can be increased to at least 198,126.

Assuming that the NMBF will be established, the challenge in terms of UHC therefore is to effectively provide health benefits to the population that remains uncovered by pre-paid health insurance or medical aid, even after the introduction of the NMBF. In terms of the WHO recommendation for sustainable health financing sources, the remaining population should be covered either through an expansion of the mandatory NMBF or through government spending raised from taxation. Currently the MoHSS is mandated to provide health benefits to this sizeable population, primarily through financing from taxation.

Mechanisms to ensure that the informal sector can contribute to the NMBF would substantially increase the membership and result in greater benefits of risk pooling; however, revenue collection mechanisms are likely to be difficult to implement. It is worth exploring the financial and other implications of whether the informal sector, near-poor, low-income populations, and groups living in economically disadvantaged areas could contribute to a prepayment insurance mechanism. The level of private household contributions and government subsidies could complement the premium and pay for a guaranteed package of services.

The aim of mandatory health insurance would be to improve equity and financial risk protection and thus it is important to ensure that the health insurance mechanism is progressive rather than regressive so that the health insurance contributions do not become a further burden to the poor. As such, the contributions should be based on the individual's ability to pay rather than other factors, such as age or health risk as used by the private medical aids in Namibia. Mandatory health insurance contributions are generally based on a person's salary income, which means that this mechanism of health financing is often less progressive than taxation as it only considers salary income rather than total income. In order to ensure that the mandatory health insurance is progressive, it is important to ensure that the insurance is fully mandatory and that nobody can opt out, particularly the rich. Furthermore, there should not be a maximum amount payable, but instead it should be based on a percentage of income only. To further ensure the progressivity of the fund, lower percentages could be charged for lower-income groups while higher percentages are charged for the richer population. The implications of introducing the NMBF need to be fully analyzed and considered in terms of affordability, effect of introducing additional taxation on the economy and employment levels, impact on the health system and its capacity to supply health services, implications and continued affordability of medical aid funds, and roles of private health care providers.

Government taxation

In order to effectively reduce the inequalities in resources between the public and private sectors, there is a need to generate more resources for public health services and ensuring the effective use of these resources. Therefore, the UHCAN in collaboration with the MoHSS and the Ministry of Finance should explore options of resource mobilization to improve equity in health, quality of health services, and financial protection of the poor. The emphasis should be on increasing revenue through the most progressive means possible, since the purpose of raising government spending for health is to meet human rights obligations, which would be defeated if that spending were funded by increasing the relative tax burden of those who are meant to benefit (McIntyre 2014a).

In evaluating taxation options as sources of revenue for health, the following criteria should be considered:

- Revenue adequacy and stability: the tax should raise a significant amount of revenue, be relatively stable, and be likely to grow over time.
- Efficiency: the tax should minimize economic distortions.
- Equity: the tax should treat different income groups fairly.
- Ease of collection: the tax should be simple to administer.
- Political acceptability: there should be transparency, broad diffusion, and clarity about the uses of the tax to promote acceptability (IMF and World Bank 2005).

The *World Health Report 2010: Health Systems Financing* (WHO 2010b) highlights three key approaches to increasing resources for health domestically. These include:

1. Increase the efficiency of revenue collection. Even in some high-income countries, tax avoidance and inefficient tax collection can be serious problems. The practical difficulties in collecting tax, particularly in countries with a large informal sector such as Namibia, are well documented. Improving the efficiency of revenue collection will increase the total government revenues, which in turn would increase funding available for all sectors including health.
2. Reprioritize government budgets. As discussed in previous sections, heads of state agreed in the 2001 Abuja Declaration to spend 15 percent of their government budget on health. While Namibia has come close to achieving this target, it has not yet consistently spent this proportion of its total budget on health. Furthermore, there have been discussions of substantially decreasing the allocation to health within the next two fiscal years, which would place the aim of improving health and achieving UHC at great risk.
3. Innovative financing. There has been a trend of introducing innovative financing mechanisms to raise additional funds for health. The high-level Taskforce on Innovative International Financing for Health Systems included increasing taxes on air tickets, foreign exchange transactions, and tobacco in its list of ways of raising additional funding for health. Other options include diaspora bonds (sold to expatriates) and solidarity levies on a range of products and services, such as mobile phone calls. Every tax has some type of distortionary effect on an economy and will be opposed by those with vested interests. Governments will need to implement those that best suit their economies and are likely to have political support. On the other hand, taxes on products that are harmful to health have the dual benefit of improving the health of the population through reduced consumption while raising more funds. The potential to increase taxation on tobacco and alcohol exists in many countries, and even if only a portion of the proceeds were allocated to health, access to services would be greatly enhanced. Some countries have also introduced taxes on other harmful products, such as sugary drinks and foods high in salt or trans fats.

While there is a need in Namibia for additional funds for health, it is also critical that the resources are used as efficiently as possible and that the absorptive capacity of the MoHSS is improved. As discussed in previous chapters, there are critical concerns relating to the allocation of resources across regions and to the various health priorities, which should be addressed in order to improve the health outcomes of the country and the cost-effectiveness of health interventions. Furthermore, substantial funding for health is returned to the Ministry of Finance each year, since the MoHSS is not able to fully absorb the funding. The underexpenditures were mainly experienced within the support directorates of the MoHSS that are not directly responsible for health service provision, which again is indicative of inappropriate resource allocation within the Ministry. Furthermore, the recruitment and procurement procedures of the MoHSS should be revisited as these have been noted to have been the main cause of underexpenditure.

6.2.1.2 Pooling

Equity in Namibia can be improved by pooling resources and risk sharing across wealth and income levels. Risk pooling is based upon the premise that contributions from the healthy pay for the care of the sick, and thus, those suffering from disease are not struck by the double burden of sickness and financial costs of health care. These principles represent the basis of moving toward preventing catastrophic expenditures related to high-cost medical conditions.

Pooling of resources pertains to the accumulation and management of funds from individual members of a pool and ensures that the individual contributors cover the risk of having to pay the full cost of care OOP in an event of illness. Establishing prepayment mechanism schemes under contributory and subsidized schemes by pooling resources reduces uncertainty for both citizens and providers. Pooling resources can be implicit, as in the case of tax revenues used to provide public health services, as well as by explicit, as in

the case of insurance. The health system in Namibia has various ways of collecting revenue, such as general taxation, medical aid fund contributions (risk-related), OOP payments, and contributions from external donors. Currently, resource pooling in Namibia is primarily done through the MOHSS in providing public services, medical aid funds, PSEMAS, the MVA Fund, and SSC Employee Compensation Fund.

Various pooling options have been implemented in other countries. Essentially there are four options in regard to risk pooling: no risk pool, a unitary risk pool, fragmented risk pools, and integrated risk pools. Risk pooling is essential to improve equity and to strengthen financial risk protection in Namibia, and therefore the option of having no risk pool is not explored further in this section. The remaining options are analyzed in the sub-sections below.

Unitary risk pool

Revenue for a unitary risk pool can either be generated by general taxation, social insurance, health care insurance, or user charges, and is placed in a single central pool that seeks to cover a chosen package of health care services. Payments are made to providers in line with the utilization of health services. Under the unitary model, risk pooling must be mandatory, to the extent that rich or healthy citizens cannot opt out of contributing. The mandatory risk pool is one possible policy response to address the current extensive inequities experienced in Namibia (Smith et al. 2004).

There are some disadvantages to a unitary risk pool, particularly in terms of the inefficiencies such a system may create. Specifically, there is a need to ensure that all providers offer the same levels and quality of care to ensure equity in service coverage. Depending on the provider reimbursement mechanism implemented, there may be a risk of supplier-induced demand, which may also affect the package of services received, resulting in further inequities. From the demand side, there is also a risk of members not being incentivized to moderate their demand, resulting in overuse of health services. Finally, the concept of a compulsory risk pool may be regarded as a curtailment of individual choice in terms of the health benefits coverage.

Fragmented risk pools

Pure unitary systems of risk pooling are usually not feasible and impractical. Although a large unitary risk pool in principle is ideal to ensure complete risk sharing at a national level, which minimizes the variations in expected expenditure, there are significant practical difficulties relating to managerial control and coordination. Therefore, most countries have devolved the health care purchasing arrangements to smaller organizations, which implies the risk pool becomes fragmented.

Risk pool fragmentation occurs whenever more than one risk pool exists. Under a fragmented risk pool system, individuals might be assigned to a particular pool depending on criteria such as geography, nature of employment, personal characteristics (age or health status), or personal choice. Membership in a particular risk pool may be voluntary or mandatory; however, countries often require that all citizens are members of at least one pool.

Fragmented risk pools will usually have different population sizes and incur different levels of per capita expected expenditure as a result of variances in risk profiles. The higher the number of risk pools, the higher the variation in health expenditure will be, which also implies there is a greater uncertainty in predicting the health expenditure needs of smaller pools.

These variations in expected health expenditures between risk pools are undesirable in terms of principles of both efficiency and equity. In terms of efficiency, variations in the per capita expenditure needs can lead to variations in insurance premiums, which are unrelated to efficiency, which in turn could result in the competitive insurance market breaking down unless corrective action is taken. In terms of equity, the fragmentation of risk pools implies that pools with sicker, poorer members are required to charge higher premiums than their less disadvantaged counterparts, which would further exacerbate issues of equity (Smith et al. 2004).

Integrated risk pools

In order to address the issues of inefficiencies and equity resulting from fragmented risk pooling systems, integrated risk pools were introduced, whereby individual risk pools can remain in place, but financial transfers are arranged between pools so that some or all of the variation caused by pure fragmentation is eliminated.

The operation of a system of transfers between risk pools might take the form of central collection of revenues, and disbursement to risk pools on the basis of estimated spending need. Alternatively, an equivalent mechanism can be effected through the collection of revenues by the pools themselves, followed by financial transfers from low-need pools to high-need pools on the basis of needs, without the intervention of a central intermediary.

If insurance premium revenues are collected by the individual pools, a further issue is the extent to which the different pools are compensated for variations in the revenues base. If the aim is to make further adjustments for equity purposes, a second set of transfers, in addition to the first set of transfers to adjust for differences in expected health expenditures, will be needed between pools to adjust for variations in revenue bases. The two sets of transfers correspond to the risk-pooling and income-redistribution functions (Smith et al. 2004).

6.2.1.3 Purchasing services

Mechanisms

Purchasing mechanisms for health services represent a major lever to achieve desired health goals. Paying for results and value for money are therefore relevant objectives of a well-functioning purchasing system. There are factors specific to each country that should be considered in health purchasing decisions such as the country's health policy objectives, the best instruments available, and a provider payment system to produce the desired financial incentives.

In Namibia, providers are reimbursed by the medical aid funds for the services they provide based on the NAMAF tariffs and the government generally allocates budgets to various levels of government, directorates, and programs on a historical budgeting basis. This approach to purchasing has been termed passive purchasing. Internationally, there has been a shift toward more active purchasing in order to improve quality and efficiency of service provision. Active purchasing considers aspects of population health needs including regional health need variances and the interventions and services required to meet the health needs taking into consideration the optimum mix of promotion, prevention, treatment, and rehabilitation. Purchasing arrangements should further consider the availability of providers and their levels of quality and efficiency.

Capitation is a payment arrangement whereby health care providers are paid a set amount for each enrolled person assigned to them for a specified period of time. The capitation payment is made to the provider regardless of whether or not that person seeks care. The amount of remuneration is based on the average expected health care utilization of that patient, with greater payment for patients with significant medical history.

Fee-for-service purchasing is where health service providers are reimbursed for each service provided and payments on this basis are made retrospectively. Fee-for-service purchasing may be a useful transition for health providers as they realize the need for reference costs and that payment will be associated with outputs and products. The process also enables further progress in targeting payments toward pro-poor service delivery and focusing on priority services such as reproductive, maternal, neonatal, and child health (RMNCH), malaria, tuberculosis, diabetes, high blood pressure, and HIV. On the other hand, this type of purchasing model can result in vast inefficiencies and cost increases as a result of provider-initiated overutilization of services.

A pay-for-performance purchasing system gives financial incentives to health care providers for better health outcomes. Also known as “value-based purchasing,” this payment model rewards physicians, hospitals, medical groups, and other health care providers for meeting certain performance measures for quality and efficiency. With this system, penalties can also be put in place for poor outcomes, medical errors, or increased costs.

Implementation considerations

Private sector engagement is a policy objective that can optimize the provision of high-quality pro-poor services by developing a mix of public-private providers under appropriate financing arrangements. Private provision and financing should be clearly differentiated in the process of developing policy objectives. Namibia currently has a strong and developed private sector with providers and private financing operating through both commercial health insurance and OOP payments.

Namibia has the opportunity of delegating substantial functions to the private sector. A progressive public-private strategy for Namibia may be able to improve public provision, financing, and management of health services while improving the quality of care and efficiency. In other words, developing a synergistic approach by strengthening the relationship between public and private provision and financing represents an inclusive a successful strategy.

The current payment mechanisms in Namibia need to be revisited, specifically, fee-for service tariffs to establish payments to private providers and historical budget for the public sector. The experience with traditional budgeting as well as fee for service is that they produce overutilization of resources and lack of accountability resulting in high costs and poor health outcomes. Controls for health care costs should be developed in parallel to any initiative to expand population as well as service coverage. Monitoring and controlling cost are integral to improving technical efficiency. The increasing cost to provide health services is a major concern among public and private health systems around the globe.

Namibia may consider an approach that combines different payment methods of capitation, pay-for-performance, and fee-for- service, so as to allow for a smooth transition, mitigating the shortcomings of each single method while promoting efficiency and quality of care.

Central procurement and price regulations of drugs would contribute to efficiency by ensuring lower prices. The development of clinical guidelines and standards of care would not only improve technical quality by providing the necessary health inputs for appropriate care but would also encourage better planning, procurement practices, and administrative oversight. Procedures for developing the lists of drugs and high-tech medical services for reimbursement should equally be based on evidence of cost-effectiveness. A National Health Technology Assessment Committee should be established in order to provide recommendations for the selection of appropriate medical technologies and prescription drugs. This agency would be better placed to develop a benefits package based on cost-effectiveness criteria and update it on a regular basis and develop economic evaluations to assess the expansion of benefits under public health insurance.

6.2.2 Consideration of remaining UHC dimensions

While this report focuses mainly on the health financing perspective of UHC, population coverage and the package of services form the other two dimensions of the UHC cube. These parameters need to be fully considered in the development of health financing policies as they have a direct influence on the health financing requirements.

In terms of these two dimensions, there are essentially two strategies countries can follow:

- Extend coverage to the whole population for a priority package of services.
- Prioritize specific population groups (for example, people in formal employment or the poorest in society), offering them a broader range of services (Nicholson et al. 2015).

6.2.2.1 Population coverage

Clearly one of the key objectives of any policy reform for UHC should include measures to improve population coverage with the ultimate goal of achieving close to 100 percent coverage. As was depicted in Figure 22 in Section 6.1, in Namibia there are key concerns in terms of population coverage with many of the poor and unemployed being reliant on health services through the public sectors, where the quality of services requires substantial improvement. Furthermore, with Namibia's significant disparities in income distribution, it is critical that the resulting health inequities in terms of population coverage are addressed. The key inequities are found in terms of coverage differences between the rich and the poor, employed and unemployed, as well as urban and rural populations with 46 percent of rural women reporting to have serious problems in accessing health care services due to the distances to health facilities versus 18.6 percent of urban women reporting the same problem (MoHSS 2013).

In terms of the health financing decisions, the following aspects need to be taken into consideration to ensure equity in terms of population coverage (World Bank 2015):

For resource generating options:

- Implications in terms of financial access and financial burden
- Extent and depth of poverty
- Incentives/disincentives for seeking care
- Cross-subsidization from rich to poor and solidarity
- Effects on quality of services

For risk pooling mechanisms:

- Share of poor/vulnerable populations covered under arrangement
- Risk of catastrophic payments
- Change in access to preventative and simple curative care

For purchasing and resource allocation mechanisms:

- Accessibility of poor/vulnerable populations to health facilities (fixed and mobile)
- Differences in population size and composition
- Health needs of different populations groups, particularly poor/vulnerable populations
- Prioritization of programs and levels of care serving the poor/vulnerable populations
- Prioritization of programs addressing demand generation among the poor/vulnerable populations
- Incentives for providers serving the poor/vulnerable populations

6.2.2.2 Package of services

The benefit packages of health services need to be determined by each country including the model of the services. The package of services should be determined on various criteria including health needs, cost-effectiveness, affordability, financial and social protection, demand and supply, opinion of the scientific community, and social acceptance. Furthermore, a country may decide to have one standardized package of benefits for the entire population or it could decide to have different benefit packages for different population groups based on specific criteria and determinants.

While the ultimate goal is health coverage for the whole population, it is not necessary that the whole population is covered by through the same mechanisms and with the benefits. As such, countries could have combinations of mechanisms covering different segments of the population, with the mechanisms being tailored to the specific characteristics and needs of these populations. Similarly, the benefit packages would then also be tailored to the specific characteristics and needs of the population. However, the objectives of equity, accessibility, quality, and efficiency need to form the foundation for any decisions on the design of such mechanisms for them to be effective.

In moving toward UHC and particularly improved equity in access to health services and benefits, a number of countries have made the decision to prioritize uniform benefits coverage, which means that they have abandoned trying to differentiate between population groups and instead have been providing a universal entitlement to pre-defined set of health services. With such a model, the whole population would have access to the same package of services.

6.3 The Way Forward

This Health Financing Review identified strengths, weaknesses, opportunities, and threats in health financing in Namibia. These were discussed in the previous chapters and in the context of five performance criteria: (1) access, (2) quality, (3) equity, (4) efficiency, and (5) sustainability of the health system.

ACCESS	
Strengths	Weaknesses
<ul style="list-style-type: none"> The government is fully committed to reducing inequalities in the access and delivery of health services and a mandate already exists for SSC to establish compulsory social health insurance Comparatively low OOP payments implying that the barriers to accessing health services are low 	<ul style="list-style-type: none"> Sub-financed public health system lacks the necessary resources to provide appropriate health services resulting in poor access and incomplete coverage, especially for a dispersed population living in rural settlements
Opportunities	Threats
<ul style="list-style-type: none"> Namibia's political commitment, social stability, and projected medium-term economic growth create an environment conducive to improving the functioning of the health system in terms of access, improving the quality of care and efficiency, and reducing inequalities in the provision of services 	<ul style="list-style-type: none"> OOP spending is increasing, which may compromise access to health services

QUALITY	
<p>Strengths</p> <ul style="list-style-type: none"> Namibia performed better than average among the WHO/AFRO upper-middle-income countries on maternal and under-five mortality indicators 	<p>Weaknesses</p> <ul style="list-style-type: none"> Poor quality of health services in the public sector as result of inadequate infrastructure, equipment, supplies, human resources, and management capacity Poor performance in terms of life expectancy, HIV prevalence, and other key health indicators Sub-financed public health system lacks the necessary resources to provide appropriate health services resulting in low quality of care, especially for a dispersed population living in rural settlements
<p>Opportunities</p> <ul style="list-style-type: none"> Namibia's political commitment, social stability, and projected medium-term economic growth create an environment conducive to improving the functioning of the health system in terms of access, improving the quality of care and efficiency, and reducing inequalities in the provision of services 	<p>Threats</p> <ul style="list-style-type: none"> Provision of poor-quality health services is likely to affect health outcomes and have a negative impact on the population's health

EQUITY	
<p>Strengths</p> <ul style="list-style-type: none"> The government is fully committed to reducing inequalities in the access and delivery of health services and a mandate already exists for SSC to establish compulsory social health insurance Namibia has proportional to progressive financing mechanisms for health, which allow for inequities to be addressed 	<p>Weaknesses</p> <ul style="list-style-type: none"> Fragmented health financing system that discriminates according to the ability to pay, job status, residence in urban or rural areas and results in inequality in the distribution of resources for health Uninsured more likely to forgo care for acute health conditions
<p>Opportunities</p> <ul style="list-style-type: none"> Namibia's political commitment, social stability, and projected medium-term economic growth create an environment conducive to improving the functioning of the health system in terms of access, improving the quality of care and efficiency, and reducing inequalities in the provision of services 	<p>Threats</p> <ul style="list-style-type: none"> Inequities in health are likely to exacerbate the existing inequities in wealth within Namibia and may have a negative impact on economic growth

EFFICIENCY	
<p>Strengths</p> <ul style="list-style-type: none"> Namibia achieved an efficiency score rating for the health system higher than the majority of sub-Saharan Africa countries 	<p>Weaknesses</p> <ul style="list-style-type: none"> Poor absorption of government funds for health High costs of private health services, indicative of inefficiencies
<p>Opportunities</p> <ul style="list-style-type: none"> Revision of Namibia's purchasing mechanisms and possible public-private partnerships could result in improved efficiencies Namibia's political commitment, social stability, and projected medium-term economic growth create an environment conducive to improving the functioning of the health system in terms of access, improving the quality of care and efficiency, and reducing inequalities in the provision of services 	<p>Threats</p> <ul style="list-style-type: none"> Inefficiencies in the allocation and use of funds will result in wastage of critical resources and ultimately in poor health outcomes Increasing costs of health services, especially in the private sector, make medical aid fund contributions less affordable and thus potentially will reduce medical aid fund membership in the future, further reducing the size of the risk pool and resulting in an even larger population being reliant on public services

SUSTAINABILITY	
<p>Strengths</p> <ul style="list-style-type: none"> Government expenditure is close to the Abuja target of 15 percent and is showing increasing trends with faster increases than the rest of the region There has been a strong trend of decreasing donor dependence 	<p>Weaknesses</p> <ul style="list-style-type: none"> Namibia has the highest level of donor dependence for health financing among other WHO-AFRO upper-middle-income countries The HIV/AIDS response is particularly donor-dependent with 51 percent of HIV funding coming from donors PSEMAS is highly subsidized by the government making it unsustainable as a financing mechanism
<p>Opportunities</p> <ul style="list-style-type: none"> The government has demonstrated its commitment to identifying sustainable financing mechanisms through the establishment of the UHCAN and its mandate 	<p>Threats</p> <ul style="list-style-type: none"> Donors are likely to continue to reduce their funding to Namibia's health response due to its upper-middle-income status, leaving the sustainability of the health response vulnerable Particularly the national HIV/AIDS response may be severely threatened if donors withdraw their funding support, which could have a catastrophic impact on the epidemic

Namibia needs to develop and implement innovative health financing reforms and in order to do this it should conduct a comprehensive assessment of funding options as part of the feasibility study that will be implemented through the UHCAN. Furthermore, one of the most critical aspects of health financing is the relationship between pooling and purchasing. Pooling is needed to obtain improvements in equity and financial risk protection. However, it's also hard to attain efficiency gains and improve access and quality without good pooling arrangements even though health purchasing mechanisms are flexible with many instruments and tools that can be used to overcome pooling deficiencies in the short-term.

Strategies to move forward in terms of UHC need significant political commitment and support from decision makers, service implementers and civil society for a successful implementation. An effective communication strategy will be able to inform the aims, expectations and results achieved. Development of a health care financing strategy is one component toward achieving universal coverage and reaching better health outcomes.

Health care financing is only one of the six building blocks of health systems but critical to complement other blocks to improve the overall performance of the system in achieving the health goals. A full impact of the health financing strategy will depend on actions that are able to produce a synergistic operation with the other building blocks: service delivery, human resources, pharmaceuticals and health technologies, information systems, and governance. The health financing model should provide a platform to integrate the building blocks while providing accountability and long term sustainability. A strong and well-functioning health system is the only option in achieving better health for Namibia.

Summary of key findings:

- ◆ Only 19 percent of Namibia's population is covered by a medical aid fund or PSEMAS, leaving 81 percent of the population reliant on the public health system or OOP spending for health services.
- ◆ An additional 21 percent of the population could potentially be covered by the NMBF.
- ◆ To ensure financial risk protection and equity, primary revenue sources for health should include government expenditure through taxation or mandatory health insurance.
- ◆ Risk pools can be unitary, fragmented, or integrated, with integrated pools providing the greatest potential for effective risk pooling for equity.
- ◆ Purchasing mechanisms should ensure efficiencies in the health system are achieved.
- ◆ Population coverage and benefits packages need to be considered in the design of health financing systems and policies.

ANNEX A: KEY HEALTH INDICATORS FOR WHO AFRO REGION

Indicator	Algeria	Angola	Botswana	Gabon	Mauritius	Namibia	South Africa	Average	Median
Life expectancy at birth (years)	76	61	71	59	73	62	60	65	62
Health Adjusted Life Expectancy at birth (years)	64	52	59	50	64	53	51	56	53
Under-five mortality rate (per 1000 live births)	36	161	48	74	15	40	57	60	48
Maternal mortality ratio (per 100,000 live births)	89	460	170	240	73	130	140	181	140
Prevalence of HIV among adults aged 15 to 49	0.1%	2.4%	21.9%	3.9%	1.1%	14.3%	19.1%	9%	3.9%

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