HEALTH FINANCING PROFILE

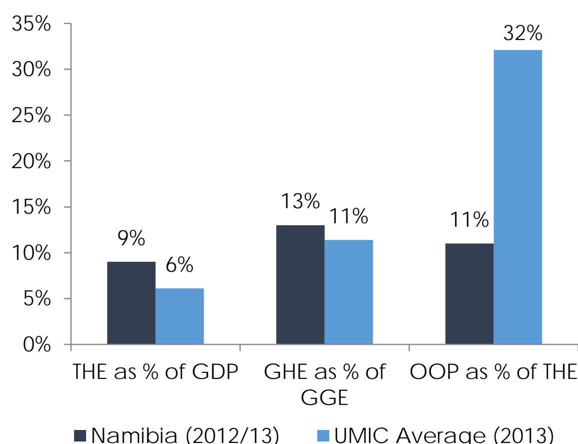
NAMIBIA

May 2016

Key Indicators	
Population (2014)	2.4 million
Per capita GDP (constant 2005 USD, 2014)	$4,571
Income group	Upper-middle
Health Financing	
THE per capita (USD)	$500
THE as % of GDP	9%
GHE as % of THE	54%
GHE as % of GGE	13%
OOP as % of THE	11%
DAH as % of THE	8%
Pooled private as % of THE	11%
HIV Financing	
HIV prevalence (ages 15–29, 2013)	14%
DHE for HIV/AIDS as % of THE	7%
TAE per capita (USD)	$118
GAE as % of GGE	1.2%
GAE as % of TAE	37%

Source: MOHSS, 2015; UNAIDS, 2014; MOHHS and ICF International, 2014.
THE = total health expenditure, GDP = gross domestic product, GHE = government health expenditure, GGE = general government expenditure, OOP = out-of-pocket payment, DHE = donor health expenditure; TAE = total AIDS expenditure, GAE = government AIDS expenditure.

Figure 1: Comparative Health Expenditure



Source: MOHSS and Health System 20/20 Project, 2008; MOHSS, 2015; WHO, 2015.

Overview

Total health expenditure (THE) in Namibia has increased steadily since the first national health accounts (NHA) survey in fiscal year (FY) 2001/02, growing by more than 12% per year. THE per capita was estimated at US$500 for FY 2012/13, representing more than a threefold increase from FY 2001/02.

The government is the largest funder of healthcare. It is committed to progressing toward universal health coverage (UHC) as outlined in the *National Health Policy Framework 2010–2020* and has been making efforts to ensure and grow the government budget line item for health. Namibia was close to achieving the Abuja target in FY 2008/09, with government health expenditure as a percentage of general government expenditure reaching 14.7%, but this declined to 13% in FY 2012/13. Namibia still has dedicated more resources to health from the government budget than other countries with a similar GDP per capita (Figure 1). Employers and households have increased their contributions to healthcare, primarily through prepayment schemes. Donor funding declined from its peak in the mid-2000s, when HIV funding spiked and donor transition ensued as the country became an upper middle-income country (see Figure 2).

Identifying new, sustainable sources of healthcare financing will be critical, especially for HIV. At the same time, the country must improve equity in access to healthcare by ensuring that risk-pooling mechanisms cover a wider segment of the population. Further, equitable and sustainable access must be achieved while improving the quality of health service. One study found that only 55% of sampled public sector health facilities were compliant with the *Namibian Standard Treatment Guidelines* (Akpabio et al., 2014). Implementing provider payment mechanisms, such as case-based payments, may incentivize better quality of care.

Health Financing Functions

Revenue contribution and collection

Namibia funds more than 75% of its THE through domestic resources. The three major domestic health financing sources are (1) general government revenue, (2) private employers' contributions, and (3) household contributions (both prepayment and other out-of-pocket (OOP) payments). The government is the largest funder of healthcare, at 54%. Employers contribute 11% of THE, primarily by making contributions to private medical aid schemes on behalf of their employees. Both employer and household prepayment contributions have increased, with households now paying 16% of THE through prepayment schemes. Although financial risk protection has improved, OOP expenditure, excluding prepayment schemes, has also increased from 6% to 11% in the most recent two rounds of the NHA.

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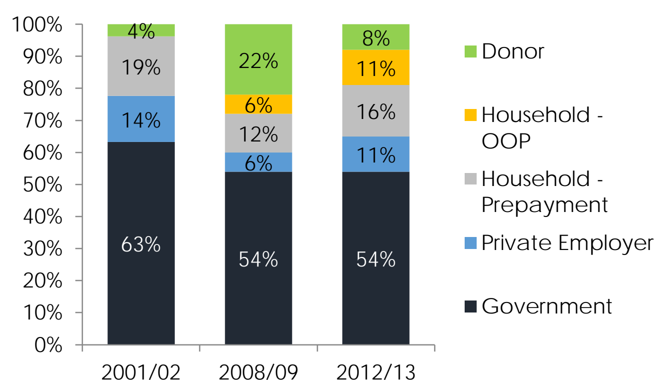
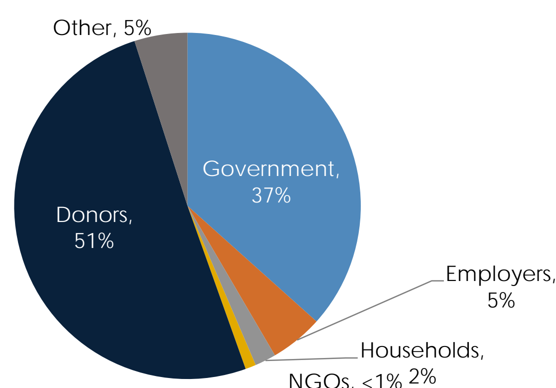
Figure 2: Shares of THE



Source: MOHSS and Health System 20/20 Project, 2008; MOHSS, 2015; WHO, 2015.

Figure 3: Total AIDS Expenditure, by Source (FY 2012/13)



Source: WHO, 2015.

OOP spending primarily comprises access to curative health services (mostly private), although a larger proportion (13%) is dedicated to pharmacies. Donor contributions have declined to 8%, in line with the donor transition.

Pooling

In addition to the government budget, Namibia offers two other risk-pooling mechanisms: a medical aid scheme for public sector employees and private medical aid schemes. The state-run Public Service Employees Medical Aid Scheme (PSEMAS) is one of the largest schemes, open to civil servants only. However, existing schemes do not offer a pathway to UHC, as the risk pools are small and there is very limited cross-subsidization between the rich and poor in either public or private schemes. Overall, access to financial risk protection is limited, with only 19% of the population covered through some form of health insurance (MOHSS, 2015). However, these schemes represent 44% of THE.

Purchasing

Public hospitals account for a large proportion of THE (42%), whereas private facilities (hospitals, clinics, pharmacies, and ancillary services combined) account for 35%. Government-managed resources are spent heavily on curative care (70%, including public and private providers), whereas the line items for purchasing drugs and medical goods, and preventive services have declined to 7% and 6%, respectively. PSEMAS uses a fee-for-service model, in which it pays providers who are contracted-in directly for services; members may also be required to pay a co-payment directly to their provider.

HIV Financing

HIV accounts for the largest proportion of lives lost (28.6%) in the country, but total AIDS expenditure accounts for an estimated 13% of THE. The financing landscape is significantly different for HIV services compared to overall health—51% of health sector HIV funding is supported by donors (primarily PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria), whereas the government pays for 37% (see Figure 3). However, according to the *National AIDS Spending Assessment* in FY 2013/14, which includes non-health sector contributions to HIV, the government paid 62% of the overall HIV response (USAID, 2015). In 2010, the public sector medical aid scheme covered antiretroviral therapy for 6% of its members by accessing care through the private sector, paying a significantly higher price for antiretrovirals than through the Ministry of Health's bulk procurement prices (Pereko et al., 2013). Private medical aid schemes cover HIV services, but employers' contributions are low, showing that people are likely accessing more HIV services through alternative means (e.g., for free through the public sector). Households pay for only 2% of HIV spending, indicating that people living with HIV are relatively well protected from financial risk.

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