Private Sector and Civil Society Engagement in Namibia's Health Sector

Landscape Report on Public-Private Partnerships

LOCAL HEALTH SYSTEM SUSTAINABILITY PROJECT

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

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Acronyms

CSO	Civil Society Organization
GRN	Government of the Republic of Namibia
LHSS	Local Health System Sustainability Project
MOHSS	Ministry of Health and Social Services
PPP	Public-Private Partnership
PSCSE	Private Sector and Civil Society Engagement
PSEMAS	Public Service Employees Medical Aid Scheme
SHOPS	Strengthening Health Outcomes through the Private Sector
UHC	Universal Health Coverage

The Need for Private Sector and Civil Society Engagement

Namibia's population was estimated to be 2.54 million people in 2020,[1] which over a land area of 823,290km translates to a population density of three people per km. Having one of the lowest population densities in the world combined with an estimated 44.8 percent of the population living in rural areas, the Namibian government faces significant challenges in ensuring access to health services for its population. Since its independence in 1990, Namibia has made notable progress in its health system, which was made possible by the strong political will of the Government of the Republic of Namibia (GRN). The GRN funding for health increased from 56 percent to 62 percent of total health expenditures in three years (2015/16–2017/18), and Namibia managed to achieve the Abuja target by 2017/18, when health spending reached 15 percent of total government spending.[2] While HIV was still the leading cause of death in 2019,[3] Namibia is on the cusp of epidemic control, having achieved 94-97-93 toward the UNAIDS 95-95-95 treatment cascade by the end of 2021.[4]

Despite these signs of progress and relatively high levels of health spending, some challenges persist. While it is an upper-middle-income country, Namibia is one of the countries with the most unequal income distributions in the world [5] as of the latest data from 2015, Namibia had a Gini index of 59.1, making it the country with the second highest income inequality after South Africa.[6] In its health outcomes in non-HIV health areas, such as maternal mortality and under-five mortality, Namibia is lagging behind its neighbors, including Botswana and South Africa.[7]

> For purposes of this report, private sector is considered to include all non-governmental entities, such as for-profit private organizations, not-for-profit organizations, civil society organizations, community-based organizations, and faith-based organizations.

While the World Bank's 2019 Public Expenditure Review points to inefficiencies in the public health system, it also identifies inequities, resulting in unequal access to quality care across regions and wealth quintiles, as key factors contributing toward the poor health outcomes. While many factors contribute to these gaps, central among them is the existence of parallel public and private health systems in Namibia. A minority of the population (an estimated 20 percent) accesses a well-resourced private system through medical aid funds,

[1] Source: Worldometer. https://www.worldometers.info/world-population/namibia-population/ Accessed May 16, 2022.
[2] Ministry of Health and Social Services, *Namibia Resource Tracking for Health and HIV: 2017/18*. (Windhoek, Namibia, April 2020).
[3] IHME. *Country Profile: Namibia*. http://www.healthdata.org/namibia. Accessed September 13, 2021.
[4] Treatment cascade estimates for end of 2021 as presented by USAID Namibia at the Chief of Party meeting on April 13th, 2022
[5] World Bank, Where We Work: Namibia. https://www.worldbank.org/en/country/namibia/overview. Accessed September 13, 2021.
[6] World Bank data portal. Gini index (World Bank estimate) – Namibia. https://data.worldbank.org/indicator/SI.POV.GINI?locations=NA&most_recent_value_desc=true. Accessed September 13, 2021.
[7] USAID/Namibia, "LHSS SOW (Draft)." May 10, 2021.

while the remaining 80 percent relies on an over-burdened public health system. While the private sector only covers a small proportion of the population, it absorbs a significant portion of the health resources in terms of financing, human resources, and infrastructure, leaving only 49 percent of total health expenditures to be spent in the public sector for the remaining 80 percent of the population. The siloed public and private systems mean that access to private health care is generally limited to the employed and richer population, who can afford private medical aid coverage. Further, contributions to medical aid funds are high and are becoming increasingly expensive due to escalating costs of private health care. Despite their high contributions to private medical aid funds, members are often also required to incur high out-of-pocket expenditures when accessing health care.

Private medical aid funds are funds that are registered with the Namibian Association of Medical Aid Funds and Namibia Financial Institutions Supervisory Authority as such a fund, with the aim of providing financial or other assistance to members of the fund and their dependents in paying for health services. Medical aid funds are established on a non-profit basis, making them distinctly different from insurance companies offering medical insurance policies.

The persistent health inequalities in Namibia can be resolved only by addressing the divide between the public, private and civil society health sectors. More effective integration of these sectors can support more strategic public-private purchasing mechanisms, total market approaches, and other strategies that promote efficient use of public resources and increase equitable access. As the GRN seeks to better leverage the resources in the private sector and the established systems of civil society to reach grassroots populations to improve health outcomes, it is important to improve the collaboration between these sectors, formalizing channels for consistent communication and cooperation. Such collaboration is necessary to facilitate a more enabling policy and regulatory environment that empowers the public sector to better steward resources across the overall health system.

To that end, the government is encouraging and actively engaging the private sector and civil society to participate in the decision-making processes that affect the broader health sector, particularly on issues such as universal health coverage (UHC) and social contracting. Furthermore, the government also has adopted policies around public-private partnerships (PPPs) to encourage more formalized relationships between the public, private and civil society sectors that would make it possible to leverage the significant resources of the private sector and the reach of civil society to improve the health of the entire country.

The purpose of this document is to review the available resources in the private health sector and civil society to:

- Justify increased private sector and civil society engagement (PSCSE) in Namibia's health system.
- Identify the relevant stakeholders and status of existing PSCSE mechanisms and platforms, highlighting success stories and challenges experienced in implementation so far.
- Discuss opportunities for increased and improved PSCSE moving forward.

This PSCSE landscape report was compiled using evidence generated from a comprehensive documentary review and selected key informant interviews conducted to gain insight into the

status of implementation of existing PPPs, and the challenges, lessons learned, and success stories.

The GRN defines **PPPs** as having three essential elements – a contractual arrangement, sharing of risk between the public sector and the private entity, and outcome-based financial rewards to the private sector. It further describes PPPs as a medium- to long-term contractual relationship between the public sector and other private partners in the sharing and transferring of risks and rewards in the performance of a departmental function, and in the provision of infrastructure and/or services. The PPP strategy of the Ministry of Health and Social Services aims to significantly improve health care and social services delivery by harnessing resources of the private sector through the application of tailor-made business and operational models.

Overview of Namibia's Private Health Sector

Namibia's private health sector brings a wealth of resources that could be better leveraged to improve health outcomes in Namibia. These include a broad swath of facilities that vary by ownership and size, as well as a large number of health staff. The facilities provide a comprehensive range of health products and services, but current financing practices limit their population coverage. Improving when and how government engages with the private health sector can create new incentives that open up these resources to a larger portion of Namibia's population.

Private Health Facilities and Providers

Currently, 257 private health facilities are registered with the Ministry of Health and Social Services (MOHSS). This includes 130 nongovernmental not-for-profit, 100 private for-profit, and 27 faith-based facilities.[8] These comprise 18 hospitals, 20 health centers, and 219 clinics. There are 368 facilities in the public sector.

Table 1: Distribution of Private Health Facilities Registered with Ministry of Health and Social Services

Region	Private For-Profit	NGO Not-for-Profit	Faith-Based	Total Private Health Facilities	Total Public Health Facilities
!Karas Region	11	7	1	19	19
Erongo Region	28	12	1	41	25
Hardap Region	3	5	1	9	18
Kavango East Region	2	13	10	25	30
Kavango West Region	0	9	5	14	26
Khomas Region	23	13	1	37	15
Kunene Region	2	3	0	5	30
Ohangwena Region	0	18	1	19	38
Omaheke Region	5	2	0	7	15
Omusati Region	4	13	3	20	51
Oshana Region	5	7	1	13	19
Oshikoto Region	3	11	2	16	28
Otjozondjupa Region	9	10	0	19	25
Zambezi Region	5	7	1	13	29
Namibia	***100***	***130***	***27***	***257***	***368***

The most recent census of private health providers was conducted in 2015, identifying a total of 664 private consulting rooms, 27 hospitals, 126 pharmacies, 29 pathology laboratories, 22 radiology laboratories, 12 ambulance services, five mobile clinics, and five medical suppliers.

[8] Source: MOHSS, https://mfl.mhss.gov.na/location-manager/locations Accessed May 18, 2022.

The distribution of these providers closely follows the country's economic activities, with most of the providers being concentrated in the Khomas, Erongo, Oshana, and Otjozondjupa regions.

The private consulting facilities surveyed (88 percent participation rate of the 664 identified above) encompass a wide range of facilities that provide various services from general practice services to specialized services. General practitioners were the most commonly available provider type (247), followed by registered nurses (105), dentists (78), physiotherapists (62), optometrists (51), and bio-kineticists (43). The services these private consulting rooms most commonly reported were general practice services (171 facilities), HIV counseling (77 facilities), other counseling services (73 facilities), HIV and AIDS treatment (66 facilities), and dental services (64 facilities).

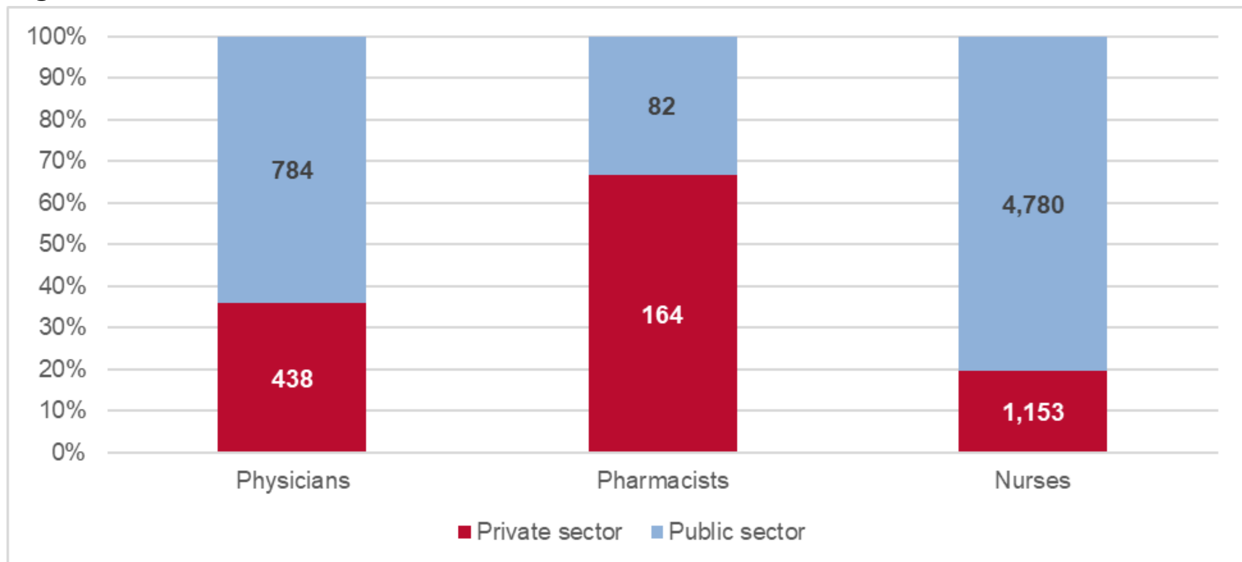
The private hospitals had an average of 12 inpatient rooms with an average of 24 beds per facility. Of the private hospitals that participated in the census, 39 percent had operating theaters. The hospitals provide various specialist services, including anesthesiology, blood transfusions, chemotherapy, counseling, general surgery, gastroenterology, obstetrics and gynecology, and pediatrics, among others.

Health care practitioners need to be registered with the Namibian Association of Medical Aid Funds for them or their patients to claim expenses from the private medical aid funds. As of October 2022, there were 2,670 health care practitioners registered with the association.[9]

Human Resources for Health in the Private Sector

While the private sector provides services to only approximately 20 percent of the population, it accounts for one-third of all physicians, two-thirds of pharmacists, and about 20 percent of nurses.

Figure 1: Distribution of Health Care Workers Between Private and Public Sectors

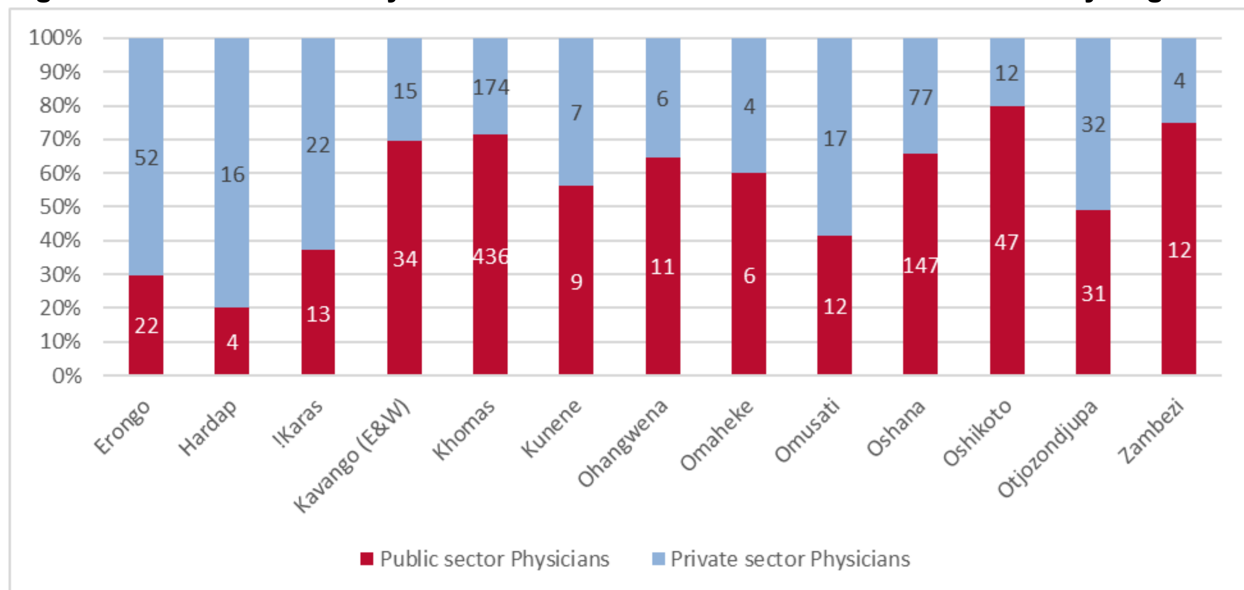


Source: World Bank, Namibia Public Expenditure Review, 2019.

[9] Data on the number and type of healthcare practitioners registered with the Namibian Association for Medical Aid Funds (NAMAF), as received from NAMAF in October 2022.

These private sector health care professionals are generally concentrated in key regions, closely aligned to the urbanization patterns of the country. Approximately 40 percent of physicians are based in Khomas, 18 percent in Oshana, 12 percent in Erongo, and 7 percent in Otjozondjupa. Similarly, 48 percent of pharmacists and 47 percent of nurses work in Khomas region. The distribution of health workers in the private sector is also closely aligned to the economic activities of the country, with a high concentration in the country's capital, as opposed to following the population's distribution. When comparing the public and private sectors, the private sector physicians are strongly represented in certain regions such as Hardap (80 percent of all physicians there are private), Erongo (70 percent), Karas (63 percent), and Omusati (59 percent)[10]. As dual practice is not regulated, medical specialists hired by the government can work in private practice while on the public payroll. This means that many of the physicians counted as working in the public sector do so on a part-time basis only, as they simultaneously run their own practices in the private sector.

Figure 2: Distribution of Physicians between the Public and Private Sectors by Region



[10] World Bank, *Namibia Public Expenditure Review,* 2019

Figure 3: Distribution of Pharmacists between the Public and Private Sectors by Region

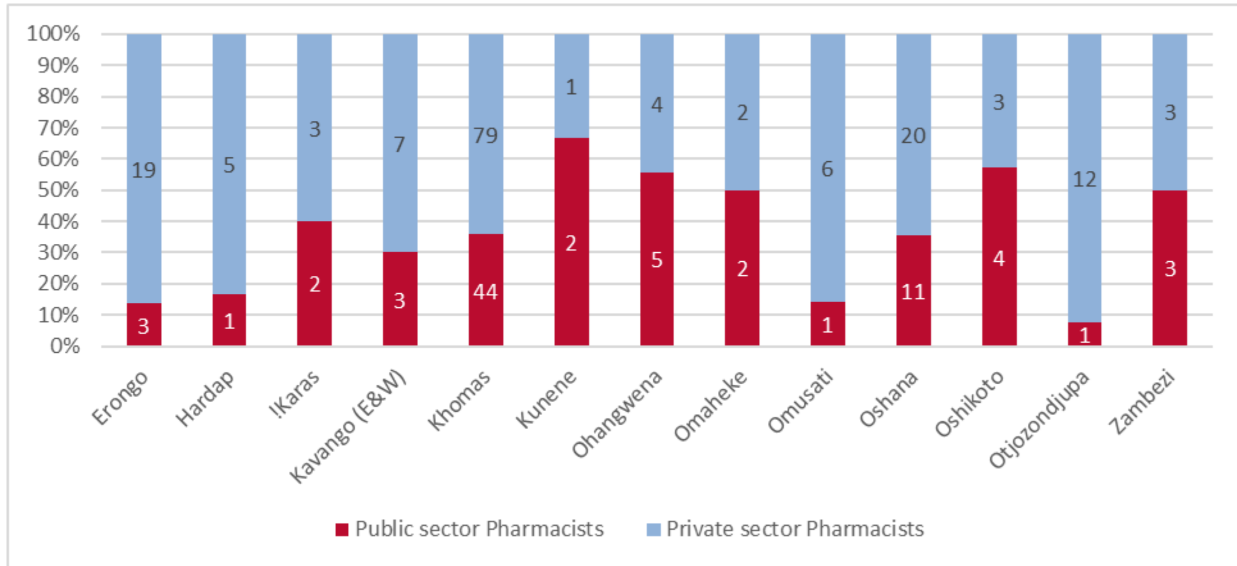
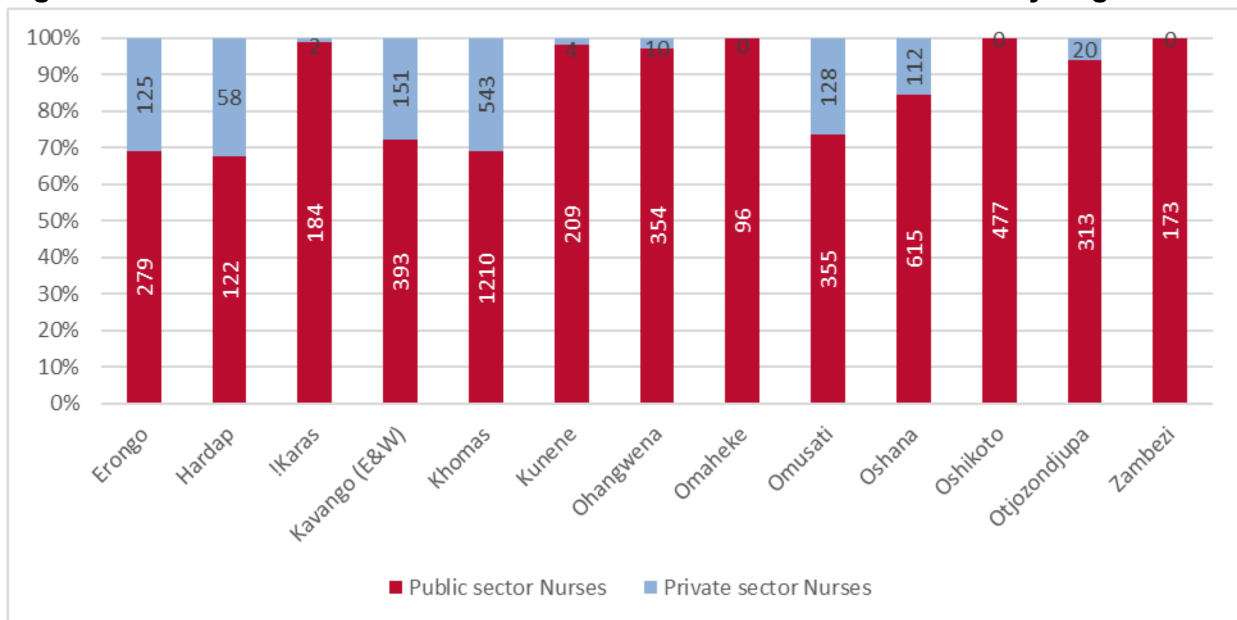


Figure 4: Distribution of Nurses between the Public and Private Sectors by Region

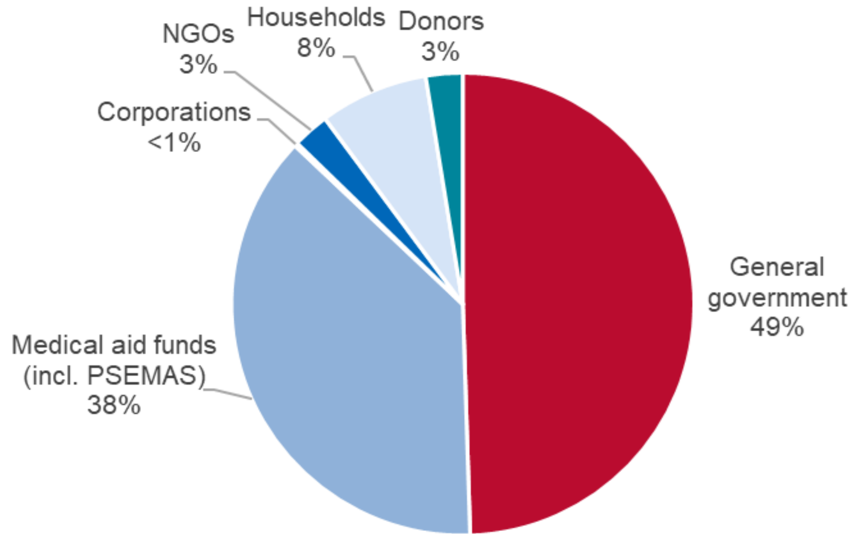


Financing for the Private Health Sector

As per the most recent resource tracking data, private health services are mostly financed through private medical aid funds and the Public Service Employees Medical Aid Scheme (PSEMAS), collectively accounting for 38 percent of total health expenditures in 2017/18. In addition, private health services are often paid for directly by private corporations or by households through out-of-pocket spending.[11]

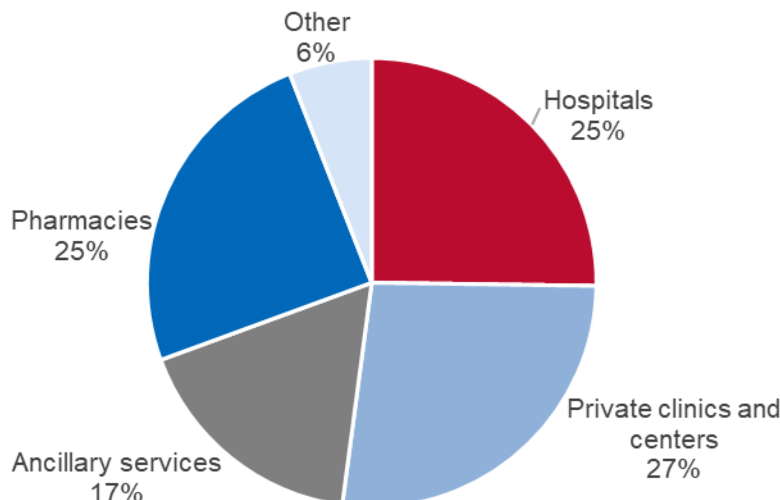
[11] MOHSS. *Namibia Resource Tracking for Health and HIV: 2017/18.* April 2020.

Figure 5: Breakdown of Total Health Expenditures by Agent, 2017/18



Approximately one-quarter of total spending by medical aid funds, including PSEMAS, is spent on hospitals, while 27 percent is spent on private clinics and health centers. It should be noted that in Namibia most hospitals do not have physicians and specialists on staff, but instead provide privately registered practitioners with privileges in their facilities. This means that the fees physicians and specialists charge for services rendered in hospitals are captured as part of the spending on clinics and health centers as opposed to hospital expenditures. Pharmacies also absorb approximately one-quarter of medical aid fund spending, while ancillary services, which mostly include laboratories and ambulance services, account for approximately 17 percent of spending by these medical aid funds.

Figure 6: Breakdown of Spending by Medical Aid Funds by Provider, 2017/18



While donor funding for health in general is relatively low, at 3 percent, donors' contributions are quite significant in the fight against communicable diseases, especially HIV/AIDS. Donor

funding for the HIV response amounted to 33 percent of total HIV expenditures. Civil society organizations (CSOs) have been instrumental in delivering HIV services at the community level, especially to marginalized and key population groups. The activities and services of these CSOs are almost exclusively financed by donors.

Private Health Insurance Market

Private health insurance options available in Namibia include private insurance policies for healthcare costs and private medical aid funds. Private insurance policies for healthcare costs are generally not measured as part of total health spending as they typically do not pay for health services directly, but instead pay claims out to clients directly. These payouts may not be linked to actual healthcare costs but are often paid based on the sum insured and also compensate other costs of being ill, such as loss of income. Namibia's private medical aid fund market is divided into two main types of funds: the private medical aid funds and PSEMAS. While contributions to both types of funds are voluntary, PSEMAS is restricted to public service employees and operates on a completely different financial model.

The private medical aid fund industry is relatively well established, with 10 medical aid funds operating in the country, of which five are open funds and five are closed funds. Open funds do not restrict their membership, while closed funds are available only to members of a certain company or industry. Medical aid funds in Namibia are regulated by the Medical Aid Funds Act 23 of 1995 and overseen by the Namibia Financial Institutions Supervisory Authority. The funds are required to adhere to solvency and liquidity requirements, and as such are required to report regularly to the Namibia Financial Institutions Supervisory Authority. The Authority also needs to review and approve all products the medical aid funds provide before these can be offered to the public. In addition, all private medical aid funds are registered with Namibian Association of Medical Aid Funds, which is a juristic body, established by the Medical Aid Funds Act to control, promote, encourage, and coordinate the establishment, development, and functioning of medical aid funds in Namibia. This body is also responsible for registering practice numbers of health care providers to facilitate their claims directly from the medical aid funds. The Namibian Association of Medical Aid Funds brings together health care providers and medical aid funds yearly to determine the Association's "tariffs," which are the amounts that medical aid funds pay to defray health care costs of members.

It is important to note that these regulations apply only to the private medical aid funds and are not applicable to PSEMAS, as the latter is managed directly by the Ministry of Finance. Employee contributions to PSEMAS are limited to approximately 15 percent of total expenditures (equivalent to 3 percent of total health spending or 0.6 percent of total general government expenditures), while the remainder are subsidized by the Treasury Department.

Despite the insurance industry being well established in Namibia, the total population coverage through these medical aid funds is quite limited, at a total coverage of only 20 percent of the population, comprising 8 percent of total population coverage by private medical aid funds and 12 percent coverage by PSEMAS.

Situational analysis of public-private sector collaboration in Namibia

Key Stakeholders

The MOHSS has ultimate authority over and oversight of Namibia's health system, responsible for coordinating both the public and private health sectors, including civil society organizations active in the health sector. Since this coordination with the private sector and civil society is necessary at various levels, from leadership and oversight to programmatic planning and implementation, these organizations are often engaged by different directorates of the MOHSS.

On a more strategic level, PSCSE and coordination should however be led by the MOHSS's Directorate of Policy and Planning. A 2010 assessment by the USAID-funded Strengthening Health Outcomes through the Private Sector (SHOPS) project identified the lack of a focal point for PSE within the MOHSS as a key challenge, and worked with the ministry to develop and operationalize a strategic framework that sought to establish a PPP unit within the ministry, under the Directorate of Policy, Planning, and Human Resources Development. The MOHSS received cabinet approval for this unit and formally launched its PPP framework in December 2014, but never formally established the PPP unit. Once established, the PPP unit would require adequate staffing and capacity building to ensure that the unit is effectively capacitated to manage these responsibilities. Furthermore, the PPP unit should work in close collaboration with the PPP unit within the Ministry of Finance, which is responsible for the coordination of the national PPP activities.

Several professional associations provide an entry point to reach various private provider cadres at scale. These include the Namibian Medical Society, the Medical Association of Namibia, the HIV Clinicians Society, and the Pharmaceutical Society of Namibia, among others. These associations typically focus on professional development and clinical skills for their members. They also present an opportunity for government to solicit inputs and feedback from private providers in the design and operations of mechanisms for public-private dialogue and engagement.

Mechanisms for Private Sector and Civil Society Dialogue and Engagement

In Namibia, formal efforts to increase PSCSE in health have largely focused on the design of PPPs. While the MOHSS will occasionally sponsor consultative meetings, these are ad hoc efforts and not a part of regular governance structures. In addition, private providers are not required to regularly report into the national health management information system, meaning that their contributions and potential opportunities are largely hidden from the government.

Governing PPP Frameworks

The GRN regards private sector participation as critical to addressing existing infrastructure and service needs and aims to realize this through PPPs. It considers PPPs a proven infrastructure procurement method that is increasingly being leveraged across the developed world alongside traditional methods to deliver infrastructure and economic development to the community. The aim of PPPs is to deliver improved services and better value for money primarily through

appropriate risk transfer, encouraging greater innovation, use of assets, and an integrated project-life management, underpinned by private financing. In 2009, the GRN started work on PPPs by developing the PPP policy, which was followed by a PPP guidance manual that was published in 2013. Eventually, the GRN introduced the PPP Act in 2017, which aims to realize the following objectives:

- Promote private sector participation in the provision of public services through PPP projects.
- Enable private sector investment in the provision of public infrastructure assets or services.
- Create frameworks and ensure oversight and governance on projects selected for development through the PPP mode.
- Enable the creation of adequate institutional capacity for processing and regulating PPP projects.
- Ensure fairness, transparency, equity, and competition in the process of awarding PPP projects.
- Provide principles, framework, and guiding procedures to assist public entities during the initiation, preparation, procurement, management, and implementation of PPP projects.

The Minister of Finance is responsible for the implementation of the regulations set out in the Act, through a committee that is to be established under the Minister's oversight.

Following the lead of the Ministry of Finance, the MOHSS forged ahead to formulate the Health PPP Strategy and Implementation Guidelines as a means of augmenting the limited public resources with the private sector's finance, human, and technical know-how. As per the MOHSS PPP strategy, enlisting the private sector in the provision of public health services has become a priority in light of an acute shortage of qualified health workers, limited capacity for domestic training, uncompetitive conditions in the public service sector, the physical aging of health facilities, fast-changing technology, re-emergence of diseases, non-robust sources of revenue, and population increase.[12] Increasing involvement of the private sector is also part of the more general change over the last decade in the role of the MOHSS in strengthening health outcomes in the country, characterized by a move from the role of the ministry as a single direct operator to one of an organizer, regulator, and overseer of medical activities and practices.

Platforms for Private Sector and Civil Society engagement

Recognizing the importance of jointly working toward the common goal of improving the health of the Namibian population, the GRN has embarked on various endeavors in which they are seeking the active participation of the private health sector, including both for and not-for-profit organizations. These platforms present a great opportunity for extensive and regular engagement with key non-governmental organizations and their representatives to strengthen collaboration and cooperation for improved national health outcomes. Some of the most pertinent platforms that the MOHSS would be able to leverage for wide stakeholder engagement are discussed in more detail in this section.

[12] Ministry of Health and Social Services, *Namibia MoHSS Public-Private Partnership Strategy*. Windhoek, Namibia, ND.

Governance Structures for UHC

The GRN is committed to making progress toward UHC and has established governance structures, led by the MOHSS, to oversee and coordinate this process. The MOHSS acknowledges that UHC can be achieved only if the inequalities in the health sector are addressed, which requires not only the cooperation of the private sector and civil society, but also a common understanding of how to address the broader weaknesses in the overall health systems that are prohibiting the attainment of UHC. The MOHSS aims to achieve this cooperation and common understanding by facilitating an ongoing all-inclusive national dialogue around UHC priorities and adopting an approach that involves engagement with a wide range of stakeholders within the health sector and beyond. The intent is to ensure consensus on the way forward, which will be essential for the successful implementation of the country's action plan for UHC.

The MOHSS has recently set up a national multi-stakeholder dialogue platform to:

- Unite stakeholders firmly behind a common understanding of the UHC concept.
- Ensure participatory equity and accountability in the UHC dialogue.
- Build cross-sectoral mechanisms for coordinated actions and investments for UHC.
- Conduct situational assessment to identify new barriers to achievement of UHC goals.
- Reach consensus among key stakeholders on the priorities and UHC objectives.
- Develop a unified pathway for Namibia to move toward UHC.

Within the governance structures established for the UHC agenda, technical working groups will address specific technical areas. The composition of these technical working groups is reflective of a multisectoral approach that will allow Namibia to make strides toward UHC. Furthermore, the MOHSS aims to regularly share its strategic orientations and priorities with critical stakeholders for feedback and improvement throughout the dialogue process.

Social Contracting and Performance-based Financing Technical Working Group

The MOHSS recognizes the country's significant progress in addressing communicable diseases, and the role that CSOs have played in realizing these achievements. CSOs are a critical partner in providing essential services, especially in marginalized communities. One of the most effective and efficient methods of bringing comprehensive services closer to clients is to have a direct presence within communities. Since CSOs have been instrumental in delivering services at the community level with the support of donor funds, the ministry recognizes the threats to sustained progress posed by the changing funding landscape. To ensure continued progress in the management and control of communicable diseases, CSOs need to be continuously engaged in the planning, coordination, and management of the health response, while their role will need to be sustained through domestic funding.

Social contracting is recognized as a suitable platform through which the GRN via the MOHSS can engage with and provide funding to CSOs to achieve goals and targets, as outlined in the national strategic guidelines. Therefore, social contracting is an opportunity for the MOHSS to engage the civil society, as a non-governmental stakeholder, and foster this relationship of close collaboration.

The MOHSS has recently embarked on development of a social contracting policy, which is being coordinated through the social contracting and performance-based financing technical working group that has been established for this purpose. The social contracting policy aims to achieve the following objectives:

- Provide sustainable and non-disruptive funding to non-state actors to ensure continuity of services.
- Expand provision of targeted essential health services to ensure access for all, including marginalized communities, hard-to-reach groups, and those inadequately served.
- Strengthen linkages with communities through direct support to CSOs with strong grassroots presence and reach of services.
- Strengthen meaningful engagement and coordination between GRN and CSOs. Promote dialogue on essential services for enhanced responsive programming consistent with community health and needs.
- Increase efficiency in using GRN funding by ensuring services are provided at the lowest cost possible.

Implementation of Health PPPs in Namibia

The MOHSS has entered into numerous PPPs over recent years, which were implemented under different contractual arrangements and enjoyed varying levels of success. Some of the PPPs the MOHSS entered into in recent years include the following:

PPP	Approach/mechanism	Status	Challenges	Lessons learnt
Mister Sister	PPP between MOHSS, PharmAcccess and the USAID-funded SHOPS project to provide primary healthcare to remote populations using private mobile health clinics. These Mister Sister mobile clinics, which were retrofitted vans and trucks, were generally staffed by a driver and two nurses, who delivered a comprehensive set of primary health services. For more-advanced care, the Mister Sister nurses referred patients to the nearest public health facility. Many of these services were paid for by employers along the clinics' routes. To keep costs low for rural and poorer populations, the MOHSS provided Mister Sister with necessary commodities.	Transitioned to another NGO – continues to be operational at smaller scale	PharmAccess closed operations in Namibia resulting in the scale of the PPP being significantly reduced after being taken over by another NGO.	Mobile clinics have proven to be an effective approach to reaching people in remote locations, dealing with Namibia's sparse population distribution, and covering vast distances between populations. Mister Sister has demonstrated that private employers are willing to contribute to healthcare costs of employees, and that collaboration between public and private sectors is an effective way to keep costs low.
Namdeb Hospital in Oranjemund	Namdeb mining company operates a hospital and clinic to serve its employees. Given the relatively small population of Oranjemund, the MOHSS runs a primary care clinic in the town only, to serve the general population. Under the PPP arrangement, nonemployees can access the Namdeb facilities when the public clinic is closed or is not able to provide specific more-specialized services. The MOHSS pays for the services rendered to public patients on a fee-for service basis.	Active	Fee-for-service charges can lead to over-servicing, however, the risk of this is relatively minimal where revenue from hospital operations is negligible.	Investment by private companies can be effectively leveraged to ensure healthcare coverage of populations in remote locations.
Specialist services	Using funds from a special fund, MOHSS pays for services outsourced to the private sector that the public sector is not able to provide due to lack of capacity or infrastructure to deliver these services.	Active	Fees charged for some specialty services are seen	Government can leverage the specialist expertise and equipment in the private sector to provide

PPP	Approach/mechanism	Status	Challenges	Lessons learnt
	These specialist services include renal dialysis, medical imaging (especially for computed tomography scans), oncology and radiology services, and the cardiac unit. Services are paid on a fee-for-service basis.		as exorbitant by public sector. Fee-for-service payment structure may result in over-servicing.	comprehensive health services, however, effective price negotiation and monitoring of patients' need for such services is essential.
Mission hospitals	Faith-based providers such as the Anglican, Roman Catholic, and Lutheran churches run numerous hospitals and health facilities across the country, especially in rural and hard-to-reach areas. These health facilities receive regular government subsidies in the form of block grants from the GRN through the national budget, particularly for salary and operational expenses. These faith-based health facilities are responsible for their own infrastructure and maintenance expenditures, which they cover with the revenues collected through user fees and other sources.	Active	Faith-based organizations tend to be highly dependent on the funds received from government.	Infrastructure of non-governmental organizations can be leveraged to ensure adequate access to health services is rural areas. The ability of faith-based organizations to retain revenue from user fees has allowed them to further invest in infrastructure in a way that is more responsive to patient needs.
Medical oxygen supply	Medical oxygen is supplied to public facilities under different types of PPP arrangements. The MOHSS has an agreement with one supplier for the rental and regular refilling of oxygen cylinders, which are used in certain facilities to deliver medical oxygen to patients. Other facilities have Pressure Swing Adsorption oxygen generating plants, which are leased under another type of PPP arrangement whereby the supplier ensures the operation and regular maintenance of the plant in exchange for a monthly fee.	Active	Limited capacity in the MoHSS to monitor the quality of services provided under these PPPs has resulted in instances of inferior quality of oxygen supply having been reported.	PPPs for the supply and lease of medical equipment can be cost-effective, while allowing the MOHSS to avoid the substantial initial investment and continuous maintenance costs of such equipment. Contractual arrangements need to be sound to ensure consistent quality and proper maintenance.
Bophelo!	The Namibian Business Coalition on AIDS and PharmAccess Namibia ran two mobile testing vans as screening clinics on behalf of the MOHSS. Patients in need of treatment were	Inactive	While initially very successful, interest in clinic services became limited due to constrained focus on HIV testing services	Comprehensive wellness or primary healthcare services are more responsive and acceptable to the population

PPP	Approach/mechanism	Status	Challenges	Lessons learnt
	referred to private providers if they have medical scheme coverage or to public clinics if they do not.		only. Services were later expanded to include general wellness (including screening for high blood pressure and cholesterol). The PPP ceased to operate after the closure of the Namibia Business Coalition on AIDS.	than the narrow focus of HIV testing services only. Wellness clinics are an effective way of delivering preventive and promotive healthcare services, especially within targeted populations (e.g., workplaces).
Non-clinical services	Some public health facilities, especially hospitals, have reverted to outsourcing non-clinical services, as they do not have the infrastructure and equipment to provide these services and to allow them to concentrate on their core function of delivering health services. Some of these services that have been outsourced include catering, security, and laundry services. These have been outsourced through formal tender processes and the private sector suppliers are paid for the services provided. In some cases, such as for the catering services, the supplier uses MOHSS resources for service delivery, such as personnel and kitchen equipment.	Active	Instances have been reported where exorbitant fees have been charged for the services provided leading to increased costs as opposed to cost savings. Performance of suppliers is not consistently monitored, resulting in private sector being paid for services that were not rendered.	Outsourcing of non-clinical services has allowed health facilities to save costs and concentrate on the provision of health services. Cost-benefit analyses need to be conducted before services are outsourced to ensure that such a PPP does in fact result in cost savings. Effective procurement and contract management policies, procedures and capacity are essential.

Challenges in the implementation of PPPs

Even without a formally established PPP unit within the MoHSS, the Ministry has been able to implement the above PPPs during recent years. However, there have been challenges in implementation. These include:

- **MOHSS capacity for PPP management.** One of the biggest challenges the ministry faces in rolling out and managing PPPs is its own limited expertise in contract management and its lack of a dedicated person or unit responsible for PPPs.
- **Inconsistent management of PPP arrangements.** Mostly due to the lack of capacity within the MOHSS, PPP arrangements tend to be managed quite haphazardly, with the ministry often having limited oversight and control over existing arrangements, particularly in terms of the performance of the private sector counterpart.
- **Inadequate PPP performance monitoring.** There is also a disconnect between the contracting, performance management, and payment functions, as each of these functions is executed at different levels within the ministry, with limited coordination and communication between them.
- **Limited scope of PPPs.** The contractual arrangements of most of the PPPs that have been implemented to date were in the form of outsourcing agreements that are similar to more-general purchasing arrangements as opposed to more-comprehensive mutually beneficial partnership arrangements.
- **Poor negotiations of PPP terms.** The MOHSS often does not fully leverage its bargaining power in fee negotiations, resulting in the ministry often overpaying for the services received.

Planned PPPs for the Near Future

In addition to the PPPs that are already in place within the health sector, the MOHSS has embarked on exploring and leveraging additional opportunities for strengthened collaboration and cooperation between the public and private health sectors. Some of these include the following:

- **Expanding the national oxygen infrastructure.** During recent years with the COVID-19 pandemic it became evident that the existing oxygen supply capacity within public health facilities is inadequate to meet demand. The MOHSS is contracting additional suppliers through PPP arrangements for the supply and management of Pressure Swing Adsorption oxygen-generating plants in various health facilities across the country.
- **Providing staff accommodation.** The MOHSS typically provides housing to its medical staff in state-owned accommodation buildings. However, some of the housing infrastructure has become dilapidated in recent years due to the ministry's limited capital expenditure and maintenance budgets. The MOHSS is negotiating a PPP whereby a private sector partner renovates, maintains, and manages the operations of the state-owned accommodation buildings and is paid a monthly rental amount by the MOHSS for these services.
- **Construction of regional hospitals.** The MOHSS is exploring PPPs as an opportunity to expand the country's health facility infrastructure. Acknowledging the need for expansion of health facility coverage in certain areas, the MOHSS has conducted a pre-feasibility assessment for construction of new hospitals in four key locations (including Windhoek, Otjiwarongo, Nkurenkuru, and Ondangwa) to meet the demand for health services in these areas. The concept is for these hospitals to be built and managed by a private sector organization, but for services to be rendered to both public and private sector patients in these facilities.

Recommendations

The private sector, including civil society, is acknowledged as critical partner in improving health outcomes in Namibia. Given the vastness of the country and the complexity of the health response as a result of its double burden of communicable and non-communicable diseases, it is critical for all stakeholders in the health sector to collaboratively coordinate, manage and implement the health response. This can be achieved by leveraging existing public-private partnerships, private sector and social contracting and continuously engaging private sector and civil society in planning and decision-making processes. For the effective collaboration between these parties and to maximize the impact, the following actions are recommended:

- **Continue engagement of private sector and civil society on decision-making platforms**. As the MOHSS continues to lead the country's efforts towards UHC and health sector sustainability, it is essential that these efforts are coordinated with and supported by the private sector. It is critical to ensure inclusion of key stakeholders in the decisions relating to health sector reforms for UHC and mechanisms for contracting (both private and social) to secure broad buy-in, improved support and continues cooperation within the health sector.
- **Create mechanisms for effective contracting of private sector and civil society.** Given the resource constraints in relation to the population served by the public sector, there are opportunities to leverage the infrastructure and human resources that are available within the private sector. Furthermore, civil society's unique positioning to effectively provide services at community-level can be leveraged through social contracting to ensure continued access to critical community-level services and expanding access to healthcare services to remote populations.
- **Explore new PPP opportunities.** There is significant potential in PPP that is yet to be explored in the Namibian context, whereby the resources in the private sector can be leveraged to support the MOHSS in providing health services to the vast majority of the country's population. These may include the distribution of publicly procured pharmaceuticals through private pharmacies at a nominal fee, provision of selected primary healthcare services through private providers, and other. Options should be assessed, possible partners identified and mechanisms for such PPPs should be explored.
- **Strengthen the MOHSS' capacity in contract and PPP management.** For the mechanisms of contracting private sector and civil society, and for PPPs to work effectively, it is essential for the capacity of the MOHSS to be strengthened. This would require the following:
  - Establish a PPP unit within the MOHSS with staff who are dedicated to the management of PPPs and other contracting arrangements.
  - Provide training and mentoring of MOHSS PPP unit staff to ensure that they have the necessary skills to fulfill their responsibilities.
  - Develop standardized protocols, procedures, and tools to guide the bidding, selection, negotiation, contracting, management and monitoring of PPPs and other contracting arrangements with private sector and civil society.
  - Strengthening negotiation capacity to ensure that the MOHSS can leverage its purchasing power for economies of scale to ensure that prices and fees are agreed for optimal cost-effectiveness.

  - Ensure effective monitoring of the implementation of PPPs and contracting arrangements for compliance with contractual terms and conditions, delivery of quality and value-for-money services.
- **Increase scope of private sector services.** Health services identified as essential in achieving the country's targets in health outcomes, as per the soon-to-be finalized Essential Health Services Package, should be included in the benefit packages of the private medical aid funds and PSEMAS to ensure that those services are comprehensively accessible to all population groups. These should include services prioritized by the GRN, such as PrEP and other preventive and promotive services.

Conclusion

The private sector and civil society play a pivotal role in the provision of health services in Namibia and could be instrumental in allowing the country to progress toward UHC. As the government mobilizes efforts to progress toward UHC and address the inequities and inefficiencies in the country's health system, it is critical to integrate and coordinate the public and private health sectors in support of total market approaches, improved strategic purchasing, and other strategies that promote efficient use of public and private resources and increase equitable access. There are opportunities for the GRN to leverage the private sector's substantial resources to improve health outcomes. To do this effectively, it is important to improve the collaboration between the public and private sectors, formalizing channels for consistent communication and cooperation. The government has started seeking the active engagement of the private sector in the decision-making processes that affect the broader health sector through PPPs. The continued engagement of and collaboration with the private sector will be critical to ensure continued progress in strengthening the national health system and achieving improved health outcomes for the country.