Agreement for Performance of Work

Support services to enable country level collaboration for improved institutional frameworks in the area of health financing systems

NAMIBIA Summary

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by

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1. BACKGROUND DOCUMENTS:

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2. ANALYSIS:

(i) Political/Governance challenges:

● The Covid 19 pandemic has negatively affected delivery of essential health services, pointing out weaknesses in the ability of the health system to respond to the pandemic. The health system in Namibia continues to struggle with the shock caused by the Covid 19 pandemic and the burden of other leading communicable and non-communicable diseases, having a negative impact on economic growth.

● The Government of Namibia has consistently provided a significant proportion of its annual budget appropriation to the health sector. In 2017/18 the Total Health Expenditure (THE) as a percentage of GDP was 8%. The government

contributed 62% towards THE, while the private sector contributed 31%. The remaining 7% was contributed by donors. Overall, the government health spending as a percentage of general government expenditures stood at 15 percent in 2017/18, which implies that Namibia has fully met its commitments in terms of the Abuja declaration. And over the last 10 years, government expenditures on health have increased while private expenditures and external resources decreased, indicating improved sustainability for financing Namibia's health care system.

● Despite the strong government commitment to invest in health, many of the health system challenges persist with insufficient delivery of health outcomes: poor quality of health services in the public sector as a result of inadequate infrastructure and equipment, human resources, and management capacity; difficulties to obtain timely and accurate data to inform decision making; lack of necessary resources to provide appropriate health services due to sub-financed public health system, and, in particular, insufficient funding for preventive and primary health care services[1]; low quality of care, especially for population living in rural and remote areas; poor absorption of government funds for health; inefficiencies in the allocation and use of funds; increasing costs of health services, especially in the private sector; poor performance in terms of life expectancy; high burden of communicable diseases such as HIV/AIDS and TB; high maternal mortality ratio and child malnutrition.

● One of the most critical issues regarding health financing is the inequality in the distribution of resources for health, caused by a fragmented health financing system that discriminates according to the ability to pay, job status, residence in urban or rural areas. As a result, access to quality medical care is not assured for a significant segment of the population (80%).

● The Public Service Medical Aid Scheme (PSEMAS) [2] perpetuates the inequities that exist in the health sector as the relatively wealthier segment of the population that is employed by government is strongly subsidized and benefits from

[1] Namibia still relies on external resources to finance health care, notably for HIV/AIDS for which over half of funding comes from donors.

[2] The health needs of employees in the public service and their dependents are provided for through the PSEMAS. The public servants and their dependents represent 12% of the population, who have access to quality health services of their choice, which may be appropriate for UHC. However, the contributions do not take into account any risk factors or the ability to pay, which means that there is limited cross-subsidization. The monthly contributions to PSEMAS are minimal to the costs of private healthcare, which means that the Government is required to strongly subsidize the fund. In recent years, the Treasury consistently subsidized approximately 85% of PSEMAS pay-outs, indicating that the scheme is not at all sustainable.

access to superior health services. In a significant way, the substantial subsidies that the government pays towards PSEMAS are not only unsustainable for the fund itself, but also work against the principles of solidarity as more public funds are spent on civil servants who generally earn more than the average income of the country, while the member contributions are also not linked to an ability to pay.

● The National Medical Benefits Fund (NMBF), which aims to provide for the payment of medical benefits to employees and essentially serves as a Social Health Insurance mechanism has not yet been established and is not operational[3]. The NMBF is mandated by the Social Security Commission (SSC)[4].

● Limited engagement with, and insufficient use of the private health sector to improve efficiency of care. Namibia has a well-established private sector which is mainly financed through medical aid funds that are regulated by the Medical Aid Funds Act of 1995[5]. However, if a number of laws have already been promulgated to regulate both the public and private health sectors, with additional regulations, policies and guidelines developed by the Ministry of Health and Social Services (MoHSS), progress and adjustments needs to be done for implementation by all health care providers.

● The premiums for private medical aid funds are risk-adjusted based on the age of the member and the dependents. Due to the rapidly increasing costs of private healthcare, private medical aid schemes are becoming increasingly

[3] The NMBF requires that every employee of every employer be registered with the Fund, except if he or she is a member of another medical aid fund approved by the Minister on recommendation of the SSC.

[4] Under the Social Security Act No. 34 of 1994, the SSC is responsible for the establishment and management of the following funds: (i) Maternity leave, Sickness leave and Death Benefit Fund (MSD fund): to provide for the payment of maternity leave benefits to female employee members, sick leave benefits to all employee members, and death benefits to dependents of all employees, subject to the provisions of the fund; (ii) Development Fund: to provide for the funding of training schemes for disadvantaged persons, employment schemes for unemployed persons, bursaries, and other forms of financial aid; (iii) National Pension Fund: to provide for the payment of pension benefits to retired employees, subject to the rules of the fund; and (iv) National Medical Benefit Fund (NMBF): to provide for the payment of medical benefits to employees.

[5] This Act defines how medical aid funds need to be registered, administered, and managed, as well as the mandate of the Namibian Association of Medical Aid Funds (NAMAF). Medical aid funds are regulated by the Namibia Financial Supervisory Authority (NAMFISA), particularly in terms of the liquidity and solvency of the funds.

unaffordable for the vast majority of the population, thus making Universal Health Coverage (UHC) increasingly difficult to attain[6].

● The significant level of spending by medical aid funds and PSEMAS in relation to the populations covered by these funds result in inequities in healthcare among different population groups in the country. It is therefore necessary to review the existing institutional and legal frameworks in the health sector, both public and private, and in particular the inequities, and to bring reforms where appropriate.

● Another challenge is the high level of donor dependence for health financing among other WHO-AFRO upper-middle-income countries (the HIV/AIDS response is particularly donor dependent).

● Political and governance is a building block that cuts across all the health system functions and must be appropriately designed to address health financing challenges and not become an obstacle, but rather an enabler for universal health coverage. Key areas that must be reviewed include policies, laws, and regulations that enable resource mobilisation, resource utilisation, procurement of services and service delivery. In particular, emphasis should be laid on: formulating fair, adequate and updated policy; generating information for decision making; putting in place tools to implement policy; enhancing multi-sectoral collaboration; and ensuring accountability.

(ii) Socio-economic challenges:

● Namibia is ranked as a middle-income country. However, it has one of the most unequal distributions of income per capita in the world. Poorer households can only allocate minor shares of expenditure to healthcare.

● Main socioeconomic factors jeopardizing progress towards UHC are the following (not exhaustive): economic recession; high unemployment rate; poor distribution of wealth in the country; increasing health costs; high costs of hiring health or medical professionals; high interest rate and inflation in the country; sterilization and abortion Act which will increase service demand; religion and

[6] Furthermore, the structure of many health insurance schemes favours wealthier populations. For example, high annual premiums instead of installment payment options and reimbursement mechanisms means that healthcare must first be paid through Out-of-Pocket Payments (OOP).

cultural practices; migration; gender-based violence; crime; high accident rates; and substance abuse.

● Namibia is mostly rural and only about 4 out of 10 people live in urban areas. The size of Namibia, combined with a low population density, makes it challenging for the health sector to provide universal access to quality health services across the country with about 21% of Namibians living more than 10 km away from a health provider.

● Barriers to health services for elderly in rural and remote areas is a strong matter of concern: although elderly people appreciate the use of modern health care and are exempted from paying health care consultation fees, they still prefer to use traditional health medicine because of the long distance to health care facilities (high transportation costs).

● If health insurance is an important component of health service utilisation in Namibia, inequities in the coverage of these insurance schemes are still predominant. Specifically, women and those with lower levels of education and wealth are less likely to be covered by health insurance.

● There is a need to identify the most important strategies and actions needed to strengthen health financing for UHC and tackle wider determinants of health beyond the health sector.

(iii) Financial challenges:

● Various factors are likely to limit the ability of the government to secure and allocate significant additional resources for health. They include: Exchange rate volatilities; Reduction of indirect tax revenues; High fiscal deficit and debt burden; High unemployment; and expected increasing inflation.

● Securing sustainable financing is one of the most important challenges. The Government actually faces increasing pressure to fund high-priority health programs. 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. For example, HIV and AIDS care and prevention are still financed primarily by donors, despite the disease being the highest-ranking cause of death and premature

mortality in the country[7].

● Key financial challenges are thus the following: Mobilizing sustainable domestic resources for the achievement of UHC in the country; Strengthening mechanisms that will minimize the role of out-of-pocket (OOP) spending; Mobilizing alternative domestic resources to finance priority areas such as HIV and AIDS (predominantly funded by development partners so far)[8]; and more broadly, ensuring that available resources for health are distributed equitably in order to promote achievement of UHC goals.

● Namibia has actually to cope with the fragmentation of the health system and differences in health coverage between people who are covered by PSEMAS, those who can afford private medical aid, and those who have neither. Namibia has not yet reach equity in finance[9]. The distribution of health resources among the population is still largely unequal[10] and the health financing system is characterized by high inequalities. It does not adequately allow for the pooling and sharing of resources on an equitable basis. Reforms must thus address these inequities and devise strategies on how best to mobilize, pool and manage resources, fund the essential health service package for all at all ages, and ensure that no one suffers financial hardship when accessing essential health services.

- Revenue raising[11]:

[7] 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

[8] UNICEF supported the development of a sustainable financing strategy for HIV in order to align with the Southern African Development Community (SADC) framework. This strategy is in place but not yet endorsed.

[9] Equity in finance refers to the distribution of the burden of financing the health system across different socio-economic groups. To be considered equitable, the burden of health financing should be distributed according to individuals' ability-to-pay. Equity requires that resources be distributed in line with needs for health services, and can be considered across various dimensions as relevant, e.g. between socioeconomic groups or geographic areas.

[10] An estimated total population of 1.79 million or approximately 81 percent of the Namibian population remains uncovered by a medical aid fund and thus is reliant on either the public health system for access to health services or on OOP payments for private health care. National health accounts show that approximately 44 percent of total health expenditure is used to provide health services to 19 percent of the population, while the remaining 56 percent of total health expenditure had to cover the remaining 81 percent.

[11] Revenue raising includes the following issues: sources of funds, structure of payments or contribution methods for funding health services and collection arrangements.

● Mobilizing additional resources for health domestically is a strategic objective. Key options include increasing the efficiency of revenue collection, reprioritizing government budgets, and implementing innovative financing mechanisms.

● There is a need to critically analyse the allocation of public resources, so that resources can be allocated in a more targeted manner that follow the government's priorities. Resources should be rebalanced from curative to preventive healthcare services, and from services being provided at tertiary healthcare level to primary healthcare. Similarly, the government should also ensure that adequate resources are allocated to maternal and neonatal health, as investments have decreased significantly.

(i) Increasing the efficiency of revenue collection[12]:

- It is critical that the resources are used as efficiently as possible and that the absorptive capacity of the MoHSS is improved. Focus should be placed on improving the quality of care provided in public facilities, ensuring health services are accessible, and appropriate benefits packages are offered.
- This may imply for example to assess the financial implications of major policy changes before being approved, e.g. introduction of new eligibility criteria and new treatments for antiretroviral therapy (ART).
- Assuming that the NMBF is established, the challenge in terms of UHC will be to effectively provide quality health benefits to the population that remains uncovered by prepaid health insurance or medical aid, even after the introduction of the NMBF.
- The remaining population should be covered either through an expansion of the mandatory NMBF or through government spending raised from taxation.
- In order to effectively reduce the inequalities in resources between the public and private sectors, there is a need to generate more resources for public health services through taxation and ensuring the effective use of these resources[13].

[12] Efficiency refers to producing as many health services, of good quality, as possible with the available resources. It implies that resources should not be wasted to provide effective and good quality services and that services should be provided at the lowest possible level of the health system.

[13] Health care financing in Namibia is mainly tax-based. Health care spending as a percentage as of total government spending is 13.5% - the highest in the region, but still short of the Abuja target of 15%.

- Adequate funding from both public Investments and private resource streams is crucial.

(ii) Reprioritizing government budgets[14]:

- Planning and budgeting are done in separate entities in the MoHSS and need to be brought together. The Medium-Term Expenditure Framework (MTEF) for the health sector requires definition of programmes.
- Others key measures include: Rationalising and streamlining planning and budgeting with one entity being responsible; Promoting greater involvement of districts in the planning process with possible de-concentration of a "real" budget for such levels; Provision of government grants to faith-based organization governed by result-based contracts; Initiating a process of bringing partner contributions into the state budget.
- The MoHSS has also made concerted efforts to move away from the historical budgeting practices and toward program-based budgeting with a revised resource allocation formula that will allocate resources to the regions on more relevant factors such as regional population sizes, poverty levels, disease burden, and differences in costs of service provision[15].
- So far, there is no institutional framework in place for programme-based budgeting. Therefore, working on this framework, including the amendment of the State Finance Act, is an opportunity for partners.
- International partners provide a substantial contribution targeting special programmes. Donor funds are included in forward public sector budgeting, but do not appear in the annual budget announcement by the Ministry of Finance (MoF)[16].

(iii) Implementing innovative financing mechanisms:

- Developing a health financing strategy that enables the exploration of alternative health financing mechanisms to ensure sustainability is crucial.

[14] The Public Finance Management Act influences the budgeting cycle in the health sector as well as the use of funds within the sector, reporting and disbursements and return of funds to the treasury.

[15] Such a budgeting approach would more effectively take into account the regional priorities and financing requirements. However, shortfalls and limitations within the current version of the financial management information system of the Ministry of Finance have prevented the MoHSS to fully move toward program-based budgeting and no final decisions have been made regarding the implementation of the revised resource allocation formula.

[16] The private sector contribution is 25%. Faith based organizations receive grants from MoHSS for provision of health services according to agreed contractual arrangements.

- Pooling[17]:

● Namibia has already made provision for the establishment of a mandatory health insurance fund in the form of the SSC's NMBF, which is envisioned to serve as social health insurance providing medical benefits to employees[18]. Mechanisms to ensure that the informal sector can contribute to the NMBF would substantially increase the membership and result in greater benefits of risk pooling.

> The NMBF offers an opportunity to promote financial protection and ensure equity in health financing. The NMBF is actually intended to provide medical benefits to every registered employee who is a member of the Fund and would therefore be open to every registered employee in Namibia, thereby extending the scope to a larger segment of the population as is currently the case. The NMBF will provide health insurance benefits to the employed population, in line with the other funds of the SSC, such as the maternity, sickness and disability fund.

> The NMBF may also serve as a medical aid scheme for public-sector employees and their dependents. This would have to be accompanied by the introduction of progressive contribution rates for government employees to the NMBF as opposed to the current highly subsidize PSEMAS. As a result, contribution rates will be higher for employees with higher salaries.

> UNICEF is currently supporting the development of a social protection policy in order to enhance social health protection[19]. This provides a real opportunity to link other social protection interventions to health such as providing health outreach services at the point of payment for cash transfers e.g. birth registration services, HIV/AIDS testing/counselling or health promotion messages[20].

[17] The arrangements for accumulating prepaid revenues for health on behalf of some or all of the population and whether these are combined in one or more fund pools.

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

[19] The social welfare mandate has now been distributed over four ministries: Ministry of Health and Social Welfare, Ministry of Gender Equality and Child Welfare, Ministry of Labour and Social welfare and Ministry of Veterans Affairs. This situation has caused fragmentation, overlapping and uncertainty, jeopardizing the process of developing a social welfare policy for the entire nation.

[20] Namibia has already a strong social protection system-child grants, elderly grants, marginalized communities, disability grants.

> The challenges that Namibia's healthcare system is facing relating to inequities in health and the limited access to quality health services, particularly by the poor and vulnerable populations, gave rise to the idea that the NMBF should be expanded to a more comprehensive National Health Insurance (NHI), which would allow for the extension of health coverage to these poor and vulnerable populations that do not form part of the employed population typically covered by the SSC.

> 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. Besides, the insurance should be fully mandatory, and nobody could opt out, to ensure effective cross-subsidization.

● Furthermore, the Ministry has established a Special Fund for the Treatment of State Patients for the purpose of assisting patients who are in need of special medical treatment that cannot be provided in state facilities[21].

● Equity in Namibia can be improved by pooling resources and risk sharing across wealth and income levels[22]. Pooling resources can be implicit, as in the case of tax revenues used to provide public health services, or explicit, as in the case of insurance[23].

● The health financing revenues are pooled in three different schemes to finance care for different population groups, categorized broadly into three groups[24].

(i) Government revenues are pooled in the Government budget to finance the government health scheme:

- The Government of Namibia is responsible for the public health service. Namibia does not have a national health insurance scheme, but 85% of the population rely on primary health care of the public health sector.

[21] The conditions that require special medical treatment have been pre-defined and the screening of persons eligible for assistance is done by a coordinating committee.

[22] Risk pooling is based upon the premise that contributions from the healthy pay for the care of the sick, and thus, those suffering from disease are not struck by the double burden of sickness and financial costs of health care.

[23] Essentially there are four options in terms of risk pooling: no risk pool, unitary risk pool, fragmented risk pools, and integrated risk pools.

[24] In 2016, 38% of Total Health Expenditure (THE) is pooled through PSEMAS and private medical aid funds covering 12% and 8% of the population respectively.

- Social Security is a government program of public provision, as through social insurance or assistance, for the economic security and social welfare of people. The State has the primary role in providing a framework for delivering social security and health insurance.
- The SSC, which provides different kinds of social protection to Namibian citizens, is task with administering different Funds[25].
- The future NMBF (included in the 1994 Social Security Act) shall provide medical benefits to every employee who is a member of the Fund, including the informal economy. However, establishing a national health insurance for all Namibian people, including the informal operators and workers, is still challenging in 2021.

(ii) Compulsory contribution payments for Government employees are pooled by PSEMAS:

- Standard contributions are payable by the employees, while the remainder of the claim expenses are covered by the Ministry of Finance[26].
- There is a lack of proper risk pooling, since the premiums contributed by the members are not based on their risk profile or ability to pay and the government has to provide the additional funds to ensure full coverage of all claims[27].

(iii) Voluntary contribution payments by private employers and households are pooled in individual Medical Aid Funds (MAF):

- Medical Aid Funds are regulated by the Medical Aid Funds Act 23 of 1995[28] and overseen by the Namibia Financial Institutions Supervisory Authority.

[25] For example, the Employees Compensation Fund is an employee's compensation insurance based on a collective liability for accidents. The fund pays benefits to an employee injured as a result of an accident arising out of and in the course of his/her employment. Compensation is paid for temporary disablement, permanent disablement (according to the degree of disablement), and death). The total amount paid out specifically for the provision of health care benefits is approximately 5 % of total revenue. The Motor Vehicle Accident (MVA) Fund is mandated to provide assistance and benefits to all people injured and the dependents of those killed in motor vehicle crashes in accordance with the MVA Fund Act No.10 of 2007.

[26] Only 15 percent of the total funds required for PSEMAS are paid by the employees, while the remaining 85 percent is subsidized by the government.

[27] The contributions are based on a flat rate regardless of salary level, which makes the contributions highly regressive.

[28] The Namibian Association of Medical Aid Funds (NAMAF) is a legal entity established by the Medical Aid Funds Act to control, promote, encourage, and coordinate the establishment,

- There are 10 medical aid funds operating in the country. Most medical aid funds have introduced low-cost options in an attempt to increase their market size and potential for risk pooling. Generally all funds provide for cross-subsidization across the different benefit package options, but each medical aid fund has its own funding pool[29].
- Namibia's proportion of health expenditures from private prepaid plans is around 25%, which is on the high end of all WHO/AFRO upper-middle-income countries.
- In 2016, 18 % of Namibia's population benefits from medical aid coverage through either the PSEMAS or one of the private medical aid funds. An estimated total population of 1.79 million or approximately 82 percent of the Namibian population remains uncovered by a medical aid fund and thus is reliant on either the public health system for access to health services or on Household out-of-pocket (OOP) health expenditures payments for private health care.
- OOP health expenditures can have a critical impact on health care choices made by the population, and they have the potential to cause financial catastrophe for individual households. As such, OOP expenditures as a percentage of total health expenditure is a critical indicator for assessing financial protection. In Namibia, OOP expenditures are relatively low and below the WHO limit of 20 percent of THE, suggesting that Namibians are protected against the financial risk of health payments[30].

● The government has been considering creating one risk pool for the employed population that can be expanded over time to include the entire population. The Government has also established a Special Fund to cope with the needs of the under-served who cannot afford specialist treatment, either in the private sector locally or abroad.

development, and functioning of medical aid funds in Namibia. One of NAMAF's functions is to bring together health care providers and medical aid funds on an annual basis to determine NAMAF benchmark tariffs, guideline amounts that medical aid funds contribute to defray the health care costs of members.

[29] However, with the promulgation of the Financial Institutions and Markets Act (2016), medical aid funds will need to ensure that each of their medical aid options is financially sound, which implies that cross-subsidization between options will no longer be allowed.

[30] An analysis of Namibia's OOP payments for health shows slight increases in these payments and total health expenditure t ten years. While household OOP spending in Namibia is relatively low in comparison with that of other southern African countries, it is important to ensure that OOP spending does not increase again.

- Purchasing[31]:

● Purchasing mechanisms for health services represent a major incentive to achieve desired health goals[32]. Paying for results and value for money are relevant objectives of a well-functioning purchasing system[33].

● Purchasing arrangements should further consider the availability of providers and their levels of quality and efficiency.

● Any purchasing decisions made at the regional level need to follow the overall government's procurement guidelines, with many of the major purchases made at central level and distributed to the regions. The Public procurement Act guides procurement including for the health sector. This is one of the biggest areas of inefficiency in the health sector. There are ongoing discussions on amendments to allow for pooled procurement in order to improve efficiency and reduce wastage.

● It is hard to attain efficiency gains and improve access and quality without good pooling arrangements even though health purchasing mechanisms are developed and flexible[34].

● Namibia also needs to improve its strategic purchasing of services e.g. private providers on the government PSEMAS scheme are paid by fee for service growing expenditure. The policy framework will set the foundation for reforms on health financing, recognising that it will be a gradual cross-government effort.

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[31] The means used to allocate the prepaid resources from the pool to the providers for service benefits.

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

[33] Active purchasing considers aspects of population health needs including regional health need variances and the interventions and services required to meet the health needs taking into consideration the optimum mix of promotion, prevention, treatment, and rehabilitation.

[34] One of the most critical aspects of health financing is the relationship between pooling and purchasing. Pooling is needed to obtain improvements in equity and financial risk protection.

- Financial rules and regulation/Budget:

● The legal framework for transparency and accountability in the budget process is quite comprehensive in Namibia with the regulations to the process being provided in the Constitution and the State Finance Act of 1991.

● However, there are still serious systems weaknesses in the budgeting process, which have resulted in an urgent need to curb and effectively manage overspending.

● 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 (SACU) revenue pool. In the medium term, the government is likely to encounter constraints in fiscal expansion and its ability to allocate greater resources to health.

(iv) Collaborative challenges:

● It is imperative that the approach for health financing involves engagement with a wide range of stakeholders within the health sector and beyond to ensure consensus is reached on the way forward, which will be essential for the successful implementation of the country's action plan for UHC.

● One of the key pre-requisites to improve collaboration on health financing is to adopt a multi-sectoral approach. Health outcomes are often influenced by decisions made outside the health sector itself. It is thus of strategic importance to involve non-health sectors to influence decisions that may impact health outcomes[35].

● Main objectives of enhanced collaboration are enhancing accountability and transparency in health financing and reaching consensus among key stakeholders on priorities for health financing.

● One of the biggest challenges affecting collaboration on health financing in Namibia is the lack of technical capacity that characterized the MoHSS. For example, the MoHSS does not have a functional Health Financing Technical

[35] A Strategy on Health in All Policies has been developed and will serve as a vehicle to mitigate negative determinants of health in other sectors.

Working Group to facilitate collaboration. Setting up a system for regular contact and collaboration with development partners as a group is essential to ensure harmonization and alignment on health financing issues.

● Building the capacity to bringing forward the health financing agenda within the sector but also cross-sectoral is currently the main opportunity for international partners (mainly WHO, ILO, USAID, UNICEF). This capacity will be critical for developing the health financing landscape including the requisite frameworks such as a health financing strategy[36].

● MoHSS should also further strengthen its collaboration with the MoF. Actually, if the MoHSS receives its allocation for health through the Appropriation Act[37], engagement between the two Ministries is of the utmost importance to advocate for more resources and to tackle issues relating to financial efficiencies, and cost savings.

● Interestingly, it should be noted that efforts to foster collaboration between the two Ministries is not focusing only on budget issues. UNICEF is actually supporting the MoF and the MoHSS to do an assessment on procurement. An interministerial committee has been established to follow up on the recommendations and to foster interministerial collaboration on health financing.

● The achievement of UHC would require a wider engagement that goes beyond traditional health sector boundaries and would benefit from contributions from various sectors both at national level (e.g., within the Government[38], private sector and insurance - including NAMAF, employers' federation - commerce and industry, civil society organizations[39], faith-based organizations, youth, and women's organizations) and at regional and international levels (e.g., development Partners and UN agencies).

[36] The MoHSS is currently in the process of discussing the opportunity to establish a leading group for advancing the health financing agenda.

[37] The Appropriation Act 21/22 is currently operative.

[38] In addition to MoHSS and MoF, the Government level includes (but is not limited to) Ministries of Finance, Gender, Poverty Eradication & Social Welfare, Industrial Relations and Employment Creation.

[39] MoHSS will bring together representatives of unions, academics and researchers.

(v) Health workforce challenges:

● Inequities in health financing are also manifested in the inequitable distribution of other resources, between private and public sector, and among the different geographical areas.

● The health workforce[40] is characterized by inequitable distribution, inadequate number of professionals and lack of skills in key service areas. This results in lack of service in some areas and lack of access to service for some segments of the population[41].

● In 2015, about 62% of all health professionals are employed in the private sector which serves only 20% of the population who have access to private health care leaving 80% of the population being cared for by just 38% of health professionals in the public health sectors.

● One of the key challenges is the development and implementation of the MoHSS human resources plan. It lays emphasis on innovative ways of managing health workforce, such as task shifting[42] as a modality to make better use of available human resources for health. Establishment of a performance management system to improve services and management of human resources is also a core recommendation. Special incentives for working in remote area settings and introduction of community service for all newly graduated health professionals are needed to retain staff. Developing nursing professionals, who can perform important management and public health and clinical functions, and other health and social welfare professionals as required is also critical. The health financing strategy should provide for all necessary resources.

(vi) Health information challenges:

● Generating intelligence, e.g. information and analysis for decision-making, is a core challenge to improve health financing. The infrastructure that drives the information, communication and technology needs to ensure effective functioning of

[40] The health workforce represents all persons employed primarily for health actions.

[41] The workforce situation in Namibia is above the WHO benchmark of 2.5 health workers per 1000 population. In Namibia there are 3.0 health workers per 1000 population. However, there is a very unequal distribution with most health workers concentrated in urban areas and a high percentage found in the private sector in particular in private clinics.

[42] Task shifting is a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers without sacrificing the quality of service provided.

the health system at all levels.

● Main weaknesses in health information systems are the following: Unreliable and outdated technology (example of system interruption such as Human Capital Information Management); Lack of required technology and equipment (example Magnetic Resonance Imaging - MRI machine); Technological skill deficit; poor maintenance; and poor/absence of network coverage in many remote areas.

● Strategic objectives are to maintain the responsiveness of the health management information system to progress towards UHC and to enhance disease surveillance and preparedness for pandemic situation and emergency responses. Other objectives are to invest in a modern health information system through an integrated Information and Communication Technology (ICT) e-health infrastructure in health facilities, a synchronized health information system, and improved health data collection and dissemination for health financing.

● Expected benefits are: to make business processes more efficient (i.e. management of patients and processing of documents), improve communication with patients and public, foster evidence-based decision making for health financing and establish a sustainable, affordable, customized and user-friendly health information system.

● The health information, research and innovation investments are needed in the following areas: Routine data sources: Health Management Information Systems and routine surveys such as Demographic and Health Surveys (DHS), Service Availability and Readiness Assessment (SARA) and National Health Accounts (NHAs); Disease surveillance; eHealth and other innovative initiatives; Biomedical and operations research.

● As a result, health facilities will have better access to information and benefit from affordable communication which can be used by health workers to improve the efficiency and quality of care.

3. WHAT IS NEEDED?

(i) Strengthening policy frameworks by:

● Adopting conducive policies and strategic plans:

- MoHSS developed in 2018/2019 a draft UHC policy framework aligned to Namibia's 5th National Development Plan[43] to support the realization of UHC. MoHSS is currently in the process of finalizing the UHC policy framework with the support of WHO. This will provide the platform to develop and implement institutional frameworks for health financing, in particular through the work undertaken by the governance/health financing TWGs[44].

- Action plans have been developed to translate the Policy framework into action: prioritization of activities is done based on sustainability, feasibility, budget implications, equity, and effectiveness.

- Monitoring and accountability for results have been put in place. In particular, a health care financing strategy will produce a health financing model that will provide accountability and long-term sustainability, and better health for Namibia.

- Policy measures proposed to strengthen the financial sustainability of the health system: Increasing Government health spending for primary health care to help finance prevention and treatment of communicable and non-communicable diseases at a cost-effective level of care; Introducing and increasing excise taxes on tobacco, alcohol, and sugar-sweetened beverages; Increasing contribution payments by public employees to public sector employees' medical aid scheme.

- Introducing the NMBF would require additional analysis to estimate its impact on access, financing, and the government's fiscal situation, and to ensure the NMBF contributes to the improved financial risk protection.

- The MoHSS is also undertaking a review to establish whether or not it needs a Medicines Pricing Policy. Medicines are a big cost driver for THE, including what government pays to the private sector through its medical aid fund for government employees. So far, prices are not well regulated resulting in cost

[43] This Plan aims to provide access to quality health care for Namibia's population, to increase Health Adjusted Life Expectancy and to reduce mortality for mothers and children.

[44] This path is informed by background studies that have been undertaken, including the National Disease Burden, Review of Health Financing in Namibia, National Health Accounts as well as policy and strategy documents such as the Vision 2030, National Development Plans and the Health Sector Strategic Plan.

escalation. This is a potential area for a framework to increase efficiencies through encouraging competition and setting benchmarks.

- The National Health Act establishes the National Health Advisory Committee which advises the Minister on all health matters, including the initiation, formulation, implementation, monitoring, evaluating and development of policies required for optimal service delivery.

● Elaborating costing frameworks:

- A priority action is the costing of priority interventions with cost implications[45].

Improving the efficiency of health financing and service delivery and how this impacts on health outcomes is core to UHC.

● Promoting equity in health system financing[46]:

- To improve equity in access and coverage through health financing, the Government will subsidize access to care for the poor by subsidizing health insurance coverage for the poor into the NMBF. Core is the identification of the population groups who will benefit from targeted government subsidies.

● Ensuring financial sustainability:

- The various health financing options for achieving greater sustainability need to be comprehensively evaluated within the country-specific context to ensure the long-term sustainability of health interventions. In particular, Namibia 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.

[45] Costing frameworks are necessary to ensure transparency and accountability, efficiency, and equity in the distribution and use of resources. The experience with traditional budgets as well as fee for service is that they produce overutilization of resources and lack of accountability resulting in high costs and poor health outcomes. Controls for health care costs should be developed in parallel to any initiative to expand population as well as service coverage. Monitoring and controlling cost are integral to improving technical efficiency. The increasing cost to provide health services is a major concern among public and private health systems around the globe.

[46] It is generally accepted that the burden of health financing should be distributed according to an individual's ability to pay, that is, the burden should increase as household income increases.

- Key health financing options for improved sustainability include: Increasing government revenue by increasing direct/indirect tax rates in order to increase overall government spending, including government spending on health[47]; Introducing a dedicated tax that will generate income exclusively for health spending[48];

- An alternative health financing option would consist in establishing one single pool for the entire population that provides coverage to a basic benefit package in the public and private sector. Services excluded from the basic package can still be offered as voluntary health insurance by the existing Medical Aid Funds (MAFs)[49].

- Increasing the role of the private sector is also likely to strengthen financial sustainability. The 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.

    - Enhancing the efficient use of resources:

- Identifying, measuring and tackling financial inefficiencies is of the utmost importance to move forward UHC. Reviewing the performance of the Namibia health system within the public and private sectors is a priority.

- Reducing wastage of resources would allow to free up these resources to allocate to priority programs and health interventions. Greater efficiency can

[47] 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.

[48] 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 levies 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 analysed 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.

[49] Enrollment of low-income groups into the single-pool would have to be fully subsidized by the government, whereas middle- and higher-income groups would pay their contributions. For the system to be effective, substantial investment into the readiness of providers and the overarching governance system would be needed.

actually be achieved by allocating resources to the interventions and health programs that produce the greatest improvements in health.

- Another measure is the review of the service delivery platform of the public health sector that should ensure that 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.

● Improving data availability to inform policy and decision making:

- Investing in integrated and functional information and communication technology (ICT) infrastructure at the government and in health facilities is a priority to ensure financial and performance data collection and management.

- The health information system is fragmented[50], grossly understaffed and slow to produce required reports[51]. There is also a problem with the completeness of data with problems of collecting data from the private sector.

- Substantial investment is needed in financial management and accounting systems in all health facilities. Accounting system will need to provide timely financial data to health facility managers in such a way that they can manage their expenditures. Accounting systems are also essential to send invoices to health insurance companies and get reimbursed for treatment provided to insured patients[52].

- A detailed assessment of health spending pointing out the use of both private and public financial resources in the health sector is also needed. Health Accounts estimation is actually a vital component of health systems strengthening, as it provides sound estimates of spending on health, and therefore provides critical information required for evidence-based decision-making[53]. It provides stakeholders with information on the value of purchased health care goods and services, and patterns in financing, provision, and

[50] where resource-strong programmes “push” their own information system agenda.

[51] Consequently annual reports have not been issued on a regular basis, see: Annual Report on Essential Indicators and National Health Account surveys.

[52] Coding systems will facilitate this process and could be installed in all public and private health facilities. Health facilities can be rewarded for collecting valid and reliable data.

[53] By comparing costed projections with Health Accounts data on past spending, the government can predict resource gaps and mobilize resources accordingly.

consumption of health care resources. This information will direct the MoHSS and other national policymakers, donors, and stakeholders in their strategic planning and dialogue to inform decision-making for health and social service delivery.

- Strategic responses include: assigning adequate human and other resources for information and research; creating closer links between information and policy and planning; enabling health workers/health managers at all levels to access and utilize information; capturing all knowledge generated in a unified accessible knowledge management system; liaising with relevant academic and other training institutions for conducting research; performing regular targeted surveys and specific inquiries according to programme needs, health status and health system; and ensuring submission of relevant data from the private sector.

(ii) Strengthening legal and regulatory frameworks by:

- Adopting robust legislations:

- A number of laws regulate both the public and private health sectors, with additional regulations, policies, and guidelines developed by the MoHSS for implementation by all health care providers[54].

- The main challenge is to create an enabling legislative and regulatory framework by reviewing current laws and regulations that are a barrier to achieving UHC[55]. Amending or developing new laws and regulations that will enhance the implementation of UHC, especially improving quality of care and patient safety, is a priority. Outdated, or inexistence of legislations are barriers to the provision of health services.

- Updating the National Health Act is a priority. It provides a framework for a structured uniform health system within Namibia, including the establishment of a National Health Advisory Committee, regional and districts boards. It also

[54] They include (not exhaustive): Allied Health Professions Act of 2004; Hospital and Health Facilities Act of 1994; Medical and Dental Act of 2004; Medical Funds Act of 1995; Medicines and related substances Control Act of 2003; National Disability Council Act of 2004; Nursing Act of 2004; Pharmacy Act of 2004; Public Service Act of 1995; Social Security Act of 1994; Social Work and Psychology Act of 2004.

[55] Actions will be required to establish legal frameworks in other sectors such as food insecurity, access to safe water, and promoting universal primary and secondary education.

promotes regulation regarding hospitals, health facilities and health services. The Act is to be reviewed to provide for incorporation of control of private hospitals, facilities and services which is now under the scope of the Health Facilities Act.

- The Social Security Act also needs to be amended. It provides for the establishment of the National Medical Benefit Fund, but the funds limits participation to registered employees. Reviewing the scope and conditions of participation on the fund is critical[56].

- Other legal instruments to be updated include: Public Health Act (1919)[57]; Municipality of Windhoek Health Regulations (1952); General Health Regulation (1969); Hospitals and Health Facilities Act (1994)[58].

- Legal instruments to be enacted include: Mental Health Bill, to provide the necessary protection of people with mental health problems; Traditional Health Practitioners Bill[59].

- It is also envisaged that the Medical Aid Funds Act, which governs medical aid funds will be replaced by Chapter 7 of the Financial Institutions and Markets (FIM) Bill. It is further proposed to strengthen NAMAF, which is established under the Medical Aid Funds Act and to broaden its scope to effectively address the challenges faced by the consumers of medical aid fund services and to aid in effective self-regulation of the industry[60].

- There is a need to work with the MoF and attorney General's office to clarify the existing procurement and disposition laws that govern the purchase and procurement of goods and services so that the processes are in line with Tender Board act, act 16 of 1996.

[56] The NMBF should be the preferred modality for ensuring financial protection in the next future.

[57] A new draft bill has been prepared but is still being edited.

[58] Two separate bills are in preparation: one for the public sector and one for the private sector.

[59] Traditional medicine is widely used in the country and often the first access to health for people in remote areas. However, there is no regulation of the practice and more should be done to appreciate its real contribution to health.

[60] These considerations are expected to eventually culminate in a Medical Control Board that will regulate the medical aid funds industry. All these aforesaid matters relating the NMBF, NAMAF and Medical Control Board must be consolidated to find common and most viable health finance risk protection for the consumers.

- The institutional/legal framework regulating the relationship between purchasers and providers also needs to be updated. Issues such as whether existing rules grant purchasers sufficient flexibility to pay for services and not just for inputs, and also whether they have the right to contract and pay non-state providers using public funds have to be clarified. Another critical issue that needs to be considered is the nature of any accountability mechanisms for purchasing agencies[61].

- Strategic health objectives that can be reached through legal instruments include labelling of tobacco, prohibiting sale of alcohol and tobacco to minors, and ensuring the quality of food items.

- With regard to social welfare services, a need to develop comprehensive policy which will inform a holistic body of legislation has been identified as a priority.

    - Adopting implementing/regulatory measures:

- Putting in place levers or tools for implementing policy such as the design of regulation, standard-setting, enforcement and sanctions is crucial.

- Effective regulation of the private sector is needed. Successful engagement with the private sector will depend on the presence of an enabling policy and regulatory framework. A regulatory framework should be developed regarding licensing, inspection and adherence to government policies and reporting. The very purpose should be to ensure quality of care, and reasonable tariffs to protect patients against high co-payments.

    - Developing "Legal epidemiology"[62]:

- Legal epidemiology is a process which aims at ensuring that laws and regulations are properly identified and collected in a country and at translating laws into data to support programmatic action and evaluation. Legal epidemiology can be used as a powerful tool to set up a robust and

[61] To whom are they accountable, and do they report publicly on the use of their funds?

[62] Legal epidemiology" is the implementation and evaluation of laws of public health importance, which encompasses the scientific, systematic tracking of relevant law to inform policy making and create robust data for evaluation

appropriate policy surveillance program in Namibia to accelerate progress towards UHC.

- The Strategic Plan for UHC should be costed using the One-Health Tool. This tool already incorporates the UN epidemiology impact models to demonstrate the achievable health gains.

(iii) Strengthening institutional frameworks by:

- Creating supportive environments:

- Governance structures have been established in Namibia to steer the process towards UHC[63].

- Advocating for new investments:

- Investments are needed in the areas of health workforce, infrastructure, medical products and technologies, health financing and effective service delivery.

- Establishing close monitoring and accountability for results:

- Ensuring accountability by putting in place mechanisms for independent oversight, monitoring, review and audit is core to strengthening the health financing system.

- Accountability requires regular public reporting on a range of key performance indicators (e.g. in the form of an annual report). It also requires that there are mechanisms for government to take action on poor performance. Public reporting also allows for civil society organizations to demand accountability

[63] The governance structure consists of: A Cabinet Committee to review, scrutinize, and approve the proposed UHC Policy Framework as endorsed by the UHC Technical Advisory Committee; Universal Health Coverage Technical Advisory Committee: it is a multi-sectoral technical group, providing technical oversight and guidance in the formulation of the UHC Policy Framework and reporting to the Cabinet Committee; Thematic Technical Working Groups constituted along the seven strategic pillars of the health system to formulate the polices and strategies specific to each health system block; UHC Technical Unit: Housed under the Division of Health Financing and Budget, the main purpose of this unit is to provide administrative and technical support to the Thematic Technical Working Groups and the UHC Technical Advisory Committee for the development and implementation of the UHC Policy framework.

and ensure that government indeed takes action to address poor performance. There may also be more direct mechanisms for communities and individuals to demand accountability, including complaints' mechanisms or the existence of an independent ombudsman.

- A M&E framework for Namibia's National Health Strategy 2017-2022 has been established. Annual performance review or the Annual Progress Report will be generated to measure the actual performance against the set targets that have been developed based on the country context and priorities to achieve UHC. Joint planning and reporting review meetings with all stakeholders will be periodically conducted[64].

    - Improving coordination between all stakeholders:

- Coordination and coalition-building across sectors and with external partners is fundamental for health financing promotion. Having a rational distribution of responsibilities between all stakeholders, without overlapping and double functions is essential.

- Emphasis should be laid on coordination of social mobilization including advocacy, community involvement and behaviour change communication[65].

    - Enhancing data collection:

- Resource tracking exercises provide sound estimates of past spending including the total amount spent on health, or a specific disease, as well as the flow of these funds through the health system. The data allows for detailed understanding of where the money comes from, who manages these funds and what it is ultimately spent on. Institutionalizing resource tracking in an inclusive manner would allow to fulfil the need for expenditure data, both on health in general and for specific disease such as HIV/AIDS.

[64] The choice of indicators will be determined by the ability of the indicator to measure progress and performance reliably and meaningfully; availability of data; and feasibility of collection. This process will seek to draw in citizen voice and collective stakeholder action in monitoring progress through fora such as the National Health Assembly.

[65] For example, the MoHSS has been mandated by Cabinet to manage and Coordinate the National response to HIV and AIDS, through the establishment of the National AIDS Coordination Program (NACOP) and the five yearly National Strategic Plans/Frameworks.

- This type of information is critical to inform health financing decisions, including adequate health financing systems for UHC, strategies to sustain health financing, and relevant measures to replace the diminishing donor funding.

● Aligning overall health system and health financing reforms:

- UHC is sufficiently embraced in the MoHSS's mission statement, which is to provide integrated, affordable, accessible, equitable, quality health and social welfare services that are responsive to the needs of the population. The strategies and aspiration articulated in Vision 2030, the 5th National Development Plan (NDP5) for 2017-2022 and the Strategic Plan 2017-2022 are in line with UHC.

● Transferring powers and resources to local authorities (decentralization):

- The way that government is organized is also an important contextual factor that influences both the attainment of UHC goals and the feasibility of different reform options. Most important here is the political-administrative structure, particularly the extent of decentralization within government and the decision-making responsibilities held at different levels.

- Decentralized public administration can be a source of fragmentation in pooling arrangements if government rules do not allow for redistribution across geographic boundaries. It is essential to understand the extent to which government is allowed to compensate or equalize funding across these boundaries, whether for overall levels of public finance or within the health sector specifically.

- The Decentralization Policy and Decentralization Enabling Act 33 of 2000 provides the basis for decentralizing health services as a means to bring services closer to the people and to increase access to and coverage of health services. Strengthening decentralization and the role of the regional levels in delivery of services is core to moving towards UHC. The decentralization of primary health care services to the regions has been identified as a priority. But the decentralization of key public services, including health, to local authorities, has progressed particularly slowly.

- The MoHSS has established regional directorates in each of the regions, with their own administrative, financial, and personnel management capacity. These regions have also established Regional Health Advisory Committees within their regional councils. The responsibility for policy decisions and treatment guidelines remains with the MoHSS at the central level.

- UNICEF is currently in the process of developing a fiscal decentralization framework. The MoF has already introduced an integrated financial management system (IFMS) which has the potential to de-concentrate access to this system. However, since the system is not yet established in the regions, regions still have difficulties to access funds. For example, the issuance of Funds Distribution Certificates (FDC) has only been possible so far at central level making it very complicate to have funds released for covering expenses in the regions.

    - Developing Public-Private Partnerships (PPP) and "contractual arrangements":

- Developing Public-Private Partnerships (PPP) for health is critical to improve efficiency of care and increase revenue for Government.

- The private sector (for profit and not-for-profit) plays an important role in Namibia. Its complementary role with the public health system should be strengthened, under the tutelage of the MoHSS. For example, PPP could allow for in-country provision of specialized services as a substitute for sending patients abroad.

- Likewise, adequate management of the contracts with service providers should be put in place to encourage MoHSS to enter into contractual arrangements through outsourcing arrangement with Faith-based organisations and other contractual partners.