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POLICY BRIEF

HEALTH FINANCING OPTIONS TOWARD UHC IN NAMIBIA

LOCAL HEALTH SYSTEM SUSTAINABILITY PROJECT

Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will strengthen local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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Contents

List of Figures

List of Tables

Acronyms

GDP	Gross Domestic Product
HTA	Health Technology Assessment
LHSS	Local Health System Sustainability Project
MOF	Ministry of Finance
MOHSS	Ministry of Health and Social Services
MVA	Motor Vehicle Accident Fund
NHI	National Health Insurance
OECD	Organisation for Economic Cooperation and Development
OOP	Out-of-Pocket
PSEMAS	Public Service Employees Medical Aid Scheme
RBF	Results-Based Financing
THE	Total Health Expenditure
UHC	Universal Health Coverage
WHO	World Health Organization

Executive Summary

Namibia has a robust and well-resourced health system primarily funded by public and private sector financing. Financing for health aims to ensure equitable, efficient, transparent, and adequate funding for health systems that promotes progress toward universal health coverage (UHC) objectives. The country has high financial protection (the first UHC goal), with out-of-pocket (OOP) payments as low as 8 percent, while only 1.2 percent of the population experiences catastrophic health expenditure. As a result, the country has achieved significant progress in providing quality and accessible health services for all and removing financial barriers to care. Namibia scored between 60 and 79 percent on the World Health Organization (WHO) UHC service coverage index (2019), showing high availability of and access to most services.

However, gaps in equity and adequacy of funding are visible. Access gaps are more significant for services broadly accessible and available to people experiencing poverty, where equity and quality gaps persist, and the ability of the government to provide adequate funding as health needs increase is at risk. Furthermore, reviewing current financing mechanisms shows the potential for inefficiencies that inhibit the sector from realizing the full value of each dollar invested in health care. Addressing resource allocation and utilization inefficiencies will potentially improve value for money and enable the delivery of more health for every dollar invested, thus expanding service availability within the current funding envelope. However, this is likely inadequate to fully scale up all the health system areas to provide all health services. Thus, this policy brief explores options available to improve resource use while generating more revenue for the sector toward expanding access and improving quality, equity, and financial protection.

This policy brief proposes that Namibia should prioritize strengthening the tax-funded public health system provided through the Ministry of Health and Social Services (MOHSS) as the backbone of its UHC financing approach over other pooling options. Financing mechanisms focusing on enhancing and expanding public sector financing and ensuring the mandatory non-contributory entitlement for all people are critical in reaching UHC. A robust public health system supported by the private sector reinforces the mixed public-private financing system, with those covered under private insurance reducing pressure on public facilities while contributing taxes to the government pool, effectively subsidizing care for the lower-income groups. Thus, reforms to improve the tax-funded public health system include providing more-robust evidence to advocate for increased allocations to the health sector and addressing allocative inefficiencies. Budgetary reforms, including more autonomy to the sub-national levels in deciding allocations, will improve resource use responsive to needs, potentially increasing equity and value for money.

Stakeholder consultation shows the need to redress inequity between the public and private sector by funding mandatory contributory pooling reforms; however, these are not feasible and may negatively impact the current robust public health system. A review of pooling arrangements showed high inequity, with the private sector pools controlling 38 percent of resources providing care to 20 percent of the population, compared to 49 percent of resources for 80 percent of the people in the public sector. To address this, expanding the public sector pool is the best approach; however, this is difficult to achieve, because of limited fiscal resources.

Alternatively, the country can explore mandatory contributory pooling mechanisms such as social health insurance and national health insurance (NHI). However, contributory schemes are

unlikely to result in expanded financing, improved access, and equity. The country will struggle to expand mandatory contributions because of the high tax burden on a small formally employed population that is shrinking as the informal sector grows. Furthermore, low- and middle-income countries can improve equity and efficiency of the health sector by replacing OOP spending with prepaid pooling mechanisms, but that is best done through budget transfers and not by contributory insurance that links payment to subpopulation entitlements (Mor and Ashraf 2023). However, many stakeholders propose that the country continue exploring mechanisms to expand pooling, especially to achieve equity and solidarity in financing health.

Namibia should transition away from passive to strategic purchasing in both the public and private sectors to enhance efficiency and value for money in health spending. Evidence and stakeholder consultations show consensus on improving purchasing arrangements, which show potentially large inefficiencies in both the public and private sectors. The country uses passive purchasing approaches with limited incentives to improve efficiency and align resource use to need. This policy brief proposes various strategic purchasing approaches to enhance efficiency, including results-based financing (RBF), capitation, health technology assessment (HTA), strategic private sector contracting, and introducing price regulation in the private sector. These methodologies aim to align incentives, encourage cost containment, optimize resource allocation, and ensure fair pricing, ultimately leading to better use of resources. While these potential reforms do not cover every possible solution, they serve as a starting point for exploring strategic purchasing options for the country.

The recommendations contained in this brief provide a starting point for policy makers to embark on financing reforms. However, there is no one-size-fits-all approach to financing health care. The country must continue assessing each option against country goals, context, and feasibility, focusing on improving health care outcomes while minimizing potential inefficiencies. Furthermore, implementing these strategies demands political commitment and robust stakeholder engagement, as complex decisions and tradeoffs will be required, with continuous monitoring and adjustment to adopted approaches as the country advances along the UHC pathway.

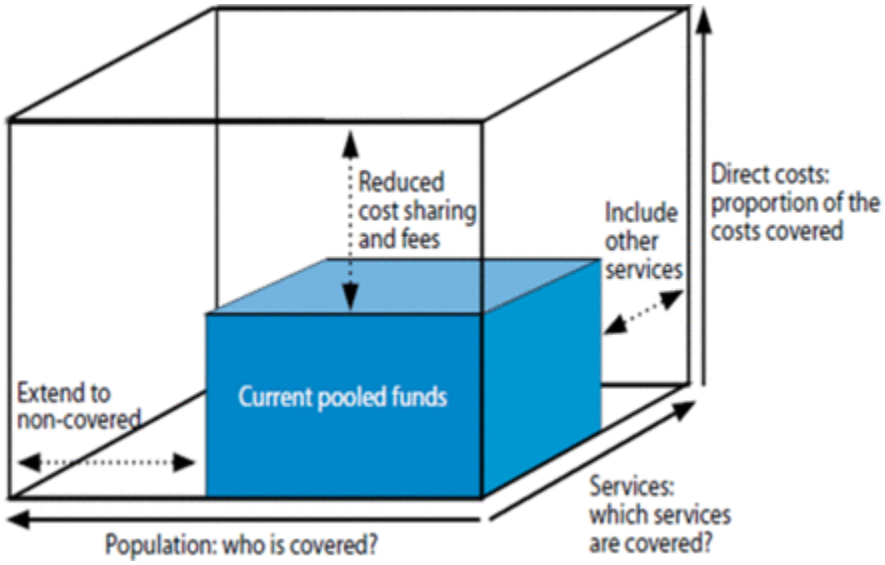
Introduction

Namibia is developing a UHC Policy to ensure that everyone can use good-quality essential health services when needed without risk of financial hardship. This will include key interventions to strengthen the health system's building blocks, including health financing. This policy brief explores the country's progress in ensuring financial protection and possible health financing reforms that can be adopted to accelerate progress toward UHC. This policy brief aims to stimulate discussion and evaluation of alternative approaches toward sustainable, adequate, efficient, and equitable ways to finance health care in Namibia. The paper proposes an adaptable approach to financing health care focused on Namibia's context and policy priorities, guided by international evidence on best practices and national stakeholder consensus. This policy brief was developed through an iterative consultative process led by the Health Financing Technical Working Group as part of the overall governance structures to inform the UHC Policy Framework for the country.

Principles of Financing for UHC

Accelerating progress toward UHC requires the country to progressively enhance the package of services offered and improve financial protection mechanisms to ensure access for all. Financial protection mechanisms should be implemented to remove financial barriers to access to care for all citizens, emphasizing the right to access health care as mandated and funded by the state through public health services. By expanding coverage, improving services, and enhancing financial protection, UHC policies can ensure that all individuals and communities can access the health care they need, regardless of their socioeconomic status or ability to pay. Figure 1 below illustrates the three dimensions and the progressive nature of UHC.

Figure 1. UHC cube showing dimensions of movement to advance progress toward UHC



Source: WHO, Developing a national health financing strategy Reference guide, (2017)

The UHC cube is a visual representation of the three dimensions of UHC: population coverage, service coverage, and financial protection (Winkelmann et al. 2018). Progress toward UHC involves a combination of practical financing principles prioritizing equity, efficiency, and sustainability. The vertical side of the cube shows the tradeoff required in cost-sharing

(financing decisions) and determining who pays for which services. The funding pool (blue area) also affects choices on "who is covered" and "what services are covered," with the country having to make choices on which direction(s) to move in as it fills the cube.

Equity in financing for UHC highlights the need for fair and inclusive resource allocation, ensuring that all population segments access necessary health services regardless of socioeconomic status. The interaction of revenue generation, pooling, and purchasing arrangements is essential to realizing these outcomes. Progressive financing mechanisms can help distribute financial burdens according to the ability to pay. Efficiency is achieved when resources are allocated optimally to maximize health outcomes. This involves strategic purchasing of health services, prioritizing cost-effective interventions, and reducing wasteful spending. Lastly, financial sustainability is vital for maintaining and expanding UHC, requiring long-term planning, sound fiscal management, and continuous monitoring and evaluation of the health system's performance. By considering these principles in designing and implementing financing strategies, Namibia can progress toward realizing the goal of UHC for all.

Financing Health Care in Namibia

Financial Protection

Namibia has made significant strides toward financing service delivery and financial protection, guaranteeing free access to public health care facilities for all populations, toward UHC. Over 92 percent of the population benefits from public sector funding, while private health insurance covers 8 percent (MoHSS 2022). With OOP spending well below the WHO benchmark of 15–20 percent, most people can access essential services without financial hardship. Development partners also finance health care, targeting communicable diseases, mainly HIV, tuberculosis, and malaria. The Special Fund for Uncommon Illnesses and the Motor Vehicle Accident Fund (MVA) extend financial protection by providing access to specialist services in the private sector funded by public finance.

The MOHSS funding pool (48 percent of Total Health Expenditure (THE)) guarantees access for all; however, its main users are the 80 percent who do not have private insurance (World Bank 2019). The MOHSS provides care through public facilities with minimal (token) charges and various exemptions for vulnerable groups such as children and older people. Furthermore, the state mandates that no one should be denied care at public facilities because of failure to pay the co-payments, thus removing this as a barrier to care. Through the Special Fund for Uncommon Illnesses (200 million Namibian dollars annually), the MOHSS provides financial protection to patients referred out of the public sector to seek specialist services from the private sector where such care is unavailable at public facilities. The fund extends financial protection to patients with special conditions, usually drivers of catastrophic spendings, such as oncology care for rare cancers.

The MVA pools risk for road accident-related injuries and deaths through levies on fuel (613 million Namibian dollars in 2021), managed under the MVA Fund Act No.10 of 2007 (MVA 2021). The fund pays for prevention, treatment, rehabilitation, and other costs arising from road accidents. In 2021, the fund also committed over $10 million Namibian dollars toward rehabilitation of the Katutura Central Hospital Emergency Unit, with the intent to strengthen public health facilities' ability to handle trauma response.

The private voluntary health sector pools risk for an estimated 20 percent of the population who access services mainly through networks of private providers. Notably, only 8 percent of the total population pools risk through private insurance, with the other 12 percent pool through the

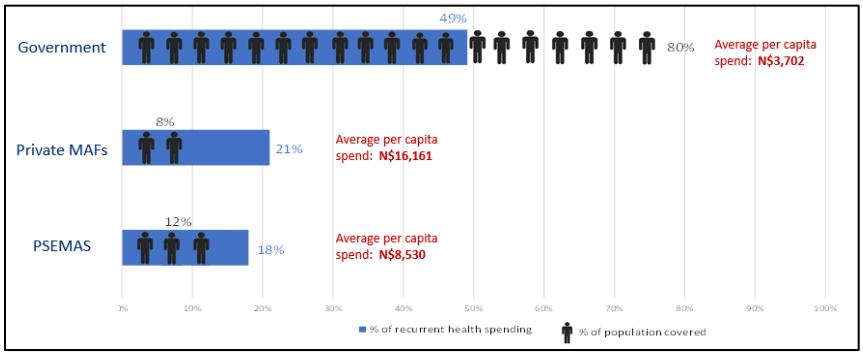
government civil service scheme, called the Public Service Employees Medical Aid Scheme (PSEMAS) (MoHSS 2022). Private health insurance provides financial protection mainly to those in the higher income quintiles and those formally employed. However, the different packages offered by private insurers mean the level of financial protection varies, with only those subscribed to the premium packages receiving maximum protection. Many patients face co-payments for services not fully covered by their insurer and where total benefits available are quickly exhausted. In cases of exhausted benefits, the public sector system provides a fallback through free services available to all.

While the country has high levels of financial protection as evidenced by low OOP, there is limited data available on the incidence of impoverishment from paying for health services (catastrophic spending). Measures such as OOP provide the national-level aggregate; however, to ensure no one is left behind, it is critical to understand households severely affected by direct payments for health services and how and why they are impacted. At the household level, a quantitative measure of financial protection is the proportion of households incurring OOP health care expenditure exceeding 40 percent of their household's non-subsistence (i.e., non-food) expenditure or 10 percent of total household expenditure (Abiiro and De Allegri 2015). This helps to unpack how the various income levels are affected by even the lowest direct payments. In addition, measures like OOP expenditure are focused on direct costs of care and ignore other indirect costs borne by patients such as transport, time spent seeking care, and the opportunity cost of long periods of illness. Hence, the country needs to better understand how OOP is incurred at the household level and ensure future financing reforms address any identified gaps.

Equity in Financing for Health

Equity is central to attaining UHC and ensuring health systems are fair and work for all. Leaving no one behind is a key theme in the attainment of Sustainable Development Goals, as well as being central to Namibia's strategic frameworks. High levels of inequity are noted in access to services between those in the higher income quintiles, who can pay for services in the private sector, compared to the lower-income groups, who rely on public facilities. Figure 2 shows that 49 percent of THE from the MOHSS pool funds services for 80 percent of the population. A further 18 percent of THE (from the Ministry of Finance (MOF)) funds services for the 12 percent of the population covered by PSEMAS. Another 21 percent is accounted for by private insurance, which benefits 8 percent of the population. Donors and OOP payments provide the balance (12 percent), with donor funding mainly targeting prevention programs for the whole population, though with a pro-poor focus.

Figure 2. Equity: comparison in access to funding for health



Source: African Collaborative for Health Financing Solutions (2021).

This inequity in funding drives other challenges, such as the skewed distribution of health care workers, with 60 percent in the private sector serving 20 percent of the population covered by PSEMAS and private insurance. The high level of funding in the private sector also has resulted in a vast network of specialist facilities, laboratory and diagnostic services, and hospitals mainly serving the insured 20 percent. This highly skews service delivery, favoring the upper- and middle-income groups primarily based in urban areas.

Socioeconomic Context for Health Financing in Namibia

Namibia has a population of approximately 2.6 million people as of 2021, and this is projected to be 4 million by 2050, with the annual growth rate projected to decrease from 1.8 percent in 2020 to 1.0 percent by 2050 (World Bank 2021). The population is relatively young, with a median age of 22 years, and 64 percent of the population under 30. This youthful population is expected to continue growing in the coming years, with the UN projecting that the percentage of people under 30 will remain relatively stable at around 60 percent by 2050 (UN 2022). This provides the potential for a demographic dividend as the working-age population and productive capacity grow. The percentage of the population aged 60 and over is projected to increase more rapidly, from about 4 percent in 2020 to 9 percent by 2050 (MoHSS 2022).

In 2020, around 49 percent of the population lived in urban areas, which is expected to increase to approximately 65 percent by 2050 (World Bank 2021). This population growth will continue to put more pressure on health services, with significant investments required to scale up available health sector capacity to match population needs. While urbanization will make it easier to provide accessible services, concentration in a few urban centers may result in high demand at tertiary hospitals that will outstrip the supply of public primary care facilities in towns.

Economic Context and Fiscal Space for Health

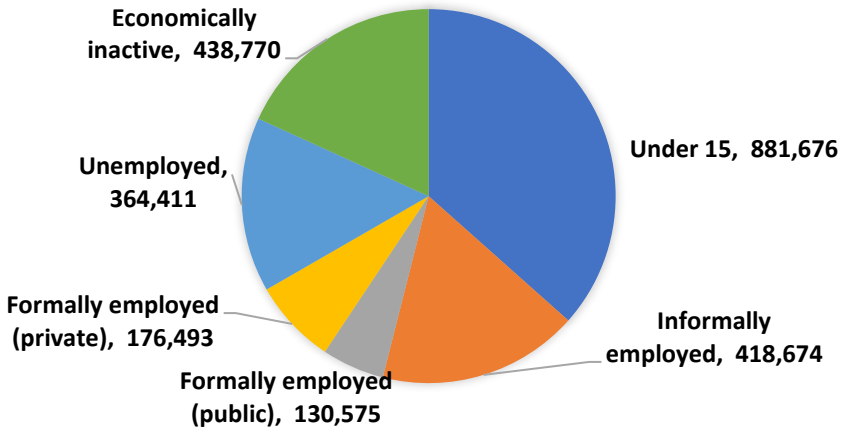
The Namibian economy has faced significant challenges because of natural disasters, slow global economic growth, and the COVID-19 pandemic. The country has been in a technical recession since 2016, with gross domestic product (GDP) growth slowing and eventually contracting. However, projections for GDP growth in the coming years show signs of recovery. Despite this, government revenue collections are expected to decline, partly because of the contraction of Southern African Customs Union receipts, impacting the government's capacity for expenditures and investment in health. With a high tax-to-GDP ratio of about 30 percent, there is limited scope for a more expansionary tax system (MoHSS 2022). Despite the government's efforts to contain public spending, fiscal deficits have increased because of reductions in revenue collections. The unsustainable growth in public debt continues to crowd out other critical expenditures, posing challenges for the country's economic recovery and development, raising the need for efficient and effective tax administration reforms to reduce tax leakages.

Namibia has made remarkable progress in reducing poverty over the years, with the poverty rate decreasing significantly between 1993 and 2016. However, the country still faces relatively high poverty levels for an upper-middle-income country. The poverty rate is projected to have increased since 2015, highlighting the need for continued efforts to address poverty and inequality. Economic challenges, such as slow GDP growth and declining government revenues, may hinder the government's ability to address poverty effectively and support vulnerable populations (World Bank 2021).

Namibia is one of the most unequal countries globally, with persistently high unemployment rates and slow economic growth further constraining wealth creation, especially among people with low incomes. Most of the population relies on informal sector jobs, subsistence farming,

social grants, and other transfers, while only a tiny segment benefits from wage income, as shown in Figure 3 below. The COVID-19 pandemic has exacerbated poverty, primarily because of its impact on employment and labor incomes.

Figure 3. Distribution of economic activity in Namibia (out of a population of 2.4 million)



Source: World Bank Poverty and Equity Brief, 2021.

This complex socioeconomic context requires careful and pragmatic consideration of potential health financing reforms. The government is the largest funder of health; however, with limited economic growth, the ability to sustain and significantly scale up health sector funding may be at risk. Conversely, complex contributory reforms are challenging because of the growing informal sector and increasing poverty levels. Scenarios proposed in this brief will be evaluated against this background to identify pros and cons for possible alternatives, including those with potential political buy-in and national leadership support.

Options to Finance UHC in Namibia

Financing for health in Namibia aims to ensure equitable, efficient, transparent, and adequate funding for the health system that promotes progress toward attaining UHC objectives. Namibia has a robust and well-resourced health system, primarily funded by the public sector complemented by private sector voluntary contributions. The country has high financial protection (the first UHC goal). However, gaps in equity and adequacy of funding are visible. This is more significant for services broadly accessible and available to the poor, where equity and quality gaps persist, and the ability of the government to provide adequate funding as health needs increase is at risk.

The proposed financing mechanisms focus on strengthening and expanding the system of public sector financing that ensures mandatory non-contributory entitlement for all people as a central pillar to accelerating progress toward UHC in Namibia. Furthermore, this builds on strengthening the "mixed public-private financing" system in Namibia, recognizing that a robust private sector enhances the value of health care by having sufficient private providers catering to individuals who can afford private care. This approach effectively removes their associated costs from the government-funded system while retaining their tax contributions, ultimately subsidizing access to care for the uninsured population. Strengthening both systems of financing is thus essential to raising adequate funding for health and removing equity and efficiency barriers.

Stakeholder consultations have highlighted inequity and access gaps for people with low incomes in Namibia who access services in the public sector. Based on the principles of UHC, which require a focus on those most disadvantaged and most at risk when accessing services, the financing options below focus on how improving efficiencies and strengthening public sector financing systems will enable the expansion of coverage and financial protection for the 80 percent of the population who use public sector facilities.

The following broad objectives summarize the health financing priorities for reform in Namibia:

i. Strengthen public sector financing for health and expand mandatory non-contributory entitlements to adequately cover the comprehensive essential health services package and provide financial protection to all people of Namibia.
ii. Improve resource allocation and utilization efficiency through strengthening the public financial management (PFM) environment.
iii. Strengthen the pooling of resources toward more-robust, less-fragmented pools and improve financial protection for all people in both the public and private sectors.
iv. Strengthen strategic purchasing for health services, ensuring resources are aligned to the essential health services package and provider payment mechanisms that provide adequate incentives to promote improved performance and efficiency at the service delivery level in the public and private sectors.

These strategic objectives recognize that Namibia cannot simply spend its way to UHC; how funds flow through the system and whether spending can be matched to priority programs, populations, and services also matters. Attention to addressing inefficiencies is essential to sustain progress, with allocation and purchasing and provider payment mechanisms central in achieving progress toward UHC. Furthermore, effective reform requires policy coherence, focusing on aligning policy measures across the financing system and the rest of the health system.

The following section provides a synthesis of potential options to strengthen the financing for UHC in Namibia to address the reform priorities listed above. The options build on the current system's strengths while exploring new ways to improve revenue collection, pooling, and purchasing for health services in line with the broad objectives above. Table 1 summarizes the options:

Table 1. Options to Finance UHC in Namibia

Options to Finance UHC in Namibia	Interventions
Option 1: Strengthen public sector financing for health and expand mandatory non-contributory entitlements	1.1 Increase allocation to the MOHSS health pool
	1.2 Improve efficiency in resource allocation, budgeting, and utilization at all levels
Option 2: Strengthen resource pooling for health	2.1 Options for contributory pooling reforms
	2.2 Special pooling arrangements/ health sector investment fund/health infrastructure investment fund
Option 3: Strengthen strategic purchasing for health services	3.1 RBF/Performance-based financing
	3.2 Capitation
	3.3 Implement HTA
	3.4 Strategic private sector contracting
	3.5 Strengthening purchasing approaches within the private sector

Option 1: Strengthen Public Sector Financing for Health and Expand Mandatory Non-Contributory Entitlements

Evidence shows that countries can only make meaningful progress toward UHC and financial protection through increased public spending on health toward non-contributory entitlements (Mor and Ashraf 2023). General taxation, underpinned by progressivity, equity, predictability, and stability principles, has shown itself to be an effective strategy for providing comprehensive coverage, particularly for the poor and vulnerable. The public-funded health system leveraging established mechanisms like the Namibia Revenue Agency and the MOHSS offers lower collection, pooling, and implementation costs than alternative models.

Moreover, progressive public funding mitigates adverse selection risks and ensures people with low incomes are covered first. The efficacy of this model is supported by empirical evidence, with countries such as the United Kingdom, Denmark, Iceland, Italy, Portugal, and Spain transitioning from contributory to non-contributory systems (Mor and Ashraf 2023). Contrarily, no affluent Organisation for Economic Cooperation and Development (OECD) nations have moved toward a premium-entitlement model, affirming the value of maintaining a tax-funded system and avoiding the high costs associated with system shifts.

Strengthening the current tax-funded public sector model that covers over 92 percent of the population will enable the country to accelerate progress toward UHC. This funding system is more sustainable, equitable, and aligns with the country's commitment to the Abuja Declaration and the right to health articulated in the constitution. Namibia has high financial protection and coverage through the public sector. Addressing potential inefficiencies in the current system can help the country quicken its pace and expand service coverage.

Intervention 1.1: Increase allocation to the MOHSS health pool

Namibia has pledged to allocate 15 percent of its government budget to health as part of its commitment to the Abuja Declaration. Although total health spending, including PSEMAS funds, exceeds the 15 percent target, PSEMAS funds are ringfenced for a small sub-population, limiting their effective pooling for the rest of the population. Furthermore, Namibia's per capita health spending, at US$379, is lower than that of other African upper-middle-income countries, and its health outcomes are worse, particularly regarding maternal and infant mortality rates (World Bank 2019). While health is a priority in allocations, in recent years health spending has been growing at a slower rate than broad government expenditure. These indications highlight the scope for potential growth in health allocations, especially if fiscal space improves.

There is a strong need for the MOHSS to engage the MOF to continue advocating for the sector, strengthening the relationship between the two ministries. Adequate evidence and investment cases are needed to show health as a social investment and a broader economic stimulus impacting all other productive sectors. Health was prioritized in the 2023/2024 budget allocation, receiving the second-largest share after the Ministry of Education in a pro-poor budget that also increased other transfers to the social sector. This demonstrates the government's commitment to improving health and well-being. However, current allocations may be inadequate given the health sector's capital and recurring expenditure requirements.

The following opportunities may allow for expanded general government revenue and larger budgets for health. However, they all lie outside the control of the MOHSS.

- **Increasing general taxes:** Namibia's tax revenue as a percentage of GDP is mid-range to high compared to in other upper-middle-income countries, suggesting room for tax

increases, though very limited room. Policy makers must balance revenue generation with potential economic growth, employment, and investment impacts. The short- to medium-term economic outlook makes it challenging for the government to expand general taxes substantially. However, the government can assess opportunities for increased tariffs in specific sectors, such as the extractive industries, instead of increases in general taxes. Additionally, pro-health taxes (sin taxes) provide further opportunities to increase taxes. While Namibia has increased such excise taxes before (as discussed below), the level of taxes is still lower than in many OECD countries. For example, in many OECD countries, excise taxes on a pack of cigarettes generate around US$4.80 compared to only US$1 in most developing countries, demonstrating scope for further increases in such taxes (WHO 2021).

- **Earmarked taxes for health**: For the country to secure adequate funding for health in the budget, specific taxes can be earmarked for health to ringfence investments in priority areas such as non-communicable diseases. Such taxes may include pro-health taxes (sin taxes) on products such as alcohol, cigarettes, and sugary products, which can be bad for health. In addition to raising revenue for health or the treasury, such taxes also reduce the consumption of such products, especially by low-income groups, and so help to reduce the need for health services (Baruwa and Watson 2022).

  Namibia recently increased sin taxes on many products; however, revenue from these additional taxes is not earmarked for health. Furthermore, there is no evidence on whether the rate of taxation is enough to deter or reduce the consumption of such products. Excise taxes should reach a certain level to be effective in discouraging consumption. For example, the WHO Framework Convention on Tobacco Control recommends that countries aim to have tax account for 75 percent of the retail price of tobacco; this is not yet the case for Namibia. The following sin taxes on the consumption of alcoholic beverages, tobacco, cigarettes, and cigars took effect from February 22, 2023 (MOF 2022).

Table 2. Sin taxes in Namibia that took effect starting February 2023

• A pack of 20 cigarettes went up by 98c.	• A kg of cigars now costs an additional 237.79 Namibian dollars.
• Unfortified wine increased by 24c per liter.	• Fortified wine went up by 41c per liter.
• Sparkling wine increased by 12c per liter.	• Spirits now cost an extra 12.08 Namibian dollars per liter.
• Clear malt beer increased by 5.99 Namibian dollars per liter.	• Ciders and alcoholic fruit beverages went up by 5.99 Namibian dollars per liter.

Excise taxes tend to be regressive and affect people with low incomes. Ensuring excise taxes are progressive requires increasing benefit incidence toward low-income groups by allocating most of the revenue from such taxes to services accessed mainly by low-income people. This can be achieved by earmarking some revenue toward addressing negative health effects caused by these products, which often disproportionately affect people with low incomes.

- **Earmarked payroll taxes:** These taxes offer an opportunity to increase equity and solidarity in funding health care for Namibia. The high spending on voluntary health insurance is mostly attributed to those formally employed, who tend to be better off than the majority. Outside of insurance reforms, an additional payroll tax earmarked to fund services used by low-income groups could be a potential option for Namibia. This is easy to collect through current payroll tax systems, has a low administrative burden, and may have broad political and moral support as it can progressively impact those with higher incomes. However, earmarked payroll taxes introduce inefficiencies in the economy by distorting labor market decisions as organisations adjust remuneration structures to avoid paying high taxes. In Namibia, they are likely to face resistance from those formally employed who are already struggling under a high tax burden, increasing inflation, and generally stagnant remuneration structures. Furthermore, those formally employed are already contributing through taxes to the cost of public health services that they themselves do not use, as they rely on private contributory insurance, increasing the likelihood of stiff resistance to further taxes.

Earmarking and budget targets do not always protect overall health funding, as the MOF may reduce appropriations to the general budget for health. Earmarking may impose fiscal policy constraints, reducing flexibility and possibly allocative efficiency. Increasing indirect taxes such as sin taxes may also be very regressive as it impacts low-income groups more than the better off. At the same time, with an increase in the informal sector population, such indirect taxes provide opportunities to target products consumed by the majority of people.

Furthermore, regressive taxes may be the only way to finance strongly progressive public expenditure. Ultimately, increases in taxes are not the only option available to increase general revenue; the country should tighten tax legislation and implementation to reduce leakages, ensuring every sector and individual effectively contributes to the government purse.

Intervention 1.2: Improve efficiency in resource allocation, budgeting, and utilization at all levels

While increasing the overall share of spending from compulsory sources is essential for progress toward UHC, how these prepaid funds are allocated also matters. Changes in these distribution arrangements can affect how countries progress toward UHC. The overall fiscal space ultimately constrains the MOF's capacity to increase health allocations. Thus, more attention should focus on efficiency and value for money for each dollar invested in health. The MOF has been calling for efficiencies and approaches to reduce spending from sector ministries as part of fiscal consolidation.

Addressing resource allocation inefficiencies can improve priority intervention targeting and equity by directing resources to where they are most needed. This can be essential to address the high inequity gap identified as a broad challenge through stakeholder consultations. Ensuring resources are directed to priority regions and populations, and to high-impact investments during the allocation process, is essential. Proper allocative decisions can also improve the absorption of the national health allocation and reduce underspending, especially in operational budgets. To improve efficiencies in allocation, the MOHSS can:

- Develop and implement resource allocation formulae in the public health sector
- Increase autonomy and decentralization of decision-making to regions

These options provide realistic and practical approaches through which the MOHSS can re-examine allocations within the health budget directly under its control. Improving allocative

efficiency should be closely aligned to the primary health care approach and directly link resources to the delivery of the comprehensive health package. These efficiency reforms can improve equity, reduce waste, increase budgetary absorption, and ultimately enhance equity through better service coverage and availability. The options are discussed in more detail below.

Develop and implement resource allocation formula in the public health sector

Resource allocation in health care should be based on rational criteria, including health needs, equity criteria, and national priorities. Formula funding systems will promote equity and efficiency by distributing national funds in line with policy objectives, such as universal health coverage. Factoring in an essential health services package ensures that priority services are considered in the allocation process. A needs-based formula accounts for factors like population size, poverty level, age distribution, and disease burden, among others, to allocate resources equitably and efficiently (LHSS 2022).

Efficiencies in resource allocation are essential toward improving equity and access to care. Potential opportunities to improve resource allocation include:

- **Full implementation of program-based budgeting** will address inherent limitations of line-item budgeting by strengthening the link between resource inputs and outputs and outcomes, promoting greater accountability and efficiency.
- **Redirecting resources toward primary care** will ensure a greater focus on prevention, early detection, and management of health conditions, as well as addressing social determinants of health. Investments in primary care provide more value for money through low-cost, high-impact interventions that reduce the number of patients requiring more-complex and costly tertiary care.
- **Increasing investment in preventive care**, including health promotion, disease prevention, and early intervention programs, will reduce the burden on curative care services.

Allocative efficiencies substantially impact equity as making decisions on what interventions and where they are delivered impacts who gets to access what services, at what cost, and how easily they can use them. By ensuring that facilities are allocated enough resources and have adequate capacity to make informed decisions, the country can improve the availability of essential health services, reduce implicit rationing, and protect patients from high OOP spending. Achieving allocative efficiencies involves moving away from the traditional budget allocation approach and shifting the way of thinking for policy makers, budget holders, and the surrounding ecosystem.

Increase autonomy and decentralization of decision-making to regions

Autonomy and decentralization of decision-making in the public health sector are crucial for enhancing the efficiency and responsiveness of health care systems. Through shifting control of budgets, procurement, and other financial management aspects from the national level to regional directorates, resources can be better tailored to address specific needs and priorities. Decentralization empowers local authorities to make informed decisions about health care spending based on their unique understanding of local health challenges. The country may consider the following options to improve autonomy at the sub-national level:

- **Retention of user fees by facility**. All user fees and collections by facilities are remitted to the MOF in line with PFM principles. Facilities cannot retain and use these funds to provide health services. Creating a framework to enable facilities to retain and use these funds may improve how facilities operate and provide flexible funds to respond to daily operational

challenges. Facility-level collections are generally low (less than 2 percent of the total MOHSS budget) and do not significantly affect MOF revenue collection estimates but can be impactful at the facility level.
- **Increasing the flexible allocation portion in the MOHSS budget for regions and facilities (including health centers and clinics).** This increases the total expenditure directly spent at the sub-national level.
- **Autonomy and decentralization of procurement**. This reduces bottlenecks associated with centralized procurements, especially for non-complicated needs such as cleaning, repairs, and hotel services in hospitals.

Capacity-strengthening and training initiatives will be required at the sub-national level to improve absorption capacity and equip sub-national budget holders with the necessary skills for effective resource management. Making the right allocation decisions also includes ensuring budgetary commitments are realized into disbursements at all levels, enabling providers to anticipate service utilization and procure the required inputs in time. However, the MOHSS will need to establish clear guidelines for decision-making processes to ensure transparency and accountability. Strengthened collaboration and communication between national and regional directorates will help align health priorities and promote efficient resource use, especially in large-scale procurements.

Option 2: Strengthen Resource Pooling for Health

Namibia has a robust public sector pool funded through progressive taxes complemented by multiple voluntary private health pools. The public sector pools funds for over 92 percent of the population, including the civil servants' PSEMAS scheme, while voluntary contributions cover only 8 percent of the population. As indicated above, there is high inequity in spending, with the private sector pool allocating over 16,000 Namibian dollars per capita compared to 8,000 Namibian dollars per capita (PSEMAS) and 3,000 Namibian dollars per capita in public funding (World Bank 2019). Despite the low per capita allocation, the public sector pool provides strong risk protection with comprehensive coverage and access to essential services in public facilities. This aligns with the best evidence to advance UHC for most countries where mandatory non-contributory risk pools funded by public finance are the preferred standard to provide financial protection to the poor and vulnerable. Analysis by Mor and Ashraf (2023) concluded that, "low and middle-income countries can improve equity and efficiency of the health sector by replacing OOP spending with prepaid pooling mechanisms, but that is best done through budget transfers and not by contributory insurance that links payment to sub-population entitlements" (Mor and Ashraf 2023).

Despite the high financial protection from the public sector pools, the high inequity between public and private sector pools remains a priority policy issue. This is especially so for Namibia, where historical injustices created the second most unequal society. Addressing these disparities through pooling reforms is perceived to increase solidarity and equity in access to services. However, addressing the disparities in spending via pooling reforms (rather than by increasing the government health budget) would require the need to work toward one of these scenarios:

- Having everyone in the same pool with the same benefits package—this has substantial implications for costs depending on which benefits package the country adopts
- Keeping multiple pools but cross-subsidizing between them and harmonizing benefit packages

Stakeholder consultations have repeatedly raised the need to enhance voluntary pools or establish mandatory contribution pools. The move toward a contributory pool aligns with provisions under the National Medical Benefits Fund provided for under the Social Security Act, 1994 (Act No. 34 of 1994), which calls for a statutory pool for formally employed workers.

Some stakeholders acknowledge the high financial protection and low catastrophic spending, but advocate for pooling reforms to improve efficiency within current pools. Notably, there is no stakeholder consensus on establishing contributory pools, with a strong division of opinion between strengthening the public sector health delivery system versus embarking on complex contributory pooling reforms. To ensure robust discussion and inform policy, potential contributory pooling reforms are discussed along with factors for the country to consider before embarking on this complex reform.

Intervention 2.1: Options for contributory pooling reforms

Contributory schemes link benefits/entitlements to payments made by an individual or made on their behalf (Kutzin et al. 2016). They can be voluntary (like current private funds) or mandatory, where the state creates legislation to compel all qualifying persons to contribute to the schemes. The following options based on stakeholder discussions are presented in brief below:

- **Establish a National Health Insurance Fund/National Benefit Fund**. This fund will pool both public and private funds. The fund will collect mandatory contributions from those able (formally employed and rich people in the informal sector), while the state subsidizes the poor and vulnerable. This would create a single pooling entity that would purchase all health services for all citizens. This effectively pools earmarked payroll tax revenue with unearmarked general tax revenue to fund health services for everyone (presumably only by those who do not have additional entitlement through private schemes *unless those are banned*). This major reform requires significant political, financial, legislative, and administrative capacity. Furthermore, this can only be pursued as a long-term reform, envisioning benefits within a 20–30-year horizon based on evidence from OECD and developing countries like Kenya, Uganda, and Ghana that have pursued such reforms (Mor and Ashraf 2023).
- **Establish a Social Health Insurance Fund**. This fund will pool health resources for all formally employed people through statutory mandatory payroll deductions. Implementing this fund will align with the existing National Medical Benefit Fund provision legislation under the Social Security Act, 1994 (Act No. 34 of 1994). It will build on the high willingness to pay by those formally employed, as evidenced by robust voluntary pools. The government would continue providing care for those not covered under this pool through the public sector system, funded from general tax revenues. Ultimately this reform perpetuates the current system of dual benefit packages based on employment status, unless the government can substantially increase funding to the public pool and match the benefits package, including quality of care, which would require significantly high general revenue allocations to the MOHSS.
- **Capitalize on reforms to PSEMAS as the starting point for NHI, with subsequent expansion of the fund to include the formally employed private sector.** Legislation for mandatory contributions will be required for the formally employed to opt into the fund, or the government will have to offer attractive benefits that can pull members from private voluntary schemes. These options are complex and challenging, especially given the large disparity in per capita spending between PSEMAS and private insurance, while benefit packages are comparable. Furthermore, the process of harmonizing benefits between the formally employed and informal sector through slowly enrolling the latter sector into the fund is often

long, costly, and near impossible to achieve, as evidenced by low coverage from countries like Ghana, Kenya, and Ethiopia.

- **Consolidate existing voluntary schemes**. This will aim to enhance the risk pools in line with requirements to provide adequate cover for an essential health package to all members and eliminate gaps in coverage because of varying scheme benefit plans. The government will continue financing those not covered under the pooled fund. In principle, this is like a Social Health Insurance Fund discussed above. However, instead of setting up new institutions, the government focuses on strengthening existing private sector institutions, moving from competitive private voluntary schemes toward a non-competitive single voluntary pool. The government will continue financing those not covered under the pooled fund.

The list above provides a synthesis of potential options and considerations Namibia can take if it decides to move toward contributory schemes, either as the only option for financing or complementary to the existing current systems. The options are not exhaustive but capture emerging themes from stakeholder consultations. Further, the options use the current scenario and context as a starting point for reform and examine how different pathways can advance financial protection, especially for the poor and vulnerable, when evaluated against best practices and evidence.

Considerations for NHI/contributory pooling reforms

Evidence from many developing and upper-middle-income countries shows that while contributory insurance can help pool resources, its success in expanding risk protection is minimal. A study of more than eight African countries that pursued contributory insurance shows that most have been unable to expand coverage, with only Gabon, Ghana, and Rwanda achieving significant results (40.8 percent, 57.7 percent, and 78.7 percent, respectively) (Mor and Ashraf 2023). For most countries, the share of THE flowing through the NHI system was around 10 percent, showing the limited impact of the reform on expanding pool sizes. Furthermore, contributory health insurance often excludes the most vulnerable populations from coverage.

Linking entitlement to payment usually covers people who can pay the premium, excluding those most in need of health coverage—people with low incomes, informal workers, and unemployed individuals. Most evidence suggests that contributory schemes such as NHI will not achieve equity automatically and require deliberate pro-poor policies (Kutzin et al. 2016). Regardless of the pooling structure adopted, general government revenue still needs to cover the worst-off, vulnerable, and low-income groups. In Kenya, for example, a review of the protection provided by the National Health Insurance Fund found that the scheme does not offer protection to people experiencing poverty, with low-income households experiencing catastrophic spending when they seek secondary care (Maritim et al. 2023). As a result, countries with contributory health insurance often experience gaps in population coverage, leaving the most vulnerable without access to health care.

Furthermore, people with low incomes subsidized by the government often get inferior packages compared to those who contribute, further entrenching inequalities when pooling structures with different benefit packages are established.

Several factors limit the potential of contributory health insurance as a practical path toward UHC Namibia:

- Namibia has a high and rising proportion of people employed in the informal sector, above 50 percent, with a declining proportion in the formal sector. The low share of formal sector

workers in the labor market reduces the number of members who can easily and efficiently contribute to employment-based pools (to raise revenue). Furthermore, formally employed workers are already highly taxed, while current voluntary schemes provide them with good access to health services. This increases the risk of resistance to any contributory schemes that increase the contribution burden or do not guarantee equal access to services.

- Social health insurance pools are unsustainable without significant government subsidies. An analysis conducted in 2021 by African Collaborative for Health Financing Solutions, modeling potential scenarios for a social health insurance scheme in Namibia covering government and private sector employees, showed the scheme would require government subsidies above 2 billion Namibian dollars per year to be sustainable if contributions align with international benchmarks (6 percent of salaries). This is similar to the analysis over the past decades by the Social Security Commission on the potential viability of implementing the Medical Benefits Fund. The SSC has explored various options for implementation of the Medical Benefits Fund and concluded the fund will be unviable without significant subsidies from the government.
- While countries like Rwanda have managed to persuade the informal sector to contribute, the administrative burden of premium collection from the sector can make this unviable compared to in the formal sector, which can be easily targeted through employer-based payroll deductions. Voluntary enrolment in NHI by informal sector workers presents additional challenges. The informal sector has a low willingness to pay and prepay for coverage. The administrative obstacles to collecting contributions from the sector are high and impose non-financial barriers to participation. Overcoming these challenges will require addressing financial and non-financial barriers to enrolling informal sector workers in NHI programs, often costly and inadequate to offset the cost of collecting revenue against the revenues that will be ultimately realized from this sector.

Furthermore, while contributory NHI systems are designed to promote equitable access to health care, there is limited evidence for efficiency, as contributory NHI systems frequently result in multiple pools intended to cover different groups, complicating the administration and management of health care systems. NHI schemes can also inadvertently encourage labor market informality, as individuals may attempt to dodge contributions by working in the informal sector, which can negatively impact overall economic outcomes. In addition, the political and economic costs of implementing NHI can be significant. The country will need to transition from existing systems and establish new infrastructure, demanding substantial financial and political resources.

To progress toward UHC and improve equity, government allocations to health financed through progressive taxes are the most efficient approach, and ensure services are available for the poor and vulnerable. Namibia's tax-funded public health has been crucial in expanding financial protection and health services, evidenced by the 8 percent OOP and very low catastrophic spending (below 1 percent). Dismantling the system and moving it toward contributory NHI may generate minimal additional revenues for the sector while disrupting the existing robust system and increasing inefficiencies.

Intervention 2.2: Special pooling arrangements/health sector investment fund/health infrastructure investment fund

Ringfenced funding pools are a financial mechanism designed to allocate specific resources for a particular purpose, usually of high significance and challenging to achieve through annual general allocations. Special funds aim to pool funds from different sources toward attaining specific objectives instead of just earmarking funds from a single source. Unlike insurance pools

that combine risk and funds, special funds focus mostly on pooling funds away from competing government priorities. These funds are separate from the general budget. The funds can only be used for the intended purpose and are protected from being used for other purposes, ensuring they remain dedicated to the intended objective, especially if accompanied by supporting legislation.

Special funds pooled through ringfencing can help prioritize specific sectors or projects, provide stability in funding, and create a sense of accountability for using the resources. Namibia established the MVA fund as a unique ringfenced pool financed by indirect taxes but with flexibility on how it invests and allocates funds annually. The fund has proven its effectiveness and efficiency in covering risks from accidents. The MVA fund can be a learning platform when considering expanding or creating new special pooling arrangements.

Establishing a particular purpose Health Sector Investment Fund/Health Infrastructure Investment Fund will complement current public sector allocations to the MOHSS. The fund can focus on identified priorities such as infrastructure, health services for vulnerable groups, and other essential health care initiatives. The fund will leverage multiple sources of revenue, including sin taxes, impact bonds, and private sector capital, to provide a sustainable and reliable source of funding to undertake complex and unique interventions that may not be adequately covered under the current budgetary allocations.

Multilateral development organizations are increasingly exploring impact bonds and debt swaps as opportunities for low- and middle-income countries to invest resources into their service delivery. This represents an opportunity for Namibia to explore how debt restructuring with entities like IMF and World Bank can be tied to reinvestment in the country. In addition, the success of such special pooled funds depends on the willingness of the MOF to earmark funds, engage in complex debt restructuring with lenders, and develop strategically attractive investment incentives for the private sector to engage in long-term public-private partnership with the government. Despite these considerations, special pooled funds provide innovative and creative approaches to address long-term investments required in health while balancing long-term economic development and private sector partnerships.

Option 3: Strengthen Strategic Purchasing for Health Services

Strategic purchasing involves the evidence-based selection of health services to fund, deciding which services to buy, from whom, and how these services will be paid for. Strategic purchasing is essential for efficient resource distribution in health care systems, aiming to improve service quality, accessibility, and affordability while curbing costs. Current purchasing in Namibia, however, is mainly passive, based on historical patterns or patient-driven use, leading to potential resource allocation inefficiencies in both the public and private sectors.

Moving toward strategic purchasing requires strengthening capacity in current entities and does not necessarily require separate purchasing agencies such as a social health insurance agency. Furthermore, strategic purchasing initiatives can be achieved within the existing legislative and PFM framework, thus providing options that Namibia can implement in the short term. Given the country's limited scope to increase health sector allocations, focusing on efficient resource utilization becomes imperative. Adopting strategic purchasing approaches can address these inefficiencies, fostering better equity, efficiency, and service access in line with universal health coverage goals.

The following options explored in brief below provide alternative strategic purchasing approaches that Namibia can implement to improve efficiency in purchasing arrangements:

- RBF/performance-based financing
- Capitation
- HTA
- Strategic private sector contracting
- Strengthening purchasing approaches within the private sector

Implementing RBF, capitation, HTA, strategic private sector contracting, and strengthening purchasing approaches in the private health sector can improve efficiency and cost management in health care. These approaches align incentives, promote cost containment, optimize resource allocation, leverage private sector expertise, and ensure fair pricing, leading to better resource utilization and affordability. While the suggested reforms are not exhaustive, they provide a starting point for evaluating strategic purchasing options for Namibia.

Intervention 3.1: Results-Based Financing/Performance Based Financing

Results-based financing (RBF), a strategy linking funding to performance targets, aims to enhance health care provider performance by incentivizing efficient resource use for achieving results. Effective in increasing service utilization and care quality, RBF moves countries away from historical budgets, which lack incentives for delivering adequate health services. The current line-item budgeting in Namibia, with its limited focus on performance, is a leading cause of inefficiencies, resulting in higher per capita spending on health without comparable improvement in quality or health outcomes. RBF could redirect focus to health resource outputs and outcomes, providing incentives to target quality and utilization indicators effectively. Furthermore, the country is in the process of strengthening program-based budgeting as it moves away from line-item allocation to output-based financing. Linking this reform with RBF could support implementation and create strong incentives to attain performance targets.

Implementing RBF requires political commitment, funding, and strong contracting, monitoring, and evaluation capacity. Key considerations for designing an RBF system in Namibia include feasibility, sustainability, equity, and efficiency. Given consistent health funding allocation and operational budget underspending, RBF could improve absorption and provide more facility autonomy. However, assessing the long-term financial viability of a performance-based financing system is crucial, considering potential challenges like a developing (nascent) monitoring and evaluation system and routine procurement contract issues. Moreover, the scheme should be designed to minimize potential inequities and adverse effects while considering its cost-effectiveness, administrative costs, and potential risks of gaming.

Intervention 3.2: Capitation

Capitation, a payment method providing a fixed sum per person to health care providers, can effectively manage rising health care costs, particularly in health insurance schemes. Its benefits include the potential to control health care costs, promote efficiency, encourage preventive care, and simplify administrative processes. As the country focuses on primary health care as the pathway to UHC, capitation can provide a more suitable approach to shift funding away from higher-level care toward the community level, primary care facilities, and preventive/promotive health services. However, capitation may incentivize providers to reduce service provision, potentially compromising care quality and leading to inadequate treatment for complex or chronic conditions. It may also overlook variations in health care needs across different population groups, causing disparities in care access. Additionally, capitation is more

suited to primary health care; and other approaches like diagnostic related groups and strategic contracting with the private sector may need to be explored for higher-level care.

Implementing capitation requires strong contracting, monitoring, and evaluation systems to ensure appropriate care levels. This involves establishing risk-adjustment mechanisms to account for variations in health care needs, developing robust quality assurance systems, and enhancing health care providers' resource management abilities through capacity-strengthening efforts. With Namibia's Social Contracting Policy (2022) and many services outsourced to the private sector, capitation could offer an efficient contracting model, particularly for prevention and community-level interventions. Moreover, modified capitation approaches could help the MOHSS negotiate more-efficient and more-favorable contract terms with current providers under the Special Fund for Uncommon Illnesses, which routinely refers patients to the private sector.

Intervention 3.3: Implement HTA

Namibia is in the process of developing an essential health service package toward explicit decision-making on what services should be included in the benefits package. The country aims to institutionalize an evidence-based process to design a package with continuous adjustments as it progresses toward UHC. To this end, HTA can provide a useful tool to inform future prioritization decisions on what services should be covered. Furthermore, the country is scaling up hospital technology and infrastructure investments, including diagnosis and treatment equipment required for complex high-level care. Such decisions are difficult, with significant capital and maintenance outlay, necessitating comprehensive tools to inform such investment decisions, an area where HTA can also be helpful.

HTA is a multidisciplinary process that systematically evaluates the clinical, economic, social, and ethical implications of using a health technology, such as a medical device, pharmaceutical, or medical procedure. The main goal of HTA is to inform decision-making by policy makers, health care providers, and patients to ensure that the best possible health outcomes are achieved at the best potential value.

HTA is a valuable tool for improving efficiency in health care by supporting evidence-based decision-making, optimizing resource allocation, and promoting the adoption of innovative and cost-effective health technologies. This enables informed decision-making regarding the allocation of limited resources to interventions that offer the best value for money. By promoting the use of cost-effective technologies, HTA helps reduce unnecessary expenditures, improves the cost-effectiveness of health care interventions, and ensures that resources are directed toward interventions that deliver the greatest benefits to patients and the health care system.

Intervention 3.4: Strategic Private Sector Contracting

Namibia has a robust private sector with excess infrastructure and medical technologies capacity and over 60 percent of health care workers, including specialists. The MOHSS routinely contracts the private sector to provide care to patients where the public facilities do not have capacity, such as intensive care and specialist diagnostic services. Even so, stakeholder consultation highlights the sector's unexhausted capacity where innovative approaches can be used to take advantage of this. For example, in Windhoek, hospitals such as Windhoek Central and Katutura have beds and hospital space shortages, but private sector facilities often have utilization rates below 50 percent. This provides an opportunity for the private sector to use this excess capacity. To ensure scarce public sector resources are not diverted to costly private

facilities for a few patients, the contracting arrangements need to be well thought out and evidence informed and ensure a win-win relationship between the two sectors.

The MOHSS currently procures referral services from the private sector; however, it is a price-taker with no evidence for strategic negotiation. There is limited evidence of strategic contracting with the MOHSS leveraging its role as a significant payer for such out-contracted services. Annually the MOHSS spends over 200 million Namibian dollars allocated to the Special Fund through private sector referrals. Yet, there is no documented systematic approach to negotiate prices, monitor quality, and ensure value for money by the MOHSS.

Opportunities to review current contracting arrangements with the private sector and move from passive purchasing include:

- Negotiating favorable service pricing structures using the MOHSS's advantage as a significant payer. This can include opportunities for capitation and diagnostic related groups payment systems.
- Leasing out and leasing in arrangements with the private sector. For example, private sector diagnostic services can be placed with public facilities, subsidizing operating costs, which can be used to offset prices offered to the MOHSS. Private sector providers can continue to use the equipment to provide services to other actors besides the MOHSS.
- Alternative payment approaches for high-cost diagnostic and treatment equipment. Specialized equipment usually requires a large capital outlay for the government. Such large outlays are generally not possible within yearly operating budgets. Payment approaches such as "pay per test, pay per result" can enable the MOHSS to partner with private sector providers and ensure such specialized services are available in public facilities. This will involve equipment placement in public facilities by private suppliers, including their servicing, while the government pays for each test/result. This reduces the burden on government procurement and human resources to operate and service such equipment. The system also reduces downturns, as the MOHSS only pays for services provided. Through this approach, the MOHSS spreads the utility and cost of specialized equipment over multiple budgets without the outright purchase of such equipment.

Public-private engagement is increasingly used to leverage private sector resources for public health goals. Public-private contracts can result in savings, but if poorly designed, they can create additional financial burdens. While implementing large-scale public-private agreements in Namibia may be challenging because of limited capacity in strategic contracting, the MOHSS can explore options with a long-term lens and develop a roadmap/framework for future use. In 2015, the MOF developed a Public-Private Partnership Policy that can be contextualized to health and provide a starting point for discussion (MOF 2015). The sustainability of public-private contracting depends on the contract design; poor design can lead to unsustainable costs for the government. Successful implementation can improve technical and allocative efficiency if challenges in designing and implementing agreements are addressed to avoid unintended consequences and financial burdens.

Intervention 3.5: Strengthening purchasing approaches within the private sector

Rising health care costs in Namibia's private health sector are driven by the fee-for-service payment mechanism, which incentivizes providers to prioritize service quantity over quality. The private sector is primarily driven by the fee-for-service model, resulting in high expenditure per member and above-average utilization. This has resulted in 20 percent of the population

exhausting over 10 billion Namibian dollars in health expenditure per year, while the public sector used 8 billion Namibian dollars for 80 percent of the population. Challenges noted in the industry include high fees per service and over-provision of services such as cesarean surgeries.

While the Namibian Association of Medical Aid Funds sets prices for reimbursement rates between insurers and providers, these are mainly directional and not adhered to. For example, specialists charge over 200 percent of the Namibian Association of Medical Aid Funds tariffs, and many insurers do not enforce referral pathways for patients to see specialists. These challenges point to inefficiencies in pricing and purchasing arrangements between insurers (who pool funds) and service providers. While the sector is voluntary and driven by profit motives, with good faith relationships between patients, insurers, and providers, stakeholders indicated a high financial risk for patients who exhaust benefits and crowd out the bottom 80 percent in public facilities.

Introducing price regulations could help mitigate the high cost of care and protect vulnerable voluntary members on lower-tier benefit packages quickly exhausted through high user fees and over-servicing. This could include strengthening the legislation around the pricing of health services, reimbursement models, and referral pathways to ensure patients are also protected from profit motives by providers. Price regulation should include consultation, hospitalization, pharmaceuticals, and diagnosis services, which stakeholders have indicated are among the most significant cost drivers for patients. Reforms to purchasing arrangements for the private sector will require substantial changes to the statutes governing how service providers, insurers, and practitioners are governed. Such legislative changes are complex and require collaboration across many actors, including the MOHSS, Namibia Association of Medical Aid Funds, Namibia Financial Institutions Supervisory Authority, and Namibia Health Professions Council, to ensure they are well aligned and do not create disincentives that destroy a sector providing coverage to over 20 percent of the population.

Strong government regulation can help overcome resistance and curb high costs in the health care sector. Learning from countries like China and South Africa, which have implemented cost-control measures and co-payment regulations, Namibia can adopt context-specific strategies that regulate prices without stifling the growth and sustainability of private health care providers (African Collaborative for Health Financing Solutions 2021). These strategies should include incentives for providers to adhere to regulations while ensuring accountability and transparency in the system.

Conclusion

Implementing these recommended reforms can help Namibia achieve more-equitable and more-efficient health financing, enhancing access and quality health care services across all income groups. This would reduce OOP health care costs, particularly for vulnerable and low-income populations, while increasing solidarity in financing. Improved resource allocation would ensure better delivery of critical health services and investments, enabling expansion of the essential health services package. Strategic purchasing could further optimize resource use, boosting the value for money in health care. Ultimately, these reforms would significantly advance Namibia toward the goal of universal health coverage, ensuring that all citizens have access to the health services they need without financial hardship. The ensuing health improvements will also positively impact economic productivity and social stability, fostering sustainable development in Namibia.

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