

REPUBLIC OF NAMIBIA



Ministry of Health and Social Services

# NAMIBIA 2014/15 HEALTH ACCOUNTS REPORT

Windhoek, September 2017

**Recommended Citation:** Namibia Ministry of Health and Social Services. September 2017.  
*Namibia 2014/15 Health Accounts Report.* Windhoek, Namibia.



# NAMIBIA 2014/15 HEALTH ACCOUNTS REPORT



**USAID**  
FROM THE AMERICAN PEOPLE



**World Health  
Organization**

# CONTENTS

<b>1. Introduction.....</b>	<b>1</b>
1.1 Importance of Health Accounts Data in Namibia.....	1
1.2 History of Health Accounts in Namibia.....	2
1.3 Study Objectives.....	2
1.4 Data Sources .....	2
1.5 Data Analyses and Capacity Building.....	3
1.6 Data Limitations .....	4
<b>2. Health Accounts Key Findings .....</b>	<b>5</b>
2.1 General Health Expenditures .....	6
2.2 HIV Expenditures .....	14
2.3 Reproductive Health Expenditures .....	17
<b>3. Policy implications and Recommendations.....</b>	<b>18</b>
3.1 Assess Options for Sustainable Domestic Health Financing.....	18
3.2 Identify Sustainable Domestic Financing for HIV, TB and Malaria.....	19
3.3 Increase the Role of the Private Sector.....	19
3.4 Continue to Manage Household Out-of-Pocket Expenditure .....	20
3.5 Improve Efficiencies and Accessibility .....	20
3.6 Allocate More Funding to the Prevention of Non-Communicable Diseases..	21
3.7 Allocate More Funding to Maternal Health .....	21
<b>References .....</b>	<b>22</b>
<b>Annex A: Key Health Indicators for Namibia and Comparative Countries with Similar Income Level, 2014 .....</b>	<b>24</b>
<b>Annex B: Contributors to the Health Accounts Exercise.....</b>	<b>25</b>

## List of Tables

Table 1. Key policy questions guiding Health Accounts estimation.....	2
Table 2. Data sources for Health Accounts 2014/15.....	3
Table 3. Key Health Accounts findings.....	5
Table 4: Total health expenditure per capita, US\$ adjusted for purchasing power parity and total health expenditure as a percentage of GDP, 2013 .....	7

## List of Figures

Figure 1. Growth in THE, 2001/02-2014/15 (real 2014/15 N\$ millions).....	6
Figure 2: Country comparison of THE as a percentage of GDP, 1995-2013.....	7
Figure 3. THE by Source of Financing.....	8
Figure 4. Trends in financing sources, 2001/02-2014/15.....	8
Figure 5: Trends in government spending on health as a percentage of total general government spending in comparison to the Abuja target, 2001/02–2014/15....	9
Figure 6. Total government expenditure and total government health expenditure, 2001/02-2014/15 (real 2014/15 N\$ millions).....	9
Figure 7. Cross-country comparison of private expenditure on health as a percent of THE.....	10
Figure 8. THE by Financing Scheme .....	11
Figure 9: Trends in OOP.....	12
Figure 10: THE by Facility Type.....	12
Figure 11: Government Health Spending by Provider .....	13
Figure 12: Household OOP Spending by Type of Provider .....	13
Figure 13: THE by Type of Service.....	13
Figure 14: Spending by Disease/ Health Condition.....	14
Figure 15. Top 20 causes of YLLs 2000-2013 Females and Males, Namibia.....	15
Figure 16: HIV Spending by Source of Financing.....	16
Figure 17: HIV Spending by Provider .....	16
Figure 18: HIV Spending by Type of Service .....	16
Figure 19: RH Spending by Source of Financing .....	17
Figure 20: RH Spending Type of Service.....	17
Figure 21. Options of Health Financing.....	18

# ACRONYMS

<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>GDP</b>	Gross domestic product
<b>HA</b>	Health Accounts
<b>HAPT</b>	Health Accounts Production Tool
<b>HFG</b>	Health Finance and Governance
<b>HIV</b>	Human immunodeficiency virus
<b>IHME</b>	Institute of Health Metrics and Evaluation
<b>MOHSS</b>	Ministry of Health and Social Services
<b>NAMFISA</b>	Namibia Financial Institutions Supervisory Authority
<b>NASA</b>	National AIDS Spending Assessment
<b>NCD</b>	Noncommunicable disease
<b>NGO</b>	Nongovernmental organization
<b>N\$</b>	Namibian dollar
<b>OECD</b>	Organization for Economic Cooperation and Development
<b>OOP</b>	Out-of-pocket
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PPHRD</b>	Policy, Planning and Human Resource Development
<b>PSEMAS</b>	Public Service Employees Medical Aid Scheme
<b>RH</b>	Reproductive health
<b>SHA</b>	System of Health Accounts
<b>TB</b>	Tuberculosis
<b>THE</b>	Total health expenditure
<b>UHC</b>	Universal health coverage
<b>UNAIDS</b>	Joint United Nations Program on HIV and AIDS
<b>USAID</b>	United States Agency for International Development
<b>USD</b>	United States dollar
<b>WHO</b>	World Health Organization
<b>YLL</b>	Years of life lost

# FOREWORD

The production of Namibia's 2014/15 Health Accounts report is the result of efforts from many individuals and institutions. It is through the continuous work by the Ministry of Health and Social Services (MOHSS) to institutionalize resource tracking in the health sector that it was possible to compile these comprehensive results.

The study provides a detailed assessment of health spending and the use of both private and public financial resources in the health sector in Namibia. Health Accounts estimation is a vital component of health systems strengthening in Namibia, as it provides sound estimates of spending on health, and therefore provides critical information required for evidence-based decision-making. It provides stakeholders with information on the value of purchased health care goods and services, and patterns in financing, provision, and consumption of health care resources. This information will direct the MOHSS and other national policy-makers, donors, and stakeholders in their strategic planning and dialogue to inform decision-making for health and social service delivery.

The data collected and analyzed came from nongovernmental organizations, donor organizations, medical aid funds, government ministries, private employers, and households. I would like to take this opportunity to express my sincere appreciation to all institutions for their contribution and support throughout this resource-tracking exercise. I thank all those who contributed to this Health Accounts estimation for Namibia: participants and stakeholders who provided key input and feedback; institutions that provided essential information for the estimation through survey responses; and the technical team that analyzed the data.

The study was conducted by a multidisciplinary technical team derived from the ministry's directorates of Policy, Planning, and Human Resource Development, Special Programs, Tertiary Health Care and Clinical Support Services, and Finance and Logistics. Other providers of technical assistance included the United States Agency for International Development-funded Health Finance and Governance (HFG) project, led by Abt Associates; the World Health Organization (WHO); and the Joint United Nations Program on HIV and AIDS (UNAIDS). We are grateful to the United States government for the financial and technical support of USAID. My sincere appreciation goes to Mr. Tesfaye Ashagari, Ms. Heather Cogswell, and Ms. Claire Jones of the USAID HFG project; Tessa Edejer from WHO; and Anna Yakusik from UNAIDS, for their technical assistance in making this project a success. Furthermore, my gratitude goes to Namibia's Health Accounts team for their efforts in finalizing this project. The team includes: Mr. T. Mbeeli, Mr. P. Ndaitwa, Ms. H. Nangombe, Mr. L.C. Usurua, Mr. M. Simasiku, Ms. J. Malule, Mr. C. John, Mr. L. Indongo, Ms. T. Block, Ms. L. Karises, and Mr. A. Uakurama (MOHSS); Mr. E. Coetzee (Ministry of Finance); Ms. E. Ilonga (National Planning Commission); Ms. M. Nakale-Gaomas (Namibia Financial Institutions Supervisory Authority (NAMFISA)); Mr. J. Hidinwa (Polytechnic of Namibia); Dr. L. van der Westhuizen (University of Namibia); Mr. G. Mbatia (Namibia Medical Aid Fund); and Mr. L. Kamwi (Namibia Chamber of Commerce and Industry).

Ms. Bertha Katjivena  
Acting Permanent Secretary



# EXECUTIVE SUMMARY

This report presents the findings of Namibia's Health Accounts estimation for the fiscal year April 2014 through March 2015 (2014/15), and analyzes the implications of these findings for key policy decisions. This round of Health Accounts is the fifth round, and the second round that was conducted using the System of Health Accounts 2011 (SHA 2011) methodology. Namibia's Health Accounts now cover a total of 13 years of spending including 1998/99 to 2008/09, 2012/13 and 2014/15. Health Accounts capture spending from all sources: the government, nongovernmental organizations, external donors, private employers, private medical aid schemes, and households. The analysis breaks down spending into the standard classifications defined by the SHA 2011 framework, namely sources of financing, financing schemes, type of provider, type of activity, and disease/health condition.

## Key Findings

Total health expenditure (THE) in Namibia in 2014/15 amounted to Namibian Dollar (N\$) N\$12,067,742,100 (USD1,329,046,487), of which 94 percent is recurrent spending. Recurrent spending is the spending on health goods and services consumed within the year of the Health Accounts analysis. The balance of spending of 6 percent was for capital investment, which includes goods and services whose benefits are consumed over a period longer than one year. Health care-related items such as social care for people living with HIV are not included in THE, and totaled an additional N\$159,024,219.

**Who funds health care?** During the 2014/15 financial year, the government of Namibia made the largest contribution to health spending, by contributing 64 percent of THE, an increase from the 54 percent it contributed in 2012/13. The substantial government contribution to health spending comprised 13 percent of the government's total spending in the fiscal year, which is close to the Abuja target of 15 percent. The percentage contributions of employers, households, and donors amounted to 20 percent, 10 percent and 6 percent respectively. These contributions all decreased in relation to the 2012/13 Health Accounts, when the contributions by these entities were 22 percent, 16 percent and 8 percent respectively. Approximately 90 percent of household spending on THE, or 9 percent of THE, in 2014/15 was out-of-pocket (OOP) expenditure.

**Who manages health funds?** The General Government managed 51 percent of THE, while medical aid schemes managed 36 percent. The remainder was managed by households (9 percent), nongovernmental organizations (NGOs) (3 percent), and corporations and donors (both less than 1 percent).

**Where are funds spent?** Forty-nine percent of health funds were spent on secondary care in public and private hospitals, while spending at the primary care level amounted to approximately 17 percent.

**On what goods and services?** The majority of funds (59 percent) were spent on curative care, while only 5 percent of funds were spent on preventive care. Administration consumed 10 percent of THE, and the purchase of medicines and medical goods accounted for 8 percent of THE.

**On which diseases?** Infectious and parasitic diseases received the highest allocation of funds, at 25 percent of THE, followed closely by reproductive health and non-communicable diseases, at 22 percent and 21 percent respectively. Within the infectious and parasitic diseases category, spending was highest on HIV/AIDS, at 10 percent of THE, followed by respiratory infections at 6 percent, and diarrheal diseases at 4 percent. Close to 2 percent of THE was spent on tuberculosis (TB), while less than 1 percent of THE was spent on malaria. The expenditure on TB and malaria was similar to what it had been in 2012/13, when 1 percent of THE was spent on each of the two diseases; but between



2012/13 and this most recent round of Health Accounts, the expenditure on HIV/AIDS decreased from 14 percent to 10 percent.

### *Policy Implications and Recommendations*

During the planning stages of the latest Health Accounts, the Ministry of Health and Social Services (MOHSS) and its Health Accounts Steering Committee identified policy questions that the Health Accounts should answer. The findings of the Health Accounts 2014/15 exercise and the analysis of the policy implications allowed the Health Accounts team to make the following recommendations:

1. **Assess options for sustainable domestic health financing.** Namibia has demonstrated its commitment to health, but will need to strengthen this commitment further to achieve and maintain the Abuja target of 15 percent. This strengthened commitment will be essential as Namibia strives to achieve universal health coverage, particularly in light of decreasing donor funding. It is also important for the MOHSS to also understand whether its health spending is sufficient and equitable across the population. The government should aim to understand the extent of unmet health needs, and where its spending does not reach those who need it the most: groups who are underusing health services because of financial and other barriers to access. By comparing costed projections with Health Accounts data on past spending, the government can predict resource gaps and mobilize resources accordingly. The different financing options need to be analyzed within the current economic and country-specific context while at the same time considering the long-term implications for the sustainability of each of these options.
2. **Identify sustainable domestic financing options for HIV and TB.** HIV/AIDS has remained the leading cause of death and premature mortality for all ages in 2013 (most recent data available). The disease's impact is especially evident in the age group 40-44 years where it accounted for up to half of all mortality among males and females (IHME 2016). Tuberculosis and lower respiratory infections were the next leading causes of death and premature mortality. Currently 47 percent of funding for HIV/AIDS is financed by donors, and approximately 23 percent of the TB funding and 18 percent of malaria funding is received from donors. This implies that both these priority diseases are largely donor-financed, which places the sustainability of their programs at risk. As Namibia reassesses its health financing options to ensure sustainability, it is important that policy-makers also focus their efforts on securing sustainable financing for these priority diseases.
3. **Increase the role of the private sector.** The private sector contributes 30 percent of THE in Namibia, comprising spending by households of 10 percent and companies of 20 percent. This private sector spending is relatively low in comparison with that of other countries with similar gross domestic product (GDP) per capita. Namibia's low level of private sector contributions to health represents an opportunity to diversify the source of funds for health and strengthen private sector involvement.
4. **Continue to manage household out-of-pocket expenditure.** While household OOP spending in Namibia is relatively low in comparison with that of other southern African countries and international guidelines, it is important to ensure that OOP spending does not increase again, as it did between 2008/09 and 2012/13. OOP payments can cause households to bear the full cost of health goods and services at the time of care, which can cause a significant – and potentially catastrophic – financial burden. The government must keep the levels of OOP payments as low as possible to prevent potential resulting inequities. Schemes that pool risk across a large group of individuals can ensure that those who cannot afford health care and are most sick receive support – essentially subsidies – from those who are wealthier and less sick.
5. **Improve efficiencies and accessibility of health services.** Namibia is spending a significant portion of its health expenditures on curative care (59 percent of THE) delivered at the secondary and tertiary levels (49 percent of THE). In contrast to these figures, only 17 percent of THE is spent at the primary health care level. The MOHSS should consider allocating a greater portion of its resources to the primary health care level and prevention initiatives, to improve the quality of services, accessibility of critical services in remote areas, and allocative

efficiency. This strategy has potential not only to free up additional resources but also to improve cost efficiency. To inform ministry decisions relating to cost efficiency and resource allocation, further analyses are necessary to determine the extent to which efficiency gains can be attained by reallocating the resources that are available.

6. **Allocate more funding to the prevention of non-communicable diseases.** Namibia is undergoing an epidemiological transition from communicable diseases to non-communicable diseases (NCDs), and for some time it will continue to face this double burden of disease. The Health Accounts results show that there is an increase in spending on NCDs, with the vast majority of this spending being on curative care, and only 2 percent on prevention. As the MOHSS starts to prepare the health system to address NCDs, it is increasingly important to incorporate NCD prevention interventions. Greater spending on prevention not only will help to improve the quality of life of the population but will also reduce the costs of care.
7. **Allocate more funding to improve maternal health.** Namibia has the second highest maternal mortality rate in comparison to the other upper-middle-income countries in the region, while its neonatal mortality rate is the third highest in the region. In 2014/15, reproductive health consumed 21 percent of THE, but spending on reproductive health as a percentage of THE has varied significantly over the years, showing that it may not be being consistently treated as a priority. Given Namibia's comparatively high maternal mortality rates, consideration should be given towards allocating greater health resources to these programs.

# I. INTRODUCTION

## I.1 Importance of Health Accounts Data in Namibia

Namibia has made a commitment to achieve universal health coverage (UHC), which requires the provision of quality health services to the population at an affordable cost. Health financing is a key element to consider in the move towards UHC, and Health Accounts provide crucial data to inform health financing mechanisms. The Health Accounts allow decision-makers to gain a better understanding of the current health financing situation, which will assist them in making decisions about the future direction of health financing in the country.

In addition to making decisions about health financing systems for UHC, Namibia needs to strategize on the sustainability of its health financing. Donor funding for priority programs such as HIV/AIDS, TB, and malaria has decreased, while these diseases continue to have a significant impact on Namibia's health status.

Aggravating matters, Namibia is experiencing a substantial decrease in its economic growth. This, combined with factors such as more than half of the population living below the poverty line (World Health Organization (WHO) 2010), and the current health financing system being predominantly tax-based (WHO 2015a), has created increasing pressures on

the fiscal space for health. At the same time, demand and costs for health services are increasing due to an aging population, increasing incidence of NCDs, and the continuous threat of communicable diseases. To increase affordable access to quality health care while funding shrinks and costs rise, the country will need to focus on equitable allocation of available resources and efficient use of those resources. That will help prevent the loss of the health gains to date.

By providing sound estimates of past spending, the Health Accounts findings can help determine whether health care spending is sufficient based on international comparisons. The Health Accounts also can help determine whether allocations are appropriate, and if not, how reallocations could achieve more value for money.

In this report, we will provide data on the sustainability of Namibia's health financing, particularly for priority diseases; the impact of current spending on key health conditions and priority diseases; and the impact of out-of-pocket expenditure on Namibia's population. This will inform strategic funding decision-making by helping determine where spending has been effective and where it is necessary to devote more money to capacity building. In light of the wealth of information the Health Accounts generate, the MOHSS is striving to move toward institutionalization (regular production and use) of Health Accounts.

“First published in 2000 by OECD, EUROSTAT, and WHO, the System of Health Accounts framework was updated in 2011 (OECD et al. 2011). SHA 2011 is now the international standard for national-level Health Accounts estimations. For additional details on the SHA 2011, please refer to the 2011 Edition of the System of Health Accounts (OECD et al. 2011) and two recently developed technical briefs on the SHA 2011 (Nakhimovsky et al. 2014; Cogswell et al. 2013).”

## 1.2 History of Health Accounts in Namibia

This report presents the findings of Namibia’s Health Accounts exercise for the 2014/15 fiscal year, which is Namibia’s fifth round of Health Accounts and is the second round conducted using the System of Health Accounts 2011 methodology. The first three rounds of Health Accounts in Namibia covered 11 years of spending between 1998/99 and 2008/09<sup>1</sup>, while the fourth round covered a one-year period of 2012/13. The results of the prior rounds of Health Accounts exercises have been critical in informing the design and review of the country’s Health Sector Strategic Plan and the current development of the fifth National Development Plan. The estimates of spending in priority areas such as reproductive health derived through the Health Accounts exercises have informed resource allocation discussions. Further, combined with information from other sources regarding the geographic distribution of health resources, Health Accounts estimates have helped the MOHSS develop a resource allocation formula that is currently under review for implementation. In addition to the Health Accounts estimations, the MOHSS has completed three rounds of National AIDS Spending Assessments (NASA). The MOHSS published the latest NASA report in 2014 (MOHSS et al. 2014). Taken together, the NASA and Health Accounts data provide the government and other stakeholders with key information on the resource flows for the health sector and for the overall HIV/AIDS response.

## 1.3 Study Objectives

The immediate objective of the 2014/15 Health Accounts exercise was to track the magnitude and flow of spending from all sources of health financing: government, households, NGOs, employers, medical aid schemes, and external donors. During the planning stages of the Health Accounts, the MOHSS and its Health Accounts Steering Committee identified policy questions that the Health Accounts should answer (Table 1). Findings will contribute to the evidence base on health spending and inform policy decisions about health financing reform.

**Table 1. Key policy questions guiding Health Accounts estimation**

Policy area	Policy question
<b>Sustainability of health financing</b>	How sustainable are the overall resources flowing to the health sector, given the potential decline of donor support as the country transitions into upper-middle-income status?
<b>Sustainability of health financing; spending by disease area</b>	How is declining donor support reflected in funding of priority areas such as HIV, TB, malaria, noncommunicable diseases, and maternal and child health?
<b>Risk pooling</b>	What share of spending on health is out of pocket?
<b>Relative spending of private sector</b>	What is the role of the private sector in provision of health care? How big is its share of total spending on health?

## 1.4 Data Sources

Health Accounts provide a comprehensive view of total health spending in a country – covering public, private and donor sources of funds. To gather primary data, the Health Accounts technical team, which the MOHSS led, surveyed a wide range of sources (Table 2). In addition to the primary data collected, the team collected secondary data to supplement the analysis. For more-detailed

<sup>1</sup> The first in 2003 for financial years 1998/99 to 2000/01 (MOHSS 2003), the second in 2008 for 2001/02 to 2006/07 (MOHSS and Health Systems 20/20 2008), and the third for 2007/08 and 2008/09 (Government of Namibia et al. 2010).

information on the methodology Namibia used, along with a list of data sources, assumptions, and limitations, please see the Statistical Report (MOHSS 2017).

**Table 2. Data sources for Health Accounts 2014/15**

<b>Data source</b>	<b>Purpose of information</b>
<b>Donors (both bilateral and multilateral donors)</b>	To understand their level of external funding for health programs in Namibia
<b>NGOs involved in health</b>	To understand flows of health resources through NGOs that manage health programs
<b>Private employers</b>	To understand the extent to which employers provide medical insurance through the workplace and, where applicable, which employers manage their own health facilities or provide workplace prevention
<b>Private medical aid funds</b>	To understand total expenditures on health by medical aid schemes through health or any other type of insurance or risk-pooling mechanism

The team collected secondary data from the following sources:

- Government spending data for the MOHSS, Ministry of Finance, Ministry of Defense, and Ministry of Education from the Republic of Namibia Estimates of Revenues and Expenditures 2014-15 (Republic of Namibia n.d.)
- Household expenditure data from the 2013 Namibia Demographic and Health Survey (MOHSS et al. 2014)
- Utilization data from the National Health Information System, electronic Patient Management System, Electronic Dispensing Tool, and MOHSS annual report for 2014/15
- Cost data from WHO Choice to triangulate the distribution keys
- Medical aid expenditure data extracted from the annual report for 2014 of the Namibia Financial Institutions Supervisory Authority (NAMFISA)
- Health Facility Census data from 2009 to develop a distribution key for the expenditure of the MOHSS
- National Population Census of 2011

## 1.5 Data Analyses and Capacity Building

Once all data was collected, the Health Accounts team worked to validate the information received from both the primary and secondary data sources, and uploaded the results into the Health Accounts Production Tool (HAPT), which is a piece of software developed by WHO that facilitates the planning and production of Health Accounts through the automation of previously time-consuming procedures. The HAPT was used to map the expenditures and to generate preliminary Health Accounts results. These preliminary results were reviewed by the Health Accounts team within the MOHSS and then presented to the MOHSS management for validation in March 2017.

It is a significant accomplishment for the MOHSS to have completed the Health Accounts estimation for 2014/15 in rapid succession to the 2012/13 Health Accounts. The production of Health Accounts estimations on a regular basis provides the ministry with a consistent information flow to enable critical decision-making. One of the critical objectives of the technical support provided by the United States Agency for International Development's (USAID's) Health Finance and Governance (HFG) for the production of the Health Accounts was building the capacity of the MOHSS Health Accounts technical team. This capacity building was accomplished: the team has gained substantial

experience and knowledge about the SHA 2011 framework, the Health Accounts methodology, and the Health Accounts Production Tool software. The Health Accounts Steering Committee, composed of representatives of the MOHSS, Ministry of Finance, National Planning Commission, Social Security Commission, Namibia Association of Medical Aid Funds, and the Namibia Chamber of Commerce and Industry, provided valuable support to the MOHSS technical team in the Health Accounts estimation process. As a result, critical relationships now exist to enable the continuous flow of data for the regular production and institutionalization of Health Accounts. The Steering Committee also is well versed in the Health Accounts estimation process, and will be a useful source of strategic direction, information, and feedback for future Health Accounts estimations.

## 1.6 Data Limitations

Despite the great accomplishments of the Health Accounts estimation process, challenges remain, which should be taken into consideration in future resource tracking exercises. The response rate on questionnaires sent to NGOs and donors was lower than expected, which could have led to some underestimation of expenditures. However, the Health Accounts team ensured that it obtained data from the two most substantial donors, including the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund, which together in the previous Health Accounts round for 2012/13 covered 92 percent of the total donor expenditures. During this round of Health Accounts, the team sought data only from NGOs that received funding from sources other than PEPFAR and the Global Fund. The rest of the NGOs that received funding from either PEPFAR or the Global Fund were accounted for in the information that the two donors provided. These measures limit the underestimation of NGO expenditures.

The response rate from the medical aid funds also was limited during this Health Accounts exercise, with a response rate of only 43 percent. The team managed the risk of underestimation of these health expenditures by obtaining the information on the medical aid industry as a whole from the NAMFISA annual report.

The Health Accounts team used a slightly different approach to collecting the employer data during this round in an attempt to streamline and simplify the data collection processes: the Health Accounts team identified key employers who are known to have in-house health facilities, health services or substantial workplace programs. These employers were selected based on the information collected during previous rounds of Health Accounts and the team's knowledge of the employers. Based on this principle, a total of 10 employers were identified for primary data collection, of which only 40 percent responded. The low response rate may have resulted in an underestimation of employer spending on health. However, the previous Health Accounts results showed that most spending by employers on health is on medical aid contributions. The data on medical aid contributions by employers was collected directly from the medical aid funds, which ensures that there is no underreporting of those expenses.

In some cases, health spending as reported in secondary sources or in surveys required additional breakdowns to allocate spending based on all classifications of the SHA framework. Part of the Health Accounts therefore involved using "distribution keys" developed based on unit cost and service utilization data, to break down spending for the functional and disease classifications.

Household spending data were obtained from the 2013 Demographic and Health Survey, which contained a module that asked respondents about their health expenditures. While this information is relatively dated, the team made adjustments to provide for inflation and population growth.

## 2. HEALTH ACCOUNTS KEY FINDINGS

Total health expenditure in Namibia in 2014/15 was N\$12,067,742,100 (USD1,329,046,487), of which 94 percent was recurring spending. Recurring spending is the spending on health goods and services consumed within the year of the Health Accounts analysis. The remaining balance of 6 percent of spending was for capital investment, which include goods and services whose benefits are consumed over a period longer than one year. Health care-related items such as social care for HIV-positive people (not included in THE above) totaled an additional N\$159,024,219. The table below summarizes the key Health Accounts results for 2014/15 and compares them to the results of the previous two rounds. In Annex A, we provide a summary of Namibia's key health spending indicators relative to those of neighboring countries, to those of countries of similar income that have conducted Health Accounts, and to those of countries with a similar level of GDP per capita.

**Table 3. Key Health Accounts findings**

Indicator	2008/09	2012/13	2014/15
Total population	2,051,896	2,142,660	2,458,830
Exchange rate (N\$/US\$1)	N\$8.20011	N\$8.58369	N\$9.08000
GDP (in 2014/15 real N\$)	N\$104,332,034,010	N\$119,397,538,856	N\$141,033,000,000
GDP per capita (in 2014/15 real N\$)	N\$50,846	N\$55,724	N\$57,358
THE (in 2014/15 real N\$)	N\$7,076,951,115	N\$10,236,134,035	N\$12,067,742,100
Total current health expenditure	N\$6,842,445,458	N\$9,820,042,384	N\$11,384,679,270
Total capital health expenditure	N\$234,505,657	N\$416,091,650	N\$683,062,830
THE per capita (in 2014/15 real N\$)	N\$3,449	N\$4,777	N\$4,908
THE/GDP	7%	9%	9%
Total government health expenditure (in 2014/15 real N\$)	N\$3,806,230,033	N\$5,529,159,704	N\$7,712,818,660
Current government health expenditure	N\$3,579,290,317	N\$5,129,441,201	N\$7,086,845,850
Capital government health expenditure	N\$226,939,716	N\$399,718,503	N\$625,972,810
Government health spending as a percentage of total general government expenditure	14%	13%	13%
<b>Who funds health? Key financing sources (% THE)</b>			
Public	54%	54%	64%
Private	24%	38%	30%
Donors	22%	8%	6%
<b>How much do households spend? Household spending (% THE)</b>			
Total household spending (prepayments to medical aid and direct payments to providers) as a % of THE	12%	16%	10%
Household OOP spending (direct payments to providers only) as a % of total health spending	6%	11%	9%
<b>Who manages health resources? Key financing agents (% THE)</b>			
General government	54%	44%	51%
Medical aid schemes	28%	37%	36%
Corporations (other than insurance corporations)	<1%	1%	<1%
NGOs	9%	6%	3%
Households	8%	11%	9%
Donors	<1%	<1%	<1%

Indicator	2008/09	2012/13	2014/15
<b>Where are health funds spent? Key health care providers (% THE)</b>			
Public hospitals	37%	41%	32%
Private hospitals	9%	14%	17%
Private clinics and doctor's offices	9%	13%	11%
Health centers*	<1%	7%	4%
Pharmacies	11%	7%	8%
Providers of preventive programs	14%	3%	2%
Providers of ancillary services	3%	<1%	12%
Health system administration	11%	12%	11%
Other	5%	2%	2%
<b>What types of health care are consumed? Key health functions (% THE)</b>			
Inpatient curative care	16%	39%	35%
Outpatient curative care	37%	30%	24%
Medical goods	11%	7%	8%
Preventive care	14%	6%	5%
Governance, health system and financing administration	11%	12%	10%
Capital formation	2%	4%	6%
Other	10%	2%	12%

Sources: All 2008/09 figures are from Government of Namibia et al. 2010, unless otherwise noted, and 2012/13 figures are from Ministry of Health and Social Services June 2015. The 2014/15 population figure is from the 2011 National Population Census of Namibia, <http://www.gov.na/population>. Exchange rates and GDP come from the Namibia Statistical Agency: Country Profile.

Notes: Where applicable, values are in real 2014/15 Namibian dollars.

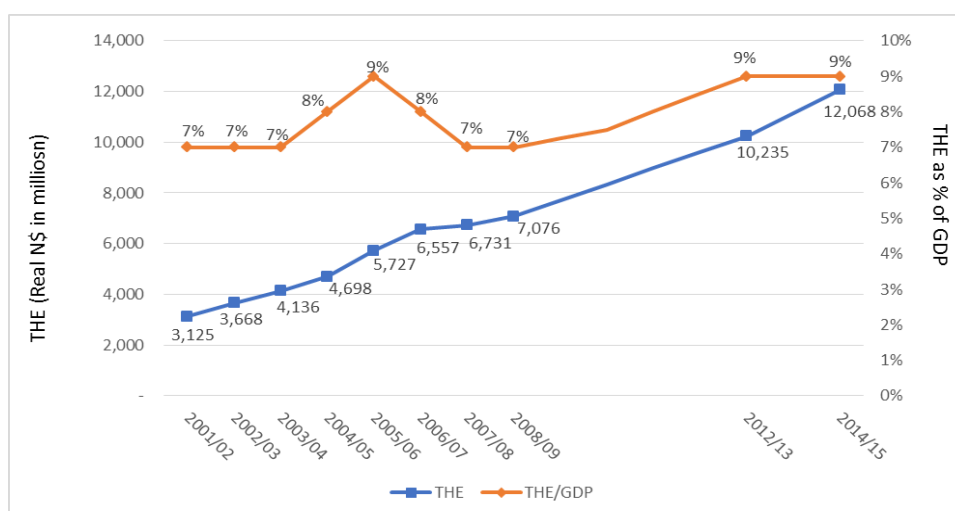
\*This includes government-owned health centers and clinics.

## 2.1 General Health Expenditures

The figures presented in this section show THE – they include both recurrent and capital spending, but exclude health care-related spending. Figure 1 shows that in real 2014/15 Namibian dollars, THE grew from N\$3.1 billion in 2001/02 to N\$12.1 billion in 2014/15, an average increase of more than 12 percent per year.

The figures show a steady increase in the real dollar amount of THE over the years in which there were Health Accounts estimations, implying that THE is increasing faster than inflation. THE as a percentage of GDP increased steadily from 2001/02 to 2005/06, from 7 percent to 9 percent, dropped back to 7 percent in 2007/08 and 2008/09, and then increased again to its peak of 9 percent, where it stayed in both 2012/13 and 2014/15. GDP growth in absolute terms in some years may have compensated for the lower percentage of THE out of GDP.

**Figure 1. Growth in THE, 2001/02-2014/15 (real 2014/15 N\$ millions)**

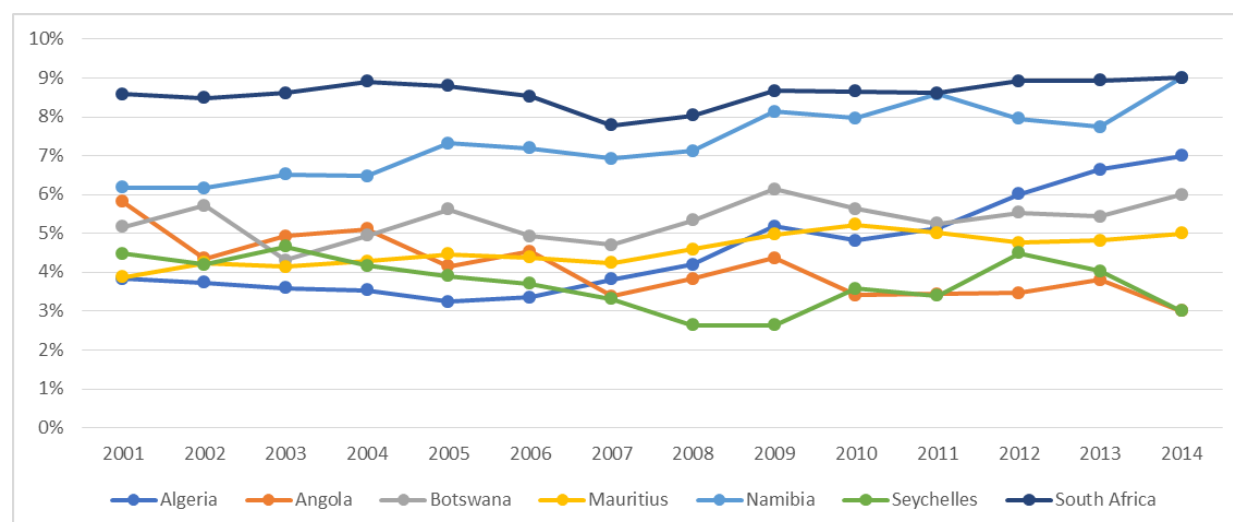


Source: Health Accounts data 2001/02-2014/15.



As stated above, in 2014/15, Namibia's total health expenditure was 9 percent of GDP. This represents a 2.53 percentage point increase over the past 10 years, while the average for the region was an increase of 0.5 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. Figure 2 shows total health expenditure as a percentage of GDP over time for all countries in WHO's African region that are classified as upper-middle income.

**Figure 2: Country comparison of THE 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.

Namibia's total health expenditure as a percentage of GDP was the highest together with South Africa for this group of comparable countries, and its total health expenditure per capita was the second highest within the group. Table 4 shows total health expenditure per capita alongside total health expenditure as a percentage of GDP in 2014. In that year, Namibia's total health expenditure per capita, at \$540, was US\$103 above the average of US\$436, and US\$58 above the median of US\$482.

**Table 4: Total health expenditure per capita, US\$ adjusted for purchasing power parity and total health expenditure as a percentage of GDP, 2013**

Country	THE per capita	THE as % of GDP
Algeria	362	7
Angola	179	3
Botswana	428	6
Mauritius	482	5
<b>Namibia</b>	<b>540</b>	<b>9</b>
Seychelles	494	3
South Africa	570	9

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

## 2.1.1 Who funds health spending and how much do they contribute?

Financing sources include all entities and institutions that contribute funds to the health system. During the 2014/15 financial year, the government of Namibia made the largest contribution to health spending, contributing close to two-thirds (64 percent) of health spending, which the government predominantly finances via its tax-based system used to generate general revenue for the government (Figure 3).

**Figure 3. THE by Source of Financing**

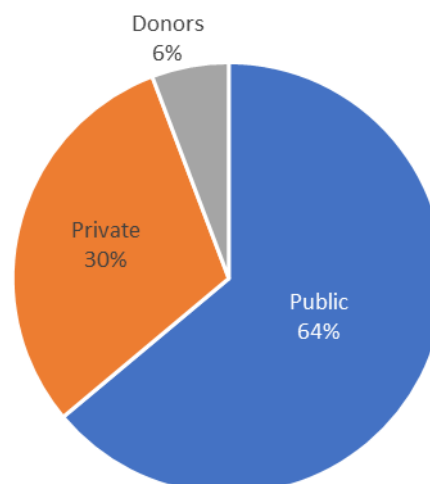
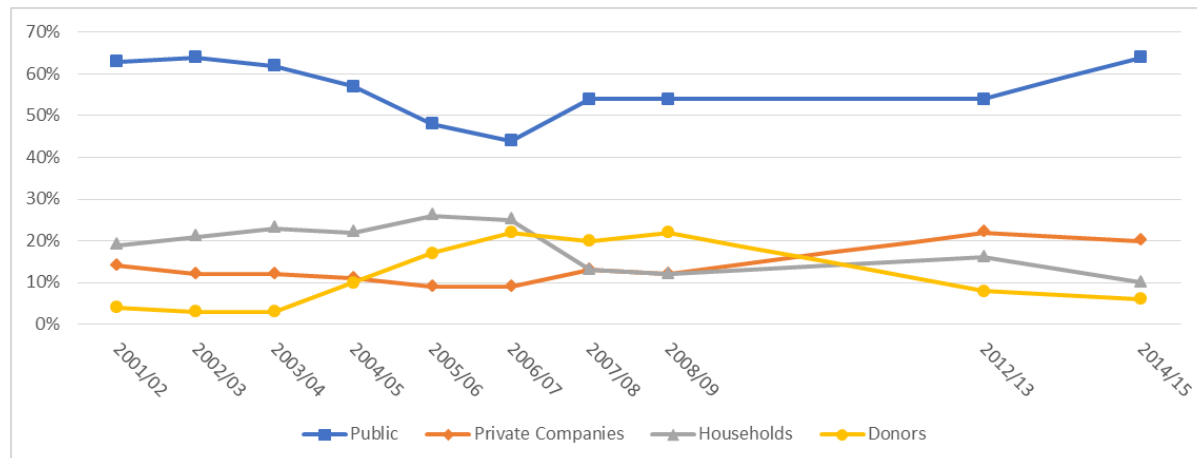


Figure 4 shows how the contributions from the different health financing sources have changed over time. The government has been the largest source of funding since 2001/02. Its relative contribution decreased to a low of 44 percent in 2006/07, but then increased again to its maximum of 64 percent in 2014/15. The decrease in the proportion of health financing funded by the government coincides with the increase of donor expenditure from 2004/05, when Namibia started receiving significant funding from PEPFAR and the Global Fund for its fight against HIV/AIDS as well as TB and malaria. The donor funding has decreased again significantly from its peak of 22 percent in 2008/09 to its current levels of only 6 percent as a result of Namibia being upgraded to an upper-middle-income country. The proportion of health financing provided by private companies has been increasing consistently over the past 5 years, while household expenditure seems to be displaying a decreasing trend.

**Figure 4. Trends in financing sources, 2001/02-2014/15**



The substantial government contribution to health spending comprises 13 percent of the government's total spending, a higher level than in other countries in the region (Annex A). Between 2001 and 2013, government health expenditure as a percentage of total government expenditure varied between 11.7 percent and 14.7 percent, the latter percentage occurring in 2007/08 (Figure 5). As of 2012/13, government health expenditure as a percentage of total government expenditure was 13 percent and remained unchanged in 2014/15. This means that the government came very close to allocating the targeted 15 percent of its budget to the health sector in accordance with the Abuja Declaration in 2007/08, but has slightly moved away from this target again in more-recent years. Nonetheless, the government has demonstrated a strong continued commitment to the achievement of the target. As the government continues its efforts to achieve universal health coverage, this commitment needs to persist.

**Figure 5: Trends in government spending on health as a percentage of total general government spending in comparison to the Abuja target, 2001/02–2014/15**

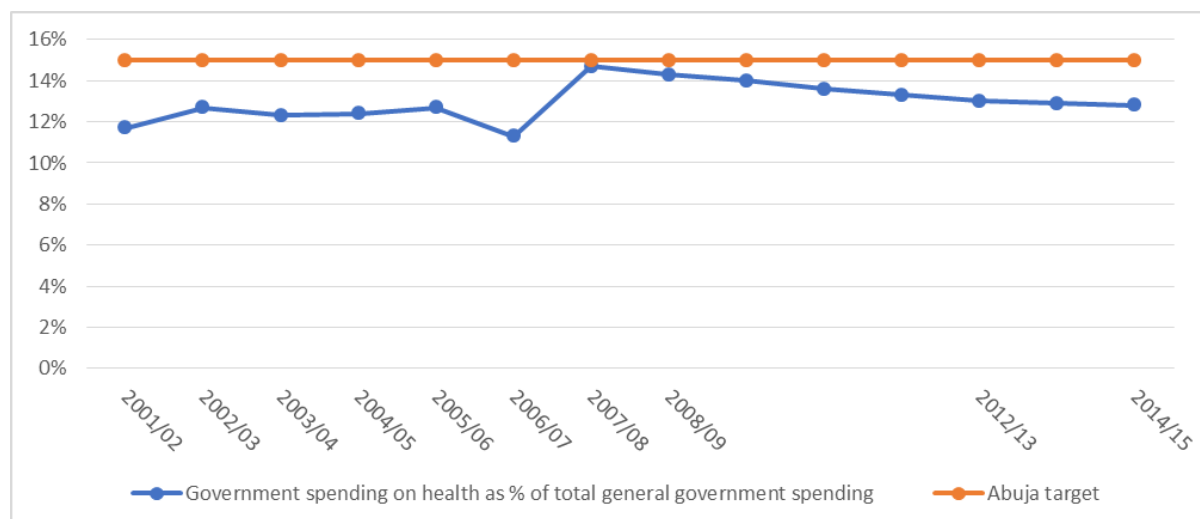
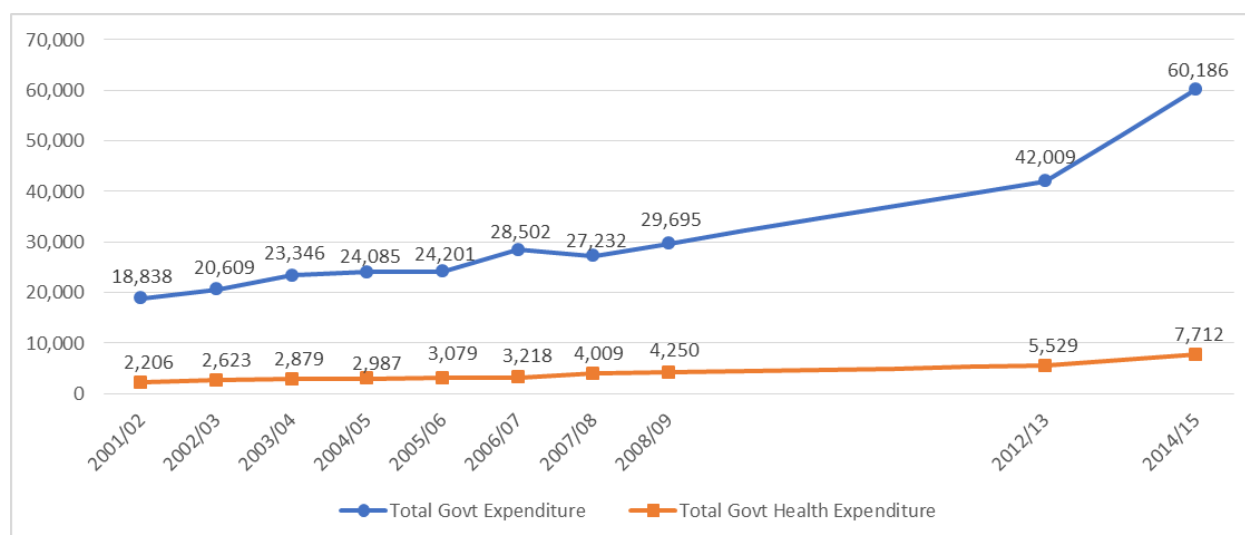


Figure 6 shows that in real Namibian dollars, the amount of government health expenditure has increased steadily from year to year, representing the government’s commitment to health. However, the total government expenditure is increasing at a faster pace than the government expenditure on health, which means that health may be of decreasing importance in terms of the government’s priorities.

**Figure 6. Total government expenditure and total government health expenditure, 2001/02-2014/15 (real 2014/15 N\$ millions)**



The 2014/15 Health Accounts estimations show a significant increase in government spending on health compared to in 2012/13, when the government contribution amounted to 54 percent. The percentage contributions of THE by employers, households, and donors all decreased in relation to the figures in the 2012/13 Health Accounts, when the contributions by these entities were 22 percent, 16 percent and 8 percent respectively. The government needed to offset the anticipated decrease in donor funding (from 22 percent in 2008/09) as donors responded to Namibia’s transition to an upper-middle-income country. The government also seems

“ Donor financing for health has decreased in recent years and this trend is expected to continue. The gap in financing created by the decreases in donor funding has mainly been compensated for by the government. ”

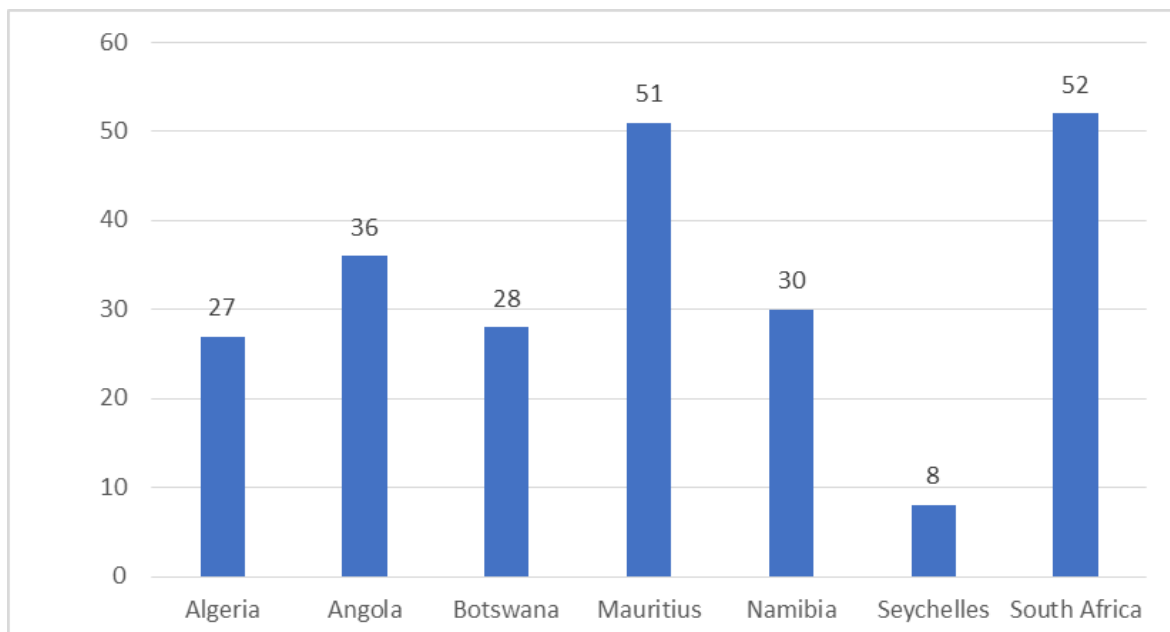
to be compensating for a proportionate decrease in spending by employers (from 22 percent to 20 percent) and households (from 16 percent to 10 percent).

The trend in the contribution by the private sector to health shows a relatively consistent increase in the spending by private companies, while the household expenditure has decreased over the years (refer to Figure above). However, between 2012/13 and 2014/15 there was a small decrease in the relative proportion of health costs carried by private companies. The absolute amount of health spending by private companies has nonetheless increased. The decrease in the private sector's share of health spending could be due to the government's increased contribution to health, thereby overshadowing the smaller increase in contribution by private companies. Alternatively the private sector may be more sensitive to changes in the economy and the decrease in GDP may be reflected in the comparatively smaller increase in health spending.

“ Private sector contributions to health are relatively low compared to in similar upper-middle income countries in the region, which means that opportunities might exist to diversify the source of funds for health and strengthen private sector involvement. ”

The private sector contributes 30 percent of THE in Namibia (comprising households, at 10 percent, and companies, at 20 percent), which is slightly lower than the average (33 percent) for the other countries in the region with similar GDP per capita (Figure 7). Private sector contributions are lower in Algeria, Botswana and Seychelles, while in Mauritius and South Africa these private expenditures approach or exceed 50 percent of total health spending. Angola's private sector contribution is only slightly less than 40 percent. Namibia's finding represents an opportunity to diversify the source of funds for health and strengthen private sector involvement.

**Figure 7. Cross-country comparison of private expenditure on health as a percent of THE**

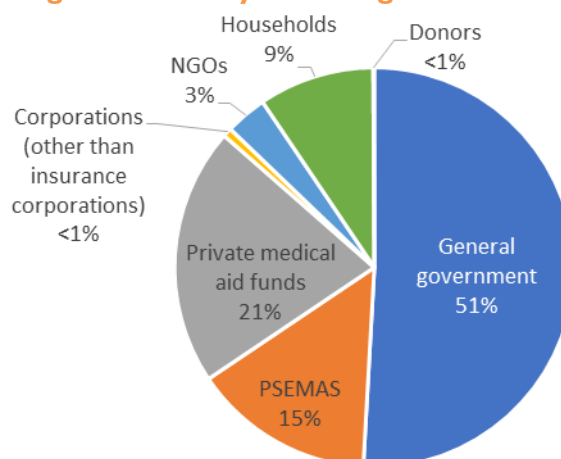


### 2.1.2 To what extent are funds for health care pooled to minimize risk?

Risk pooling in health spending is one of the key indicators of the level of equity in paying for health care, as it determines the extent to which individuals will bear financial burdens when they require health care. Pooling risk across a large group of individuals is important to ensure the even spread of risks so those who cannot afford health care and are most sick receive support from those who are wealthier and less sick. Therefore, the risk of incurring a financial burden or catastrophic health expenditures as a result of seeking health care is spread across the population group.

Financing “schemes” describe the type of financing arrangement through which people receive health care. The MOHSS, Ministry of Education, and Ministry of Defense are referred to as General Government. The General Government financing scheme accounts for more than half of health spending (51 percent of THE) and pools resources (and therefore spreads the risk) across the entire population (Figure 8). In addition to the General Government scheme, the public sector effectively manages an additional 15 percent of health spending by means of the Public Service Employees Medical Aid Scheme (PSEMAS), which covers public service employees. Private medical aid funds are responsible for pooling 21 percent of health spending, which is a considerable reduction from 30 percent in 2012/13. Voluntary, regular pre-payments to these schemes pool resources across policy holders to reduce the financial risk for households that might otherwise incur large outlays when they receive care.

**Figure 8. THE by Financing Scheme**



There is risk pooling in the Namibian health sector via the government financing schemes and the medical aid funds and PSEMAS financing schemes, but there is very limited cross-subsidization between the rich and the poor in either private medical aid schemes or public medical aid schemes through 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. Furthermore, the government is highly subsidizing civil servants, who tend to be wealthier than the overall population, by funding 85 percent of the premium, which represents N\$1.5 billion.

Namibia, the country with the second highest Gini coefficient<sup>2</sup> in the world (World Bank 2015), has large income inequality across its population. The health system reflects this inequality, which is exacerbated by the lack of cross-subsidies and the existence of the parallel health system. Approximately 445,000 people, or 18 percent of Namibia’s population, are enrolled, or receive coverage as dependents, under either PSEMAS or one of the private medical aid funds. The private medical aid funds and PSEMAS together spend N\$4.4 billion on health, which implies that 36 percent of THE is spent on health care for only 18 percent of the population. The remaining 64 percent of THE covers the other 82 percent of the population, who are mostly informal workers, the unemployed, and other vulnerable populations.

“ The private sector could be one possible source of domestic financing that the government should consider in its assessment of sustainable financing sources to increase the total funding for health in the country. In the country’s efforts to achieve UHC, the government may want to consider options of contracting private providers in the provision of health care to relieve some of the pressure on the public health system and to achieve greater efficiencies. ”

The population covered through PSEMAS and medical aid funds decreased from 19 percent in 2012/13 to the current 18 percent, which could indicate possible affordability issues. This corresponds to the reduction in the percentage of THE medical aid funds spent.

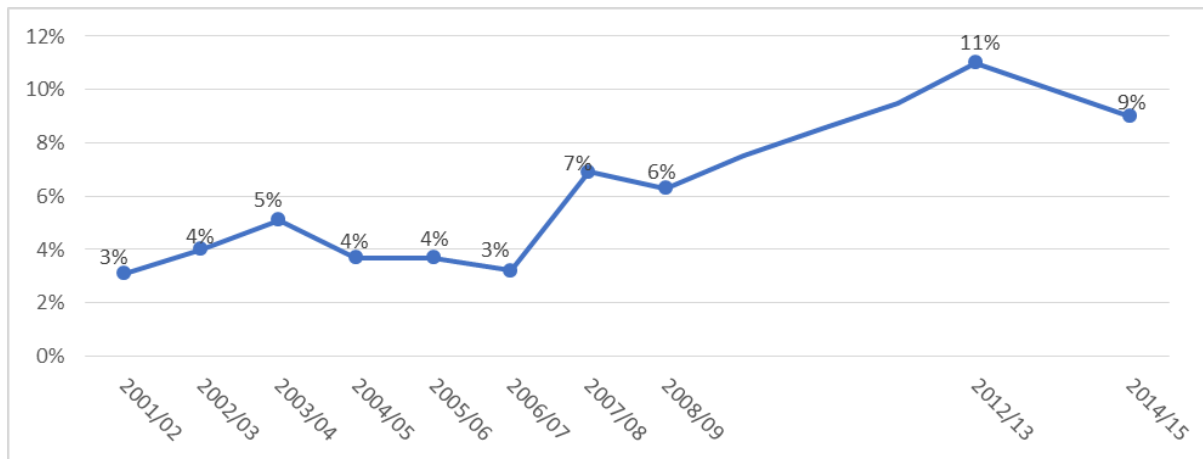
Household spending on health is currently estimated to be 10 percent of THE, of which 90 percent (i.e., 9 percent of THE) is estimated to be incurred out of pocket for the cost of health goods and services at the time of care. The remainder is contributions to medical aid funds. A WHO study indicated that countries with OOP spending less than 20 percent of total health spending reduce the likelihood of having significant catastrophic spending (Xu et al. 2010). Namibia thus falls well within

<sup>2</sup> The Gini coefficient is a measure of statistical dispersion intended to represent the income distribution of a nation’s residents, and is the most commonly used measure of inequality.

this limit. Namibia's level of OOP spending places the country in the middle of the group with countries with similar income levels. Botswana, South Africa, and Seychelles have lower OOP spending (Annex A).

In past years, Namibia's OOP spending has been significantly lower than the current level of 9 percent, with a low of 3 percent in 2001/02 and 2006/07 (Figure 9). Since 2006/07 the OOP spending in Namibia shows an increasing trend, which means that there is a greater risk of financial burden. Though OOP spending decreased again after 2012/13, when it had reached a high of 11 percent, there is room for Namibia to continue to increase risk pooling and to actively manage OOP spending by households.

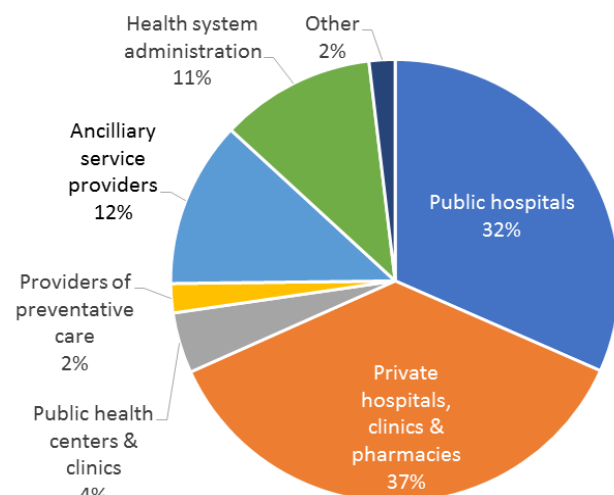
**Figure 9: Trends in OOP**



### 2.1.3 Who uses health funds to deliver health care?

Government hospitals and private health facilities use the greatest portion of health spending to deliver care, with public hospitals accounting for 32 percent and private providers for 37 percent of THE (Figure 10). The 37 percent of THE used by private health facilities can be further broken down as 17 percent of THE for private hospitals, followed by 11 percent for private clinics and 9 percent for private pharmacies. Public health centers and clinics use only 4 percent of THE, which is low given that these facilities are the entry point into the public health care system and the main providers of primary health care. The most notable change from the 2012/13 results is the decrease in spending on public hospitals, which was previously 41 percent of THE.

**Figure 10: THE by Facility Type**

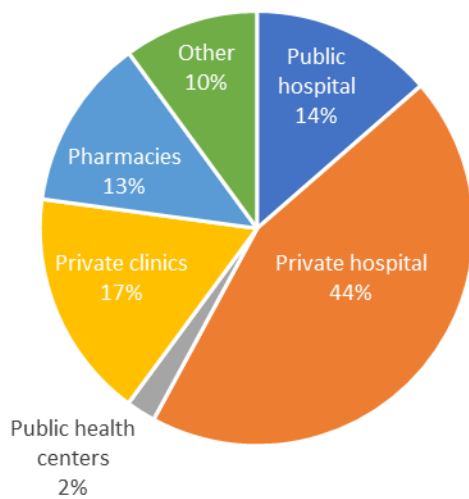


The spending on the different types of users can be further analyzed according to who is managing these funds. It is important to determine whether there are significant differences in the spending patterns of the different financing agents.

The funds that are managed by the government are mostly spent in public hospitals, with a total of 63 percent of government spending being allocated to their hospitals (Figure 11). Consistent with the overall health spending by provider, 8 percent of government expenditure is in public health centers and clinics, and only 2 percent on providers of preventative care. Health system administration absorbed 20 percent of the government health spending. The spending by the government on private hospitals of 7 percent comprises mostly funding contributions to mission or faith-based hospitals.

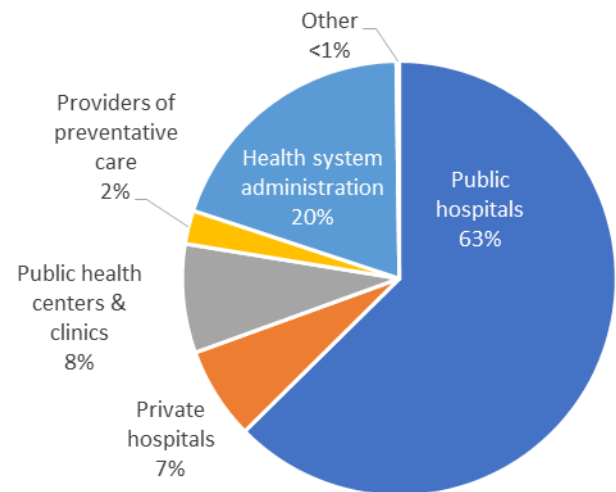
Given the implications of OOP spending for the population’s risk of financial burdens due to sickness, it is important to understand how households spend the money. The majority of spending (74 percent) is on private providers, including private hospitals (44 percent), private clinics (17 percent) and private pharmacies (13 percent) (Figure 12). On the other hand, a combined total of only 16 percent of the spending

**Figure 12: Household OOP Spending by Type of Provider**



persons, such as people living with HIV, pregnant women and children under age five.

**Figure 11: Government Health Spending by Provider**



is on public facilities: more specifically, 14 percent is spent on public hospitals and 2 percent at public health centers. The low level of OOP spending on public health providers shows that the user fees charged in these facilities are unlikely to create an excessive burden on households in terms of their OOP spending in relation to costs incurred for private health services. User fees are waived for persons who cannot afford payment, as well as vulnerable

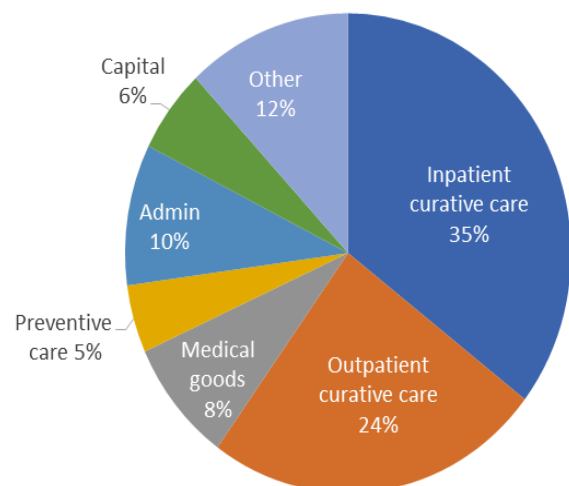
### 2.1.4 How is health spending allocated among treatment, prevention, and other activities?

Curative care continues to dominate health spending in Namibia, with 35 percent being spent on inpatient and 24 percent on outpatient curative care (Figure 13). These amounts have decreased slightly in comparison with the ones reported in the 2012/13 Health Accounts, in which inpatient curative care amounted to 39 percent and outpatient curative care amounted to 31 percent at all health facilities, both public and private.

Spending on prevention services has decreased even further from the 6 percent in 2012/13, which was already significantly lower than the 14 percent estimated in 2008/09. This trend may indicate an inappropriate balance between curative services versus preventive services, as limited prevention spending may cause patients to seek treatment when illnesses become more acute – and therefore more expensive.

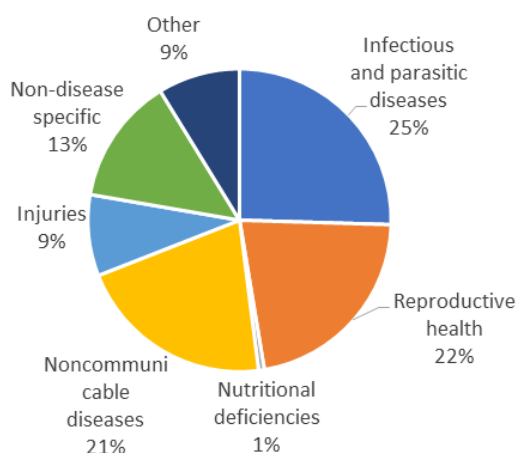
The purchase of medicine and medical goods represents 8 percent of health spending. General management accounts for 10 percent of health spending, which fell from 12 percent in 2012/13.

**Figure 13: THE by Type of Service**



## 2.1.5 Which diseases and health conditions does Namibia spend on?

**Figure 14: Spending by Disease/Health Condition**



Infectious and parasitic diseases received the highest allocation of funds, with 25 percent of THE, followed closely by reproductive health and non-communicable diseases, with 22 percent and 21 percent respectively (Figure 14). These allocations show the commitment the government of Namibia has made to prioritizing communicable diseases. Within the infectious and parasitic diseases category, spending is highest on HIV/AIDS, at 10 percent of THE, followed by respiratory infections at 6 percent, and diarrheal diseases at 4 percent. Close to 2 percent of THE was spent on TB, while less than 1 percent of THE was spent on malaria. While the expenditure on TB and malaria was similar to what was shown in the 2012/13 THE, with 1 percent of THE being spent on each of the diseases, the expenditure on HIV/AIDS has decreased over that same period, from 14 percent

of THE. Since HIV/AIDS prevention and care are largely funded by donors, the decrease in spending evidences the transition of donor financing. The next two sections will examine in more detail the spending on HIV and reproductive health in Namibia.

Spending on non-communicable diseases has increased significantly, from 5 percent of THE in 2012/13 to 21 percent in 2014/15. This reflects the fact that these diseases are starting to pose greater health challenges in Namibia as it undergoes an epidemiological transition from communicable diseases to NCDs. NCDs currently represent roughly one-third of the disease burden, and they are an increasing percentage of the burden (Institute of Health Metrics and Evaluation (IHME) 2016). However, NCD prevention receives less than 2 percent of the spending on NCDs. If Namibia does not address NCDs clinically and financially, they will have economic implications, as Namibians who suffer from them work for fewer years and are less productive when they work.

“Non-communicable diseases are becoming a greater threat to Namibia as the country undergoes an epidemiological transition. Spending on NCDs has increased significantly, from 5 percent in 2012/13 to 21 percent of THE, reflecting the greater burden of the diseases. Spending on the prevention of NCDs remains very low, at 2 percent of spending on NCDs, and should be increased to avoid the comparatively more substantial costs of treatment.”

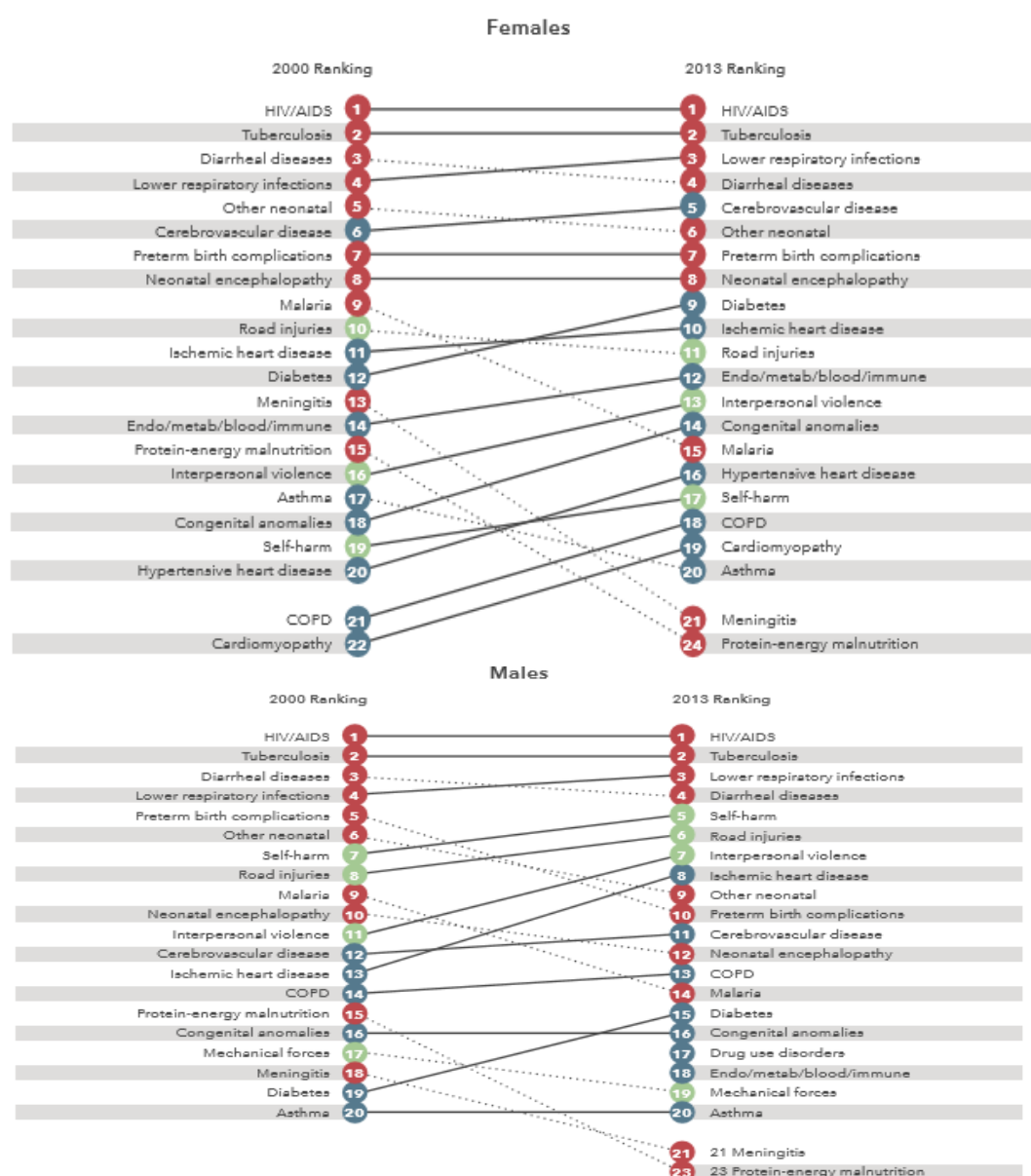
## 2.2 HIV Expenditures

This section discusses the subset of health spending that goes to HIV health goods and services only. HIV/AIDS remains the leading cause of premature death and has had a major impact on the country's life expectancy, which in turn has resulted in substantial health spending to try to manage the disease.

Figure 15 shows that HIV continues to rank first in the Namibian Burden of Disease list ranking of the top causes of years of life lost (YLL). Total spending for HIV in 2014/15 was N\$1,254,780,920 (10 percent of THE), with 95 percent of it representing recurring spending and 5 percent capital spending. Despite the continued significance of the disease, the portion of THE spent on HIV has decreased since 2012/13, when spending on HIV amounted to 13% of THE.



Figure 15. Top 20 causes of YLLs 2000-2013 Females and Males, Namibia



This chart shows the change in the top causes of YLLs due to premature mortality from 2000 to 2013. Solid lines indicate a cause has moved up in rank or stayed the same. Broken lines indicate a cause has moved down in rank. The causes are color coded by blue for non-communicable diseases, green for injuries, and red for communicable, maternal, neonatal, and nutritional causes of death.

Source: IHME (2016)

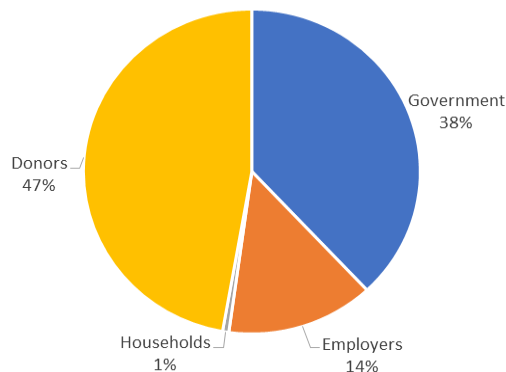
## 2.2.1 Who is funding HIV health goods and services?

Even though Namibia has been experiencing the withdrawal of significant donor funds as the country transitions into upper-middle income status, donors still provide the greatest portion of funding for HIV (47 percent) (Figure 16). The government partially compensated for the slight decrease in donor spending for HIV from 51 percent in 2012/13 as Government spending increased to 38 percent from 37 percent in 2012/13. The contribution of household spending remains very low at only 1 percent

“ HIV continues to obtain the largest share of its financing from donors. Although HIV remains the leading cause of death and premature mortality in Namibia, spending on the disease as a percentage of THE has decreased significantly, from 30 percent in 2008 to 10 percent in 2015. ”

of HIV spending, which means that people living with HIV have protection from financial risk when seeking care.

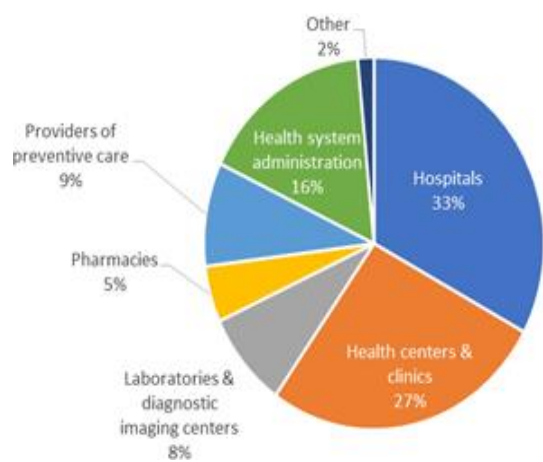
**Figure 16: HIV Spending by Source of Financing**



### 2.2.2 Who uses health funds to deliver HIV services?

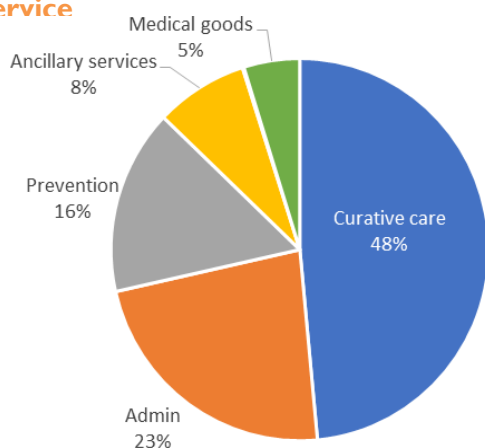
One-third (33 percent) of HIV health spending was incurred at hospital level, while 27 percent was incurred in health centers and clinics (Figure 17). The provision of HIV services at secondary or tertiary health facility level is more expensive than service provision at primary health facilities, particularly for HIV services. With hospitals consuming the largest portion of HIV spending, efforts should be focused on moving the provision of HIV services from hospitals to health centers and clinics in order to achieve greater efficiencies in service delivery. This approach will also improve the accessibility of HIV services. Provider of preventative care consumed 9 percent of HIV health spending. Approximately 5 percent was spent on providers of ancillary services and 5 percent on medical goods. Spending on administration amounted to 16 percent of the total HIV health spending.

**Figure 17: HIV Spending by Provider**



### 2.2.3 What types of HIV health goods and services are purchased?

**Figure 18: HIV Spending by Type of Service**



Approximately 48 percent of HIV health spending was on care and treatment, while 16 percent was on prevention, which includes counselling and testing, distribution of condoms, and information, education and communication (Figure 18). Spending for the prevention of HIV/AIDS remains higher than the overall spending on prevention for all diseases combined. General management of the HIV/AIDS program represents 23 percent of HIV spending. Compared with general health spending, where the share of THE spent on administration is 9 percent, the proportion of HIV spending spent on administration is high. This comparison suggests that there might be some efficiency gains to be made through pooling administration spending across different service categories.

## 2.3 Reproductive Health Expenditures

This section looks at spending on reproductive health (RH) goods and services. This category is a subset of the results presented in Section 2.1. Spending on RH, which comprises maternal health, family planning, and other services, accounts for 21 percent of THE. Spending for RH in 2012/13 totaled N\$3,526,296,384, with 93 percent of it representing recurring spending and 7 percent capital spending. Spending on reproductive health decreased from 37 percent in 2012/13 to 21 percent in 2014/15, but is still significantly higher than it was in 2007/08 (12 percent) and 2008/09 (10 percent).

“Spending on reproductive health as a percentage of THE has varied significantly over the years, showing that it may not be being consistently treated as a priority.”

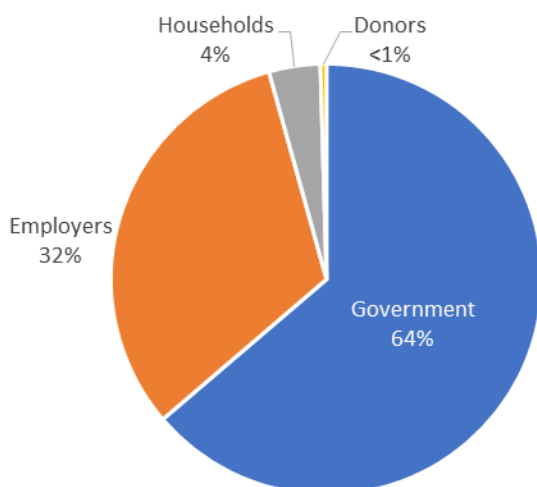
### 2.3.1 Who is funding reproductive health goods and services?

The government provides the majority (64 percent) of spending on RH (Figure 19). Employers provide the second largest portion of spending, 32 percent. The spending by donors and households is low, with less than 1 percent and 4 percent respectively. This means that RH services will be sustainable as donors reduce their funding. The Namibian people have fairly good protection from financial risk when seeking RH care.

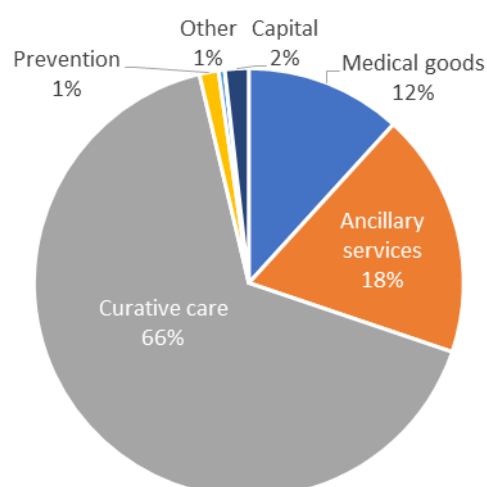
### 2.3.2 What types of reproductive health goods and services are purchased?

The majority of RH spending at 66 percent is for care and treatment, while only 1 percent goes to prevention (Figure 20). Eighteen percent is spent on ancillary services and 12 percent is spent on medical goods.

**Figure 19: RH Spending by Source of Financing**



**Figure 20: RH Spending Type of Service**



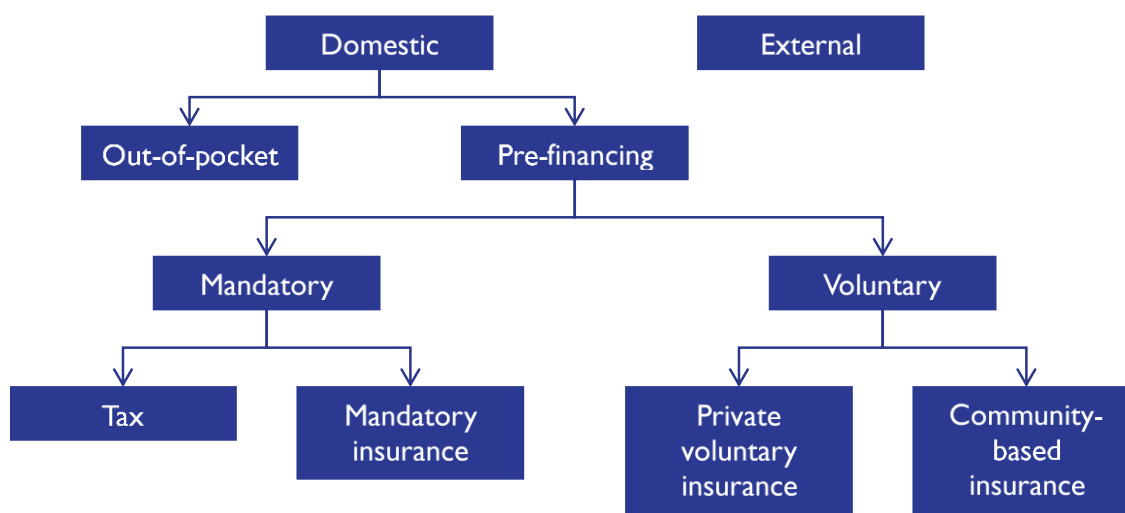
### 3. POLICY IMPLICATIONS AND RECOMMENDATIONS

The results of the Health Accounts exercise elicit a number of recommendations to inform financing of the overall health system in Namibia. The implications of the Health Accounts results for key policy considerations are discussed in this section and corresponding recommendations are provided.

#### 3.1 Assess Options for Sustainable Domestic Health Financing

Donor funding in Namibia has decreased significantly over recent years and this trend is expected to continue as Namibia transitions to an upper-middle-income country. In addition to identifying alternative sources of financing to maintain the same level and standard of services and health outcomes as donor funding for health is reduced, Namibia has committed to the achievement of UHC, which will require additional financial resources. There are various options of financing that the government could explore to increase the fiscal space for health (Figure 21).

Figure 21. Options of Health Financing



WHO recommends pre-financing mechanisms as sustainable sources of funding for health, and that health care financing be secured through mandatory prepayments to ensure effective risk pooling and cross-subsidization. That implies that either a mandatory health insurance system or government spending through taxation should be adopted. Increasing government spending on taxation can be achieved by increasing the government’s allocation to health as a percentage of total government spending to reach the Abuja target; increasing tax rates; or introducing a dedicated health tax (e.g., on international flights; sin taxes).

The government’s ability to mobilize resources through the general tax revenue system may be a challenge given the recent state of the economy, which even resulted in the need for budget cuts in 2016. As the government’s overall ability to raise revenue is limited as a result of the slowing economy and reduced economic growth, the government will likely face difficulties in increasing its overall allocation to health. Furthermore, as the government needs to reprioritize its funding as a result of budget cuts, the potential to increase the percentage allocated to health in relation to the overall government expenditure may be limited. Therefore, the different financing options need to

be analyzed within the current economic and country-specific context, while at the same time considering the long-term implications for the sustainability of each of these options.

Another way of increasing the domestic fiscal space is by improving efficiencies, which will result in better use of resources to achieve specific results, rather than simply spending more on health. The government has demonstrated a strong commitment to health; however, going forward, it will be important for the MOHSS to also understand whether its health spending is sufficient and equitable across the population. The government should aim to understand the extent of unmet health needs and where its spending does not reach those who need it the most: groups who are underusing health services because of financial and other barriers to access. By comparing costed projections with Health Accounts data on past spending, the government can predict resource gaps and mobilize resources accordingly. The various health financing options need to be comprehensively evaluated to ensure the long-term sustainability of health interventions.

## 3.2 Identify Sustainable Domestic Financing for HIV, TB and Malaria

HIV/AIDS remains the leading cause of death and premature mortality for all ages. Tuberculosis and lower respiratory infections were the next leading causes of death and premature mortality in 2013. Although Namibia is close to achieving its goal of malaria elimination, the country did experience outbreaks in 2017, which means that renewed efforts will be required to fully achieve the goal.

Despite the diseases' positions on the list of top causes of death and premature mortality in Namibia, the spending on HIV/AIDS as a percentage of THE has decreased significantly, from 30 percent in 2008 to 10 percent in 2015, while spending on TB remains low, at less than 2 percent of THE. Spending on malaria amounted to less than 1 percent of THE. Currently 47 percent of funding for HIV/AIDS is financed by donors, while approximately 23 percent of the TB funding and 18 percent of malaria funding is received from donors. This implies that care for these priority diseases that pose a significant risk to the health of Namibia's population is largely donor financed, which places the sustainability of their programs at risk. Although the decrease in funding for HIV/AIDS as a percentage of THE has not yet had a notable negative impact on the HIV programmatic results, it is important for the government to ensure that adequate financing is sourced domestically to sustain the HIV/AIDS, TB and malaria programs as donor funding is transitioned, so that the progress made and successes achieved thus far are not reversed. As Namibia reassesses its health financing options to ensure sustainability, it is important that policy-makers also focus their efforts on securing sustainable financing for these priority diseases.

## 3.3 Increase the Role of the Private Sector

At 30 percent of THE, Namibia's private sector spending is relatively low in comparison with that of other countries with similar GDP per capita. This represents an opportunity to diversify the source of funds for health and strengthen private sector involvement.

In the country's efforts to achieve UHC, the government should evaluate the private sector as a possible domestic source for additional health financing, as it could prove to be a significant sustainable financing source that will allow the country to increase its total funding for health. Furthermore, the government may want to consider options of contracting with private providers in the provision of health care to relieve some of the pressure on the public health system and to achieve greater efficiencies.

## 3.4 Continue to Manage Household Out-of-Pocket Expenditure

In Namibia, only 18 percent of the population is covered by PSEMAS or private medical aid funds, which account for approximately 36 percent of THE. As a result, the remaining 82 percent of the population are covered by the remainder (only 64 percent of THE) either through the public health system or OOP. The population that needs to be covered either through the public health system or OOP spending is particularly vulnerable, as it comprises mostly informal workers and unemployed or vulnerable persons. Household OOP spending in Namibia is relatively low in comparison with that of other southern African countries. But it is important to ensure that OOP spending does not increase again as it did between 2008/09 and 2012/13. OOP payments cause households to bear the full cost of health goods and services at the time of care, which can cause a significant – and potentially catastrophic<sup>3</sup> – financial burden, particularly for a vulnerable population group.

Pooling risk across a large group of individuals is important to ensure that risks are evenly spread so that those who cannot afford health care and are most sick receive support from those who are wealthier and less sick. Risk pooling reduces the risk of individuals incurring a financial burden or catastrophic health expenditure as a result of seeking health care. It ensures equity in paying for health care, as it determines the extent to which individuals will bear financial burdens when they require health care.

A WHO study indicated that countries with less than 20 percent of total health spending are less likely to have significant catastrophic health expenditures (Xu, Ke et al. 2010). In 2014/15, Namibia's OOP spending was 9 percent of THE, which is considerably less than this threshold and which is also significantly less than the average of OOP spending of similar upper-middle-income countries in the region, which is 16.8 percent. Despite this, OOP spending in Namibia has increased substantially following 2006/07. The government must maintain the levels of OOP payments as low as possible to prevent potential resulting inequities. Schemes that pool risk across a large group of individuals can ensure that those who cannot afford health care and are most sick receive support – essentially subsidies – from those who are wealthier and less sick. In addition, the government needs to address issues that contribute to household payments, such as the escalating cost of medical aid premiums.

## 3.5 Improve Efficiencies and Accessibility

Namibia is devoting a significant portion of its health expenditures to curative care (59 percent of THE) delivered at the secondary and tertiary levels (49 percent of THE). In contrast to these figures, only 17 percent of THE is spent at the primary health care level. One of the key constraints to the provision of health care services in Namibia is the lack of human resources. Namibia's public health sector has barely two health workers per 1,000 people, which puts it short of the WHO recommendation of at least 2.5 health workers per 1,000 population (WHO 2015b). The primary health care level is understaffed, especially in rural areas. In those areas, the public health sector experiences chronic shortages of frontline primary care workers, including doctors and nurses (McQuide et al. 2013). To improve the quality of services, improve accessibility of critical services in remote areas, and achieve greater allocative efficiency, the MOHSS should consider allocating a greater portion of its resources (human and other) to the primary health care level and prevention initiatives, to ensure that staffing is sufficient to meet the demand for primary health care and prevention interventions at these levels, particularly in rural areas. In addition to reallocation or additional allocation of human resources, the MOHSS could also consider task-shifting as a possible means of providing the services more efficiently. This strategy has the potential not only to free up additional resources but also to improve cost efficiency. To inform ministry decisions relating to cost efficiency and resource allocation, we recommend further research and analyses.

---

<sup>3</sup> Catastrophic health expenditure occurs when OOP spending for health exceeds 40 percent of a household's non-subsistence spending.

Health Accounts track total expenditure on health within a given year, and, when paired with additional health system data and indicators, can provide insight into the efficiency of the spending. We recommend an analysis in the public and private sectors to identify bottlenecks in service delivery, reduce unnecessary costs, and improve efficiencies so that each dollar spent has its greatest possible impact on health.

### 3.6 Allocate More Funding to the Prevention of Non-Communicable Diseases

Namibia is undergoing an epidemiological transition from communicable diseases to NCDs, and for some time it will continue to face this double burden of disease. The percentage of deaths caused by NCDs increased from 31 percent in 2010 to 34 percent in 2015, while the percentage of disability-adjusted life years caused by NCDs has increased from 28 percent to 31 percent. This increasing burden of NCDs is also evident from the increases in expenditure on these diseases, whereby spending on NCDs increased significantly, from 5 percent of THE in 2012/13 to 21 percent in 2014/15. If not addressed clinically and financially, NCDs will have economic costs, as Namibians who suffer from them work for fewer years and are less productive when they work. The Health Accounts results show an increase in spending on NCDs. But the vast majority of this spending is on curative care, and only 2 percent is on prevention. As the MOHSS starts to prepare the health system to address NCDs, it is increasingly important to incorporate NCD prevention interventions. Greater spending on prevention not only will help to improve the quality of life of the population but will also reduce the costs of care.

The government will require further resources to build the capacity of the system, and more health workers to respond to NCDs. That will ensure the availability and affordability of key medicines and basic technologies, and integrate NCD prevention and control into national policies (Henry J. Kaiser Family Foundation 2014). All this requires that NCDs get an even higher share of THE.

### 3.7 Allocate More Funding to Maternal Health

In terms of modelled maternal mortality rates per 100,000 live births, Namibia has the second highest maternal mortality rate in comparison to the other upper-middle-income countries in the regions, with only Angola's maternal mortality rate being higher, at 477 deaths per 100,000 live births. Namibia's maternal mortality rate is 265 deaths per 100,000 live births – higher than the average maternal mortality rate of these countries, where the average is 200 deaths per 100,000 live births. In terms of neonatal mortality, Namibia is the country with the third highest mortality rate, with 15.9 neonatal deaths per 1,000 live births. This rate is, however, lower than the average for the peer countries of 18.8 neonatal deaths per 1,000 live births, which is driven up significantly by Angola with a neonatal mortality rate of 48.7 per 1,000 live births. In 2014/15 reproductive health consumed 21 percent of THE, but spending on reproductive health as a percentage of THE has varied significantly over the years, showing that it may not be being consistently treated as a priority. Given Namibia's comparatively high maternal mortality rates, consideration should be given towards allocating greater health resources to these programs.

## REFERENCES

- Botswana Ministry of Health and Wellness. December 2016. Botswana 2013/2014 Health Accounts Report. Gaborone, Botswana.
- Cogswell, Heather, Catherine Connor, Tesfaye Dereje, Avril Kaplan, and Sharon Nakhimovsky. September 2013. *System of Health Accounts 2011: What Is SHA 2011 and How Are SHA 2011 Data Produced and Used?* Bethesda, MD: Health Finance and Governance project, Abt Associates.
- Government of Namibia, Health Systems 20/20 Project, World Health Organization, and UNAIDS. December 2010. *Namibia Health Resource Tracking: 2007/08 & 2008/09*. Bethesda, MD: Health Systems 20/20 project, Abt Associates.
- Government of Namibia, National Statistics Agency. n.d. *Namibia 2011 Population & Housing Census Main Report*. Windhoek, Namibia.
- Henry J. Kaiser Family Foundation. April 2014. Global Health Policy: The U.S. Government and Global Non-Communicable Diseases. Accessed on May 26, 2015 from: <http://kff.org/global-health-policy/fact-sheet/the-u-s-government-and-global-non-communicable-diseases/>
- Institute for Health Metrics and Evaluation (IHME). *Namibia: State of the Nation's Health: Findings from the Global Burden of Disease*. Seattle, WA: IHME, 2016.
- McQuide, P., R. Kolehmainen-Aitken, and N. Forster. 2013. Applying the workload indicators of staffing need (WISN) method in Namibia: challenges and implications for human resources for health policy. *Human Resources for Health*, 11:64.
- Ministry of Health and Social Services. September 2017. *Namibia 2014/15 Health Accounts: Statistical Report*. Windhoek, Namibia.
- Ministry of Health and Social Services. June 2015. *Namibia 2012/13 Health Accounts Report*. Windhoek, Namibia.
- Ministry of Health and Social Services. June 2015. *Namibia 2012/13 Health Accounts: Statistical Report*. Windhoek, Namibia.
- Ministry of Health and Social Services (MOHSS) [Namibia] and Health Systems 20/20. August 2008. *Namibia National Health Accounts 2001/02–2006/07*. Windhoek, Namibia and Bethesda, MD, USA: Health Systems 20/20 project, Abt Associates.
- Ministry of Health and Social Services [Namibia] (MOHSS) Directorate of Special Programs, Global Fund, and UNAIDS. 2014. *Namibia National AIDS Spending Assessment 2012/13 and 2013/14*. Windhoek, Namibia.
- Nakhimovsky, Sharon, Patricia Hernandez-Pena, Cornelius van Mosseveld, and Alan Palacios. June 2014. *System of Health Accounts (2011) and Health Satellite Accounts (2005): Comparison of Approaches*. Bethesda, MD: Health Finance and Governance project, Abt Associates.
- Organization for Economic Cooperation and Development (OECD), Eurostat, and World Health Organization (WHO). 2011. *A System of Health Accounts*. OECD Publishing.
- Republic of Namibia. n.d. *Estimates of Revenue, Income and Expenditure: 01 April 2015 to 31 March 2018*. Windhoek, Namibia.



- World Bank. 2015. GINI Index. Retrieved on May 26, 2015 from:  
[http://data.worldbank.org/indicator/SI.POV.GINI?order=wbapi\\_data\\_value\\_2009+wbapi\\_data\\_value+wbapi\\_data\\_value-last&sort=desc&page=1](http://data.worldbank.org/indicator/SI.POV.GINI?order=wbapi_data_value_2009+wbapi_data_value+wbapi_data_value-last&sort=desc&page=1)
- World Health Organization. May 2010. Country Cooperation Strategy at a Glance—Namibia. Retrieved from: [http://www.who.int/countryfocus/cooperation\\_strategy/ccsbrief\\_nam\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_nam_en.pdf).
- WHO. 2015a. Namibia Analytical Summary. Retrieved on June 2, 2015 from:  
[http://www.who.int/profiles\\_information/index.php/Namibia:Analytical\\_summary\\_-\\_Health\\_financing\\_system](http://www.who.int/profiles_information/index.php/Namibia:Analytical_summary_-_Health_financing_system)
- WHO. 2015b. Namibia Health Workforce Analytical Summary. Retrieved on May 26, 2015 from:  
[http://www.who.int/profiles\\_information/index.php/Namibia:Analytical\\_summary\\_-\\_Health\\_workforce](http://www.who.int/profiles_information/index.php/Namibia:Analytical_summary_-_Health_workforce)
- WHO GHED. n.d. WHO Global Health Expenditure Database. Accessed May 17, 2017 from:  
<http://apps.who.int/nha/database/ViewData/Indicators/en>
- Xu, Ke et al. 2010. *Exploring the thresholds of health expenditure for protection against financial risk*. World Health Report Background Paper, No. 19. Geneva.

# ANNEX A: KEY HEALTH INDICATORS FOR NAMIBIA AND COMPARATIVE COUNTRIES WITH SIMILAR INCOME LEVEL, 2014

Indicator	Namibia (2014/15)	Algeria	Angola	Botswana	Mauritius	Seychelles	South Africa
THE per capita at exchange rate (USD)	\$540	\$362	\$179	\$428	\$482	\$494	\$570
THE as % GDP	9	7	3	6	5	3	9
Government health spending as % THE	64	73	64	65	49	92	48
Government health spending as % total government spending	13	10	5	12	10	10	14
Private expenditure on health as % of THE	30	27	36	28	51	8	52
OOP spending as % THE	9	26	24	4	46	2	6

Source: WHO GHED n.d., and Botswana Ministry of Health and Wellness 2016.

# ANNEX B: CONTRIBUTORS TO THE HEALTH ACCOUNTS EXERCISE

## Core Technical Team:

ORGANIZATION	NAME	POSITION
MOHSS, Directorate of Policy, Planning and Human Resource Development (PPHRD)	Mr. T. Mbeeli	Deputy Director
	Mr. L.C. Usurua	Control Health Program Officer
	Ms. J. Malule	Senior Health Program Officer
MOHSS, Directorate of Finance and Logistics	Ms. T. Block	Accountant
USAID HFG project	Mr. T. Ashagari	Health Resource Tracking Advisor
	Ms. H. Cogswell	Health Resource Tracking Specialist
	Ms. C. Jones	Health Resource Tracking Specialist

## Other Contributors:

ORGANIZATION	NAME	POSITION
MOHSS: Directorate of PPHRD	Mr. P. Ndaitwa	Undersecretary
MOHSS: Directorate of PPHRD	Ms. H. Nangombe	Chief Health Program Administrator
	Mr. MS. Simasiku	Senior Health Program Administrator
MOHSS: Directorate of Special Programs	Mr. A. Uakurama	Chief Health Program Administrator
MOHSS: Directorate of Finance and Logistics	Ms. L. Karises	Deputy Director
MOHSS: Directorate of Tertiary Health Care and Clinical Support Services	Mr. L. Indongo	Deputy Director
MOHSS: Directorate of Primary Health Care	Mr. C. John	Chief Health Program Administrator
Ministry of Finance: Medical Aid Division	Mr. E. Coetzee	Chief Account
National Planning Commission	Ms. E. Ilonga	National Development Advisor
NAMFISA	Ms. M. Nakale-Gaomas	General Manager, Provident Institutions
Namibia Association of Medical Aid Funds	Mr. G. Mbapaha	Chief Executive Officer
Namibia Chamber of Commerce and Industry	Mr. L. Kamwi	Head of Research
University of Namibia: Faculty of Nursing and Public Health Science	Dr. L. v/d Westhuizen	Lecturer
Polytechnic of Namibia: School of Health and Applied Science	Mr. J. Hidinwa	Lecturer





