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HEALTH

NAMIBIA

BUDGET BRIEF

Strengthening health financing to accelerate progress towards universal health coverage

KEY MESSAGES AND RECOMMENDATIONS

- **Total Government Health Expenditure exceeds the commitment by African Union member states to commit at least 15% of their budgets to the health sector.** With a sector allocation of 16.6% of total budget in 2022/23 and average per capita spending estimated at US$407 (N$6,500.00), health spending in Namibia is one of the highest in SADC. The Government is thus encouraged to sustain this level of investment to safeguard the gains achieved and make progress towards SDGs. This could be achieved through the development of a national health financing strategy to mobilise additional and innovative resources for the sector.

- **However, there are spending inequalities, including along geographical lines.** Regional spending shows no clear relationship to regional health needs and poverty trends. Hence the need for the development of an equitable regional resource allocation framework to guide future regional budgetary allocations.

- **Although the public health system is based on the primary healthcare principle (PHC), the current spending pattern appears to be misaligned, with PHC getting $1.28 billion (15.4%) of the total 2022/23 MoHSS budget.** Strengthening PHC through greater prioritization in the budget would help improve quality, accessibility and reduce the costs of care by abating avoidable, yet costly referrals. But first, PHC needs to be clearly defined and costed to guide public investment decisions.

- **A significant share (28.9%) of the Total Government Health Expenditure is spent on Public Service Employee Medical Aid Scheme (PSEMAS), whose coverage is 12% of the total population, raising equity concerns.** There is need to review PSEMAS operations and benefit packages, with a view to reduce the government contribution and create savings that can be reinvested towards PHC.

- **The public health sector is hampered by shortages of critical staff, including doctors and specialists.** With an estimated 0.6 physicians and 2 nurses per 1000 people, staff shortages not only impact on the quality of care, but result in costly overtime, feeding into high wage outturn. A review of key personnel establishment for the MoHSS is needed to right-size it in line with the disease burden.

- **The development budget suffers from both low allocation at 4.2% of the 2022/23 MoHSS budget and low execution, with a 5-year average implementation rate of 71.0%.** Addressing the existing gaps in infrastructure and medical devices requires a rebalancing of the expenditure mix towards the development budget whilst putting in place strategies to enhance execution, including resolving bureaucracies in procurement and improving coordination with Ministries and Agencies involved in construction.

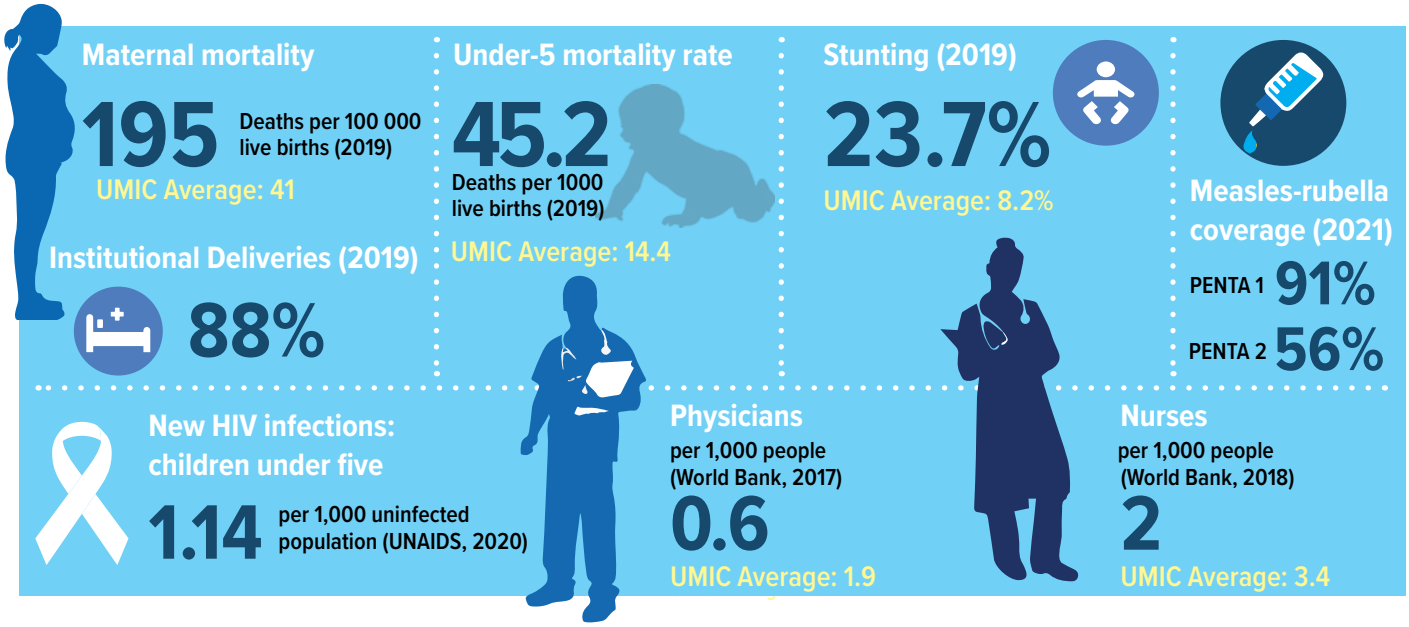
INTRODUCTION

This brief assesses the extent to which the 2022/23 National Budget addresses the health financing needs for children in Namibia. It provides an analysis of the size and composition of the health budget, a summary of, and recommendations on, critical financing issues related to: adequacy, allocative efficiency, effectiveness and equity of current and past health spending. The brief therefore focuses on the budget for the Ministry of Health and Social Services (MoHSS), which is mandated to provide quality health care and social services to the people and children of Namibia.

Health Sector Overview

Namibia has strengthened efforts to ensure quality, equity, and access to health care for all, since it adopted the Sustainable Development Goals (SDGs) in 2015. Provision of health care is guided by the country's Constitution, specifically Article 95 which calls upon the State to ensure that citizens have rights to fair and reasonable access to public health facilities and services in accordance with the law. This is supported by the 5th National Development Plan (NDP5) for 2017-2022, Harambee Prosperity Plan (II) (2021 – 2025), and MoHSS Strategic Plan (2017 – 2022), among others. These frameworks aim to provide universal access to quality health care and reduce mortality for women and children, among other key priorities.

Chart 1 Key health sector performance indicators



The COVID-19 pandemic has led to a massive drag on progress towards SDG 3. Since the onset of COVID-19, the country has registered a significant decline in immunization coverage, especially for Measles-Rubella vaccine, and a reduction in health care access for underserved communities, demonstrated by a decline in outreach services. The country is faced with the double burden of both communicable and noncommunicable disease (NCDs), with high HIV/AIDS, stunting, and maternal mortality rates (Chart 1) that predominately affect the poor, and an increasing prevalence in NCDs whose treatment is costly, contributing to high health expenditure.

The country has adopted the Primary Health Care (PHC) approach to deliver care to citizens. The PHC is based on 4 pillars: i) health promotion, ii) disease prevention, iii) curative services, and iv) rehabilitation services. However, this notwithstanding, there is still no clear definition of PHC, and health services organisation around PHC.[1]

Takeaway

- **Significant gains made in the health sector were somewhat halted by the COVID-19 pandemic, inevitably increasing the burden of diseases. This emphasizes the need for greater political commitment and action, including strengthening health financing to reverse the slide on SDG 3, and accelerate progress towards universal health coverage.**

HEALTH SECTOR SPENDING TRENDS

Trends in Total Health Expenditure

Total Government Health Expenditure (TGHE) has, over the past 5 years, trended above the 15% Abuja target. TGHE for 2022/23, inclusive of government spending in the Public Service Employee Medical Aid Scheme (PSEMAS), is projected at 16.6% of total budget, and 5.9% of GDP (Figure 1). At N$3.4 billion, the allocation to PSEMAS, which is made through the Ministry of Finance, is 40.1% of the total MoHSS budget.

The government provides substantial co-financing of PSEMAS, with more than 75% of the contribution being funded from the fiscus, and the rest coming from the employees (MoHSS 2022). However, there are concerns that contributions by the employees are inequitable since they are a flat rate of the employees' earnings; and hence not based on their ability to pay. Furthermore, the government is spending more on the approximately 12% of the population, who are civil servants, than the 80% of the population who depend on the public health system. Approximately 8% of the population is covered by private health insurance and rely mostly on private health facilities.

Spending trends for the MoHSS

The MoHSS was allocated the third largest share of the National Budget, after the Ministries of Finance and Education. In the financial year 2022/23, the MoHSS was allocated N$8.4 billion, equivalent to 11.8% of the total budget. In nominal terms, the allocation is 0.9% lower than the estimated N$8.42 billion in 2021/22, and 3.6% lower in real terms (Figure 2).

However, at a time when progress in the sector has been upended by the COVID-19 pandemic, real spending in health is projected to continue on a declining trend over the medium term to 2025. Whilst real health spending, through MoHSS, was highest in 2020/21 at N$6.5 billion, boosted by COVID-19 spending, over the medium term, real spending is projected to decline to N$5.8 billion by 2025 (Figure 2). This raises concerns over the adequacy of such spending in reversing the impacts of COVID-19, and progress towards SDG 3.

Approximately 8% of the population is covered by private health insurance.

Figure 1 Trends in Total Health Expenditure

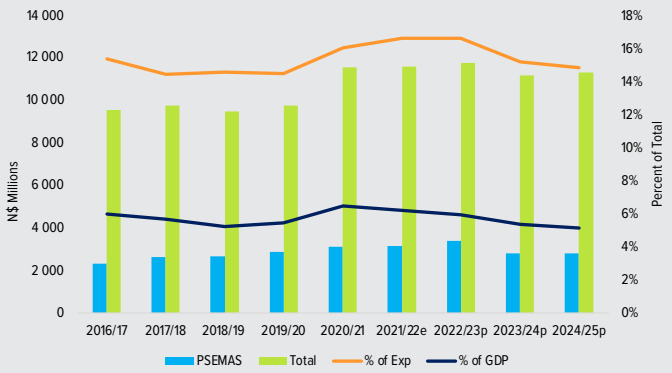
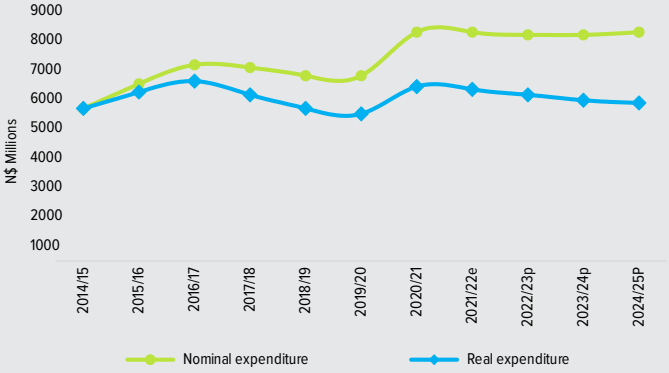


Figure 2 Trends in Nominal and Real Health Sector Spending



Source: Various Budget Statements: 2016/17 – 2022/23, own calculations

[1]According to MoHSS (2022): Health Sector Performance Review, PHC refers to the lowest level of care (community, clinics and health center service delivery levels).

Prioritization of MoHSS spending

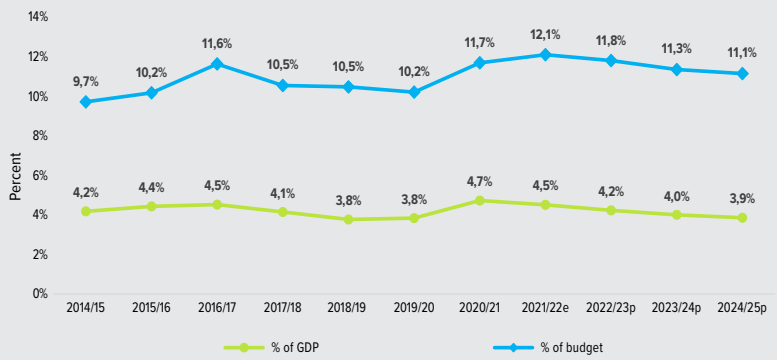
Since 2019/20, healthcare spending through the MoHSS, as a share of total budget, has been trending upwards, albeit with a projected decline in 2022/23. Having peaked at an estimated 12.1% in 2021/22, the MoHSS allocation for 2022/23 is projected to decline to 11.8% of total budget. As a share of GDP, the 2022/23 allocation at 4.2% is 0.8 percentage points lower than the Sub-Sahara Africa (SSA) average of 5% (Figure 3).

Namibia's spending in health ranks among the highest in the East and Southern Africa Region (ESAR).

Health Spending Against Other Countries

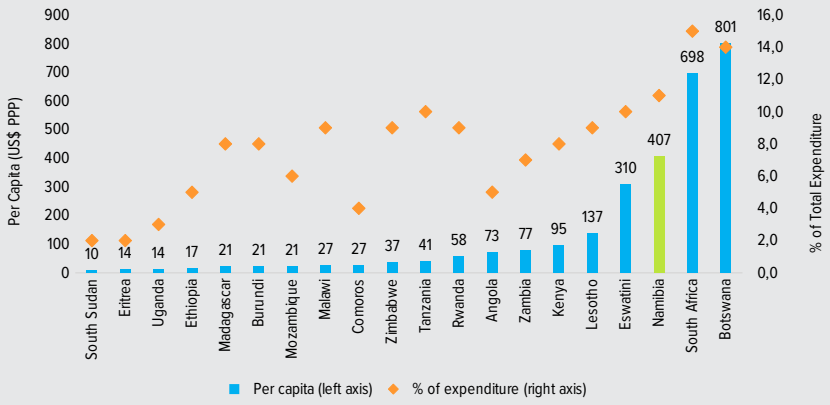
Namibia's spending in health ranks among the highest in the Eastern and Southern Africa Region (ESAR). With a per capita expenditure of US$407.00, (in PPP terms), Namibia ranks 3rd in ESAR (Figure 4), albeit ranking the lowest among the Upper Middle-Income Countries (UMICs) in the region (South Africa and Botswana). Government expenditure per capita gives an indication of the adequacy of spending on health. Protecting and promoting such spending over time, should remain a key priority for the government, if the country is to achieve its objectives and commitments under SDG 3. This is particularly important given the vastness, and therefore relative cost of health service delivery in Namibia.

Figure 3 MoHSS Spending Trends



Source: Various Budget Statements: 2016/17 – 2022/23, own calculations

Figure 4 Health spending in selected countries, (Per Capita PPP, 2019 constant)



Source: Namibia National Health Accounts for 2019, WHO

Takeaways

- **Total spending in health is relatively high, exceeding the 15% Abuja target and averaging at US$407.00, in per capita terms. This level of spending needs to be protected and promoted over time.**
- **Consistent with the above, there would be need to enhance allocative efficiencies, including reviewing spending under PSEMAS, with a view to reduce the government contribution and create savings that can be reinvested in other areas that are currently underfunded, such as PHC and nutrition.**

COMPOSITION OF MoHSS SPENDING

Composition of the MoHSS Spending by Programmes

Expenditure by the MoHSS is skewed towards curative care instead of prevention of diseases. In the fiscal year 2022/23, allocations to Curative and Clinical Health Care are projected to increase to 76.9% of the total MoHSS budget, from the estimated 72% in 2021/22 (Figure 5). High curative spending is a source of inefficiency, as this is largely consumption expenditure, which is more expensive than public health interventions, impacting on value for money and overall health outcomes.

Expenditure on public health is projected to remain relatively low compared to other MoHSS programmes. With Curative and Clinical Health Care accounting for a significantly large share of the budget, other programmes, such as Public Health remain significantly underfunded. Although Public Health allocation is projected to double to N$107 million in 2022/23, overall spending will remain below 1.6% of the total MoHSS budget. Underfunding of public health has implications on adequacy and quality of preventive services for both communicable and non-communicable diseases, as well as environmental health services.

Figure 5 Composition of MoHSS Spending by Programmes

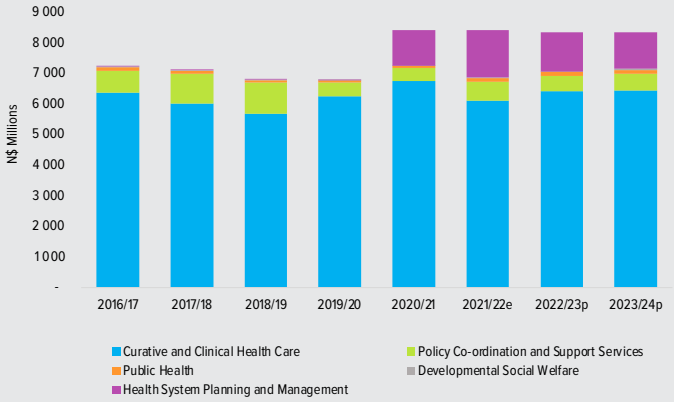
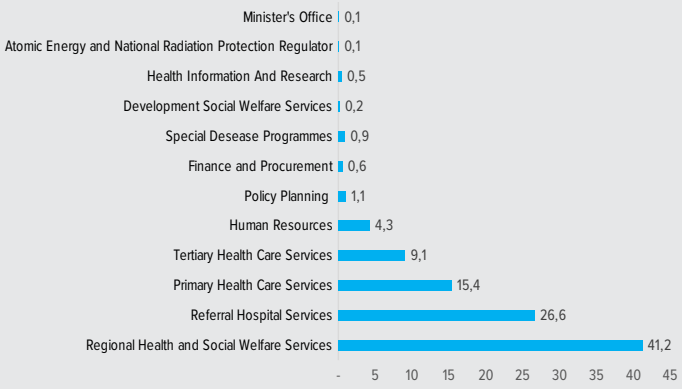


Figure 6 Composition of the MoHSS budget allocation for 2022/23



Source: Various Budget Statements: 2016/17 – 2022/23, own calculations

Furthermore, despite the government's commitment towards primary health care, spending remains relatively low. In the 2022/23 budget, allocation to PHC level of care at N$1.28 billion is 15.4% of the MoHSS Budget, compared to 35.7% for referral and tertiary care services, and 41.2% allocated towards Regional Health and Social Welfare Services (Figure 6).

Consistent with the policy objectives, there would be need for a gradual rebalancing of the expenditure mix towards PHC. This would also help improve access and mitigate against patients bypassing PHC to higher levels of care, which is costly for households due to transport costs. In addition, this skewed allocation is a source of inefficiencies as it overburdens higher levels of care, and tends to increase the overall cost and compromise the quality of care, which otherwise should be available at a relatively less cost, at the low levels of care. Equally important is the need to clearly define and cost PHC beyond the level of healthcare facilities, to determine and guide future budget needs for PHC.

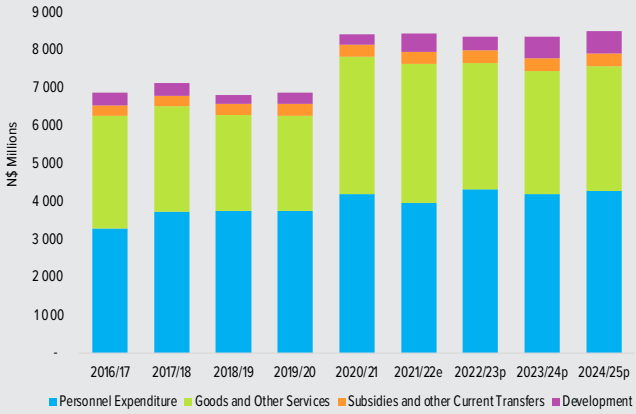
The Health Information and Research budget is significantly low, raising concerns over the country's capacity to innovate and respond to health emergencies. At N$40.8 million, or 0.5% of the total MoHSS 2022/23 budget (Figure 6), the allocation towards Health Information and Research needs to be increased to meet the MoHSS target of 5%, to help strengthen research and innovations to respond to any emerging health crisis. The recent lessons from the COVID-19 pandemic, underscores the need for the country to build sustainable research and innovation capacity.

Composition of the MoHSS Spending by Economic Classification

Wage expenditure typically is the largest cost driver relative to other inputs (physical infrastructure and medical devices) in the health sector. In the 2022/23 Budget, personnel expenditure is projected to account for 51.7%, whilst other current expenditures account for 44.1% and the remainder of 4.2% being development budget (Figure 7). However, despite personnel cost accounting for half of the health budget, there are significant gaps in critical health personnel, impacting on outcomes. At 0.6 physicians and 2 nurses per 1,000 people, this is much less than the UMICs average of 2.3 physicians and 3.4 nurses. Further, the number of physicians in Namibia is not only lower than other countries (Figure 8), but an estimated 62% of health professionals are in the private sector, only serving 20% of the population.[2] The overall vacancy rate is 26%, with areas such as Health Information and Research (72%), Policy Planning (76%), and human resources for health (58%), having the highest staffing gaps.[3]

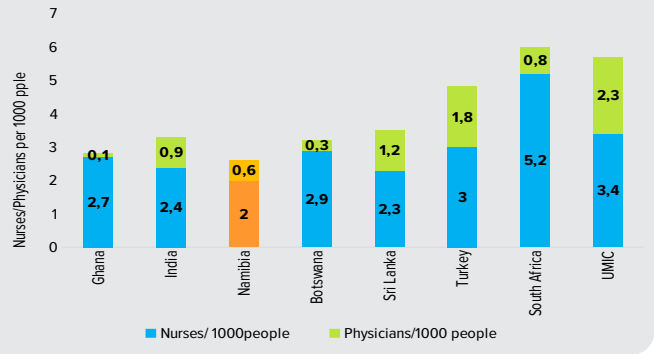
The relatively high current spending tends to crowd out development spending. Total development budget was allocated N$350.9 million (4.2%) of the 2022/23 MoHSS. Over the period 2016 – 2021/22, development budget spending averaged 4.0% of the total MoHSS annual spending. This has, in part contributed to gaps in health infrastructure, with 23,4% of households having geographic access barriers, as they stay more than 10kms from the nearest health facility, whilst some facilities are facing aging infrastructure and inadequate maintenance.[4] Furthermore, there is undersupply of medical devices such as MRI and CT in the public sector.[5]

Figure 7 Composition of MoHSS budget by economic classification



Source: Various Budget Statements: 2016/17 – 2022/23, own calculations

Figure 8 Nurses and Physicians per 1000 people in selected UMICs



Source: World Bank Database on health indicators

Funding for Health Information and Research needs to be increased to help strengthen research and innovations to respond to any emerging health crisis.

[2]Ministry of Health and Social Services (2022), Health Sector Performance Review for 2009 to 2021, an estimated 79% of the medical specialists and pharmacists work in the private sector.
[3]Ministry of Health and Social Services (2022), Health Sector Performance Review for 2009 to 2021
[4]Ministry of Health and Social Services (2022), Health Sector Performance Review for 2009 to 2021
[5]According to the World Bank (2019), all the 7 MRI in Namibia in private facilities and 4 of the 8 CT scanners are in the public hospitals

Composition of MoHSS Spending by Diseases

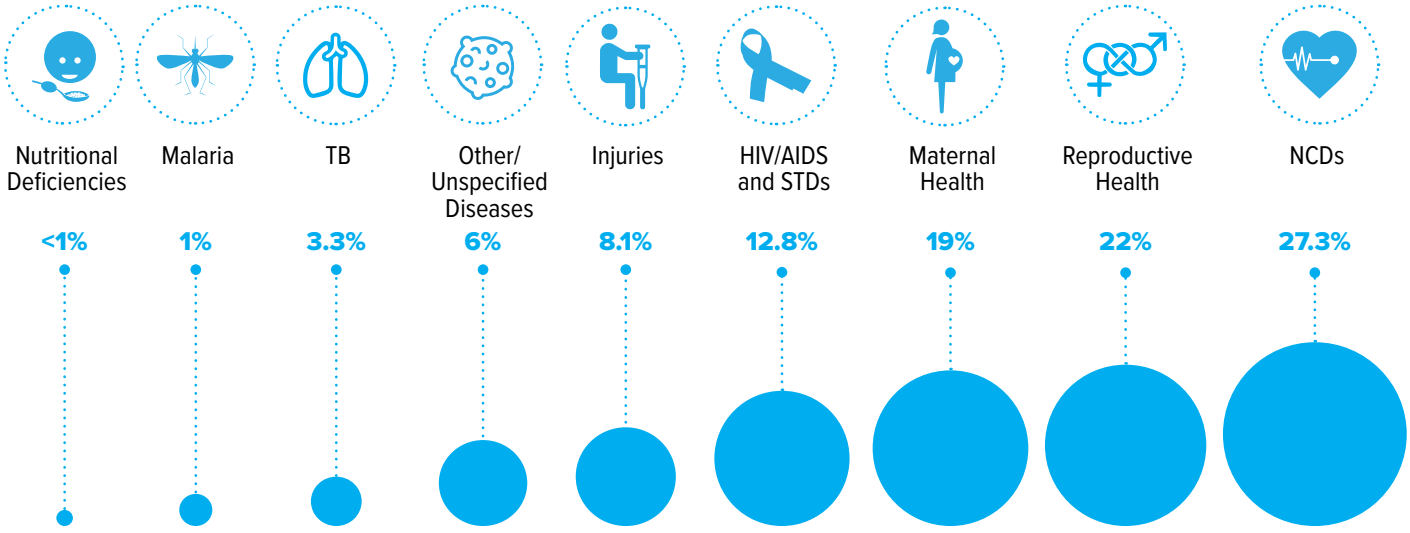
While health expenditure is generally skewed towards hospital care, expenditure on diseases is also skewed towards medicines for non-communicable diseases. National health account data shows that over the period 2015 – 2019, expenditure on NCDs accounted for an average 27.3% of total current health expenditure. This is followed by reproductive (22.0%) and maternal health (19.0%) (Figure 9). Spending on nutrition deficiencies remained below 1%, albeit the relatively high rates of malnutrition in Namibia. While therapeutic foods for the treatment of acute malnutrition and Vitamin A are in the essential medicines list, the MoHSS has not been providing budget for their purchase, leaving this intervention entirely to development partner contributions and vulnerable to stock-outs.

Despite Malaria, TB and HIV/aids accounting for a combined 17.1% of the current public health spending, more resources are received through donor support. According to the PHC Expenditure Assessment Report[6], an estimated 80% of donor support goes towards funding HIV/AIDS programmes, with malaria, tuberculosis and reproductive health accounting for the remaining 20%. The largest contribution for HIV/AIDS came from the US Government at 23%, with other multilateral donors and the Global Fund contributing 10% and 9% respectively. Reliance on donor funding raises sustainability concerns to maintain the gains, against declining global aid flows, with potential negative implications on service delivery.

Takeaways

- **Allocative efficiencies in the MoHSS budget could be improved for better outcomes. This includes greater prioritization of PHC, in line with policy commitments and rebalancing the expenditure mix towards preventive services, Health Information and Research and the development budget.**
- **Despite huge spending on personnel, staff gaps exist, which not only impact on the quality of care but also result in costly overtime. A review of key personnel establishment is needed to right-size it in line with the disease burden.**

Figure 9 5-Year Average Composition of Health Spending by Diseases (2015 -19)



Source: Namibia National Health Accounts, WHO

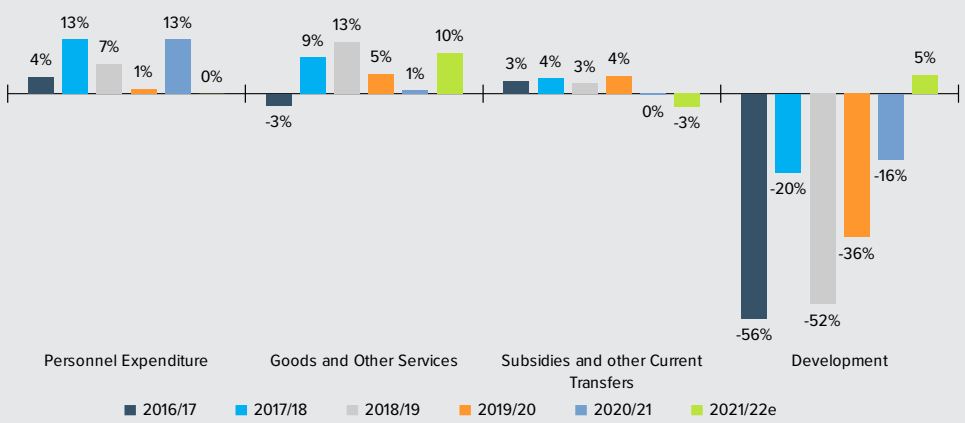
[6] Ministry of Health and Social Services (2022), Health Sector Performance Review: Brief on Primary Health Care Expenditure

HEALTH BUDGET EXECUTION

Low budget execution[7] is an area of major concern for Namibia, particularly the non-wage budget. The Development Budget, in particular, suffers low execution, with negative impacts on outcomes. Part of the reason is due to employment cost overruns, on account of staff overtime, which is paid at 1.5 times the normal salary rates. Despite an estimated 4.7% overspending in 2021/22, the Development Budget execution averaged 29% lower than Approved Budget over the past 6 years (Figure 10). This raises concern on whether the development expenditure is deprioritized at implementation. Low development budget execution can be a lost opportunity, which undermines the health sector's ability to deliver services and reduces the MoHSS' bargaining power to request for more resources for hospital and other infrastructure investments.

Development budget execution challenges arise from several factors. From discussions with stakeholders, the main issues impacting on budget execution are summarized in Table 1.

Figure 10 Trends in Budget Execution for the MoHSS



Source: Various Budget Statements: 2016/17 – 2022/23, own calculations

Table 1 Main issues and challenges impacting on Budget Execution and potential mitigation

Constraints/ Challenges	Possible mitigation
Delays in funds release from the Ministry of Finance, partly on account of delays in passing the budget	• Revision of the Budget Calendar in alignment with Budget Transparency Guidelines for it to be presented at least 2 months before the start of the financial year. • Improved expenditure planning, forecasting and request for funds, including the need to have a multi-year Infrastructure Investment Plan to guide capital budget request from MoF and implementation.
Procurement delays	• Capacity strengthening of planning and procurement units within the MoHSS, CMS and other institutions involved in health procurements at regional levels to improve procurement efficiencies. • Development and use of long-term frameworks in health infrastructure development, to cut back on procurement delays. • Development and use of standard bidding documents to simplify the procurement process and enhance efficiencies.
Employment costs overruns crowding out spending on the development budget	• Strengthen capacity for better expenditure planning and controls in the MoHSS.
Insufficient coordination with key Ministries and Agencies responsible for health infrastructure development.	• Improve coordination between the MoHSS and Ministry of Works to reduce delays in processing tenders, in particular.

Takeaway

- **Development budget execution remains relatively low compared to current budget. There is need to address the key challenges impacting on the execution of the development budget, in particular, improving expenditure planning and addressing procurement delays.**

[7] Budget execution rate measures the extent to which the Actual Budget Expenditure deviates from the Approved Budget.

EQUITY IN THE HEALTH SECTOR

The current health system benefits the wealthier more than the poor. Even though public health services are essentially free, poverty can be a major factor impacting on accessing healthcare services. Of those who needed health care, only 62.4% among the poorest received medical care whilst 72.5% among the richest received healthcare (Figure 11).

With 43.1% of the population living in multidimensional poverty, evidence shows that it is difficult for the poor to access healthcare. An estimated 28% of the poorest cannot afford to access healthcare when they need it, compared to only 11% among the richest[8] (Figure 12). Lack of transport to travel to health facilities is one deterrent to seeking healthcare, and given the sparse distribution of the population, patients are forced to travel long distances to access public health facilities. Lack of transport discouraged 16% and 19% of the poorest from seeking care, compared to 15% of the richest quintile (Figure 12).

Furthermore, there are inequalities along geographical lines. Regional spending shows no clear relationship to regional needs and poverty trends. In fact, there is a weak positive correlation between per capital health spending with poverty (Figure 13). Regions such as //Karas and Hardap with low child multidimensional poverty rates tend to have higher spending per capita than the Kavangos and Zambezi region.

Figure 11 % of those who needed and actually received care

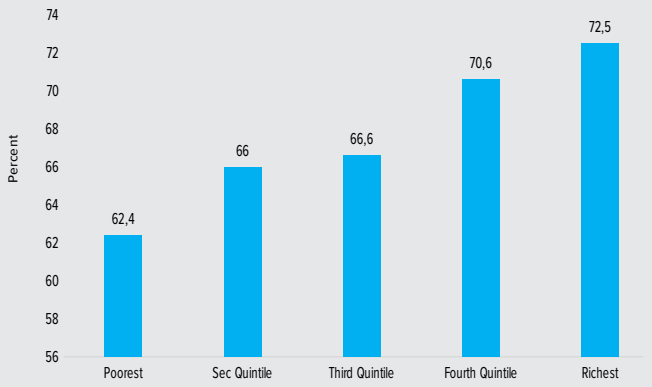
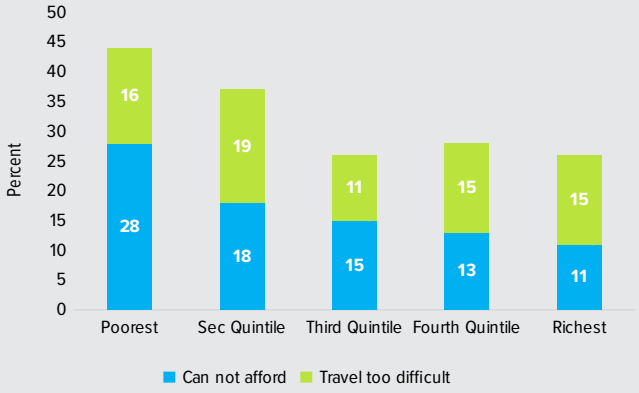
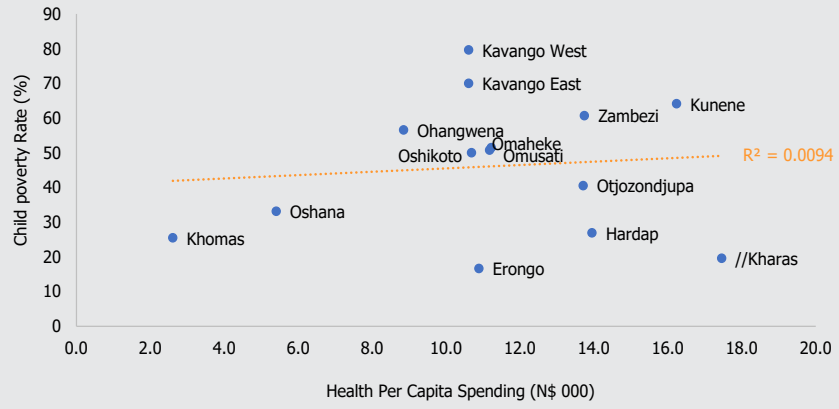


Figure 12 Access to Health Services by Wealth Quintile



Source: National Income and Expenditure Survey, 2016

Figure 13 Health per Capita Spending (2013-2021) vs child poverty rate (as a %)



Takeaway

- **There are spending inequalities, including along geographical lines, hence the need for the development of an equitable regional resource allocation formula.**

[8] World Bank (2019), "Namibia Health Sector Public Expenditure Review"

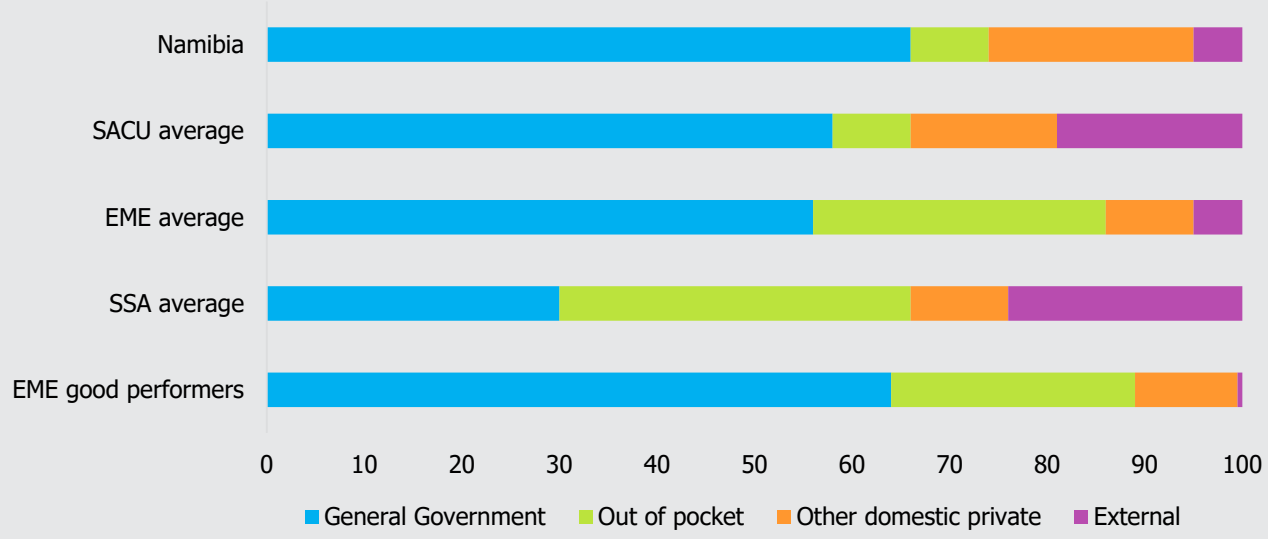
FINANCING THE HEALTH SECTOR

The Government budget remains the major source of health financing in Namibia. According to the National Health Accounts data, general government accounts for over 66% of total current health expenditure (Figure 14), which is almost on par with good performing Emerging Market Economies (EMEs), and much higher than the Southern African Customs Union (SACU) and Sub-Saharan Africa (SSA) average. Five percent of total health expenditure comes from international development partners, similar to the EME average, but well below the 25% contribution by external donors of the previous decade.[9]

On average, every person in Namibia pays approximately N$542.50 to access care.

Despite declining overtime, Out-of-Pocket (OPP) expenditure accounts for a significant share of total health expenditure. OPP expenditure as share of total health expenditure declined from 11% in 2012 to 8% in 2019, which is comparable to the SACU average but much lower than SSA and EME averages (Figure 14). This notwithstanding, OPP health expenditure per capita in Namibia remains significantly high at US$35.00 (N$542.50). This means, on average, every person pays approximately N$542.50 to access care. High OPPs are associated with catastrophic and impoverishing household spending and needs to be reduced, in line with the government's Universal Health Coverage objectives. This can be achieved through the development of a national health financing strategy to mobilise additional and innovative resources for the sector.

Figure 14 Healthcare Spending by Source



Source: IMF (2022): Namibia Expenditures in 2030 to Support the SDGs (unpublished)

Takeaway

- **Despite the decline in the share of OPP to total health expenditure, OPP per capita remains significantly high at N$542.50, which is a significant constraint to access, particularly for the poor and marginalized communities, and those on the cusp of poverty. This would need to be reduced, over time, in line with the government's Universal Health Coverage objectives.**

JOINT SDG FUND

[9] Global Health Expenditure Database, World Health Organization (accessed August 2022)