



Securing Sustainable Financing: A Priority for Health Programs in Namibia

The Problem: The Government Faces Increasing Pressure to Fund High-priority Health Programs

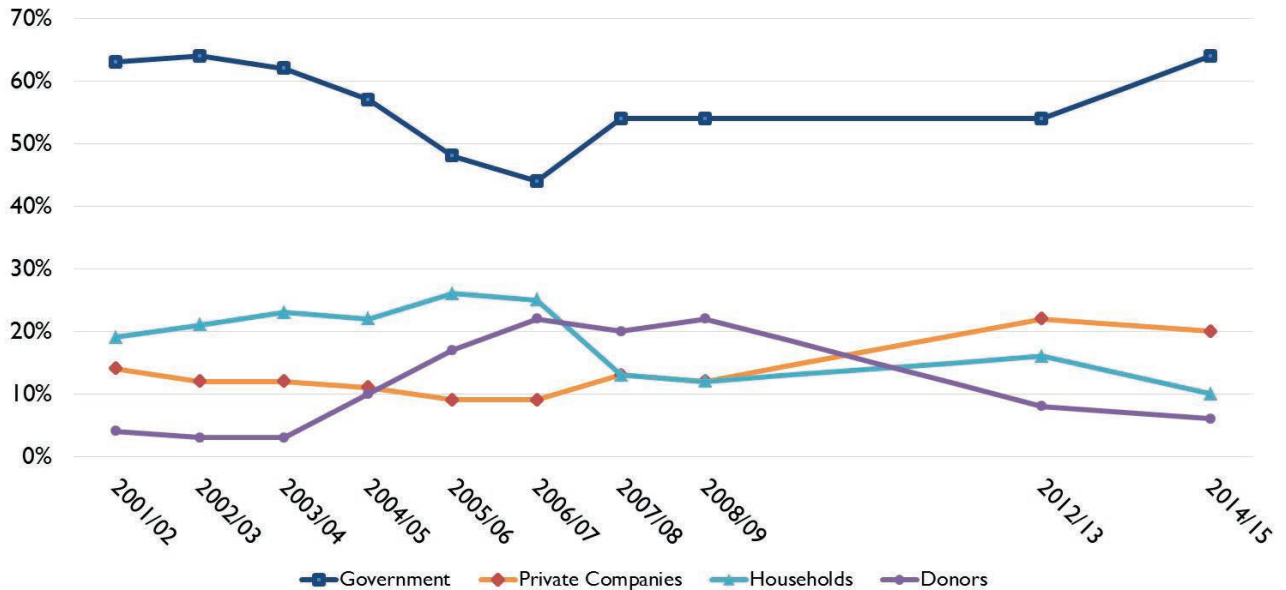
Namibia has adopted the United Nations' Sustainable Development Goals, including Goal #3: to ensure healthy lives and promote wellbeing for all, at all ages. One of the targets under this goal is to achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality and affordable essential medicines and vaccines¹. Namibia is making concerted efforts towards the achievement of UHC, and is assessing the different options for achieving this ambitious goal. Part of this assessment involves deciding on the financing mechanism that will make it possible to fund health interventions sustainably.

The country's 2014/15 Health Accounts results (the most recent data available) show that Namibia's total health expenditure (THE) per gross domestic product of 9 percent remains the second highest in the group of similar upper-middle-income countries in the World Health Organization's AFRO region. The Health Accounts also show that the country is close to meeting the Abuja target of allocating 15 percent of the general government expenditure budget to health, with its allocation of 13 percent in 2014/15. The government has consistently been the main source of financing for health, and its contribution as a percentage of THE increased significantly between 2012/13 and 2014/15, from 54 percent to 64 percent. In contrast, donor financing for health has decreased in recent years, and this trend is expected to continue. Over the last six years of Health Accounts, Namibia's dependence on external resources for health has decreased by 16 percent, with donor financing having decreased from 22 percent of THE in 2008/09 to 6 percent in 2014/15 (See Figure 1). The government has had primary responsibility for making up for this shortfall.

¹United Nations. 2015. Sustainable development goals. Retrieved on October 27, 2015 from: <https://sustainabledevelopment.un.org/topics>



Figure 1. Trends in Financing Sources, 2001/02–2014/15

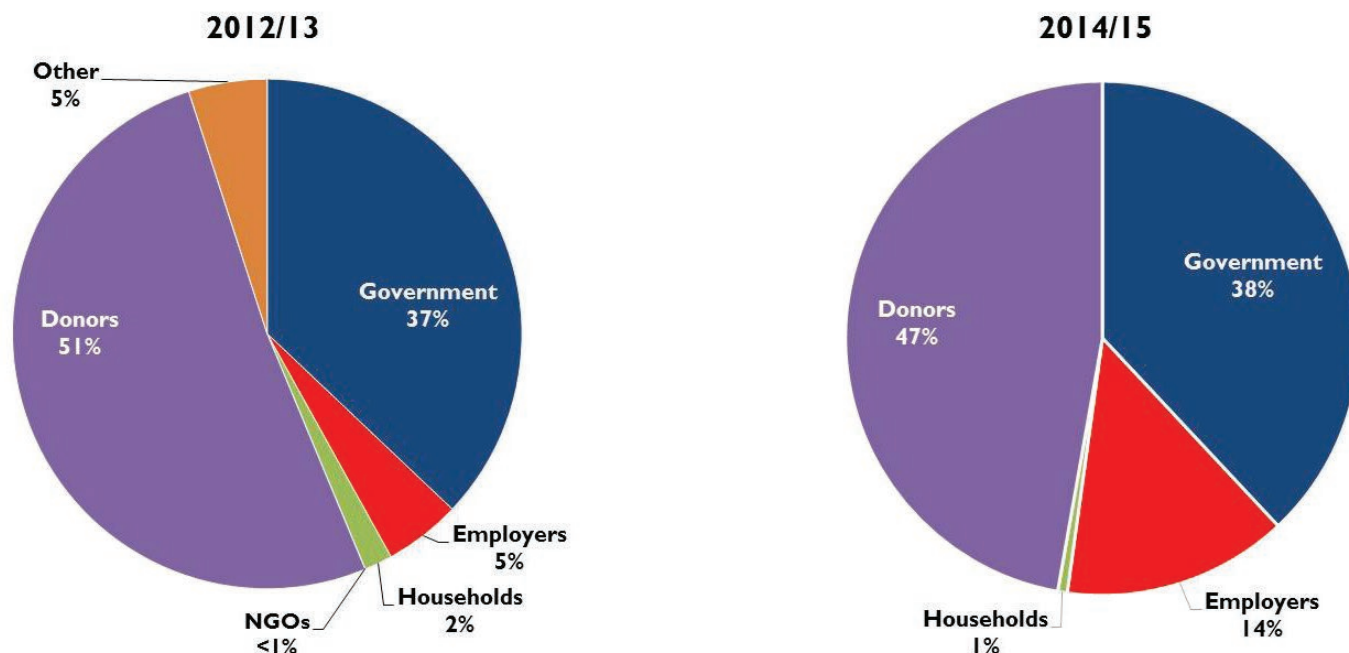


Source: Namibia Health Accounts Reports of 2012/13 and 2014/15

While Namibia's move towards sustainable domestic financing has been strong and consistent, more work is needed to make some of the priority programs sustainable. Dependence on external resources for HIV funding is particularly worrisome. HIV and AIDS care and prevention in Namibia are still financed primarily by donors, despite the disease being the highest-ranking cause of death and premature mortality in the country.² Namibia has made great advances in its fight against HIV and AIDS. The program to prevent mother-to-child transmission has achieved a 95 percent antiretroviral therapy (ART) coverage rate for HIV-positive pregnant women between 2013 and 2015, while the ART coverage rate of people living with HIV has also been increasing steadily over the years, to 69 percent coverage in 2015. The impact of the HIV interventions is evidenced by a decrease in HIV prevalence from 15 percent in 2009 to 13 percent in 2015.

It is critical at this stage that these interventions be sustained in order to gain control over the disease, but spending on HIV and AIDS in Namibia decreased from 14 percent of THE in 2012/13 to 10 percent in 2014/15. (In absolute terms, spending on HIV and AIDS increased from N\$2.891 billion to N\$2.913 billion, which is an increase of less than 1 percent over the two-year period.) Furthermore, in 2014/15, 47 percent of the financing for HIV and AIDS was provided by donors and only 38 percent by the government. (See Figure 2.) Although the donor contribution has decreased from 51 percent in 2012/13, and the government contribution has increased marginally from 37 percent in 2012/13, there is a substantial risk to sustainability of the response due to the continued high reliance on donors. This risk is exacerbated by the decrease in resources allocated to the disease as a percentage of THE.

²Institute for Health Metrics and Evaluation (IHME). Namibia: State of the Nation's Health: Findings from the Global Burden of Disease. Seattle, WA: IHME, 2016

Figure 2. Financing Sources for HIV Care and Prevention in 2012/13 and 2014/15

Source: Namibia Health Accounts Reports of 2012/13 and 2014/15

In order to sustain the programmatic progress that has been made, it will be important to ensure that domestic resources are aligned to finance the HIV and AIDS-related programs, especially given that HIV and AIDS remain such a significant health concern in the country.

Namibia also over-relies on donor financing for tuberculosis and malaria care and prevention. Tuberculosis and lower respiratory infections were the second greatest causes of death and premature mortality in 2013. Although Namibia is close to achieving its goal of eliminating malaria, the country did experience outbreaks in 2017, which means that renewed efforts will be required to fully achieve the goal. Despite TB's position on the list of top causes of death and premature mortality in Namibia, spending on TB remained low, at 2 percent of THE, while spending on malaria amounted to less than 1 percent of THE. In 2014/15, 30 percent of TB funding and 18 percent of malaria funding came from donors. This implies that these priority diseases, which pose a significant risk to the health of Namibia's population, are also heavily donor financed, which places the sustainability of their programs at risk. It is important for the government to ensure that adequate financing is sourced domestically to sustain the HIV and AIDS, TB, and malaria programs as donor funding is transitioned, so that the progress made and successes achieved thus far are not lost.

To summarize, Namibia will require additional financial resources for health as it aims to achieve UHC and looks for domestic sources of financing to replace donor funding for health, particularly in the case of priority programs such as those addressing HIV and AIDS.

Adding to these challenges, the Namibian economy slowed significantly in 2016: the annual gross domestic product reached a low of 1.2 percent after having shown an average growth rate of more than 5 percent over the preceding five years. The government of Namibia was required to go through a process of fiscal consolidation in October 2016 due to various factors, including the depreciation of the Namibian currency, the deterioration of economic activity, and reduction of revenue through the South African Customs Union revenue pool. With the current economic situation, and only slow improvements being forecast for the economy in the medium term, the government is likely to encounter constraints in fiscal expansion and its ability to allocate greater resources to health.



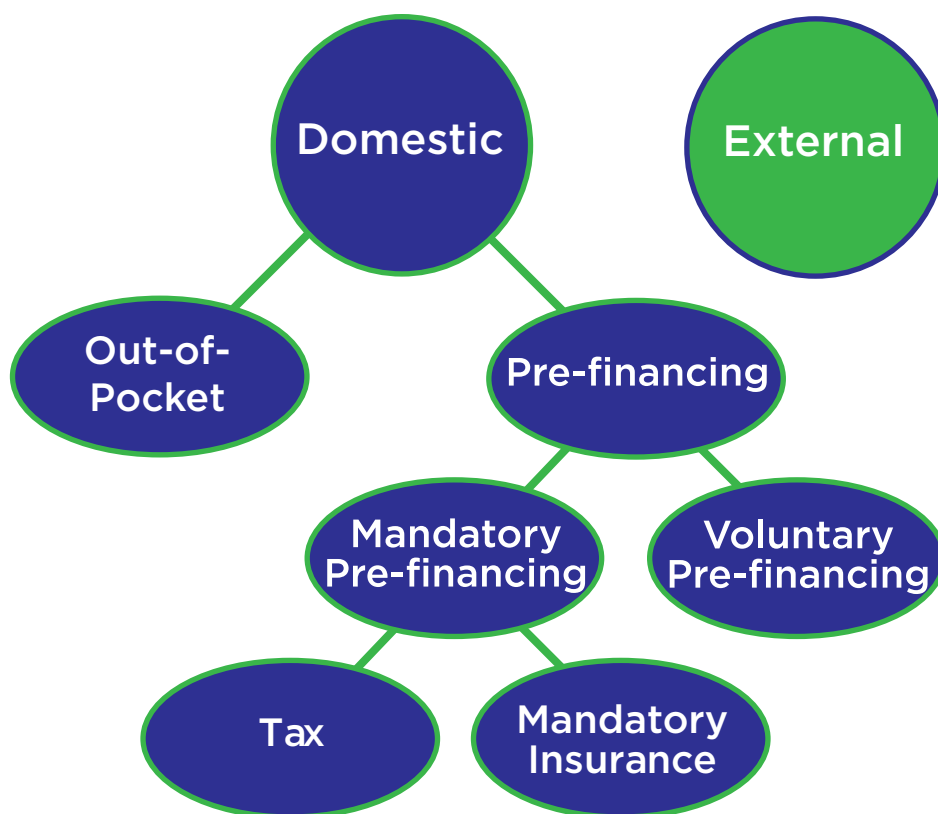
Assessing Alternative Sources of Sustainable Financing

Building on the current progress and sustaining the financing for health in general and for priority areas such as HIV—particularly in an equitable way—would require tackling three key related challenges:

- ▶ Mobilize alternative domestic resources to take over financing of the priority areas such as HIV and AIDS that are predominantly being funded by development partners.
- ▶ Mobilize sustainable domestic resources that will be required for the achievement of UHC in the country.
- ▶ Strengthen mechanisms that will minimize the role of out-of-pocket (OOP) spending.

The government could explore various options as demonstrated in Figure 3.

Figure 3. Options for Health Financing



Given the trend of decreasing donor funding, it is important that the efforts to identify additional sources of financing for health focus on domestic sources, for which there are two overarching options: OOP expenditure or prepayment. The sections below discuss these domestic financing options taking into consideration the results of the recently completed Health Accounts and other sources.

1. Mandatory prepayment through taxation: In 2014/15 the government of Namibia contributed 64 percent of THE, which comprised 13 percent of the total general government expenditure. Ninety-four percent of the government's 2014/15 revenue was derived from tax revenue, comprising direct taxes (44 percent of tax revenue) and indirect taxes (56 percent of tax revenue). Increasing government spending on health through taxation can be achieved by increasing the government's allocation to health as a percentage of total government spending, increasing direct and/or indirect tax rates, or introducing a dedicated health tax (on international flights, a "sin" tax, etc.). Increasing the allocation to health as a percentage of total government spending would allow Namibia to fully achieve the 15 percent Abuja target, and is likely the most feasible option. Taking into consideration the current economic situation in Namibia, it may not be feasible to increase direct or indirect tax rates or to introduce additional taxes. However, this may be an option that could be explored once the economic situation has improved and stabilized again.

2. Prepayment through mandatory health insurance: Mandatory health insurance would require a specified population to make compulsory contributions into a fund that would pool these financial resources for the payment of medical expenses. The aim of mandatory health insurance would be to improve equity and financial risk protection, so it is important to ensure that the health insurance mechanism would be progressive rather than regressive. This would be done by linking contributions to income or ability to pay, so that the health insurance contributions do not become a further burden to the poor. Namibia currently has no mandatory health insurance. The 2016 Labour Force Survey results show that 66.5 percent of the employed population works in informal employment, which means that these people do not benefit from any formal social protection, such as pensions, medical aid funds, or social security. The Government could increase the level of risk pooling by creating a mandatory risk-pooling mechanism that would enroll both the formally employed and a significant portion of those informally employed to cover the population for essential health services. For this approach to work, the government would need to find a means of enrolling the significant portion of the labor force that is employed informally.

3. Voluntary prepayment through private health insurance: Currently, 18 percent of Namibia's population benefits from medical aid coverage through either the Public Service Employees Medical Aid Scheme (PSEMAS) or one of the private medical aid funds. In 2014/15 the private medical aid funds and PSEMAS together consumed 36 percent of THE, which is disproportionate to the population covered by these funds. Furthermore, there is very limited cross-subsidization between the rich and the poor in either private medical aid schemes or PSEMAS. Contributions to medical aid funds to some extent reflect the risk of getting sick, but not the ability to pay. PSEMAS contributions are a flat rate regardless of the earnings of the employee, which imposes a greater financial burden on the poor than on the rich.

The lack of cross-subsidization in PSEMAS is exacerbated by the fact that civil servants tend to be wealthier than the overall population, and yet the government is greatly subsidizing civil servants by funding 85 percent of the total PSEMAS expenditure through the general government budget. While some risk-pooling does occur through these voluntary private health insurance mechanisms, serious concerns need to be addressed to ensure greater equity and cross-subsidization.

4. Out of pocket: In 2014/15, 9 percent of THE for the cost of health goods and services was estimated to be incurred OOP at the time of care. Namibia thus falls well within the acceptable limit of OOP spending as per the WHO guidelines intended to maintain the risk of financial burden at a manageable level and avoid catastrophic expenditures. However, in past years Namibia's OOP spending has been significantly lower; it was as low as 3 percent in 2001/02 and 2006/07. Since 2006/07 it has shown an increasing trend overall. OOP spending reached a high of 11 percent in 2012/13 and has since declined; still, policymakers should try to keep it at or below its 2014/15 level. In doing so the government should focus on the prepayment options mentioned above, as it evaluates its health financing options.



Policy Recommendations

Namibia needs to find a means of sustainable financing to provide affordable UHC. At the same time, it needs to ensure that programs for priority diseases such as HIV and AIDS, TB and Malaria continue, and that the results of these programs are maintained or improved as donor funding decreases.

The various health financing options for achieving greater sustainability need to be comprehensively evaluated within the current economic and country-specific context to ensure the long-term sustainability of health interventions.

The key health financing options for improved sustainability include the following:

- ▶ **Increasing government health spending through taxation, by increasing the allocation of general government expenditure to health and thereby achieving the Abuja target.** Namibia is one of the countries in southern Africa with the highest proportion of government health spending as a percentage of total government spending. However, Namibia will need to strengthen its commitment to health to achieve the Abuja target of 15 percent.
- ▶ **Increasing government revenue by increasing direct/indirect tax rates in order to increase overall government spending, including government spending on health.** An increase in the overall revenue of the government would in turn allow the government to spend more. Assuming the percentage allocation to health remained unchanged, THE would rise through the increase in general government expenditure. However, increases in tax rates and government revenue may be difficult to implement given the country's current economic situation and may be an option that should only be explored once the economy stabilizes.
- ▶ **Introducing a dedicated tax that will generate income exclusively for health spending.** Many countries have started introducing innovative financing mechanisms to raise additional funds for health, such as dedicated taxes on air tickets, foreign exchange transactions, and tobacco, or solidarity levies³ on a range of products and services, such as mobile phone calls. It will be important to ensure that the implications of the introduction of such taxes or levies are fully analyzed to ensure a limited impact on the economy, and particularly on the poor. 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.
- ▶ **Implementing mandatory health insurance.** In order to improve equity and financial risk protection, it is important to ensure that the health insurance mechanism is progressive rather than regressive. The contributions should be based on the individual's ability to pay rather than factors such as age or health risk. It is important to ensure that the insurance is fully mandatory and that nobody—particularly not the rich—can opt out, to ensure effective cross-subsidization.
- ▶ **Improving the efficiency of health programs.** Efficiencies can be introduced by reducing wastage of resources and thereby freeing up these resources to allocate to priority programs and health interventions. Greater efficiency can also be achieved by allocating resources to the interventions and health programs that yield the greatest improvements in health. Furthermore, a review of the service delivery platform of the public health sector should be conducted to ensure services are provided efficiently. Possible options of improving service delivery for greater efficiency may include a redistribution of services from hospitals to health centers as these tend to be more cost-efficient.

³Definition: A government-imposed tax levied in an attempt to provide funding towards theoretically unifying (or solidifying) projects. <http://www.investopedia.com/terms/s/solidarity-tax.asp>; Accessed 07.08.2017