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# Namibia Health Financing Reform An Analysis



by Steven F Koch and Mr. Muine Samahiya

## Executive Summary

Namibia is an upper-middle income country (UMIC) that has recently seen reduced growth rates, including an 8.5% contraction in 2020, due to Covid-19. The current constitution mandates government to provide reasonable access to public health facilities and improve public health. As a World Health Organization (WHO) member state, it is committed to achieving universal health coverage (UHC), although it has not, yet, reached that goal. The health system represents a policy challenge in Namibia, because the population is sparse in many areas, while most health care is concentrated in urban areas. Thus, many Namibians, including the non-poor, find health care difficult to access due to both cost and transport reasons.

Health outcomes in Namibia are not particularly great, when compared to other UMICs. Its under-5 mortality rate (45.2 per 1000) is 3.1 times the UMIC average (14.4), while maternal mortality rate (265 per 100 000 live births) is 6.5 times higher than UMIC average. Those health outcomes should be seen within a country that has a budget execution rate of nearly 100% every year, while nearly 15% of its budget is devoted to health care. Government covers around 60% of total health care expenditure, which itself is near 8% of GDP. Government's expenditure includes a relatively large share that works through PSEMAS. The private sector and donors fund the remaining, with 16% borne by private companies, and 15% by households, of which approximately half is out-of-pocket spending. Currently, 7% comes from donors, although that share is falling. The relatively heavy spending on health, including by government, along with relatively poor health outcomes suggests a health system that supplies health care inefficiently, although there is no recent evidence to understand possible sources of the inefficiencies.

Many of these issues are understood, as government, with the support of the WHO, works towards UHC. The development of UHC within Namibia will require a rethink of the current system, including research into problems within the system, extensive stakeholder engagement, and a streak of practicality. UHC implies large improvements in health care access in Namibia, which implies that the definition of UHC in Namibia should be widely agreed to. Given the recent performance of the economy and the withdrawal of donors, funding sustainability will need to be an important focus. Whether one should work towards the development of a comprehensive national insurance fund, possibly through an expansion of PSEMAS to the rest of the country, or to a combined system that changes the regulatory structure around medical aid schemes (including PSEMAS), but still allows them to operate beside a wider national insurer should continue to be discussed. Regardless of the approach to be developed, health care delivery efficiency, including cost efficiency will need to receive attention.

## 1. Introduction

In 2001, in an effort to fight the scourge of HIV/AIDS on the African continent, heads of African states agreed to what is now referred to as the Abuja Declaration (OAU, 2001). Formal commitments contained in that declaration include a pledge to allocate 15% of the annual budget towards the health sector. Although it might be reasonable to assume that more expenditure on health will lead to better health outcomes, wasteful spending reduces the effectiveness of any budget allocation (Olaere and Gatome-Munya, 2020). Economically, it is also not obvious that blanket expenditure share targets are appropriate. In addition to potential waste, money spent on public infrastructure (water and sanitation) or food security, neither of which are typically listed under the health department budget, could offer a greater return on expenditure.

Such concerns were implicit in the Millennium Development Goals, although they have become explicit in the Sustainable Development Goals. The SDGs, as they are more widely known, captures direct health targets under goal 3, including 3.8 "Achieve universal health coverage," along with many targets likely to impact on health under most of the remaining goals. Taking directly from the World Health Organization (WHO, 2021a), emphasis added, "Universal

health coverage means that all people have access to the health services that they need, when and where they need it, without financial hardship.” Economically, that level of universality is impossible to achieve in a world with constrained resources and many other pressing needs, as represented by the other SDGs and political realities.

Despite, or maybe because of, the unrealistic economic implications associated with SDG 3.8, policy and economic research advancing universal health coverage has often been supportive of moves to implement a national or social health insurance system, due to the fact that insurance is based on third-party payments. It should be understood that universal health coverage and national health insurance are not the same thing. National health insurance, if fully implemented, creates one pool of funds and one buyer of services, implying there will be one payment or reimbursement structure associated with the use of health care services by the population.

Even though national health insurance is not universal coverage, it can clearly support universal coverage, and, more importantly, it does separate the individual needing care from any direct payments associated with care. Thus, a sick individual is not required to pay for care that they seek, when they seek it, and, therefore, the individual is not subject to out-of-pocket healthcare payments and will not be subject to health-related impoverishment or catastrophic health expenditures (Wagstaff and van Doorslaer, 2003; Xu, 2005). However, out-of-pocket payments can be eliminated through the simple abolition of any user fees associated with access and use of care, as is done in many countries, including public sector clinics in neighbouring South Africa. Furthermore, insurance can be associated with both moral hazard and adverse selection, while it is also important to note that out-of-pocket payments are not the only form of financial hardship associated with needing, accessing and using health care.

With respect to moral hazard, there is fairly convincing evidence that individuals will seek more health care, if they do not have to pay directly for it (Einav and Finkelstein, 2018). Such issues also arise in research related to health care financial protection; it is often of concern that the poor may not seek healthcare, because there are costs involved in seeking that care, and their budgets are limited. In terms of adverse selection, we find that healthier people tend to choose health insurance plans with fewer benefits, while less healthy people or those expecting to use more health care tend to choose plans with more benefits (Belli, 2001). The existence of adverse selection is another important problem that can be resolved through national insurance; if all individuals are in the insurance pool, there is no potential for adverse selection. In other words, adverse selection is a concern when there is voluntary enrolment, as it implies insufficient risk pooling and could threaten the financial viability of the insurance scheme. Wang et al (2006) find that high risk characteristics (eg, chronic illness and poor self-rated health status) are associated with increased health insurance enrolment. Furthermore, larger households are more likely to join, especially if schemes do not set premiums based on expected need.

Although there are a number of ways to work towards universal health coverage (Meessen et al. 2011), two approaches represent the range of available options in pursuit of universal health coverage. The UK’s (Beveridge) National Health Service model and Germany’s (Bismarck) social health insurance model; countries such as Japan, Canada, and France use models with similarities. The former relies on general taxes, uses one national risk pool, and provides services publicly. The latter requires household premiums and payroll taxes, but yields many risk pools, while the services are purchased largely from private providers – yet, services are only for participants (Kutzin et al, 2009).

In high-income countries, there is a larger tax base, and, thus, more freedom to pursue these goals in a variety of ways. However, lower-income countries need to think carefully about how to generate resources, pool risk, and provide services. As might be expected, countries in Africa pursuing universal coverage do not follow the same approach, given the differences in their cultures, their access to health care resources, social solidarity and incumbent health care systems.

If population health is to be improved, the provision of services, especially public health services and public health investments, is of foundational importance. Thus, it is necessary to consider coverage packages, either via insurance or whatever other means might be considered by the country's government. In terms of financial protection, the same issues need to be considered. The packages that offer the most for population health may not be the same as those offered for financial protection. Furthermore, there are deeper ethical issues with regards to services, especially since some health outcomes are, at least partly, determined by individual actions, while others may be completely no fault of the individual. For population health reasons, countries offer comprehensive preventive and primary care, while for financial protection purposes, countries are likely to offer additional cover, including hospital coverage and at least some medicine benefits.

In what follows, we describe a number of features of the Namibian health sector, although some additional research is yet to be undertaken, with respect to Namibia. We also describe schemes in a few other African countries with a view towards universality, strong features and weaknesses. It is hoped that these descriptions offer insight into design features that may or may not be appropriate to apply in Namibia.

## 2. Namibia

Namibia is an upper-middle income country with a projected population of 2.6 million. Namibia's GDP growth remained relatively stable in 2013, 2014 and 2015 posting growth rates of 5.4%, 6.1% and 4.3%, respectively (Ministry of Finance, 2021). However, since 2016 GDP growth has been on a downward trajectory, recording a growth rate of 0.0% in 2016, which worsened to -1.0% in the following year. However, the growth rate increased to 1.1% in 2018 before declining by 0.9% in 2019. Moreover, the economy contracted sharply by 8.5% in 2020 due to the slow economic activities caused by domestic and global lockdowns due to the Covid-19 pandemic.

The Constitution of the Republic of Namibia (Article 95) mandates the government to provide reasonable access to public facilities and improve public health. Namibia's Vision 2030 states that by 2030 the country "operates a healthcare system that ensures equity of access to quality healthcare services; promotes community involvement and greater citizen participation in the provision of health services; provides affordable health services; facilitates cooperation and inter-sectoral action with all major players in the provision of healthcare services; institutes measures to counter major health risks including the prevailing communicable diseases, such as malaria, tuberculosis, HIV/AIDS, etc; ensures the development of human resources, in sufficient numbers, for staffing various health delivery systems."

In addition, the health system ensures the development of a national healthcare system, which is capable of providing a fully comprehensive range of preventative, curative and rehabilitative healthcare that is cost-effective, sustainable and acceptable to the most disadvantaged communities, and which promotes equity and facilitates the effective implementation of defined strategies and interventions" (Republic of Namibia, 2004). The current and 5th National Development Plan (NDP5) for the period 2017-2022 states that "by 2022, all Namibians will have access to quality healthcare" (Republic of Namibia, 2017).

Moreover, Namibia is a signatory to many international conventions and agreements on health. According to the Constitution these international conventions and agreements to which Namibia is a signatory "form part of the law of Namibia". One such agreement Namibia ratified is the African Charter on Human and Peoples' Human Rights. The Charter states that every person shall have access to the best attainable level of physical and mental health.

Namibia is also a member state of the World Health Organization (WHO), and committed to achieving universal health coverage in 2005, when all WHO member states made such a commitment (Dye et al, 2013). To achieve universal health coverage, countries must make sure that all individuals and household have access to the health services they need when they need them without risk of financial ruin or poverty, both now and in the future (Dye et al, 2013).

## **2.1 Healthcare Service Delivery**

The health system is the most challenging policy area in Namibia because the country's people are scattered all over the place, such that the ministry of health and social services has problems reaching the workers in the remotest areas to provide health services. Thus, as one might expect in a sparsely populated country, the health system in Namibia is fragmented with a high concentration of infrastructure in urban areas such as Windhoek. Healthcare service delivery in Namibia is provided through the public and private sectors.

### **2.1.1 The Public Sector**

The diseases that pose the greatest challenge to the health sector in the country are HIV/AIDS, Tuberculosis and Malaria. In the attempt to curb the spread of HIV/AIDS the public health sector has made free antiretroviral treatment (ART) and drugs available as well as the preventing mother to child transmission program (PMTCT).

In the public sector, most of the health services are delivered by government through the Ministry of Health and Social Services (MoHSS). The MoHSS is divided into 7 Directorates at national level, 14 Regional Directorates and 34 districts. Regional directorates are headed by directors who are chairpersons of the regional management teams as the highest body at that level. Each regional directorate is divided into health districts and the health district is headed by Principal Medical Officers, who are the head of the district coordinating committees – the highest body at that level. Health facilities are divided into five categories determined by the nature of health services offered at facilities. The national referral hospital is the highest health facility, while the clinic is the lowest at the district level. There is only the one national referral hospital, there are three intermediate hospitals, 27 district hospitals, 44 health centres, 265 clinics and 1150 outreach points throughout the country (Ministry of Health and Social Services, 2021).

Around 1.5 million (uninsured) Namibians, which account for 85% of the total population, rely on primary health care of the public sector. It includes cheap, quick and easy medical treatment. The public health services usually charge flat user fees depending on the level of the facility. Due to highly subsidized user fees, medicine is generally affordable. The stance of the Ministry of Health and Social Services is that everybody in the country can have access to public healthcare, even if they are not able to pay, but those who are able to pay should pay for the health services.

Public health service delivery is founded upon the fundamental principle of primary health care (PHC) (Ministry of Health and Social Services, 2010). The PHC approach to service delivery entails a health system that is people centred, equitable and socially inclusive. PHC is delivered through community outreach sites, clinics and health centres whilst district hospitals and referral hospitals handle more complex medical procedures. Each services delivery level has its own specific-functions, however, complicated cases at one level are referred to the next level. At the community level, health extension workers identify health needs in the community and refer them to clinics. Cases that cannot be handled at the clinic level are referred to the health centres, whilst these facilities refer complex cases to district hospitals. In turn, district hospitals refer complicated procedures to referral hospitals.

According to Zere et al (2006), the public sector hospitals are not particularly efficient – unfortunately, a more recent analysis is not available. Their analysis is a three-input (total recurrent expenditure, beds and nursing staff) and two-output (total outpatient visits and inpatient days) Data Envelopment Analysis; it covers 1997/98 through 2000/01 fiscal years. Their results suggest efficiency averages around 62-74%, which is within the range estimated

from data collected in the mid-2000s in Gauteng, South Africa (Kibambe and Koch, 2007), as well as research from the Cape area of South Africa (Zere et al, 2001).

### **2.1.2 The Private Sector**

The private health system consists of 27 hospitals, 664 private consulting rooms, 126 pharmacies, 29 pathology laboratories, 22 radiology laboratories, 12 ambulance services, five mobile clinics, and 5 medical suppliers. Most private health facilities are situated in Khomas region, however, Erongo, Oshana, and Otjozondjupa regions also have a substantial number of private health facilities (Choi et al, 2015).

The private health sector is well organized compared to other African countries. The private health industry is primarily driven by non-profit medical aid funds (which are administered financially by for-profit administrators) that pay benefits directly to medical providers in proportion to the services rendered to the beneficiary. There are ten medical aid funds, including public service employee medical aid scheme (PSEMAS), six closed funds and four open funds. The closed funds limit membership to employees in a particular industry or company.

PSEMAS is financed by monthly fees on each joining civil servant and tax payers' money provided by the Ministry of Finance thus operating differently from other medical aid funds. Most of the offered products of private medical aid funds are too expensive for the majority of the population, especially for low-income workers in the formal/informal economy. The employee shares of premiums for such schemes have been too high for products including coverage for both inpatient and outpatient services.

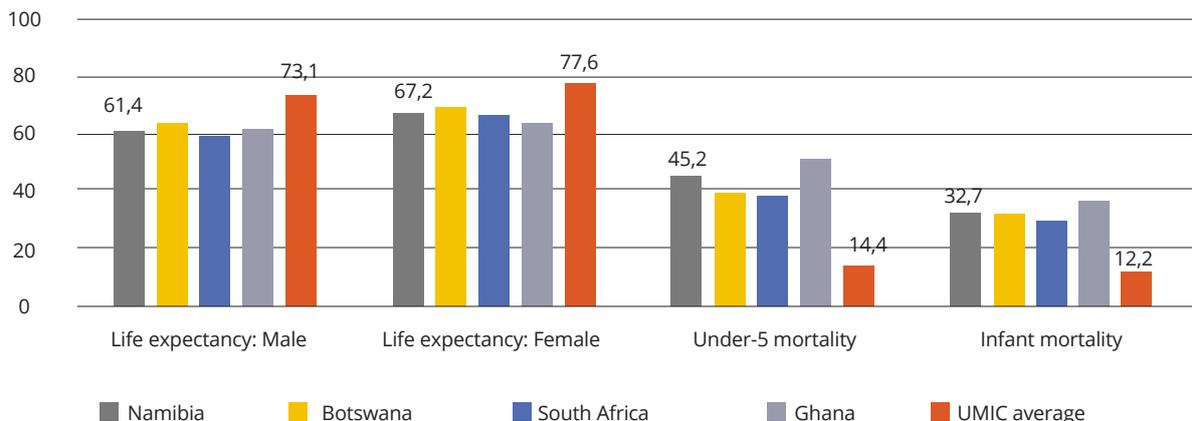
The main reason many individuals lack health insurance in Namibia appears to be the inability to pay health insurance premiums. Health insurance is available, but even the cheapest product of medical aid funds, a low-income worker would still pay 15% of his/her monthly income and an unskilled worker would still pay 19-22% of his/her income for family coverage. It would therefore be advisable for the government to establish an affordable national health insurance such as the National Medical Benefit Fund (NMBF) which is part of the 1994 Social Security Act of Namibia. This health insurance could cover all Namibian citizens, including informal sector workers as well as unemployed people.

## **2.2 Quality and Equity**

Quality health services is a key element of universal health care (World Health Organization, 2021b). WHO defines quality health services in terms of seven quality indicators, namely, effectiveness, safety, people-centredness, time-ous, equity and integration. Whilst it is beyond the scope of this report to provide a comprehensive assessment of the quality of health services in Namibia, it provides an overall picture of quality health services in Namibia.

Despite efforts by the government to improve access to quality healthcare the health system performs very poorly compared to other Upper-Middle Income Countries (UMIC). For example, the maternal mortality rate per 100,000 live births of 265 is much higher than the global target of 70 by 2030 and is 6.5 times higher than the average for UMIC. Moreover the under-5 mortality rate of 45.2 per 1,000 live births is higher than the world target of 25 under-5 deaths by 2030 and is 3.1 times higher than the UMIC average of 14.4. In addition, life expectancy at birth for both males and females is considerably lower in Namibia compared to other UMIC (Figure 1).

**Figure 1: Selected health outcomes in Namibia compared to other middle-income countries**

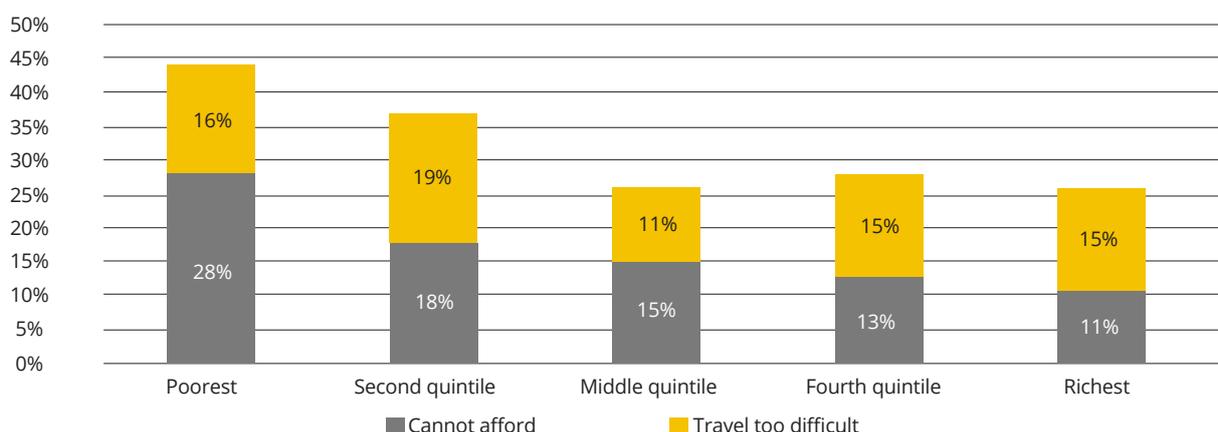


Source: World Bank (2019)

Moreover, WHO emphasize the need for health services to be equitable, in that health care services provided to different groups should be of the same quality, regardless of race, gender, ethnicity, age, geographical location, religion, socio-economic background, linguistic or political affiliation (World Health Organization 2021). In Namibia, evidence suggests that whilst those individuals in the poorest and second poorest wealth quintile use 62.4% and 66% of health services, respectively, those in the second and richest wealth quintiles use 70.6% and 72.5% of health services. Furthermore, poor women use public health facilities 30% less than their rich counterparts for child delivery services (Zere et al, 2010). Women covered by health insurance with secondary and higher education, who are likely to be wealthier, are more likely to be screened for breast cancer than their counterparts, who are not covered by health insurance and are less educated (Kangmennang et al 2017).

As depicted in Figure 2, some poor people have limited access to health services, due to affordability issues. The figure highlights the negative relationship between health-seeking behaviour and wealth: 28% of the poorest cannot afford to seek healthcare, when they need it. However, only 11% of the richest could not afford to . Similar inequities can be seen in other areas of the Namibian health sector. For example, Zere et al (2007) argue that part of the problem related to inequalities, such as those highlighted here, is that resources are not sent where they are needed. They use principal components over assets, some of which are more specific to health than others, to estimate need, which they use to suggest regional budget targets. Their results suggest that poor regions, such as Oshana, Oshana and Oshana, are under-resourced.

**Figure 2: Cannot afford seeking healthcare when needed, by socio-economic group**



Source: World Bank (2019)

Furthermore, Zere et al. (2011) examine inequity in skilled birth attendance in Namibia. At a descriptive level, they find that skilled birth attendance is pro-rich, and this relates to the availability of skilled birth attendants. Erongo, Hardap, Karas, Khomas are better-off regions, while Ohangwena, Omusati and Oshikoto regions are not. As might be expected, urban residence, mother’s education, and insurance coverage are also pro-poor, while female head-ed households are less well-off. Finally, Kavango, Kunene and Ohangwena have the lowest rates of skilled birth attendance and are mainly inhabited by the poor. Upon decomposition, they find education, urbanity and wealth to be important (positive) social determinants of inequality in skilled birth attendance; partly, this is because these variables are related to access, which also determines health (Marmot et al 2008).

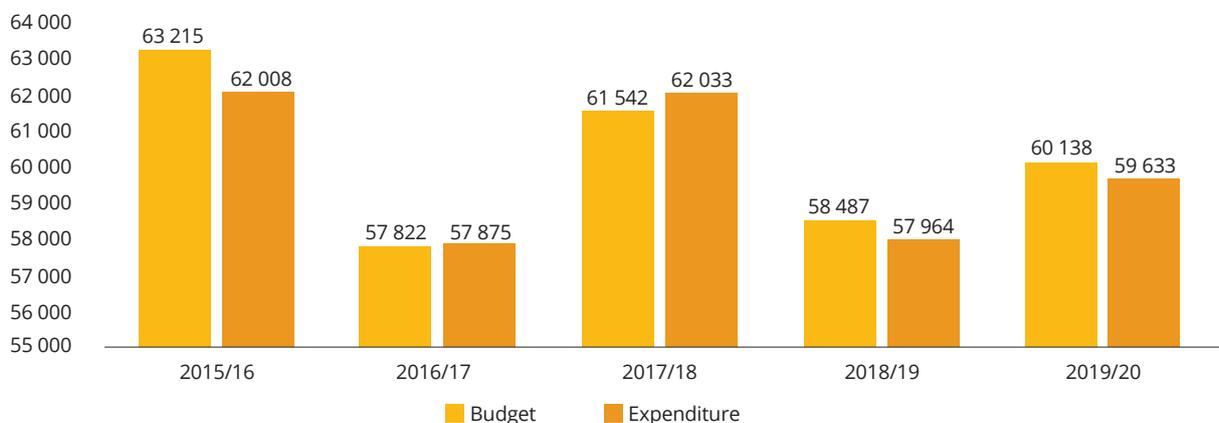
Zere et al (2010) offer a deeper dive than Zere et al (2011), as they look into additional maternal health indicators, such as antenatal care (and place received), skilled birth delivery (and place received, caesarean delivery and post-natal check-ups. As expected, private health care (delivery and antenatal care) is pro-rich, as is the use of caesarean delivery and postnatal check-ups. Such results can be explained by unequal distribution of health workers between the private and public sectors. Although there is an average of 3 health workers per 1,000 population (Ministry of Health and Social Services 2008), which exceeds the minimum 2.5 required to achieve 80% coverage of immunization and delivery by skilled attendants (Chen et al 2004). Across sectors, however, the difference is astounding. There are 8 per 1000 in the private sector, but only 2 per 1000 in the public sector.

There is some encouraging evidence that medicines are properly prescribed in the country, although fewer generic medicines than recommended are prescribed (Niaz et al 2020). It does appear that more access to national standard treatment guidelines and training would be of value; furthermore, prescription guideline adherence might increase if there were proper systems to regulate noncompliance.

### 2.3 Fiscal Overview and Health Financing

Figure 3 shows the government budget and expenditure for the financial years 2015/16-2019/20. It is evident that the budget was biggest in the 2015/16 financial year amount to about N\$63.2 billion. However, the budget was smallest in the following financial year at about N\$57.8 billion. The expenditure was biggest in the 2017/18 financial year, the same year in which the budget execution rate peaked at 100.8%. The smallest expenditure was in the 2016/17 financial year with a budget execution rate of 100.1%. However, the budget execution rate remained under 100% in the 2015/16, 2018/19 and 2019/20 financial years.

**Figure 3: Government Budget and Expenditure for 2015/16-2019/20 Financial Years (in N\$ Millions).**

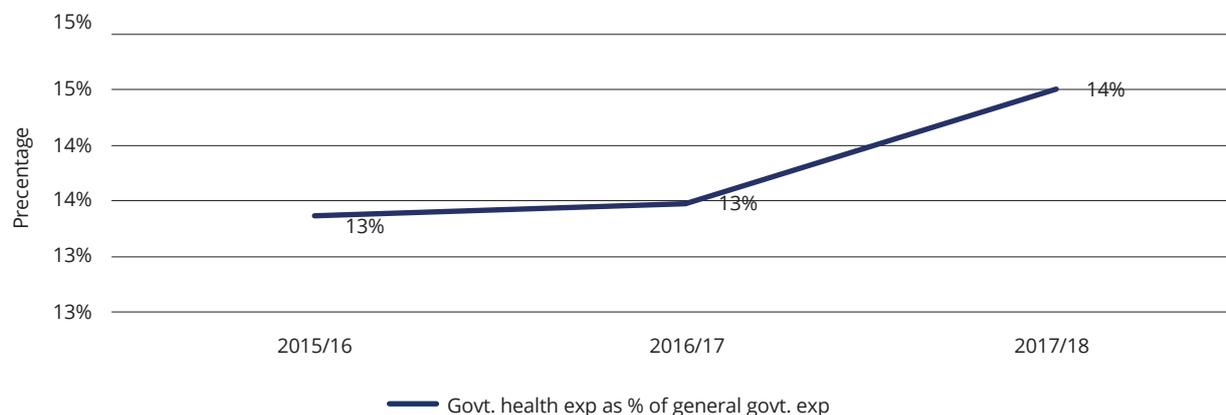


Source: Various Government Accountability Reports

The major sources of funding for the national health system are government, private sector, and donors. In 2019, government revenue contributed 62% of total health expenditure (THE), followed by the private sector and donors, at 31% and 7%, respectively (Ministry of Health and Social Services, 2020). Of the 31% private sector health expenditure, 16% comprise private companies' expenditure, 8% household (excluding out-of-pocket) and 7% household out-of-pocket (OOP) spending. The contribution of donor funding as a percentage of THE has declined over the years from a high of 22% in 2008/09 to the current 7% (Ministry of Health and Social Services, 2020). This reflects the withdrawal of donors, as Namibia reached its upper-middle income status.

Government spends nearly 15% (Figure 4) of its total expenditure on the health sector, which would meet the Abuja Declaration of 2001, where African Union countries committed to spending 15% of their national budgets on health (Ministry of Health and Social Services, 2020). This government spending on health includes expenditure on health from other ministries other than the MoHSS. These ministries include the Ministry of Defence, which operates its own military hospitals, Ministry of Education, which runs the school health programme, and several other ministries, which operate HIV and AIDS workplace programmes for their employees.

**Figure 4: Government health expenditure as a percent of government expenditure.**

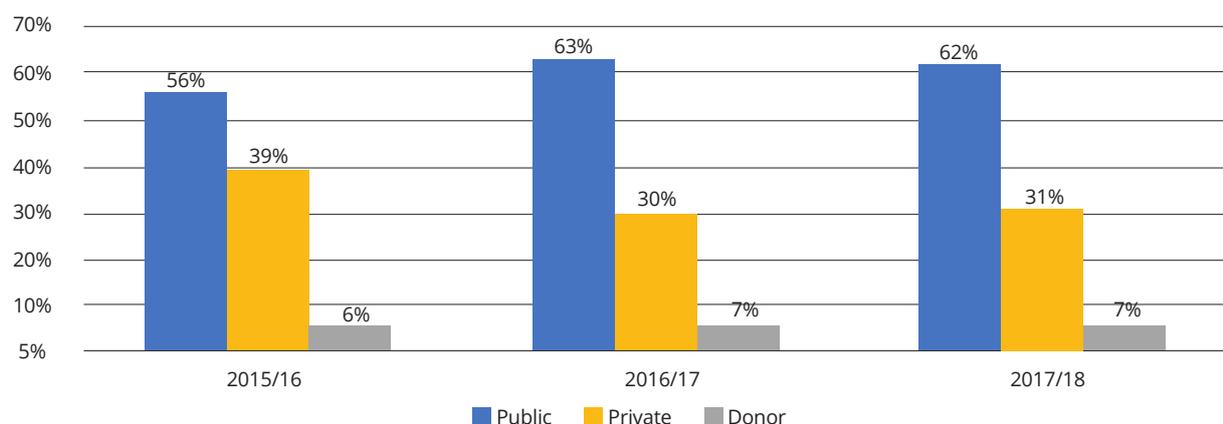


**Source:** World Bank (2019)

The breakdown of public spending by provider in the 2017/18 financial year shows that three major items on which funds were spent are public hospitals (66%), health system administration (20%) and public health centres (11%). Moreover, the public health spending breakdown by health function shows that four major functions on which funds were spent are outpatient curative care (36%), inpatient curative care (32%), governance, health system and financing administration (18%) and capital formation (6%).

Government revenue remains a major source of health financing in the country. Namibia Resource Tracking for Health and HIV: 2017/18 indicates that the major sources of funding for the national health system are government, private sector, and donors. In 2017/18, government revenue contributed 62% to total health expenditure (THE), followed by the private sector and donors, at 31% and 7%, respectively (Ministry of Health and Social Services, 2020). Government spending fluctuated between 56% and 63% during the period 2015/16-2017/18. Of the 31% private sector health expenditure, 16% comprise private companies' expenditure, 8% household (excluding out-of-pocket) and 7% household out-of-pocket (OOP) spending. The contribution of donor funding as a percentage of THE has declined over the years from a high of 22% in 2008/09 to the current 7% (Ministry of Health and Social Services, 2020). This reflects the withdrawal of donors as Namibia moved from a lower- to a middle-income country. Whilst this may be current a hindrance, it shows that the government is taking more and more control over health financing in the country.

Figure 5: Sources of health financing: 2015/16-2017/18



Source: Namibia Resource Tracking for Health and HIV: 2017/18

Moreover, the government funds most of the public health services through the MoHSS’s budget. In 2017/18, 97% of the MoHSS’s budget was funded from public sources (Ministry of Health and Social Services, 2020). Below, Table 1 shows that the MoHSS’s budget as a percentage of government budget ranged between 10% and 12% in the past five years. The budget share was highest in the financial year 2016/17. However, in absolute numbers the budget was highest in 2017/18 financial year before declining in 2018/19. However, the budget picked up in 2019/20.

Table 1: Government and MoHSS’s budget for the past 5 years (N\$’0000’)

	2015/16	2016/17	2017/18	2018/19	2019/20
MoHSS	6 236 793	6 955 536	6 961 898	6 712 176	6 872 753
GRN	63 215 277	57 821 741	61 542 121	58 487 111	60 138 143
MoHSS % share	9,9%	12,0%	11,3%	11,5%	11,4%

Source: Government Accountability Reports: 2015/16 – 2019/20 FY

In 2017/18, see Table 2, 97% of the MoHSS’s budget was funded from public sources (Ministry of Health and Social Services, 2020). Namibia’s HIV/AIDS response is mainly financed through government and donor funds accounting for 55% and 36%, respectively. Private companies and households only contribute 8% and 1% respectively. This heavy reliance on donors has is a concern for universal health coverage (African Collaborative for Health Financing Solutions, 2019).

Table 2: Trends in total and government health finances, in million N\$, 2015-2018

	2015/16	2016/17	2017/18
Total MoHSS expenditure	6 506,37	7 203,69	7 059,94
Government health expenditure by other Ministries	192,13	190,21	190,21
Government transfer to PSEMAS medical aid	2 273,65	2 212,87	2 537,08
<b>Total Government Health Expenditure, in million N\$</b>	<b>8 972,15</b>	<b>9 606,77</b>	<b>9 787,23</b>
MoHSS expenditure as % total government expenditure	73%	75%	72%
PSEMAS as % of Gov. Health Expenditure	25%	23%	26%
Government Health Expenditure as % of GDP	6%	6%	5%
Gov. Health Expenditure as % of General Gov. Expenditure	13,4%	13,5%	14,5%
GDP, current in million N\$	150 083,00	164 155,57	183 488,25
General Government Expenditure	67 091,54	71 243,98	67 523,02

Source: World Bank (2019)

The level of health expenditure in Namibia could possibly be larger, while the distribution of that expenditure could also be more even. Despite that, recent research implies that Namibia's relatively large public health expenditure share and middle-income status are important contributors to reduced catastrophic health expenditures associated with surgical care services (Boz et al, 2021).

## **2.4 Health Finances and Financial Protection**

Financial protection is at the centre of universal health coverage (Dye et al, 2013). WHO classifies OOP health expenditure higher than 20% of THE as catastrophic health expenditure (Ministry of Health and Social Services, 2020). As noted earlier, OOP contribution to THE in Namibia is only 7%, which is far below the WHO recommended threshold. Thus, the fact that OOP is far below the recommended threshold suggests that there is relatively strong financial protection in Namibia. The level of OOP is due to many reasons, one of which is that public health services are heavily subsidised by government.

However, the OOP criteria might not be reflective of the extent to which poor individuals and households are excluded from the mainstream health system and are, thus, unprotected. Evidence shows that poor individuals delay seeking health. Therefore, other indicators, such as health seeking behaviours of the poor compared to those of the rich may help uncover the extent to which the poor are left out. In Namibia, for example, evidence shows that poor women use public health facilities 30% less than their rich counterparts for child delivery (Zere et al, 2010), and that women covered by health insurance with secondary and higher education are more likely to be screened for breast cancer (Kangmennaang et al, 2017).

Moreover, pooling funds is an important step towards universal health coverage, as it potentially furthers coverage and financial risk protection. However, in most developing countries, poor households lack access to health insurance (Akinkugbe et al 2012). In Namibia, 80% of the population is not covered by health insurance schemes (Ministry of Health and Social Services, 2020). Lack of health insurance can result in substantial financial loss and impoverishment, when vulnerable households face health shocks. Such outcomes are relatively more likely in sub-Saharan Africa, where the AIDS pandemic has put tremendous pressure on the financial well-being of households (Gustafsson-Wright et al, 2011). In Namibia, there is evidence that health shocks can have major consequences on the uninsured including selling assets, taking up credit or receiving financial support from relatives and friends (Gustafsson-Wright et al, 2011).

## **2.5 Medical Aids and PSEMAS**

Health insurance forms a significant proportion of THE, amounting to 38% in 2017/18. Whilst 21% was pooled via several private medical aid funds (MFAs), 18% came from the public employee's health insurance scheme, the Public Service Employees Medical Aid Scheme (PSEMAS) (Ministry of Health and Social Services, 2020). However, these funds are limited to beneficiaries of the health insurance schemes, who represent only 20% of the population, with private health insurance schemes covering 8% and PSEMAS covering 12%.

There are various small pools of funds in Namibia, which provide cover for medical expenses. These include private medical aid funds (MFAs), PSEMAS, Motor Vehicle Accident Fund (MVAf), Workman's Compensation Fund (WCF) and maternity leave benefit Fund. According to Namibia Association of Medical Aid Funds (NAMAF), there are 8 operating private MFAs. MFAs are non-profit organizations, which pool funds from its members to provide health insurance cover for its members and their dependents. MFAs can either be open or closed. Open MFAs are those whose membership is open to any individual who qualifies whilst closed MFAs are those whose membership is restricted to the industry of employment, i.e. BANKMED is restricted to employees of the banking industry only. As of March 2021, there were 203,609 MFA beneficiaries in the country, of which 182,831 belonged to open funds and

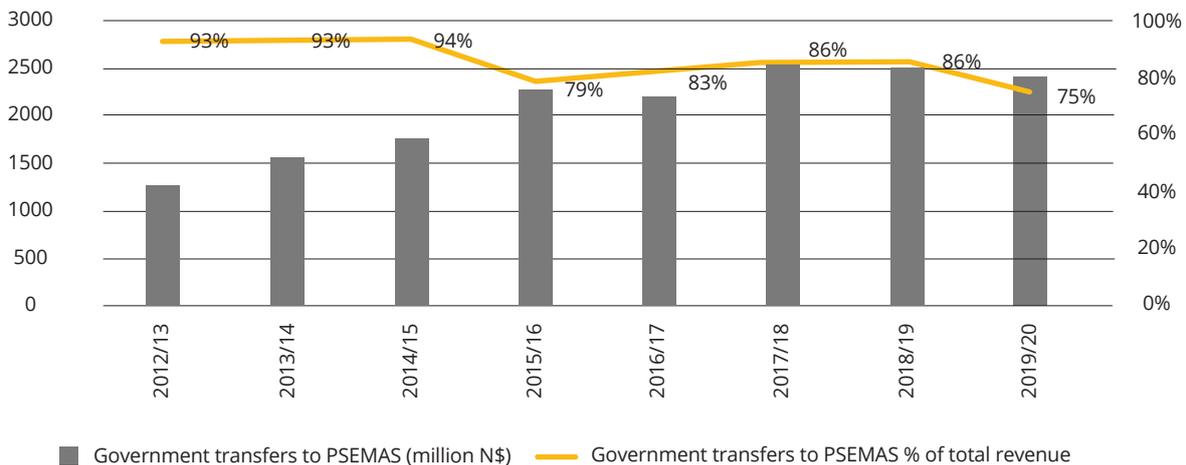
20,778 belonged to closed MFAs. However, contributors were 85,247 for open and 8,882 for closed funds. Average monthly contribution per member was N\$1,900.34, while the average monthly claim per beneficiary was \$1,685.32, which translates into an average monthly claims ratio of 88.7%, which is beyond the maximum prudential threshold of 87.0% set by the Namibia Financial Institutions Supervisory Authority (NAMFISA). However, for closed funds, the average monthly claims ratio was higher at 108.2% compared to open funds at 86.2%.

One concern associated with the private medical aid funds industry is that premium costs tend to rise with the level of medical wages and medicines, healthcare utilisation, which in turn is related to the burden of disease and demographic trends, and administration costs, amongst others (Erasmus and Fourie, 2014). In order to mitigate some of those increases, Levin-Scherz (2010) suggests: increasing competition and transparency in pricing among healthcare providers to help contain costs; giving consumers responsibility for their elective care spending (medical savings accounts might be appropriate in this regard); developing capitation arrangements that pay set rates per patient regardless of services provided; and integrate smaller practices into multispecialty groups or delivery systems.

Shivolo (2016) undertook a qualitative study including participants from the Namibian medical aid industry. Of the responses, 24 suggested that price increase mitigation could be alleviated by government subsidization of all private medical funds as a solution to curb the increases in medical premiums, while 21 suggested the introduction of a mandatory national healthcare fund. A further 19 felt that improved lifestyle habits would be important, while 13 believed that educating members to use aid funds properly was important. Price regulation or suggestion were also deemed important. Benchmark tariffs to manage prices were deemed important by 18, while 15 were in favour of more specific price or service charge regulation. for services charged by service providers as a solution to curb these escalating costs.

PSEMAS is another pooled fund for healthcare services, albeit for public service employees. The total membership of PSEMAS is not clear as there is no easily accessible information on PSEMAS. However, according to the report on Health financing in Namibia conducted by USAID in 2016, PSEMAS membership including dependents amounts to 230, 248 members. The same study reported that member contributions to the scheme amounted to N\$196 million in the 2012/13 financial year and that the government contribution amounted to N\$1.112 billion. This translates into a government subsidy to the health insurance scheme of about 85%. The total claims in that same year amounted to N\$1.307 billion, which represents a claims ratio of 99.9% and equivalent to N\$5,681 per beneficiary. Currently, government bears the biggest burden associated PSEMAS; Figure 6.

Figure 6. Government funding to PSEMAS



Source: World Bank (2019)

The Motor Vehicle Accident Fund (MVAf) is established by the Motor Vehicle Accident Fund Act of 2007. Costs associated with that fund are described in Table 3. The MVAf provides benefits to persons injured in motor vehicle accidents and to dependents of persons killed in such accidents. The Fund's benefits include an injury grant, funeral grant, loss of income grant, loss of support grant and medical benefit. The revenues of the Fund come from the Motor Vehicle Accident Fund levy, which is collected by the National Energy Fund hosted in the Ministry of Mines and Energy. The levy is 47.7 cents per litre of fuel.

**Table 3: Number of claims and associated medical expenses on motor vehicle accidents**

	2013	2014	2015	2016	2017	2018
Number of Claims	22 291	29 709	40 341	24 037	52 393	51 799
Medical Expenses (N\$'000')	84 500	104 900	132 400	143 600	166 700	194 800
Average Cost per Claim (N\$)	3 791	3 531	3 282	5 974	3 182	3 761

Source: MVAf Annual Report 2018

Table 3 shows that the number of claims related to motor vehicle accidents increased from 22,291 in 2013 to 51,799 in 2018, which is an average annual increase of 22.1%. However, the average annual increase in medical expenses was relatively lower at 21.8%. Notwithstanding, the average medical expenses relatively remained stable during the period under review.

The Namibian Health Sector Expenditure Review (World Bank, 2019) notes a number of problems with medical aids, PSEMAS and government regulation around such funds. For example, there has been a substantial increase in funds to PSEMAS: its revenue has doubled since 2012. However, since PSEMAS members are a small share of the population, approximately 12.5%. Employees contribute a fixed rate, which is how insurance schemes are often designed, at least within a pool, and is not tied to income; thus, contributions are regressive. The review also offers a few suggestions for re-arranging the relative contribution between government subsidy and employee, which would allow the government budget to go further than it currently does. A further concern is that PSEMAS appears to purchase inefficiently, especially, when it comes to medicines, and appears to retain a rather large profit share, since only 75% of its revenues are spent on healthcare utilisation, which is quite a bit lower than the 88% (and higher) shares in the open and closed medical aid schemes in the country.

Currently, medical aid fund reimbursement for healthcare is based on fee-for-service, which comes with concerns related to 'supplier-induced-demand', and, therefore, deserves further attention. There are other ways to make payments, including payments (at least partially) based on the case-mix seen at the hospitals that can improve payment efficiency. However, the more general problem is that the insured are also subject to rather high out-of-pocket payments. Although there are benchmark tariffs, specialists and other providers charge patients directly, at rates well beyond the benchmark; thus, the level of financial protection offered through insurance is weakened. One form of potentially beneficial price regulation could revolve around a basic benefit package. However, if the supply side remains the rationing point in the market, which is likely the case, at least for specialists, the supply side will continue to enjoy exceptional pricing power; thus, a payments system implemented, devoid of policies and programs designed to increase the availability of healthcare workers is unlikely to yield the desired results.

Furthermore, coverage, as noted above, is incomplete. According to Allcock et al (2019), 17.5% of the 2013 DHS sample had health insurance. More men were covered than women, and coverage was also higher amongst those of a working or child-rearing age. Coverage was especially high for the professionally employed, which translated into employer-provided coverage being the largest share of insurance, although 7% of the unemployed were covered. Coverage also was higher for those with more education and wealth, as well as those living in urban areas. Nearly 30% were covered by social security insurance, while 21% had their 'own' coverage, which was not linked to either

the employer or social security. Unsurprisingly, they also find that those who had insurance were more likely to seek both inpatient and outpatient healthcare. Furthermore, the poorest, men and those with the lowest levels of education were the least likely to seek healthcare. They do suggest that coverage would increase if employer schemes could be extended to the informal sector, citing evidence that commercial farm workers might be receptive to premium co-payments (De Beer et al, 2011). On the other hand De Beer et al (2009) find that anonymous HIV-screening in the workplace can health insurance uptake, because it provides information to management about the healthiness of their workforce, which can be used to develop health insurance packages/products for its workforce.

Health insurance is assumed to offer households a certain level of financial protection against health shocks. Gustafsson-Wright et al (2011) find mixed evidence that this happens in Namibia. They find that uninsured households coping strategies for hospitalization costs are driven by reduced expenditures elsewhere and through asset sales. However, this does come with the caveat that it might impact their future shock absorbing capabilities. On the other hand, insured household credit take-up, in the event of hospitalization, is rather limited, suggesting that the insured, who are also better-off, tend to borrow for productive reasons. Leive and Xu (2009) offer some support for these findings, although they consider additional countries. Their main findings suggest that increased out-of-pocket payments are associated with increased borrowing and increased asset sales. Furthermore, the relationship appears to be larger for the three poorest wealth quintile households relative to the two richest wealth quintiles.

## 2.6 Views Related to Health Care Financing Reform

Although Shivolo (2016) finds that people in the medical aid industry believe there is reform potential, and that it can include a national health insurance scheme, there has not been extensive stakeholder engagement on possibilities, which would include those in medical aid schemes, especially PSEMAS, and the broader electorate. However, in early October, we were able to engage in discussions with a number of stakeholders to discuss issues and options with regard to something that might be more akin to a national health insurance scheme. The represented stakeholders in this engagement were:

- Ministry of Finance
- Ministry of Health and Social Welfare
- Social Security Commission
- Ministry of Labor
- Hanns Seidel Foundation

The Ministry of Finance was represented by the Deputy Minister of Finance, the Honorable Maureen Hinda-Mbunde, as well as senior management executive, Mrs. Elizabeth Kharuchas. They raised two concerns. One was that corruption is the greatest challenge to PSEAMAS. Such concerns are noteworthy, and in need of more careful investigation. In their view, health professionals and/or service providers are creating false claims, which is unethical, as well as bad for the performance of the state's medical aid fund. The other was increasing expenditures within PSEMAS that do not appear to be a strong correlation to this increase and improved health outcomes. Again, such concerns deserve further scrutiny, to determine what expenditures are rising, and whether there are health outcome benefits or if there are other potential explanations for the increase. For example, given Namibia's health system, it is possible that cost increases are associated with the treatment of medical migrants. Unfortunately, not much is known about the extent of medical migration, or even the costs; thus, again, additional research is needed to understand its contribution. Clearly, if the corruption concern is investigated and found to be true, that would provide one explanation for lack of efficiency in translating increased expenditure into better health. However, little is known about the extent of corruption, and, therefore, there is a need for deeper investigation and evidence regarding the amount of funding that goes towards health and the amount that might be lining pockets. Furthermore, appropriate actions against corrupt and unethical health professionals could not be undertaken without supporting evidence.

In addition to these concerns, there are plenty of practical problems relating to PSEMAS, especially if it is to be part of a national health insurance fund. For example, PSEMAS is an employee benefit; thus, it would need to be compensated, if removed, while medical aid fund systems and health systems are not interfaced; thus, a complete, or at least more extensive, health information management system is needed. Finally, as with any potentially large policy change, more and better engagement between stakeholders is likely to pay dividends.

The Ministry of Health and Social Services was represented by the Deputy Minister of Health and Social Services, the Honorable Dr Ester Utjiua Muinjangu. This ministry pointed out many difficulties related to health service delivery. For example, there are limited resources to achieve intended targets, especially those related to improved service quality. For that reason, there remains a place for donor assistance; however, donor funding is decreasing. Despite that, there is an acknowledgement that the health sector can be restructured to support a national health policy to provide equitable access to quality healthcare for all. Part of that restructuring is reflected in the universal health coverage framework, which could help achieve this policy goal, specifically through an assessment of funding sources that would ensure sustainability, and processes are in place.

Regardless of the importance of funding, there is a need to improve operational processes within the sector to ensure the quality of health service delivery is enhanced. The deputy minister also noted that the ministry has started analyzing and reviewing the framework that will help move towards UHC, with the support of the WHO, and she said that regarding corruption they deal with the doctors and that the process of claiming is done by PSEMAS, and not by the ministry of health and social services. She further said that irregularities are dealt with by the Health Professionals Council of Namibia.

The representative from the Ministry of Labor noted that the ministry focused on workers, and had, otherwise, not had extensive engagements with the Ministry of Health and Social Services, even though their policies might directly impact labour. Implied within their comments was that an NMBF has been feasibly examined, although there remained a need for further consultations.

During the question-and-answer session, additional questions and comments were raised. For example, there is a need for improvement in health service delivery, and not just financing. In particular, was it possible to better examine inefficiency in the system. The only study of which we are aware is that by Zere et al (2006). Such an analysis can and should be updated in many dimensions, as a matter of urgency, to better understand inefficiencies in the sector. Additional comments included an important reminder health care is more consistently viewed as a right, rather than a privilege for the formally employed or well-off, who have access to medical aid schemes, and, implicitly, better private sector health care. Creating a system, wherein, everyone feels that they are not excluded from access health is a priority in Namibia. Getting there will require many hard choices and sacrifices to reach a policy compact. Importantly, in a resource limited setting, not all wants can be satisfied. That economic maxim should never be ignored, when designing a policy.

## **2.7 A Path Forward**

In the following section (Section 3), we provide a review of three countries' health systems (Rwanda, Ghana and Ethiopia). The first two have moved quite some way towards a fully national system, while the last is in a relatively early stage. Certainly, other countries could also have been considered, including Nigeria, South Africa, Uganda and Zambia, which either have plans in place or have implemented them. Although the details will differ, it is unlikely that the conclusions would be significantly altered if the review included these additional countries. We begin with a brief overview of Section 3 – the interested reader is welcome to read that section for more detail. We then provide a brief review from Namibia and conclude with reasonable options going forward.

### 2.7.1 Overview from Africa

As we noted at the outset, health insurance is one way to decouple the payment for services from the use of services, and, therefore, reduce financial hardship associated with ill-health. However, there are other ways to accomplish this task; for example, the elimination of user fees does the same thing, because there are no health service costs associated with ill-health. Decoupling the price from the purchase is, in economic terms, not generally a great idea. It tends to lead to excessive use. In many countries in Africa, where there are no user fees, 'excessive' use is mitigated with indirect rationing devices, such as: long queues, medicine stock-outs, poor health sector staff attitudes and bribes.

By the same token, firms that do not charge for their services, as is the case in the abolished user fee environment, are not able to manage their costs or even deliver the right mix of services or even the socially desired quality of service. Thus, in places without user fees, we may be more likely to see medicine stock-outs, bad staff attitudes and/or corruption. Although insurance does potentially lead to excessive use of health services, an insurance system does imply a reimbursement mechanism for the hospital/clinic, and, therefore, the potential to develop better management that matches services with need, improving health care and the customer experience, amongst other things.

The main difficulties with health insurance are (i) relatively low take-up rates, (ii) limited willingness and ability to pay premiums, which is related to the first, but also reduces overall funds available for health care, (iii) political economy issues related to legitimacy, such as support of the plan and capturing the funding needed for the scheme, and (iv) the limited financial and management skills needed for the proper performance of the clinics and hospitals that were publicly operated, previously. This review has mostly focused on the first three, as well as the main benefits, such as improved access to health care and reduced financial burdens.

It should also be noted, though, that no health insurance scheme can address the other two financial hardships associated with ill-health; those are: transportation costs and lost work and the associated pay, the latter of which is especially important for in the informal sector. It is not feasible to take hospitals to the people, at least literally, although it is feasible to develop community health programs that employ community health workers, for example. It is also not feasible to provide full earnings support (or extended childcare for that matter) for everyone in need of health care, because it requires an extensive formalisation of the labour market that is dependent on an economy that is much larger, per capita, than any African country is, currently.

Our review highlights that, at least within this set of African countries, the NHI-UHC process was initialised via a decentralized structure. Under that structure, local communities are the risk pools; thus, there is incomplete pooling of risks. However, the local nature of these structures allows for local tailoring of the plans and even 'arm-twisting' related to enrolment. Regardless of which is more important, the data suggests greater participation, and, therefore, the community schemes appear to be perceived more positively. Despite that, the plans still required funding injections, often from donors. Such approaches may or may not be relevant for Namibia, although the extent of informality and unemployment within Namibia are reasonably similar to what was present in the countries reviewed.

Many countries have tried to extend or nationalise these schemes, although the result has been less than satisfactory take-up rates, even if the schemes are mandated. The schemes have resulted in lower financial burdens, while non-members also appear to understand the reduced financial burden (at least at the point of service) associated with the service; in some cases, this means that some/many people join only when they know they need healthcare, which hurts the risk pooling properties and the financial viability of the schemes. There is still evidence of health care related financial burden in some of these countries, as well as overburdened healthcare staff, which suggests that, for the most part, these schemes have not achieved what was expected of them. One conclusion to

be deduced from these reviewed studies is that focussing only on the demand side is not enough to get to universal health cover. One might even be willing to reach a step further and deduce that improving the management and delivery of health care in the public sector is of exceptional importance both for the improvement of the health of the populace, but also for legitimacy of the underlying scheme and implied mandated premiums.

Kiendrébéogo et al (2021, Box1) summarise the above challenges slightly differently, by highlighting barriers to UHC.

- **Barriers to accountability:** despite the existence of accountability frameworks: limited ability to translate policy to implementation and lack of clear implementation strategies.
- **Barriers to collaboration:** lack of effective engagement, poor stakeholder inclusion, fragmentation of efforts and poor coordination of UHC platforms.
- **Barriers to implementation:** insufficient financial resources, inefficient allocation of existing resources, lack of a standard process for information sharing, insufficient use of evidence to guide decision-making, and organisational or cultural barriers to knowledge exchange for learning.
- **Barriers to accessibility (especially for the poor and people living in rural settings):** insufficient human resources, supplies and commodities, as well as inadequate infrastructure and service delivery systems.

### 2.7.2 An Overview from Namibia

Although somewhat simplistic, many of the preceding barriers exist in Namibia. For example, people are widely dispersed, and the rural population does not have as much access to healthcare as their urban counterparts. Financial resources are limited and declining, and some of that decline in external funds has led to the demise of evidence gathering that could inform policy, e.g., the latest available health accounts resource tracking report appears to be from 2017/18. Although there was UHC momentum in the early 2010's, that momentum has tapered, possibly because the specialised UHC secretariat within the Social Security Commission ceased as a separate entity and was rolled into the broader MoHSS (African Collaborative for University Health Financing, 2019). Furthermore, despite the development of an NHI Roadmap in 2012, a focus shift from NHI to UHC meant that the roadmap was never implemented (African Collaborative for Health Financing Solutions, 2019).

The effect of these barriers within the Namibian context is the system that we see today. Despite the fact that the government budgets is at or near the Abuja 15% target on healthcare, and, in fact, out-of-pocket payments are not a serious problem, the system is inequitable and population health could be better. There are not enough resources available to cater to all healthcare needs, although, economically, catering to all needs is a recipe for poor resource allocation. From both a government and an economy point of view, it is difficult to see where enough additional funds might be located to address some of the preceding concerns.

The recent economic climate characterized by low economic growth, decline in donor funding for health services, and the financial unsustainability of PSEMAS has encouraged talks around a sustainable health financing mechanism for universal health coverage in the country (World Bank, 2019). As such, attention has been drawn to the National Medical Benefits Fund (NMBF), which is established under the Social Security Act (SSA) of 1994. The same legislation states that the purpose of the NMBF is to provide medical benefits to every employee who qualifies to be a member of the Fund. The SSA defines the financing sources of NMBF as prescribed contributions to the Fund by its members, moneys appropriated by Parliament, interest or dividend earned, and any fines charged in respect of the Fund. The Social Security Commission (SSC) is mandated to implement the NMBF, however, this has not been done so far.

In recent years, the MoHSS and SSC have been exploring possible health financing mechanisms for universal health coverage. As such, the Universal Health Coverage Advisory Committee of Namibia (UHCAN) was established for

this purpose. The UHCAN was established to serve as an advisory body in the development of sustainable systems and policies for UHC in Namibia. Considering these developments, the United States Agency for International Development (USAID) commissioned several studies to inform the sustainable financing for UHC. Although some recommendations have been made, it is not clear how those recommendations have been taken into consideration.

### 2.7.3 A Proposal

WHO defines UHC in terms of “need”; however, need is not a feasible concept for managing resources. Thus, it is imperative for the country to form a social compact related to an acceptable understanding of need. In terms of financing, public economics tells us that positive externalities should be funded through the public purse; otherwise, too little will be purchased/used. Thus, we recommend that standard public health interventions be paid for through taxation. This includes antenatal care and immunisation, amongst other things; such activities should also be agreed to within the social compact and can also be subsidised in the private sector, assuming it remains – and it should – to encourage better uptake.

Many other health interventions are exclusionary, e.g., if I receive surgery for a broken arm, no one can receive that same surgery at that same time. Furthermore, they are of benefit primarily to the individual or to friends and family of the individual. Some of these interventions can exceed the means of the friends and family, and, where cost-benefit or cost-utility calculations agree, should be supported through an insurance system with the widest pool possible, and the premiums should be determined for the pool. Thus, we recommend a concerted effort to determine a premium that would be actuarially fair and offer coverage for interventions that are cost-effective. The difficulty underlying this calculation is the determination of latent demand for health care in Namibia and is likely to require a large scale survey or experimental roll-out of insurance within regions.

Another important feature of the actuarial fair premium is the development and costing of healthcare delivery in the public sector. Specifically, it is necessary to determine the cost of delivering the services it delivers and working to lower those costs while maintaining adequate quality – hopefully improving delivery quality. Thus, it is necessary to change or train the management structure of the public healthcare system to be able to respond to incentives. It is also important for policies to incorporate, to the extent feasible, the correct incentives.

Extreme health shocks, such as those we have observed during the Covid-19 pandemic would unlikely be captured in an actuarial calculation. As such, reserves should be built-up over time, to allow the country to manage exceptional events, although government should also be in a position to borrow, if needed, to deal with these events.

One of the defining features of private medical aid coverage, especially in the last few years, is its willingness to incentivise members to be more healthy and use healthcare appropriately. Although the same cannot always be said for the providers of care, who may abuse the fee-for-service reimbursement mechanism or take advantage of their market position to charge (potentially) excessive prices – notably, more research into pricing in the private healthcare market is needed, which will also require a change in regulation to improve data availability for research purposes.

Regardless of the need for more research, a one-size-fits-all premium model and single insurer – the typical NHI solution, unfortunately, could take away from innovativeness amongst insurers; thus, it could be ideal to allow for plan/package experimentation within the larger insurance pool. For example, healthy living activities could be subsidised from the pool, again, on an actuarially fair basis. Furthermore, the skills developed within the private sector to manage medical aid funds should be harnessed, properly compensated and incentivised to make a national (or close to national) pool work. As suggested above, such insurers can also be allowed to continue; for example, they could offer the standard package, which would be determined nationally, as well as additional cover.

Although there is an obvious vehicle for the standard package, which is current government scheme, PSEMAS, there are concerns over its financial viability, as well as complicated labour relations issues regarding compensation. PSEMAS is an employee benefit, and, therefore, if it were to be nationalised in some way, the employee benefit might need to be replaced through wage increases or other employment benefits. However, given what has been discussed above regarding all medical schemes, along with the fact that 85% of the country does not have access to such a scheme, it might be more appropriate to develop a complete fund that focuses on the needs of the 85%. From a regulatory perspective, all other schemes could be required to offer an equivalent standard package, and be allowed to compete on the offering of extensions to that standard package. However, more discussion amongst stakeholders is needed to develop the appropriate structure. It is fairly obvious that the actuarially fair premium will be too high for many, possibly even a majority of, Namibians. Thus, the fund will also require subsidisation from the public purse, which cannot be done in such a way that the relatively small tax base in the country faces an even greater tax burden.

Finally, it is well-understood in economics that one “instrument” is not capable of addressing a multitude of issues. Thus, it is imperative that communication be clear and transparent. Where will money come from, who will it benefit and how it will it benefit them? Furthermore, it is imperative that there is accountability for proper management of the fund. If there is a perception that the money is being improperly used, the fund and the entire system will lose its legitimacy, leading to failure.

Whether, in the end, a decision is made to extend PSEMAS or to create a separate large fund for many is a question that can only be answered through additional engagement. Although it is always easier to suggest more research be done, it is clear from our analysis that not enough is actually known, and, therefore, more work to understand the good and the bad within the current system, including medical aids, is warranted. The one thing that is clear, however, is that the current system can be improved, and, therefore, it should be. This understanding has already been taken on board by the government, and, therefore, we look forward to engaging further on this front.

### **3. A Brief Review of Experiences in Other African Countries**

Although there is an obvious interest in the development of a national health insurance or social insurance scheme in Namibia, the African Collaborative for Health Financing Solutions (2019, pg. 3) has highlighted the fact that, “... NHI could be a combination of the existing health insurance systems (PSEMAS and private schemes) plus new models of health insurance designed in such a way that the overall system works efficiently while ensuring optimum population and benefits coverage for all people. It could also involve significant reforms, such as converting PSEMAS to SHI for the formal sector employees, establishing CBHI for the informal sector employees, and a system of government subsidies for the unemployed to ensure coverage from either CBHI, SHI or private insurance schemes.” Therefore, we have embarked on a brief analysis of the process followed and being followed in a few other countries.

#### **3.1 Ghana**

In 2003, Ghana became the first sub-Saharan African NHIS country, although it began the following year. It is the first national scheme in Africa that was initiated by government, and the scheme covers services from all public, faith-based and quasi-government facilities, as well as some private facilities; it is also meant to include pharmacies and chemists that have been accepted under the scheme. Enrolees are both formal and informal sector workers, and although there is no co-payment, as discussed below, there are a myriad of point-of-service fees. Furthermore, health indicators remain relatively poor. The infant mortality rate was 41 deaths per 1000 live births, while under-five mortality stood at 60 deaths per 1000 live births in 2014 (GSS 2014) and maternal deaths at 380 per 100 000 life births in 2013 (WHO Ghana, 2014). Life expectancy at birth in 2014 was 60.3 years and 62.5 years for males and females, respectively.

The NHIS was put into place partly in response to the previous system that required user fees, was of fairly decent quality, but offered very limited access (Nyonator and Kutzin, 1999; Asenso-Okyere et al, 1998; Waddington and Enyimayew, 1989, 1990). Ghana was also the first to break from Britain's colonial yoke in 1957. NHIS was amended in 2012, and the amendment mandated enrolment. Financing comes from the National Health Insurance Fund (NHIF), which receives its funding from the National Health Insurance Levy (NHIL) – a 2.5% tax on selected goods and services – Social Security and National Insurance Trust (SSNIT) contributions – again 2.5% of all, although arising from the formal sector – premiums (in 2012 this was between USD2 and USD10; Okoroh et al., 2018), investments and donor funds. There are a range of premium exemptions, however. Formal sector workers contributing towards social security, children under 18, adults 70 and over, pregnant women and indigents are exempt. Although there is evidence that financial protection has improved, as have a variety of maternal health outcomes, see below, the exemptions are a source of financial burden on the system (Ansah et al., 2009; Witter et al., 2009).

Alhassan et al. (2106) examined both insured and uninsured Ghanaians, finding the insured to feel hard done by. They felt they were subject to longer wait times and that they encountered poor staff attitudes; yet, they also felt there was nothing they could do about it. Ansah et al. (2009) and Witter et al. (2009) also argued that premiums were too low, given the benefits package on offer. To increase funding, increased tax revenues have been suggested, as has redirecting some of the expected oil revenues (Abihiro and McIntyre, 2012; Blanchet et al, 2012). On the other hand, it has been suggested that funding could be raised through co-payments, while costs could potentially be better managed through capitation. It has also been suggested that the referral system needs to be improved (Blanchet et al., 2012).

Although finances are an obvious concern, the system also must be administered, and there are operational concerns. There is evidence of longer wait times, as noted above, as well as illegal fees (bribes, maybe), drug availability issues and worries that the community is neither engaged nor necessarily trusting of the health care they receive (Dzakapasu et al, 2012). Furthermore, the geographic distribution of health resources is not adequate for the population, while forcing relatively high workloads on health human resources (Dalinjong and Laar, 2012).

Despite some of the aforementioned concerns, the literature does suggest that some health outcomes have improved, while financial protection is also better; however, there are still gaps in participation, even though it is mandated. In reality, there are many challenges with the identification and enrolment of the poor for whom OOPes present a greater threat of catastrophic expenses. Studies suggest that the poor are far less likely to enrol than the rich, even if the poor were informed of the benefits (Kotoh et al, 2016). Presumably, premiums are too high, at least for some, although individual perceptions of need (based on their self-assessed health), and concerns related to quality also have affected take-up (Jehu-Appiah et al, 2011a, 2011b). In some cases, the premiums might be affordable, although still perceived to be too high (Kusi et al, 2015) or affordable for those who are exempt, but could contribute (Amporfu, 2013).

It should also be noted that health cost coverage is not complete; there are still point-of-care payments, including fees for medicine, consultation and user fees; thus, poor households are still less likely to seek care or locate other resources. These out-of-pocket payments put poorer households at financial risk as they are more likely to forego care, borrow, or liquidate assets in order to afford needed health services (Kruk, 2009).

### 3.2 Ethiopia

Ethiopia is the second most populous nation in Africa; however, the country sits near the bottom of access and health indicators, even compared to its region. There are, however, a few good pieces of information. Primary care services were accessible to 92% of the population in 2014/5, while the five years to 2015 suggested a doubling (from an exceptionally low base) of the per capita visits for outpatient services from 0.29 to 0.48 (Federal Ministry of Health 2015a,b). In other words between 2010 and 2015, Ethiopian access and use of health services increased substantially.

Ethiopia's health sector annual spending has not reached the WHO-recommended minimum of US\$60 per capita for basic health-care services. In 2010/11, financing came from donations (50%), households (34%), and government (16%). Such a large household component is associated with financial burden that should be alleviated, if the country is to achieve appropriate financial protection and universal health care. Only about 2% of financing came from employers, via insurance.

A financing plan was approved in 1998 identifying health insurance as an appropriate structure. It was meant to support sector revenues and increase the quality of services, increase utilization, and, presumably, reduce the overall financial burden on households or, at least, un-tie the financial burden from the health need. Two such schemes are now in place, one is mandatory and meant to cover the formal sector, Social Health Insurance (SHI), while the other is voluntary and meant to cover the much larger informal sector, Community Based Health Insurance (CBHI). The latter was piloted across 13 districts of the four largest regional states of the country in June 2011, but is being scaled to the national level. By 2015/16, it was available in nearly 200 districts and served nearly 7 million people (Lavers 2016).

The CBHI is a government program, but communities are involved in design, management, and supervision, while financing comes from premiums, 25% of the total premium subsidy comes from the central government. Even though some funds come from the federal government, districts and regional governments must cover fee waivers for the poorest (about 10% of the total population). CBHI covers outpatient and inpatient services in public facilities inside the country, unless the treatment is cosmetic; however, the system operates on referral, so members must first visit a health centre, before any further care at higher levels can be sought, and they must only be sought under referral.

Although in some sense, CBHI is fairly old, at least as an idea, it is not widely available. In the early pilot districts, enrolment was close to 50% fairly quickly (Lavers 2016). However, in 2016, overall coverage was only about 5% of the entire population; partly, that is due to its limited availability (Central Statistics Agency, 2016). For that reason, there is little in the way of nationally representative research, as in some other African countries. There are a number of very recent papers examining determinants of enrolment, such as Abdilwohab et al (2021), Fite et al (2021) and Nageso et al (2020); however, they cover small numbers of individuals; thus, the studies may not capture a proper control group and should be treated with some caution.

In terms of participation in CBHI in Ethiopia, studies are becoming more available. Atafu and Kwon (2018) offer some insight, although for one region in Ethiopia. They find that household and social capital, as well as health facility characteristics, are a barrier to enrolment in CBHI. Enrolment was influenced by the education and age of the household head, as well as their knowledge (and awareness and understanding) of CBHI, and even participation in other local credit associations (suggesting a further knowledge of the benefits of risk-pooling). Furthermore, self-rated health status, the perceived quality of the health services (as well as the availability of basic lab testing), and household size also affected enrolment.

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## About the Authors:

**Steven F Koch** is Professor of Economics and Head of the Department of Economics at the University of Pretoria and the managing editor of the South African Journal of Economics. He is an NRF Rated Researcher and a research fellow at the Mannheim Center for Evaluation and Development. He sits on the Board of Directors of the University of Pretoria Malaria Centre, as well as the executive committee of the Economic Society of South Africa. He has been a technical consultant to the South African Council for Medical Schemes, as well as the South African and Namibian Competition Commissions and undertaken research for the European and South African Departments of Labour and the World Health Organization, amongst others.

**Mr. Muine Samahiya** is a lecturer in the Department of Economics in the Faculty of Commerce, Management and Law at the University of Namibia. His previous experience includes working in different government ministries as an economist and as a consultant for various organizations including the United Nations Children's Fund (UNICEF), the United Nations Programme on AIDS (UNAIDS) and the Namibia Students Financial Assistance Fund (NASFAF). As such, Mr. Samahiya has gained valuable experience and skills in the areas of public finance, health financing, research, data analysis, writing, teamwork, and communication. He is currently pursuing his PhD in Economics with the University of Pretoria, South Africa.

## About the EAN:

The Economic Association of Namibia (EAN) is a Namibian Think Tank conducting research and providing public policy advisory services. The Association also organizes public discussion forums on topical issues in order to inform the broader public and stimulate public debates on current issues. Moreover, the EAN has established an online document repository accessible through its website that provides access to relevant socio-economic research reports and official documents.

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## Contact details

**Tel:** +264 61 244 300

**Cell:** +264 81 155 9775

**Email:** [info@ean.org.na](mailto:info@ean.org.na)

**Website:** [www.ean.org.na](http://www.ean.org.na)

70 -72 Dr. Frans Indongo Street

PO Box 6148

Windhoek, Namibia

economic  
association  
of namibia



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