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At Independence in 1990, Namibia inherited a fragmented health system based on racial segregation. The health systems’ financial, physical and human resources were ill-distributed geographically, by level and type of service provision resulting in a concentration of infrastructure and services in the urban areas.

This created inequalities in the access of health care services. These services were more of a curative nature and were managed by the Second Tier Authorities that were running parallel programmes.

The Government consolidated these Second Tier Authorities into the Ministry of Health and Social Services (MoHSS) thus using all available resources more efficiently. Some of the reform initiatives that took place were the:

• Adoption of the Primary Health Care (PHC) approach based on principles of accessibility, equity, affordability, involvement of communities and participation of other sectors

• Creation of Regional Management Teams (RMT) to ensure decentralisation and expansion of PHC services to the underserved communities

• Allowance for limited private practice for full time medical specialists

• Engagement with the private sector and service providers on quality health service delivery.
INVESTMENT IN HEALTH INFRASTRUCTURE

The Government made significant investments in the development of health care for Namibians. Since independence, there was greater access to health facilities in Namibia due to the increased numbers of health facilities from 246 in 1990 to 346 in 2012 as depicted in Table 1. It is to be noted that the investment was not only in the construction of new health facilities but included renovations and upgrading of old infrastructure.

**TABLE 1:**
Comparison of health facilities and number of beds: 1990 and 2012
Source: MoHSS administrative records

<table>
<thead>
<tr>
<th>Facility</th>
<th>1990</th>
<th>2012</th>
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</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>65</td>
<td>34</td>
</tr>
<tr>
<td>Health centres</td>
<td>0</td>
<td>45</td>
</tr>
<tr>
<td>Clinics</td>
<td>181</td>
<td>267</td>
</tr>
<tr>
<td>Beds</td>
<td>7102</td>
<td>6932</td>
</tr>
</tbody>
</table>

Table 1 elucidates the harmonisation and reduction of parallel programmes. With the increase in the number of health facilities in the country, the area of coverage within 20 kilometres of a health facility has more than tripled. It is estimated that 1.2 million people live within 20km of a public health facility. However, there are still challenges with equitable distribution of health services across the country as a sizeable population still leaves outside the reach of health services. Furthermore, health facilities remain under pressure to respond to the country’s growing health needs, while the human resource base continues to lag behind.
The health sector is financed largely through public resources. This is augmented with private sector and development partner inputs. Table 2 shows that the greatest contributor to health service delivery is public financing.

**TABLE 2:**
Financing of the health sector in billion N$

Source: NHA

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
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<th></th>
</tr>
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<tbody>
<tr>
<td>Public</td>
<td>1,382</td>
<td>1.643</td>
<td>1,803</td>
<td>1,871</td>
<td>1,929</td>
<td>2,016</td>
<td>2,511</td>
<td>2,662</td>
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<tr>
<td>Private companies</td>
<td>312</td>
<td>308</td>
<td>347</td>
<td>358</td>
<td>376</td>
<td>408</td>
<td>630</td>
<td>605</td>
</tr>
<tr>
<td>Households</td>
<td>406</td>
<td>533</td>
<td>653</td>
<td>735</td>
<td>1,020</td>
<td>1,132</td>
<td>621</td>
<td>605</td>
</tr>
<tr>
<td>Donors</td>
<td>83</td>
<td>82</td>
<td>87</td>
<td>318</td>
<td>676</td>
<td>1,026</td>
<td>941</td>
<td>1,073</td>
</tr>
</tbody>
</table>

To meet the greater challenges and demands made to the public health system, efforts should be made to sustain and maintain the investments made. All facilities must have the means to ensure that both the equipment and infrastructure are in good working condition and there is adequate staff to provide quality health services. For instance, the provision of medicines should be in line with the health needs of the people.
PARTNER INVESTMENT IN HEALTH

The health sector has benefitted significantly from donor support. In 1990, the percentage allocation of donor support stood at 3% but by 2011 this increased significantly to 19.7%. External resources were targeted towards infrastructure development, health systems planning and management. Today, development partners provide support to reproductive health interventions which will contribute to the improvement of quality and access of services to especially women and children thereby reducing maternal and child mortality. Other programmes considered for support include adolescent friendly health services, Integrated Management of Childhood illnesses, broader health system support and interventions on TB, Malaria and HIV/AIDS.

With the reclassification of the country to middle income status, Namibia has started to see donor funding decrease. The reduction in donor support is expected to impact both the funding levels and technical capacity to deliver quality health services.

Non-government organisations (NGOs) notably, churches and missionaries provided health services to local communities, prior to independence. Thus, Government decided not to build health facilities where missionaries had already built them, but rather supported these services through 100% subsidization of capital costs, partial reimbursement of operational costs (salaries and pharmaceuticals), and human resource development.

CHALLENGES IN THE HEALTH SECTOR

In addition to its mandate of providing quality social services to all Namibians, especially to the weak and vulnerable members of society, the MoHSS’ other key responsibilities include overseeing, and regulating the private and NGO health sectors. The MoHSS ensures equity, accessibility, affordability and sustainability of this sector.

Over the years, the MoHSS has made great strides in carrying out this mandate and significant progress was made as seen in the health indicators. But while great gains were noticed in key health indicators, the demographic and health survey showed a reversal in some of the key indicators in 2006. The MoHSS, therefore, wishes to use all available resources to arrest the declining health indicators and sustain the improved ones. This will require investment in infrastructure, specialised human resources and advanced medical technologies.
Infectious diseases still remain a major contributor to the burden of diseases, especially HIV/AIDS, Tuberculosis (TB) and Malaria; and health problems related to maternal and child health. In addition, non-communicable diseases are on the rise. The MoHSS also confronts several health system challenges, key among them is the shortage of health staff. The 2008 Health and Social Services System Review Report shows that the public sector has 2.0 health workers per 1,000 population.

This is below the World Health Organisation (WHO) benchmark of 2.5 per 1,000 population, resulting in chronic staff shortages amongst frontline workers (doctors and nurses).

The staffing structure is not adequate in terms of the right mix of skills to cater for a dynamic health services provision. It lacks skills in areas like e-health, data-base management, patient record management, data analysis, research, hospital and human resource management, logistics, finance and medical technology.

The human resource shortage is further exacerbated by the lengthy process of recruitment, resignations, and poor work ethics and attitudes of health workers towards service delivery.

OTHER CHALLENGES FACING THE MOHSS & AFFECTING SERVICE DELIVERY INCLUDE

• **Infrastructure:** The public sector cannot adequately respond to the needs for certain specialised services due to new and advanced technologies that are not available within the public sector. Thus it was forced in some cases to send patients to neighbouring countries for treatment.

• **Routine and systematic maintenance:** The lack of it has led to a general degradation and reduction in the life of the current infrastructure, negatively impacting both on the quality of health care services and long term sustainability and value of the assets. Furthermore, there are serious challenges related to the functions and competencies of different authorities within the Government, for example moveable and immovable
properties of the government are owned by the Ministry of Works and Transport, who until recently were also responsible for the maintenance of such properties. Line have now been assigned to take over this responsibility.

- **Replacement of medical equipment**: The country has developed a big backlog during the past 10 years, when health care resources were allocated to urgent service delivery and staffing needs. The MoHSS failed to cover its operational or development budget.

- **Minor and major equipment**: While some equipment was appropriately used, there were exceptional instances where some major equipment was not used at all mainly due to staff shortages. Some had not even been installed mainly due to failure of a needs assessment while some were under utilised for the same reasons. Endemic problems were a high staff turnover, failures in training delivery, incorrect use of equipment, high-tech used for low-tech and vice versa.

- **Ambulance services**: There is no coordinated system to manage or regulate the use of these services. Additionally, there are few ambulance drivers with basic pre-hospital care services.

- **Service delivery**: The National Health Policy Framework 2012—2020 recognises overcrowding and congestion at public facilities as one of the service delivery challenges.

- **Donor-funding**: This is a challenge and an opportunity. It provides opportunities for improved efficiencies in resource allocation and for innovative funding mechanisms including leveraging private sector investments.

- **Accommodation**: The unavailability of accommodation especially in rural areas and settlements has failed to attract experienced health professional to such areas.
2. CURRENT STATUS OF PPP IN THE HEALTH SECTOR

The private sector plays an important role in providing health care services. There are currently 844 private health care entities in the country. They include 13 hospitals, 75 primary health care clinics, eight health centres and 75 pharmacies. They are manned by 557 medical practitioners who include dentists, psychologists, and physiotherapists. Private health care services are mostly concentrated in the urban areas in the Oshana, Kavango, Erongo and Khomas regions.

It is important to note that private businesses and companies are seen as an integral part of the fight against the HIV/AIDS pandemic and therefore crucial for leveraging national resources for a sustainable response in Namibia. The business community is currently active in workplace programmes, private health insurance and other public private partnerships. There are a number of private health care providers offering various HIV and AIDS services including male circumcision, a procedure now covered by private medical aid policies. This role is recognised and expected to expand.

APPLICATION OF SCIENCE AND TECHNOLOGY

Infectious diseases still remain a major contributor to the burden of diseases, especially HIV/AIDS, Tuberculosis (TB) and Malaria; and health problems related to maternal and child health. In addition, non-communicable diseases are on the rise. The MoHSS also confronts several health system challenges, key among them is the shortage of health staff. The 2008 Health and Social Services System Review Report shows that the public sector has 2.0 health workers per 1,000 population.
PATIENT SERVICES

District level: The Hospitals and Health Facilities Act, Act 36 of 1994 provides for the classification of state hospitals and other facilities. Under this classification a Class F facility is identified as a mobile outreach service point or community health post. The service range is the regular promotion of preventative services and intermittent general nursing care. Due to staff and fleet shortages, the MoHSS’ Otjozondjupa, Khomas and Omaheke regional health directorates, have entered into an agreement with pharmacies to provide mobile outreach services. Mobile clinics often go to rural areas and provide PHC services on routes that were previously serviced by the MoHSS. The MoHSS provides medicines while the private sector provides the clinics and pays for running costs and staff who run these clinics.

Clinics are classified as Class E. They provide promotive and preventative services such as general nursing and midwifery, and intermittent family medical care. Clinics’ referrals are sent to health centres or district hospitals. The MoHSS runs clinics in Oranjemund and Rosh Pinah but because of the locality and security matters at Oranjemund, the MoHSS has entered into an agreement with Namdeb to allow the two clinics to refer public patients to the Namdeb private hospital while the MoHSS pays for their care.

At Rosh Pinah, the state clinic did not have suitable accommodation for health professionals and therefore could not provide midwifery services. All maternal cases were referred to the Lüderitz Hospital which is 290 km away. The clinic was therefore upgraded on a 50/50 basis with the Skorpion Zinc Mine to provide the appropriate services.

The Lutheran, Anglican and Catholic churches provide health services at five hospitals, eight health centres and 21 clinics. The amenities are part of the public health facilities and are classified as per Schedule of the Hospitals and Health Facilities Act, Act 36 of 1994 under Classification of State Hospitals and State Facilities. The MoHSS and the Church Health Services entered into a partnership agreement on health service delivery. But, there are shortcomings in the implementation of the agreement with respect to performance and audited financial reports.

District hospitals are classified as Class C and their service range includes general family medical care, nursing and midwifery care, and promotive, preventative, rehabilitative and limited social care. The scope of practise is limited to the 29 district hospitals as they cannot provide specialised services. They rely on outreach services from the intermediate and national referral hospitals. Sometimes district hospitals make use of the referral system to book patients for specialist services at intermediate and national referral hospitals.
Therefore, the scope of practice at district hospitals is limited and does not allow for orthopaedic surgeons, neurologists, paediatricians, physiotherapists and radiologists to practise. The situation is further compounded by the appointment of specialists to some district hospitals who end up working as general practitioners as the Act does not authorise them to provide specialist services. In such cases the specialist services are provided by the private sector.

Regarding the sterilisation of equipment, informal arrangements are in place between public and private hospitals to sterilise equipment from public health facilities when their autoclaves are non–functional or are being maintained. The same principle is applicable when certain medicines are out of stock.

**REFERRAL HOSPITALS**

Referral hospitals are classified into three groups:

- **Class A**: Windhoek Central Hospital – The services offered here are advanced and highly sophisticated and include specialised nursing and midwifery care, promotive, preventative and rehabilitative and social care.

- **Class B1**: Rundu, Katutura and Oshakati hospitals. Under this classification health services offered are essential and advanced specialist services, including a wide range of sub-specialisations such as nursing and midwifery care, promotive, preventative and rehabilitative and social care.

- **Class B2**: Onandjokwe Hospital - The services offered at this hospital are selected essential specialist services, restricted to mainly general nursing and midwifery care, promotive, preventative and rehabilitative, and social care.

As an intermediate hospital, Oshakati Hospital should offer specialised services in computerized tomography (CT) that enhances diagnostic capability for head injuries and
intracranial pathology among others. But, due to a lack of appropriate infrastructure patients from this hospital were in the past referred to Windhoek Central Hospital. With the establishment of the Ongwediva Medi Park, these services are now obtainable at this hospital because it has the appropriate infrastructure and human resources. An agreement was signed between the MoHSS and Medi Park for Medi Park to provide such services in the region. This has led to a reduction of referral cases to Windhoek and has increased efficiency on patient diagnosis and treatment.

Tuberculosis is an infectious disease and warrants strict infection control and hygiene measures. Katutura Hospital as a Class B1 hospital has a TB Unit which not only caters for the Khomas district and region, but the entire country, especially for difficult to treat TB patients. The patients come from other Class B1 hospitals. About 50% of bed occupants at this unit are multi-drug TB resistant patients or extreme-drug resistant TB cases. Supporting this Unit’s feasibility and documentation studies of the TB on a 50/50 basis with the Ministry is Skorpion Zinc Mine.

Windhoek Central Hospital as a Class 1 hospital also provides other highly sophisticated medical services such as medical imaging (MRI), dialysis, neurology surgery, Endoscopic Retrograde Cholangiopancreatogram (ERCP) and cardiac services. Some of these services are sought from the private sector within the country because of the unavailability of equipment, lack of maintenance in certain cases and the absence of a cardiothoracic doctor. But, there remains a backlog in paediatric cardiology and with many young patients still being referred to Cape Town, South Africa for treatment. No formal agreement exists between the MoHSS and the private sector for these services, therefore, the MoHSS is being billed for all the procedures including all medical supplies used on the patients. Furthermore, dialysis services are provided at the Windhoek Medi Clinic for acute renal failure for patients 50 years and below who are HIV negative.

Referral hospitals such as Rundu, Oshakati, Katutura and Windhoek Central do not have dedicated district hospitals for the fast expanding urban areas. It is almost impossible to provide quality health services at these hospital and hence the endemic long waiting lists and inequitable distribution of health services.
ANCILLARY HEALTH SERVICES

Catering: The MoHSS has been outsourcing catering services on a two-year-basis since independence. The catering agreements entail contracting Government kitchen staff to the successful tenderer at each hospital. As per contract, the kitchen staff report to and resort under the tenderer’s management while being fully remunerated by the Ministry. The fully equipped kitchen and storage facilities are yielded to the successful tenderer to help them provide quality catering services, at no cost to them. In addition the Ministry provides energy and water at own costs. This has led to numerous challenges such as;

• Poor management of staff in the kitchen as they are considered Government employees
• A lack of functional equipment at the Ministry’s kitchens as they are supposed to be maintained and refurbished by MoHSS and not by the tenderer
• Lack of funds to replace aging and obsolete kitchen equipment

The situation has resulted in inefficient service delivery to patients. The delineation of responsibilities in particular to the staff allocated to the hospital kitchen further exacerbates the problem.

Security: The MoHSS has equally been outsourcing its security services for all health facilities, on a two-year-basis, since independence. This is done through the Tender Board and entails two parties signing a contractual performance agreement binding them to meet specific set standards. Despite this being the case the set standards agreed upon are not beneficial to the MoHSS in respect of securing property. Furthermore, there is a need to delineate responsibilities between Government security services for protection of VIPs in health facilities and private security guards.

Maintenance: The MoHSS has annual maintenance contracts with suppliers of high tech medical equipment such as Genmed, Erongo Agencies, Bio Dynamics and Nam X-Ray. The service contract specifies the unit prices for all equipment, although the price does not distinguish whether this relates to service, maintenance or repairs, but includes all spare parts. There are additional hourly rates, travel time and costs for technicians. Challenges are experienced with the frequency of drawing tenders for a sole supplier such as the one maintaining the Cobalt-60 machine for cancer patients.
Commercialisation of laboratory services: The National Institute of Pathology was established through Act 15 of 1999 as a public limited liability company. It started its operations in December 2000, with the sole objective to take over the medical laboratory services from the MoHSS. Its mandate includes operating medical laboratories and providing laboratory services to the private and public sector on a commercial basis. Before commercialisation there were 17 medical laboratories operating throughout the country although many could not perform some tests because of lack of equipment. Today, laboratory services are available at all public hospitals classified as District/PHC laboratories, regional, area and central laboratories. These laboratories provide a full range of tests in clinical chemistry and haematology. Although the establishment of laboratories and provision of services has improved, the Ministry is concerned with the rising costs of services rendered. There is therefore, a need for continuous assessment of the performance contract entered into between NIP and Government.

All these examples of partnerships demonstrate possibilities to improve access to service delivery to the public.

VALUE FOR MONEY

In the past, the MoHSS has tried to explore and fully use PPP opportunities to strengthen health care services in the country. The desired outcome is number three of the Namibia Development Plan (NDP4) which states that by 2017, Namibians should have access to quality health systems in terms of prevention, cure and rehabilitation.

Access to quality health care for all Namibians, therefore, remains a priority for the Government as evidenced by the large budget funding that the MoHSS gets and the 2012 Presidential Commission of Enquiry instituted in the public health sector. However, the declining donor funding will impact on the MoHSS’ technical ability to deliver quality health services due to the country’s sparse population, dilapidating infrastructure, lack of qualified health staff and the high disease burden on both communicable and non-communicable diseases.

In 2008, Government viewed private sector participation, especially public private partnership, as critical to addressing existing infrastructure and service needs. Hence, in 2009, Government, with the assistance of the International Monetary Fund (IMF), started its work on the PPP Policy. In 2010, further work was commissioned by the Ministry of Trade and Industry to review the legal and institutional framework. The MoHSS wishes to acknowledge the current ongoing work on the PPP Policy and it is on that basis that the Ministry built its submission of PPP in the health sector.
3. MOHSS’ PROPOSAL TO PARTNER WITH THE PRIVATE SECTOR

3.1 Purpose and rationale for PPPs in health
Over the past decade, use of PPPs as a strategy to achieve global health objectives has gained widespread acceptance. There is broad recognition that the private health sector can expand its contribution to improve health systems and health outcomes in the developing world. The MoHSS’ goal is to strengthen the overall health system by integrating the private sector to attain national health goals. Namibia has a well developed private sector which could be harnessed by Government to complement the state medical services in terms of facilities, skills, technology and finance. This would help Government fulfil its constitutional obligation of providing universal access to health care services to all, especially the poor and vulnerable members of the society.

From the PPP, there are opportunities to increase revenue for Government as follows:

1. Private wards that could admit both private and public patients for treatment and share revenue;
2. Introducing a catering system in which the caterer has to pay a leasing fee for use of State facilities. This will mean that Government will not make the required capital investment. Furthermore, PPP will strengthen Government oversight of the health sector with better enforcement of regulations and the revision of fees on pharmaceuticals, inspection and registration that have not been market related for a long time. Other reasons for the MoHSS partnering with the private sector include:

   • Delivery of high-quality services and products by the building sector;
   • Increased distribution of skilled health personnel to deliver needed services particularly to the underserved groups;
   • Mobilisation of health resources in a manner that would increase access, improve risk protection and incentivize providers appropriately;
• Improved generation, dissemination and use of health information that reflects all stakeholders in the health sector;
• Enhancement of Government’s ability to ensure the availability of high-quality medical products, vaccines, and technologies;
• Enhancement of Government’s ability to maintain infrastructure and provide accommodation for health personnel in the rural areas and settlements;
• Strengthening of Government oversight of the health sector, especially through better enforcement of regulations;
• Harnessing of private sector efficiencies in asset creation, maintenance and service delivery;
• Creating opportunities to bring in innovation and technological improvements; and
• Limiting unsolicited proposals from both international and local private sector entities whose PPP ideas are not in alignment with the MoHSS objectives.

3.2 Methodology to establish national priorities and partnership opportunities
Examples from other African countries show that ministries of health are often besieged by unsolicited proposals from both international and local private sector entities and hence Namibia is not immune to this bombardment. What this means is that the MoHSS ought to set standards and put guidelines in place that will support the MoHSS in engaging with the private sector.

3.3 The framework proposed for implementing the PPP for the health sector is as follows:

3.3.1 Public Private Dialogue: The exchange of information between the public and private sectors is encouraged. This may be as basic as the public sector reaching out to the private sector to ensure that they have received Government policies and regulations and understand them. Conversely, the private health sector health providers should share their data on case detection and treatment with the public sector.

3.3.2 Public Private Interaction: In this partnership, the public and private sectors are encouraged to cooperate and negotiate around issues of mutual interest especially Government policies and regulations that impact on the private sector. The interaction does not require a formal agreement or a shared investment, but emphasises the need for both sectors to work together to ensure that policy is formulated effectively to have the best possible outcome for the health sector.
3.3.3 **Public Private Partnership**: The setting up of a formal agreement between the public and private sector partners, with clearly defined respective roles and responsibilities around the joint implementation of an activity designed to address a weakness in the health system. The agreements which are of importance to the sector are service and management, build—own-lease-transfer, build-operate-transfer and build-own-operate-transfer contracts.

This framework is derived from the PPP models commonly found in the health sector as illustrated in Figure 1. The challenge is for the ministries of health and PPP Units to expand their PPP experience in contracts and in leasing/concession agreements.

**FIGURE 1**: Types of PPP Models Commonly Found in the Health Sector
Resource sharing: The MoHSS offers the private sector access to donated and/or affordable pricing for key inputs (e.g. commodities, staffing)

Memorandum of Understanding (MOU) and contracts: MOUs are agreements between ministries of health and the private sector to share staff, equipment, facilities in exchange for a service to target a certain population group. Contracts are used to engage private operators to deliver services and/or manage facilities for an agreed upon fee.

Concessions/Co-locations/Leases: The private sector invests its own capital to rehabilitate facilities and manages service in a public facility in exchange for revenue for fixed time periods after which management reverts to the ministry of health. Under a lease, the MoHSS would make a specified lease fee payment at a subsidized rate to the private sector owner for use of the facility and/or equipment.

Build-Operate-Transfer (BOT): The private sector constructs a public asset by financing the capital cost during construction, in some cases the private sector would operate such an asset, and eventually transfer the asset to the Ministry.

INSTITUTIONAL ARRANGEMENTS SUPPORTING HEALTH PUBLIC PRIVATE PARTNERSHIPS

Under the revision of the staff establishment of the MoHSS which was last updated in 2003, it is proposed to create a PPP sub-division under the Directorate: Policy Planning and Human Resource Development. Like other PPP units in the SADC region, the core purpose of the PPP Unit in Namibia will be to:

- Establish priorities and identifying PPP projects
- Encourage competition
- Ensure due diligence
- Facilitate transparent bidding processes
- Ensure the most effective use of Government resources

In addition, the MoHSS will establish a Management Committee which will support the activities of the PPP Unit. The Committee will review PPP proposals and support the implementation and monitoring of the activities and serve as a review board for proposals above a certain threshold level. During the development of TORs for the PPP Unit, a threshold for proposals that can be handled internally by the unit will be determined.
The Draft National PPP Policy recommends that a PPP Committee be established to direct PPP activities under the chairmanship of the Permanent Secretary of the Ministry of Finance (MoF). In the absence of this committee, the Ministry proposes that a Management Committee, mainly comprising MoHSS officials and other relevant Government ministries and agencies (MoF, MTI, MWT, NPC and AG) and private sector specialists not involved in the proposals, be sought.

Successful engagement with the private sector will depend on the presence of an enabling policy and legal framework. The MoHSS will, through the Management Committee, develop terms of reference for engaging with the private sector. Furthermore, there is need to work with the MoF and Attorney General’s office to clarify the existing procurement and disposition laws that govern the purchase and procurement of goods and services so that the processes are in line with Tender Board Act, Act 16 of 1996.

The duration of the PPP will depend on the type of PPP agreed to. Physical infrastructure PPPs require more time but this should be limited to a maximum of 15 years on machinery and a maximum of five years or less on plants. Recent evidence indicates that PPPs for service delivery should not only be for shorter timeframes but also afford a wide flexibility in the TORs to allow for both parties to adapt the terms as the partnerships are implemented.

POSSIBLE PARTNERSHIP OPPORTUNITIES

Whereas the identification of gaps in the health sector is usually a consultative process with all stakeholders, the MoHSS has through the Health and Social Services review, identified some critical areas that will be priority areas for PPP. When considering the mentioned possibilities, due regard should be given to the maximum protection of Government interests, policies and laws. In addition affordability, access to health services, creation of new employment opportunities, sustenance of existing jobs, transfer of skills and knowledge, technology adaptation, protection of the vulnerable, value addition, and the overall development and improvement of the health sector, all play a major role. The areas include, but are not limited to:

3.4 Patient services
(a) Specialised services: Many Namibians specialists are in the private sector offering cardiology, dentistry, oncology, ophthalmology and dialysis services among others. There are different types of partnership arrangements to leverage private sector infrastructure, capacity and expertise. They include:
i. Contracting specialists at regional and national levels to receive public patients and be reimbursed at reduced rates; 
ii. Leasing space in public facilities, e.g. operating theatres and sharing the profits; and 
iii. Retaining qualified private health personnel to train and consult with MoHSS staff in speciality areas to build Government capacity.

(b) **Specialised equipment:** The private health sector owns and manages a significant percentage of specialised equipment, such as X-rays, radiographs, and dialysis machines. Potential PPP mechanisms could include:

i. Private individuals investing their own funds to buy and operate equipment in their own private practices. They would then also receive public referrals at reduced prices; and 
ii. Co-location of diagnostic equipment and services and other specialised health services in public facilities in exchange for revenue sharing.

(c) **Private wards:** Many MoHSS wards are underutilised due to the deteriorating facilities, lack of equipment or insufficient personnel. The Ministry can maximise use of these state wards through different partnership mechanisms. Suggestions are as follows:

i. Renovate and provide amenities to allow people with medical aid to use public health facilities that are distributed across the country at a fee; 
ii. Renovate wards to allow PSEMAs and MVA clients to be admitted to public hospitals as they can help curtail increasing costs at private health institutions. The existence and use of private wards will increase Government revenue.

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**ANCILLARY SERVICES**

(a) **Incentives to attract and retain health staff in remote or rural areas:** The public health sector faces chronic staff shortages particularly in rural areas, among its frontline workers who include doctors and nurses. The situation is further compounded by the high attrition rates. The Health Systems Review Report shows an average annual attrition rate of 5%. One of the challenges associated with retention of staff especially in rural areas is the lack of adequate accommodation. Many of the health facilities in the rural areas and non proclaimed towns lack private investments, Government houses and
sufficient financial resources to build clinics and accommodation facilities. Partnerships can, therefore, be developed between the Government and private sector to construct health villages. Government would provide guarantee for lease of accommodation. Another possible strategy is to contract and or retain private providers to deliver services for a specific unserviced area. The MoHSS would guarantee the facility and other needed inputs to fully operationalise the services.

(b) **Catering services:** For Government to deal with the challenges outlined earlier, it is proposed that a full PPP concept, which allows for the refurbishment of the current kitchen facilities, replacement and repair of obsolete and non-functional equipment by the contractor at own cost, be introduced. The arrangement would allow the infrastructure to remain the property of the MoHSS. The existing system does not guarantee adherence to the quality and standards of food delivered to patients because both the catering equipment and the facilities belong to Government and are managed by it. Procurement of catering equipment and the process of replacement and maintenance is also cumbersome. The current conditions of service are not attractive enough to retain qualified dieticians and food specialists.

(c) **Laundry and dry cleaning services:** The MoHSS runs an in-house laundry service from its hospitals and health centres. The Ministry is faced with the frequent breakdowns of its machinery which do not work optimally due to age and the lack of investment. The breakdowns have led to increased transportation of linen to other hospitals and or private laundries for cleaning. This has resulted in the unavailability of linen at critical times, thus negatively impacting on quality health service delivery. Furthermore, laundry operations have contributed to a higher utility bill, for instance, water, electricity and diesel for the boiler house, a situation that can be remedied with private investment.

(d) **Maintenance and minor renovations:** In terms of maintenance, there are serious challenges related to the functions and competencies of different authorities within the government. For example Government moveable and immovable properties are owned by the Ministry of Works and Transport, who also, until recently were responsible for their maintenance. Maintenance has now been assigned to line ministries. However, challenges
remain when it comes to the appointment of consultants as this still lies with the Ministry of Works and Transport, limiting the Ministry’s chances to act timely. This arrangement has contributed to the dilapidation of structures. There is therefore, a need for partnerships with private sector for the maintenance of health equipment and buildings.

(e) Fleet services: The Ministerial Master Vehicle List reflects that the Ministry had a fleet of 1,777 vehicles as of March 2012. Of this figure, 1,229 are running, representing a fleet availability at 69%. Of the vehicles on the Master List, 118 are ambulances. The fleet availability at 69% hampers services in reaching the under-serviced rural areas and the transportation to and from referral clinics, health centres, district and referral hospitals. Fleet availability further serves as a proxy for vehicle fleet management. Vehicles have to undergo fitness and roadworthiness tests, and have licences renewed and are sometimes written off after an accident. The administration of fleet is further exacerbated by the centralisation of the issuing of roadworthiness certificates and licences in Windhoek.

(f) Incinerators: The MoHSS currently operates incinerators in all its facilities. The incinerators are used by private entities to incinerate medical waste at a fee that is not market related. The rapid growth in volumes of medical waste delivered for destruction at the facilities means that incinerators are overused and this may lead to incorrect operations resulting in the release of pollutants in the atmosphere.

The MoHSS should outsource specific services through performance-based contracts for a defined period at negotiated affordable prices.
4. THE WAY FORWARD

The MoHSS has identified priority areas that need urgent attention in improving health service delivery. These areas need immediate implementation.

However, to ensure that only priority proposals are considered, the MoHSS will work towards reaching a consensus with both the Ministry leadership and the private sector stakeholders on the public health goals that can help plug health system gaps. This will be the focus of the health PPPs.