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Namibia

Private Health Sector Assessment



BRIEF

SHOPS

Strengthening Health Outcomes
through the Private Sector

Summary: This brief is a summary of the *Namibia Private Sector Assessment*, September 2010, conducted by the SHOPS project. Thierry Uwamahoro prepared the brief, which discusses the assessment methods and findings and presents key recommendations for engaging the private sector.

Given the context of declining donor funding in Namibia, the overall goal of the recommendations is to craft a national HIV response that is sustainable and leverages private sector resources—both in financing and service delivery.

Note: The Namibia private sector assessment was conducted in March and April 2010. The brief, its findings, and its recommendations present a snapshot of Namibia’s health sector landscape at the time of the assessment and do not address increasing levels of public-private engagement and partnership in the health sector since 2010.

Keywords: HIV/AIDS, insurance, Namibia, NGO sustainability, policy, private sector assessment, private sector health

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Project Description: The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID’s flagship initiative in private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV/AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O’Hanlon Health Consulting.

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Namibia Private Health Sector Assessment

In early 2010, the United States Agency for International Development/ Namibia asked the SHOPS project to conduct a private health sector assessment in Namibia (1) to determine the potential role of the private sector in decreasing costs and improving efficiencies in the delivery of HIV/ AIDS services and (2) to recommend options for mobilizing all potential sources of financing. This brief summarizes the assessment's¹ methods, findings, and recommendations for engaging the private health sector.

Largely because of the dramatic increase in donor funding, Namibia's national HIV response was in scale-up mode between 2004 and 2009. The country made significant progress as it witnessed a slowdown in the spread of the HIV epidemic amid soaring rates of antiretroviral therapy coverage. However, the assessment found that Namibia's response, which relied heavily on donor funding, is not sustainable. Government documents underscore a continued reliance on external resources for ART delivery. The majority of faith-based organizations and nongovernmental organizations that have invested in HIV/AIDS prevention, care, and treatment are wholly dependent on foreign donations. Even though the for-profit private sector plays an important role in Namibia's overall health system, the sector's contribution to HIV/AIDS services remains negligible, at about 1 percent. This finding, coupled with the existence of a substantial health insurance industry, led to the conclusion that Namibia's private sector represents untapped potential for ensuring the sustainable provision of HIV/AIDS services once donor funding is scaled back. The assessment presented ways to engage the private sector using the World Health Organization's health systems strengthening framework.

Background

Located in southwestern Africa, Namibia has a highly dispersed population of 2.1 million, with the majority residing in rural areas (UNAIDS, WHO, 2008). Namibia is a country of contrasts. On one hand, the nation faces a serious HIV epidemic, a high unemployment rate, and one of the world's highest rates of income inequality. Despite its high gross national income per capita, Namibia exhibits the largest income disparity in the world, with a Gini Coefficient of 0.6 and more than half the population living below the poverty line (WHO, 2010). At the same time, the country boasts high ART coverage rates and high literacy rates and has recently been classified as an upper-middle income country (World Bank Group 2010a; 2010b). Likely drivers of Namibia's relatively high GNI are: significant rates of foreign investment, an economy closely linked to South Africa's, moderate inflation, and low indebtedness. It is against this backdrop that the private sector has flourished.

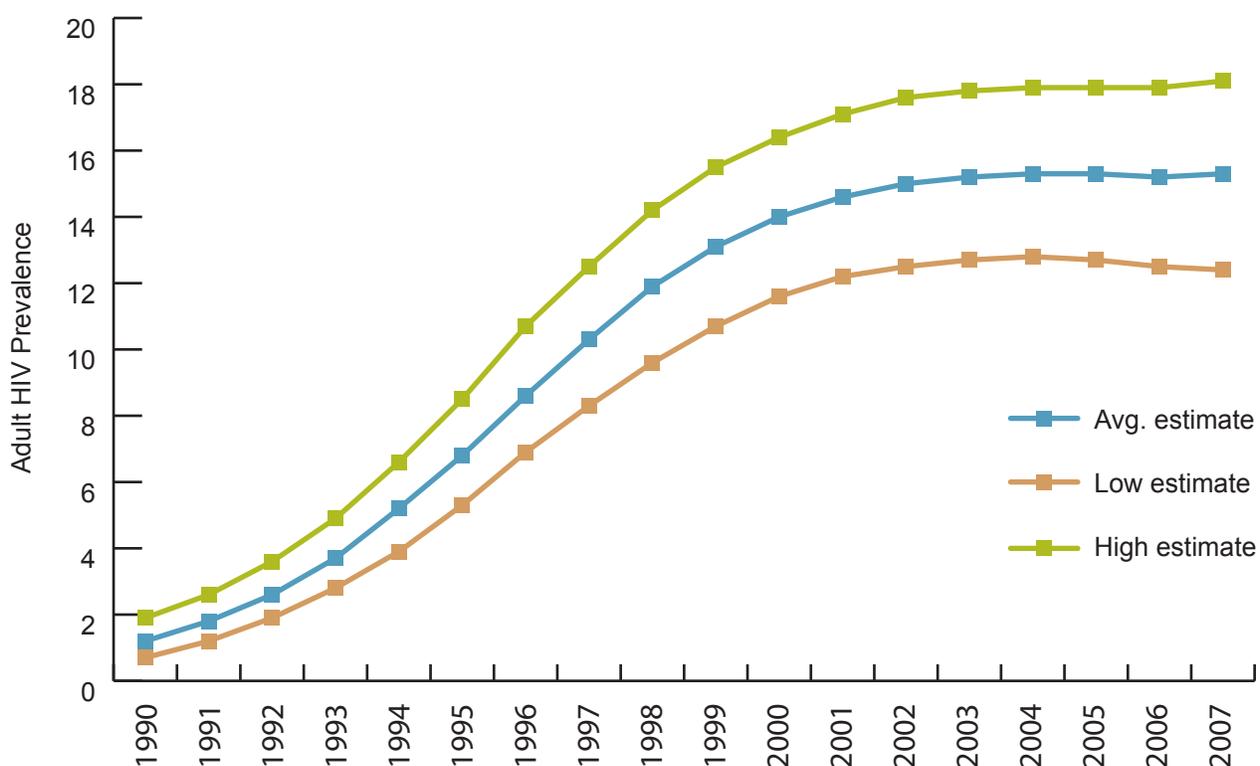
Namibia has been dealing with the HIV/AIDS epidemic since 1986, when the first case of HIV infection was reported. Since then, the epidemic grew rapidly until it peaked in 2002, with 22 percent of pregnant women testing

¹ O'Hanlon, Barbara, Frank Feeley, Ingrid de Beer, Sara Sulzbach, and Heather Vincent. September 2010. *Namibia Private Sector Assessment*. Bethesda, MD: SHOPS Project, Abt Associates.

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positive (MoHSS, 2010b). Recent surveillance data indicate a slowdown of the epidemic (MoHSS, 2008d). Nonetheless, Namibia faces a serious HIV/AIDS epidemic, with adult prevalence estimated at 13 percent (MoHSS, 2010b). Approximately 175,000 adults and children are estimated to be living with HIV/AIDS, and approximately 66,000 children from birth to age 17 have been orphaned by AIDS (UNAIDS, WHO, 2008).

Figure 1. Estimated HIV Adult Prevalence in Namibia



Source: UNAIDS, WHO 2008

Between 2004 and 2009, Namibia's HIV response could be characterized as in scale-up mode, largely as a consequence of a dramatic increase in external aid from the U.S. President's Emergency Plan for AIDS Relief and funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria. PEPFAR funding increased fourfold during the period, from \$24.5 million between 2004 and 2005 to about \$109.4 million between 2009 and 2010, and has remained relatively steady since then. The Global Fund has

approved grants worth \$255 million, of which \$213 million are devoted to HIV/AIDS programs. As of 2010, \$97 million has been disbursed for HIV/AIDS. As with other PEPFAR-supported countries, Namibia has focused on the aggressive pursuit of targets related to prevention, care, and treatment to demonstrate the effectiveness of the emergency response in mitigating the epidemic. However, scale-up was hindered by a dearth of health workers, a highly dispersed population, high rates of HIV/tuberculosis co-infection, limited in-country laboratory capacity, and a social context characterized by a high prevalence of gender-based violence and alcoholism.

Despite these challenges, Namibia has made significant progress in achieving its treatment targets, and aid from PEPFAR and other external donors has helped overcome some of the health system's constraints to financing and service delivery. Namibia receives support from the Global Fund and the Clinton Foundation for the procurement of antiretrovirals, with the government funding roughly a quarter of the total cost of procurement. Through PEPFAR, the United States government has supported the contracting in of health care workers from outside Namibia (a large proportion of workers came from Zimbabwe) to alleviate the public health system's constraints in clinical capacity.

By 2009, over 80 percent of adults and 95 percent of children eligible for treatment were receiving treatment, and 58 percent of HIV-positive pregnant women received ARVs to reduce the risk of mother-to-child transmission (MoHSS, 2010b). Treatment rates compare favorably with those of the region as a whole—in sub-Saharan Africa, on average, only 44 percent of adults and children in need of ART have access to treatment (UNAIDS, WHO, 2008).

Namibia, however, faces serious health system constraints as it prepares to sustain its HIV response for the longer term.

As of 2010, the United States and the government of Namibia demonstrated considerable interest in exploring strategies for both decreasing costs/improving efficiencies in the delivery of HIV/AIDS services and mobilizing all potential sources of financing, including private sector sources. Amid some evidence that the private for-profit sector was involved in the HIV response, the sector's role was not well defined, coordinated, or maximized to its fullest potential.

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Scope of the Assessment

The scope of the assessment included the following elements:

- Reviewing the impact on Namibia's current policy environment of stakeholders' perceptions regarding private sector involvement in the HIV response and health system
- Analyzing and mapping the private for-profit sector's involvement in the HIV response and health system
- Examining the degree to which partnerships addressing HIV needs exist between the private for-profit and public sectors, as well as with civil society
- Identifying opportunities to create and strengthen partnerships with the commercial sector that could contribute to sustainable HIV/AIDS and health system goals
- Identifying partnership opportunities for the for-profit private sector to help sustain the USAID program after PEPFAR graduation

Nearly 96 percent of HIV funds are spent in the public sector, with 4 percent spent in the private sector.

METHODS

SHOPS conducted a review of available published and gray literature pertinent to the assessment's objectives. The literature review permitted a fuller understanding of how the private sector could contribute to Namibia's national HIV response. Stakeholder interviews were crucial (1) to understanding the prevailing attitudes of public and private sector actors, donors, and implementers and (2) to identifying existing constraints and challenges as well as potential solutions. The SHOPS team developed interview guides tailored to each stakeholder group and conducted key informant interviews during March and April 2010.

FINDINGS

Overview of the Private Health Sector

As of 2010, Namibia's private health sector had mounted a strong response to HIV/AIDS and the nation's orphans and vulnerable children. The private health sector comprises nonprofit and for-profit entities. The nonprofit sector, in turn, constitutes FBOs, NGOs, and community-based organizations that deliver HIV/AIDS prevention, care, and treatment. Several FBOs and NGOs also provide care and support for orphans and vulnerable children.

The increase in donor funding targeted to the scale-up of HIV/AIDS services gave rise to the emergence of a host of NGOs, FBOs, and CBOs, all fully dependent on external resources. The Namibia Network of AIDS Service Organizations, the main umbrella organization in the NGO sector, counts over 400 member organizations. In addition, several hundred CBOs deliver a narrow range of services, accounting for a patchwork of organizations and services. Most of the organizations have limited capacity to expand

and gain financial independence and therefore depend on donor funding to keep operating.

The for-profit sector includes private health care providers, represented by a range of medical professional associations that deliver HIV/AIDS services, as well as key industries—agriculture, finance, mining, tourism—that offer prevention and sometimes general health services to their employees and surrounding communities. A medical insurance sector sells health insurance with HIV/AIDS benefits. With respect to orphans and vulnerable children, businesses provide largely in-kind contributions and limited funding through corporate social responsibility.

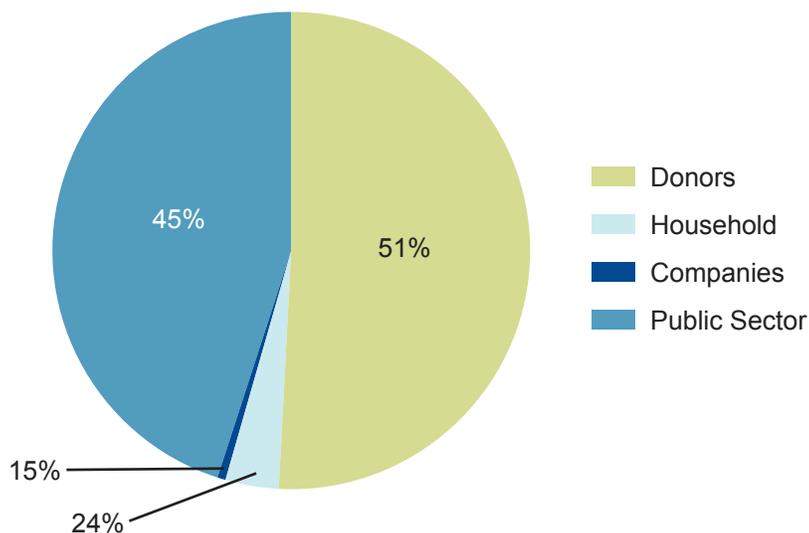
The value of the private health sector market totaled nearly N\$1.3 billion (Namibian dollars) in 2008–2009, equivalent to US \$144 million (MoHSS, 2010a). The 2008–2009 National Health Accounts showed that nearly 33 percent of private funds were spent in private for-profit hospitals, followed by 25 percent in private dispensing chemists and 11 percent in private for-profit clinics. A significant amount (17 percent) of out-of-pocket and health insurance premiums were paid to a range of private providers at hospitals, clinics, and individual consultation rooms. Moreover, 4 percent of mission hospitals received private funding, also through individuals and private insurance.

The public sector and donors are the core funders of HIV/AIDS services in Namibia (45 and 51 percent, respectively). The private sector contribution is negligible, at less than 1 percent. Unlike the case in other African countries, household spending is extremely low at 3.4 percent. Nearly 96 percent of HIV funds are spent in the public sector, with 4 percent spent in the private sector (MoHSS, 2010a).



A private medical center in Namibia.

Figure 2. Finance Sources of HIV/AIDS Services in Namibia (2008/2009)



Source: MoHSS 2010a

MoHSS statistics show that the public and nonprofit sectors account for almost three times the number of hospitals and 3.5 times the number of clinics as the private for-profit sector. However, the 550 private for-profit consulting rooms and 75 private pharmacies represent possible resources for HIV/AIDS programs.

The private sector employs the majority of physicians in Namibia—three-quarters of all doctors.

The scarcity of qualified health care professionals is a critical challenge in both the public and private health sectors. As of 2008, Namibia counted 7,697 health workers nationwide. While the public sector continues to be the primary employer of health care workers (53 percent), the private sector attracts a large percentage of health care workers as well (47 percent). The private sector employs the majority of physicians—three-quarters of all doctors. Two professional groups that work predominantly in the private sector are pharmacists and social workers: nine out of 10 pharmacists and seven out of 10 social workers practice in this sector.

The distribution of private health facilities is uneven; a small number of large, successful private providers own hospitals and clinics that offer high-quality services concentrated in Windhoek and Swakopmund. These providers compete for a small high-income clientele that either can afford to pay out-of-pocket or, more commonly, are covered by a health insurance scheme. Below the level of high-end private providers is a large number of small-scale providers—typically nurses—in private consulting rooms who struggle to remain financially viable and whose quality varies. They are located in both urban and peri-urban areas as well as throughout the country and usually serve a lower- to middle-income clientele.

Even though Namibia's private health sector is relatively small compared to that of other countries in sub-Saharan Africa, it still plays an important role in key public areas, such as HIV testing and treatment for sexually transmitted infections, childhood illnesses, and maternal health. According to 2008 statistics, 15 percent of women and 25 percent of men turn to the private sector for HIV testing; 14 percent of mothers take their children to the private sector to treat diarrhea, and 22 percent seek private sector care for fever or cough symptoms; and approximately 5 percent of Namibian women deliver in a private facility.

Private Sector Engagement in HIV/AIDS

Health care in Namibia is clearly a complex mix of public and private elements. Although formal communication and collaboration between the public and private health sectors has been limited, there is some experience with arrangements that would ordinarily be classified as public-private partnerships. These arrangements are apparent in the continuum of HIV/AIDS services, in the funding of services, and in specific partnerships established to provide care and treatment.

1. HIV/AIDS Continuum of Care

The roles played by the public and private sectors vary across the HIV/AIDS continuum of care.

- **Workplace prevention and education.** The largest companies in Namibia (both private and parastatal) have well-developed workplace programs, usually with a designated HIV/AIDS or wellness coordinator within the human resources department. In smaller companies, however, such programs are uncommon. Nationally, the Namibian Business Coalition on AIDS provides a forum for employers to combat AIDS. Together with PharmAccess, NABCOA helped start the Bopheho! wellness screening initiative and offered informational sessions on low-cost health insurance plans. It supports employer HIV/AIDS education efforts and has received support from the Global Fund.
- **Screening (voluntary counseling and testing).** The private sector is active in this area. USAID has funded a chain of screening clinics called New Start, although it had reduced funding for this effort by the time of the assessment. HIV tests are widely available in



Bopheho! mobile clinic at a rural site.

private hospitals and physician offices, and are generally covered by medical schemes, which employ disease management organizations to monitor the care of beneficiaries identified as HIV-positive.

- **Treatment of AIDS and opportunistic infections.** The first patients to receive ART in Namibia were private patients; they were supported by their employers or medical schemes and received care from company clinics or private providers. Namdeb, the diamond mining company, has been providing ART for its employees for over a decade. In 2007, there were approximately 7,000 ART patients in the private sector (including public employees covered by the Public Service Employees Medical Aid Scheme). By September 2008, the number of ART patients treated in the public sector totaled 58,000. Although the public and private sectors both treat AIDS, they tended to work unilaterally rather than in partnership.

Public-Private Partnerships

The PPPs described in this brief are collaborative ventures in which resources from public (government-owned) and private (for-profit or nonprofit) entities are combined to achieve a health objective.

2. Funding of Care and Treatment

Namibia, like South Africa, has a substantial health insurance industry that covers a significant portion of the population. For HIV/AIDS services, private sector providers are generally paid fee-for-service by medical schemes according to a price list updated annually by the Namibian Association of Medical Aid Funds. The medical schemes cover ARVs (and most prescription drugs), and the prevailing rate paid to pharmacists is essentially the South African wholesale or production price plus a 50 percent retail markup. A reference pricing scheme ensures that the schemes pay only the rate for the lowest-cost products in the reference group.

- **Traditional medical schemes.** At the end of 2004, some 132,000 Namibians were enrolled in private medical schemes, both closed (limited to a particular company or industry) and open to any employer or individual. A further 118,000 civil servants and their dependents were enrolled in PSEMAS. Combined, the private medical schemes and PSEMAS covered 12 percent of the Namibian population at the end of 2004.
- **Low-cost schemes.** In 2004, Diamond Health Service—the first low-cost medical scheme—entered the market. It relies on a limited network of primary care providers paid on a capitation basis. Other low-cost schemes followed Blue Diamond into the market. Vitality, for example, covers only HIV care and was initially offered in 2006 at N\$30 per worker per month. Growth has been slow in the low-cost plans; the total share of privately insured individuals represented by such plans was about 13 percent of the population at the time of the assessment.
- **Risk equalization fund.** One medical scheme tried to form a risk equalization fund to spread the HIV risk across a large number of insured groups. An “HIV reinsurance premium” would be paid into

a central fund for each insured, and the fund would even out the cost of AIDS coverage between groups. The risk equalization fund now operates only within the plans controlled by a single medical aid scheme.

3. Partnerships to Provide Care and Treatment

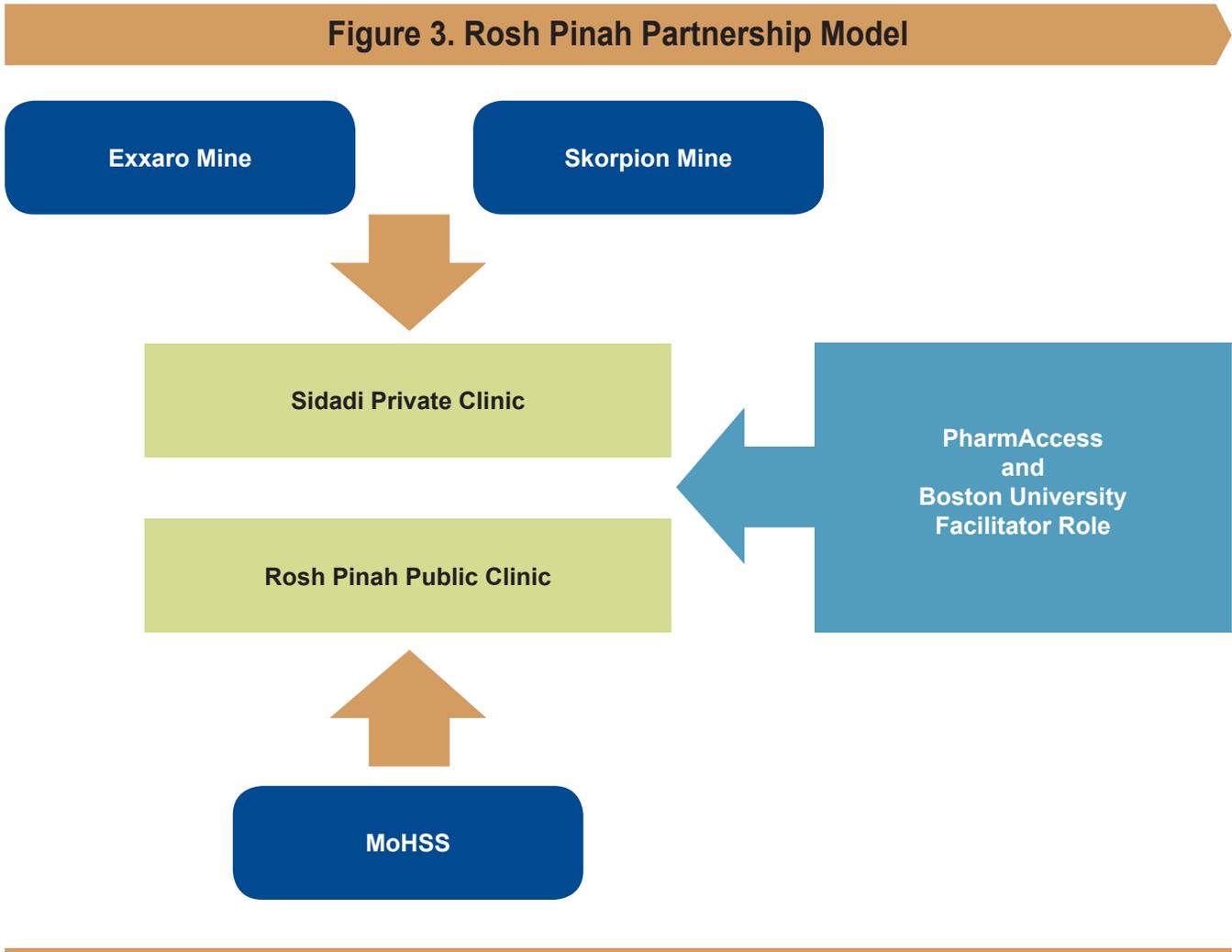
By mid-2010, three public-private initiatives had emerged to offer patient screening and treatment. Beyond the projects discussed here and the ongoing mission hospital contracts (to provide support services for facilities, such as catering), the assessment team did not identify any other public-private health partnerships and did not find a policy or mechanism to encourage new partnerships.

- **Namdeb hospital in Oranjemund.** Oranjemund is a “company town” located in the restricted diamond area, which is off limits to those without the proper permit. To serve its workers in this isolated location, Namdeb operates its own hospital and clinic. MoHSS runs a primary care clinic in the town for those not employed or insured by Namdeb. When patients cannot be treated by the nurses at the public clinic, they are referred to the Namdeb hospital, and MoHSS pays for their care under a negotiated agreement.
- **Rosh Pinah.** The proposed partnership at Rosh Pinah is an attempt to give public patients access to mine-operated medical facilities. The fully equipped outpatient clinic founded by the two mines at Rosh Pinah has two physicians and a full range of support personnel. It also has basic diagnostic equipment (X-ray, ultrasound) that is not available at the nurse-staffed public clinic. At the time of the assessment, representatives from the regional MoHSS and the private clinic were close to completing an agreement facilitated by PharmAccess Foundation and Boston University. The rapidly expanding uranium mine at Rossing offers a similar opportunity for partnership.
- **Bophelo!** This classic PPP facilitates the screening of the population for HIV and other diseases. NABCOA and PharmAccess Namibia own and operate two mobile testing vans that are licensed as screening clinics by MoHSS. For follow-up, patients are referred to private providers if they have medical scheme coverage or to public clinics if they do not have insurance. A portion of the costs is paid by employer fees and the rest by donor funds. The Namibia Institute of Pathology has contributed the monitoring costs.



MetHealth Namibia is one of the medical aid schemes that finances HIV/AIDS care and treatment.

By leveraging the unique capabilities of the public and private sectors, all three partnerships have expanded access to medical services that would have otherwise been out of reach for many Namibians. The negotiated agreements between MoHSS and its private sector partners ensure the efficient use of resources and save costs.



Policy Landscape

Overall, the policy environment in Namibia supports the private sector's provision of health care. There are no major barriers to entry or continued involvement in the delivery of HIV services. However, the public and private sectors appear to operate in two parallel universes; they do not coordinate their support of the national HIV/AIDS response. In fact, the absence of coordination poses a challenge to fostering greater private sector engagement and collaboration.

Despite a measure of receptivity among key individuals within MoHSS, obstacles persist. First, unlike the case in other African countries (Nigeria, Uganda, Ghana, and, more recently, Kenya), Namibia lacks a policy framework such that it suffers from an absence of guidance on how the public and private sectors could work together. Second, Namibia lacks a clear agenda that prioritizes opportunities for PPPs. Third, MoHSS lacks the capacity to identify, establish, and monitor PPPs that bring the most value in terms of cost-effectiveness and positive health outcomes.

Even though it has supported partnerships in general pronouncements and in occasional specific arrangements (Rosh Pinah, Oranjemund), the government, as of 2010, had not mobilized the staff support or leadership needed to create a PPP policy or forum. The regulatory regime controlling the private health sector has functioned remarkably well—better than in many developing countries—and has not come under pressure for reform. Despite occasional statements of concern about private sector providers who do not follow national AIDS treatment guidelines, the government has continued to focus on expanding ART availability through public facilities rather than through PPPs or more effective regulation of the private sector. Perhaps such a strategy is understandable given Namibia’s enviably low rate of out-of-pocket health spending and the high proportion of AIDS patients requiring and receiving ARVs. Moving toward an expansion of true partnerships may be a diversion from the government’s focus on public facilities and public services.

For the financing of health services, the split between the public and private sectors was still obvious when this assessment was published, although PSEMAS’s structure somewhat blurred the split. By 2010, Namibia was in the early stages of investigating the possibility of a national health insurance plan. Senior officials continued to point to the need for private employers to redouble their efforts to provide health care for their workers.

It is important to note that the 1998 policy framework established the public and private sectors as equals, and national policy continues to assert that the sectors shall co-exist in accordance with the government’s mixed economy policy.



Jessica Scanton

Identified Opportunities and Challenges

At the time of the assessment's publication, financial sustainability was the greatest challenge facing Namibia's nonprofit sector. As for the well-established private insurance industry, its willingness to develop low-cost health insurance options has been hindered by the gap between the cost of the most affordable health insurance plans and what households and employers are willing to pay. A previous experiment in Namibia showed that the gap may be narrowed by temporarily subsidizing health insurance premiums as employees' and employers' willingness to pay increases. However, several other issues confront the private sector's ability to fulfill its HIV/AIDS obligations:

The 1998 policy framework in Namibia established the public and private sectors as equals.

- **Lack of a formal platform for dialogue framework between the public and private sectors.** MoHSS occasionally sponsors consultation meetings to which the private sector is invited, but there is no forum—despite the several coordinating mechanisms—that permits the public and private sectors to share information and discuss roles and responsibilities.
- **Limited public sector capacity for effectively engaging the private sector.** The National Planning Commission and MoHSS have neither the staff nor capacity to engage the private sector. Capacity building is needed in the evaluation of partnerships, negotiation, legal documentation, and oversight.
- **Uncertain policy and regulatory regime supporting private sector engagement.** By and large, Namibia's policy and regulatory environment has supported the private provision of care, professional certification, and facility licensing. Moreover, the private sector regards professional councils as fair, effective, and approachable. Larger policy issues, however, such as the legal framework needed to form public-private partnerships, remain a challenge.
- **A crowded field of small CBOs of questionable impact.** Hundreds of small CBOs deliver a narrow range of services, creating a patchwork of organizations and services and generating management and financial challenges in working with the sheer number, diversity, and size of CBOs.
- **Financial sustainability.** Funding from PEPFAR and the Global Fund prompted a dramatic increase in NGOs wholly dependent on foreign and domestic donations. While the government has traditionally provided funds to mission hospitals, its funds have generally not been used to contract for the expanded prevention and treatment services provided by NGOs under PEPFAR. Moreover, the government has relatively little experience in writing and enforcing contracts for health and social services. Local funds from the private sector have been scarce, given uncertainty about the rules allowing high-income individuals and/or local businesses to deduct NGO donations from taxable income.

RECOMMENDATIONS

The assessment demonstrated that the private sector is an important part of Namibia's health system and is in fact poised to play a greater role in ensuring the sustainable provision of essential health services, such as HIV/AIDS care and treatment services, once donor funding is scaled back. Drawing on the WHO health systems strengthening framework, the assessment outlined the following recommendations for engaging the private sector:

Governance

- Foster dialogue between leaders and champions representing all sectors. Structure a short process that brings together the respective leaders in HIV/AIDS and creates a "level playing field".
- Create a policy framework for PPPs in HIV/AIDS and other key health areas. Form a group to draft a framework, vet it with all sectors, and finalize it.
- Develop an institutional strategy that will build MoHSS capacity to engage the private health sector.

Health Financing

- Support dialogue between MoHSS and private health insurers to explore the expansion of low-cost health insurance for the uninsured employed population and their dependents.
- Encourage the government to make health insurance mandatory—either through private health insurance or by covering the uninsured through the Social Security Commission.
- Support dialogue among sectors to amend taxation regulations to incentivize the purchase of health insurance.

Health Work Force

- Build the capacity of existing private providers by making donor-supported training available to private practitioners—physicians, nurses, pharmacists, social workers.
- Equip private nurses and lower-level health workers with strengthened clinical skills, access to finance, and business skills so that they can expand their role in providing HIV/AIDS services in private practices.
- Expand the supply of health workers by providing incentives that encourage workers to remain in Namibia, by making medical school more affordable, and by aligning public sector pay scales with those of other sub-Saharan African countries.

Service Delivery

- For the private for-profit sector, use a variety of strategies to incentivize private practitioners to provide HIV/AIDS services according to geographic setting. A precondition for the strategies

The assessment demonstrated that the private sector is poised to play a greater role in ensuring the sustainable provision of essential health services.

would be the formulation of a work place policy requiring all employers to provide a minimum package of health services.

- Provide continued support for FBOs and their services to ensure that services reach rural and poor population groups. Work with FBO leaders to scale up promising cost-recovery schemes and experiments already underway.
- Given that the marketplace is crowded, consolidate the number of NGOs and CBOs providing HIV/AIDS services through a certification and competitive grant process. Harness the private sector's contribution by clarifying the law on taxable donations for NGOs.

Medical Products (ARVs)

- Promote dialogue among all supply chain stakeholders to discuss strategies for reducing the cost of ARVs in the public and private sectors.
- Create a mechanism so that trained and qualified private providers can offer ARVs to clients at a reduced price.
- Encourage private insurers to procure generic ARVs—as recommended by MoHSS guidelines—thus reducing overall costs of HIV/AIDS care. Establish a transparent system to monitor and regulate the price of ARVs.

Information

- Through a consultative process, work with private provider associations, FBO/NGO groups, and medical aid funds to develop a short list of health indicators, design a simple reporting format, and establish an easy reporting system.
- Ensure that basic information reaches appropriate end users—public and private alike—thereby ensuring a two-way flow of information.

The SHOPS team also proposed areas in which USAID/Namibia could make strategic investments to maximize the private commercial sector's contributions to the HIV/AIDS response in Namibia. In particular, the SHOPS team recommends extending medical aid and health services to low-income workers in the formal sector.

Increasing private health services to lower-wage workers requires several initiatives that may be realized through four pathways, which also correspond to health systems strengthening building blocks:

- **Governance and Policy.** Improve MoHSS capacity to engage and interact with the private health sector.
- **Health Financing.** Establish and/or expand low-cost medical insurance schemes that cover basic health and HIV/AIDS services.
- **Service Delivery.** Increase the number and expand the location of private providers delivering affordable health services, including HIV/AIDS services.
- **Health Products.** Increase private providers' access to low-cost ARVs for low-income clients.

These pathways address the private sector's major barriers in meeting the health needs of lower-income workers. On the demand side, the medical schemes will help remove lower-income workers' financial barriers to accessing health care offered in the private sector. Increasing access to subsidized and/or donated ARVs will also drive down the cost of private health care, which in turn will reduce the cost of medical scheme premiums, permitting a larger number of employers and low-wage employees to purchase coverage. On the supply side, the proposed initiatives will ensure an adequate supply of private health care providers who deliver health services at an affordable price. The recommendations also include four service delivery models to organize private providers given the geographic challenges in Namibia. Finally, the proposed policy initiatives will not only create the legal and regulatory framework required to expand health insurance and services to low-wage earners but will also lay the foundation for greater public-private dialogue to support other recommendations for expansion of the private sector's role.

The key is to leverage private investment to increase efficiencies, improve access to care for underserved groups, and achieve national health goals.

CONCLUSION

In support of Namibia's national health objectives, the intent of the assessment and its recommendations was to craft a sustainable national HIV response that leverages private sector resources—both in financing and service delivery. Although Namibia has been classified as an upper-middle income country and has a vibrant private sector, such a response may require initial donor investment and, in the long run, will rely on public support. The key is to leverage private investment to increase efficiencies, improve access to care for underserved population groups, and achieve national health goals, including mitigating the HIV epidemic. The true measure of success for these efforts is not whether they are “public” or “private” but rather whether they improve access to quality health care for all Namibians in an equitable and sustainable way.

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BRIEF

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