The Health System in Namibia
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Deliberations about an affordable national health insurance for the low-income workforce in Namibia

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1. Introduction

This analysis focuses on the structure of the Namibian health system and availability of affordable health insurances for low-income workers such as informal operators and their employees. Most of the products provided by private medical aid funds are too expensive for the majority of the population, especially for low-income workers in the formal/ informal economy.[1]

In Namibia, there has been a discussion about the implementation of a National Medical Benefit Fund (NMBF) which is part of the 1994 Social Security Act of Namibia. One main aim of the NMBF is to cover both the low-income workers as well as the unemployed people by a national health insurance.[2] This analysis focuses on two questions: How can a national health insurance in general, and for the informal economy in particular, be established? What characteristics should be implemented? To find an answer to these questions this analysis is structured as follows:

Section 2 describes the characteristics of the Namibian health system including the public health sector which is facing a lot of challenges such as the lack of quality in health services. It also addresses the affordability issue of private medical aid products which are too expensive for the (very) low-income workforce in Namibia. This raises the question of whether the government will design a NMBF which is affordable to everybody in the country, including the informal sector workers.

Section 3 presents the definition of the informal economy in Namibia as well as the 2011 established Namibian Informal Sector Organisation (NISO). It also includes the current challenges for informal operators and workers in Namibia, including the lack of access to social security such as medical aid. Furthermore, this chapter describes the some selected benefits of the current social security system.

Section 4 is dedicated to the current challenges of uninsured workers and the deliberations about the characteristics, potential target audience and funding of a NMBF which covers all formal and informal workers as well as unemployed people. The Social Security Commission (SSC) is currently researching, thus the NMBF is not implemented yet.

Section 5 addresses the potential challenges during the implementation of a NMBF. It illustrates some suggestions for improvement including a proposal which points out what characteristics might be part of a new NMBF. As with the other chapters which point out possible elements of a new NMBF, this section is based on interviews with the Namibian Employers' Federation (NEF), Ministry of Health and Social Services (MoHSS), Ministry of Labour and Social Welfare (MoL), Namibian

1 cf. Rinke de Wit, Tobias/ van de Gaag, Jacques: The Okambilimbili Health Insurance Project in Namibia: Lessons Learned. PharmAccess International. Booklet. p. 26.

2 cf. Interview Ngaujake, Uahatjiri – Manager of Research and Development at Social Security Commission 2012: 02:38-09:41 Min.

Informal Sector Organisation (NISO), Legal Assistance Centre (LAC), Social Security Commission (SSC), labour consultant Herbert Jauch as well as journalist David Lush. The Okambilimbili Project, which is also part of this section, can serve as a positive example in respect of cooperation with private medical aid funds to provide low-cost health insurance. Section 6 summarizes this paper and stresses the essential points.

2. Health system in Namibia

At independence, the health system in Namibia was very fragmented and based on racial segregation and a concentration of infrastructure in urban areas such as Windhoek. Since independence, a number of reforms have taken place. The country has about 265 clinics, 44 health centres, 1,150 outreach points, 30 district hospitals, three intermediate hospitals and one national referral hospital as well as various social welfare service points. There are 13 MoHSS regional directorates and 34 districts. The main challenges are HIV/AIDS, tuberculosis, malaria as well as the increasing number of child and mother mortality.[3] Given that it has been the leading cause of death in Namibia since 1996, one of the largest burdens for Namibian health care is the treatment and prevention of HIV/AIDS. According to that there has been many efforts to fight the prevalence of HIV/AIDS such as making free anti-retroviral treatment (ART) and drugs available as well as the preventing mother-to-child transmission programme (PMTCT).[4] Because of the gaps in access to health care facilities between rural and urban areas, between white and black as well as between the rich and the poor population, the Namibian health system is very unequal. The total expenditure on health care is about 7% of Gross Domestic Product (GDP).[5] The health system is the most challenging policy area in Namibia because the country's people are scattered all over the place and the MoHSS has problems reaching the workers in the remotest areas to provide health services.[6]

There are two pillars in the Namibian health system: The private health sector and public health services. The government of Namibia is responsible for the public health service, while the private health sector is driven by private medical aid funds (see Table 1). It is important to mention that Namibia does *not* have a national health insurance scheme.[7]

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3 cf. World Health Organisation 2010: Namibia Country Cooperation Strategy. Online: www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=6579.

4 cf. Rinke de Wit, Tobias/ van de Gaag, Jacques: p. 25.

5 cf. Ibid. p. 24.

6 cf. Interview Katjiuongua, Batseba – Director of Social Welfare Services in the Ministry of Health and Social Services 2012: 00:56-01:48 Min.

7 cf. cf. Rinke de Wit, Tobias/ van de Gaag, Jacques: p. 24.

About 1.5 million (uninsured) Namibians, which account for 85% of the total population, rely on primary health care of the public health sector. It includes cheap, quick and easy medical treatment. But the health conditions in the public hospitals in Rundu, Oshakati and Windhoek are more professional. The public health services generally charge flat user fees depending on the level of the facility. Due to the highly subsidized flat user fees, medicine is generally affordable. But the public health sector is highly understaffed because in 2003, there was an average of 947 patients per registered nurse and over 7.000 patients per registered doctor.[8] Especially the mother mortality is another evidence for the lack of quality in the Namibian health system. In 2010 over 80 mothers and in 2011, 62 mothers died in state health facilities. Even the Minister of Health and Social Services, Richard Kamwi, "admitted that there is a lot wrong at the country's State medical facilities"[9]. He also admitted that the health supervision is lacking and called on the staff to take charge. He criticized the hygiene at certain state facilities and has therefore decided to organise a national health conference this year to solve the overwhelming problems of the public health system.[10] The MoHSS is saying, everybody in the country can have access to public health care, even if they are not able to pay, but those who are able to pay should pay for health services.[11]

The private health sector is well-organized compared to other African countries. Because of the colonial history, Namibia's health insurance industry is very similar to that in the bordering country South Africa. The private health industry is primarily driven by non-profit medical aid funds (which are administered financially by for-profit administrators) that "pay benefits directly to medical providers in proportion to the services rendered to the beneficiary"[12]. There are ten medical aid funds, including Public Service Employee Medical Aid Scheme (PSEMAS), six closed funds and four open funds. The closed funds limit membership to employees in a particular industry or company such as NAMDEB Medical Scheme or NAPOTEL Medical Aid Fund. Other closed funds are Bankmed Medical Aid Scheme, Roads Contractor Company Medical Aid Fund and Woermann & Brock Medical Aid Fund.[13] The largest closed fund is the government's fund called Public Sector Employees Medical Aid Scheme (PSEMAS) for civil servants. PSEMAS is financed by a monthly fee on each joining civil

8 cf. Ibid. p. 25.

9 Kisting, Denver 2012: Kamwi calls for calm over deaths. The Namibian 31.05.2012. p. 1.

10 cf. ibid.

11 cf. Katjiuongua, Batseba 2012: 02:47-03:03 Min.

12 Rinke de Wit, Tobias/ van de Gaag, Jacques: p. 26.

13 cf. Namibian Association of Medical Aid Funds (NAMAF): Registered Funds. Online: http://www.namaf.org.na/funds/.

servant and taxpayer's money provided by the Ministry of Finance, thus it operates differently from the other medical aid funds.[14]

Membership in an open medical fund is "optional, with employers usually providing some subsidy for premiums, a fringe benefit that is subject to individual income tax"[15]. The open medical aid funds are Namibia Medical Care (NMC), Nammed Medical Aid Fund, Namibia Health Plan (NHP) and Renaissance Health Medical Aid Fund.[16] The open funds "sell medical aid policies to any company that wishes to provide medical aid cover to its employees"[17] and every individual, but contributions for individuals are usually higher. Every medical aid fund is a separate organisation with its own board of trustees. The for-profit administrators which run each medical fund are Medscheme, Prosperity Health, Paramount Health and Methealth.[18]

Most of the offered products of the private medical aid funds are too expensive for the majority of the population, especially for low-income workers in the formal/informal economy. The employee share of premiums for such schemes has been too high for products including coverage for both inpatient and outpatient services.[19] In 2006, only about 316,000 Namibian people (18.6% of the total population) were covered by medical aid funds, thus over 1.7 million Namibians didn't have any health insurance. With respect to the total workforce in Namibia (530,000), over 200,000 employed Namibians were uncovered.[20] Thus, even a large number of *formal* workers didn't have access to medical aid benefits because there are no low cost products available on the market. In 2004, there was an average of 535 patients per registered nurse and 810 patients per registered doctor in the private sector. 24% of total health expenditure in the country was covered by medical aid funds, covering only a minority of the population (15% – mostly formal sector employees with a middle or high level income).[21]

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14 cf. Lush, David 2006: Passport to health?. Medical aid and the uninsured. Insight, special publication. p. 7.

15 Rinke de Wit, Tobias/ van de Gaag, Jacques: p. 26.

16 cf. ibid. and Namibian Association of Medical Aid Funds (NAMAF): Registered Funds. Online: http://www.namaf.org.na/funds/.

17 Lush, David 2006: p. 7.

18 cf. ibid.

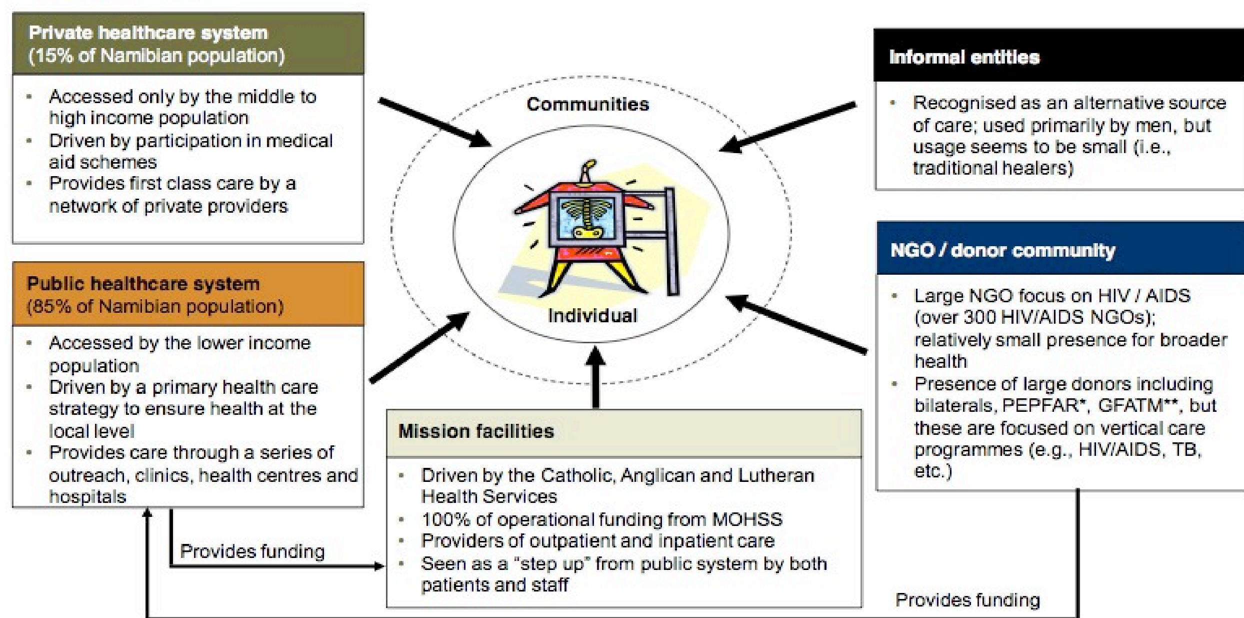
19 cf. Rinke de Wit, Tobias/ van de Gaag, Jacques: p. 26.

20 cf. Mbapaha, Gabriel 2011: Presentation - Facts & Figures pertaining to the Medical Aid Funds within the Healthcare Industry. Online: http://www.namaf.org.na/trusteetraining2011.html.

21 cf. Rinke de Wit, Tobias/ van de Gaag, Jacques: p. 26.

The "main reason many individuals lack health insurance in Namibia appears related to the inability to pay for health insurance premiums"[22]. Health insurance is available, but even with the cheapest product of medical aid funds, a low-income worker would still pay 15% of her/his monthly income and an unskilled worker would still pay 19-22% of her/his income for family coverage. It would therefore be advisable for the government to establish an affordable national health insurance such as the National Medical Benefit Fund (NMBF) which is part of the 1994 Social Security Act of Namibia. This health insurance could cover all Namibian citizens, including informal sector workers as well as unemployed people. The implementation of an affordable NMBF for all will be discussed in the following chapters.

Table 1



Source: Presentation - African Public Health Leadership Initiative. Health System Assessment: Maternal Health. p. 3. Online: www.africanhealthleadership.org/

22 Ibid. p. 29.

3. Informal sector in Namibia – definition and challenges

3.1 Definition

In Namibia, the informal economy is an ever-present challenge for the domestic economy. According to a study by the Labour Resource and Research Institute (LaRRI) in 2006, the total number of informal operators and workers stands at about 133,000.[23] The Secretary General of the Namibian Informal Sector Organisation, Veripi Kandenge, considers that currently more than 150,000 workers earn their money in the informal economy of Namibia.[24] More than half of the informal sector workers are women. Almost 50% of the informal economy operators work in the "wholesale and retail sector, in manufacturing of food products, in the beverages industry (18.9%) and agriculture (11%)"[25]. Compared to other Sub-Saharan countries such as Ghana, where the informal economy constitutes about 90% of the country's labour force, the informal economy in Namibia is relatively small. In 1971, when the term 'informal economy' was used first by the British Economist Keith Hart, it was seen as a phenomenon. After a period of time, the unregulated informal sector began to grow and from that moment on it became a well-established economic system within the group of developing countries. One of the main reasons for the increased informal sector is the "inability of the formal economy to create new jobs"[26]. Because of an unemployment rate of over 50%, a bulk of a surplus in labour supply has to find other ways to survive. Therefore, they started their own businesses in the informal sector.[27] Nearly 75% of informal business owners were aged by 15-40.[28] "The average of the wages in the informal sector range from N$375 for workers to N$1450 for operators"[29], which is very low. According to the research by LaRRI, only about one-third of the respondent operators employed workers and less than 40% provided contracts to their employees.[30]

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23 cf. Mwilima, Ntwala 2006: Namibia's informal economy. Possibilities for Trade Union Intervention. LaRRI, p. 2.

24 cf. Interview Kandenge, Veripi – Secretary General of the Namibian Informal Sector Organization 2012: 16:30-16:37 Min.

25 Mwilima, Ntwala 2006: Namibia's informal economy, p. 2

26 Ibid. p. 4.

27 cf. Flodman Becker, Kristina 2004: The Informal Economy. Facts finding study. Department for Infrastructure and Economic Cooperation, Sida, Edita Sveriga. p. 8.

28 cf. White, Simon 2011: Namibia Informal Sector Organisation. Transforming the Informal Sector for Economic Development and More Productive and Decent Work, A Position Paper. Southern African IDEAS. p. 12

29 Tjaronda, Wezi 2006: Hope Lies in Informal Economy But..., in: New Era 27.10.2006, online: http://www.newera.com.na/article.php?articleid=13691.

30 cf. White, Simon 2011: Namibian Informal Sector Organisation. p. 12.

An informal economy is generally characterized by a small scale of operations, by skills which are often acquired outside of formal education as well as low entry requirements in terms of qualification and capital. The informal economy might often be associated with "illegal and criminal activity"[31] though it acts as an instrument of survival. However, the majority of the informal economy "provide[s] goods and services whose production and distribution are perfectly legal"[32]. The International Labour Organisation (ILO) describes the informal economy as very small and scale units with very little or no capital and a low level of technology and skills. The producers are independent and self-employed and their employees are mostly family members. The incomes are paid irregular and employment can thus be considered precarious.[33] In Namibia, the characteristics of the informal economy reads as follows[34]: (1) operating at low level organisation, (2) little or no division between labour and capital, (3) production expenditure and household expenditure is not being kept separated, (4) labour relations are based on casual employment, kinship or personal and social relations, (5) informal enterprises are not registered under national legislation, (5) no set of accounts.

According to the 2001 Namibia Informal Sector Survey, the informal sector is characterized by the limitation of no more than five employees.[35] "Informal enterprises are characterised as informal because they rarely comply with all the regulations that apply for their trade, for example concerning registration, tax payment, conditions of employment and operating licenses"[36], as Flodman Becker said. The precarious nature of the employment in the informal economy is mirrored in the lack of legislation, irregular (and low) salaries and the "little or no access to social security"[37], there are no benefits such as medical aid. This access to social security or medical aid for the informal economy will be the main topic of the following chapters in this analysis. Less than 8% of the interviewed operators registered their workers with the Social Security Commission.[38] According to Mwilima,

31 Flodman Becker, Kristina 2004: The Informal Economy. p. 11.

32 Ibid.

33 cf. Mwilima, Ntwala 2006: Namibia's informal economy. p. 2.

34 cf. ibid.

35 cf. Informal sector, definition, concepts and weighting in African economies, online: http://www.uneca.org/statistics/statcom2008/documents/InformalSector.pdf .

36 Flodman Becker, Kristina 2004: The Informal Economy. p. 12.

37 Mwilima, Ntwala 2006: Namibia's informal economy. p. 3.

38 cf. ibid p. 48.

mainstream policies of the government do not have impacts on the informal economy. But there are four policies that would have direct impacts and one of them includes “social protection policies, which extend coverage to the informal sector workers”[39] by extending or creating new schemes.

3.2 Namibian Informal Sector Organisation (NISO)

The Namibian Informal Sector Organisation was launched in 2011 to organize, formalize and develop the informal sector in Namibia. It responds to the needs and demands of the informal economy, its workers and operators. According to NISO, there is no official definition of the informal sector in Namibia, but they are referring to the above-mentioned definition of the ILO.[40] Up to the launch of NISO, “the informal operators were not able to benefit from governmental initiatives”[41]. Since then, the informal sector has been supported and assisted by the Ministry of Trade and Industry. The establishment of NISO occurs within an African Builders Association, Namibia Shebeen Association (NASA), Namibia Small Traders Association (NAMSTA), Okutumbatumba Hawkers Assocation (OHA) and Panel Beaters and Motor Mechanics Association.
NISO wants to address the following issues[42]:

- Informality as a legitimate option to get out of poverty
- Ways to move to formal business
- Cognition and acceptance of informality
- Government’s role in recognizing informality as one of the gatekeepers for enterprise development
- Creating an official definition of the informal economy

The main aim of NISO is “to build the capacity”[43] of the informal sector. They want to represent and develop the informal enterprises “by recognizing the legitimacy of informality, providing assistance to firms willing to move from informality to formality, and addressing the concerns of small formal enterprises, which find it difficult to comply with the regulatory environment”[44]. The objectives of

39 Ibid p. 6.

40 cf. White, Simon 2011: Namibian Informal Sector Organisation. p. 1.

41 Ibid. p. 3.

42 cf. ibid. p. 4.

43 Ibid.

44 Ibid.

NISO are as follows: They want to become the voice of all informal workers and operators by establishing a connection between the informal sector and the Government of Namibia and other organizations such as ILO. They want to provide “opportunities for networking” and “effective on-demand services to organised informal sector associations with a view to improve their respective services to members”[45]. They also want to assist the representation of the informal operators' interests.

3.3 Challenges for the informal economy

According to Veripi Kandenge, the majority (almost 80%) of the informal businesses are mostly for survival.[46] Taking Jauch into account, a current challenge for the informal sector is that the relationships between workers are also informal because there are no official contracts or agreements and in many cases employees are family members. The wages in the informal economy are very low, there are long working hours and no paid holiday.[47] In addition, businesses are usually endowed with only small or even no capital. Another problem is that a worker can be a worker today and tomorrow he can start a similar business and start operating, thus it is not easy to detect how this sector is organized. Therefore, it is challenging when it comes to unions to protect the workers, as Kandenge said. Other problems are the very few profits of the micro businesses in the informal sector and the question of decent work as well as providing a decent salary level.[48] Furthermore, because of bureaucratic decisions the informal enterprises are mostly occurred in townships like Katutura, Windhoek.[49]

The most important problem is the challenge of understanding the laws, e.g. the child labour laws and social security laws which the Ministry of Labour and Social Welfare and the Social Security Commission are advocating for. The literacy level of the informal operators and workers is also a challenge because most of the workers are not educated and they cannot understand why they should pay for social security. Another necessity is that the informal sector needs to register with the Ministry of Trade and Industry and other related Ministries. But when the informal operators are registering themselves, the requirements imply e.g. the employment of auditors to inform about

45 Ibid.

46 cf. Kandenge, Veripi 2012: 03:13-03:22 Min.

47 cf. Interview Jauch, Herbert – Labour consultant 2012: 03:30-04:27 Min.

48 cf. Kandenge, Veripi 2012: 03:45-04:54 Min.

49 cf. Jauch, Herbert 2012: 02:00-02:47 Min.

their finances. Most of the informal workers do not understand how they can release this information to other people and therefore they are falling short of these requirements.[50] The informal sector workers also have a problem of accessing finance to grow their businesses.[51] All in all, the informal economy in Namibia "is totally not protected"[52], as Kandenge warns.

3.4 Current social security structure in Namibia

Social security is a government program of "public provision (as through social insurance or assistance) for the economic security and social welfare of the individual and his or her family"[53].
According to Becker and Olivier, Namibia is "one of the countries with the most innovative social security approaches, structures and models"[54]. The Republic of Namibia aimed at a "comprehensive codification of the social insurance part of its system, inclusive of retirement and – in principle – health provision"[55] by establishing the Social Security Commission (SSC) in early 1995. Its tasks included publicising and administering funds, implementing the reforms and introducing the social security number and social security card for claim and identification purposes.[56] The administration of funds includes the registration of new members and the collection of contributions. The SSC also makes recommendations to the Minister of Labour and Social Welfare regarding possible amendments and changes to the Social Security Act.[57]
Article 95 of the Constitution of Namibia covers the active promotion of welfare of the population such as the right of the citizens to have "access to public facilities and services in accordance with the law". Furthermore, the state is responsible for the "consistent planning to raise and maintain an acceptable level of nutrition and standard of living of the Namibian people and to improve public health" and the health and strength of the Namibian workers must not be abused.

50 cf. Kandenge, Veripi 04:55-07:09 Min.

51 Interview Mwiya, Albius – Deputy Director of Employment Services in the Ministry of Labour and Social Welfare 2012.

52 Kandenge, Veripi 07:39-07:42 Min.

53 Merriam-Webster (2012): Definition of social security. Online: http://www.merriam-webster.com/dictionary/social+security.

54 Becker, Ulrich/ Olivier, Marius 2008: Access to Social Security for Non-citizens and Informal Sector Workers. An International, South African and German Perspective. AFRICAN SUN MeDIA, Stellenbosch. p. 150.

55 Ibid.

56 cf. ibid.

57 cf. Social Security Commission. Overview. Online: http://www.ssc.org.na/index.php?option=com_content&view=article&id=44.

The SSC provides different kinds of social protection to Namibian citizens, e.g. payments to employees of maternity leave, sick leave and death benefit fund (MSD) for occupational injuries, death, invalidity, funeral and survivors' benefit. The new system determines employees' contributions to social security. "Employment injury benefits are financed entirely by employees, retirement benefits are payable to workers over 60 who have worked and contributed to social security for at least 15 years"[58]. Referring to Becker et al., one of the future projects of the government is the development of a national medical aid scheme, which is the main topic of this paper.

The MSD is for all working people who receive a basic wage for their services in Namibia. This includes domestic employees as well as Small and Medium Enterprises (SMEs) like construction workers or shebeens.[59] The contribution rate for this fund will remain at 1.8% of the employee's basic salary shared on a 50/50 basis by the employer (0.9%) and the employee (0.9%), with a maximum monthly payment of N$ 54.[60] In March 2012, the maternity leave benefits have been increased from the former maximum of N$10,000 to N$10,500. The sick leave benefits "are paid at 75% of the new maximum basic wage of N$10,500 per month for the first 12 months and 65% for the last 12 months, translating into a maximum of N$7,875 per month"[61]. The death, disability and retirement benefits have also been increased from N$5,000 to N$5,515.[62]

The Employees' Compensation Fund (ECF) of the SSC includes compensation for payment of benefits to injured employees as a result of accidents on duty or industrial diseases. The industries have different classes, the higher the risk of injuries the higher the contributions for this fund. An employee who is dealing with administration work will not pay the same amount as an employee of a construction company.[63] The Development Fund is to take care of the socio-economically disadvantageous persons and students at institutions of higher learning. Its main objectives are to conduct training and employment schemes and to grant bursaries, loans and other forms of financial aid to enrolled students.

58 Ibid.

59 cf. Social Security Commission 2012: SSC improves its benefits and assessment rates. online: http://www.ssc.org.na/index.php?option=com_content&view=article&id=52:msd-a-ecf-benefits-increases&catid=1:latest-news&Itemid=70.

60 cf. Interview Olivier, Anthea – Communications Officer at Social Security Commission 2012: 10:30-10:51 Min.

61 Social Security Commission 2012: SSC improves its benefits and assessment rates.

62 cf. ibid.

63 cf. Olivier, Anthea 2012: 10:53-11:30 Min.

The 1994 Social Security Act includes the National Medical Benefit Fund (NMBF) which shall be implemented to provide an adequate safety net for the workforce of Namibia. The Parliament should appropriate money to the fund and any "fines by virtue of penalties imposed under this Act in respect of an offence involving the Fund"[64]. The aim of this fund is to "provide medical benefits to every employee who is a member of the Fund"[65] including the informal economy. According to section 21 every employee shall be a member of the National Medical Benefit Fund except the person is a member of any other fund or scheme. The "medical benefits payable in respect of medical expenses incurred by any member, shall be as prescribed"[66].

The 1995 Medical Aid Funds Act regulates the Namibian medical aid funds by controlling and promoting the funds and establishing the Namibian Association of Medical Aid Funds (NAMAF). The NAMAF's main objective is to "be the representative body of the health funding industry promoting equitable, affordable, accessible qualitative and value-adding services"[67]. Moreover, the NAMAF also wants to have a bearing on the policy-making and regulatory measures for the benefit of their members as well as the long-term sustainability of the Namibian health funding industry. All Namibian medical funds (excluding PSEMAS), four open and five closed funds are registered with the NAMAF.

4. Implementation of a national health insurance in the informal economy of Namibia

Provision of social security protection for the informal sector is a win-win-situation because on the one hand, the SSC will be able to cover a significant fraction of informal sector workers. Through their monthly contributions this could have a positive impact on the revenues of the SSC. On the other hand, it will also help to create a conducive environment for the majority of informal sector workers who currently do not have any type of protection. Registration with the SSC creates opportunities for informal operators and workers to apply for government tenders. But before this can happen, the SSC must recognize and admit the presence of the informal sector in Namibia, as Amon Ngavetene said.[68] The Social Security Commission has already started targeting the informal

64 Republic of Namibia 2004: Social Security Act 1994. p. 31. online: http://www.parliament.gov.na/acts_documents/111_social_security_act_34_of_1994.pdf.

65 Ibid. p. 32.

66 Ibid.

67 Namibian Association of Medical Aid Funds: Guiding Principles. Online: http://www.namaf.org.na/vision.htm.

68 cf. Interview Ngavetene, Amon – Project Coordinator for Aids Law Unit at Legal Assistance Center 2012: 02:45-04:41 Min.

economy in terms of the MSD benefits but Ngavetene thinks that this “intervention is still quite very narrow and it doesn't recover a large part of the country”[69].

4.1 Current challenges of uninsured workforce

In 2006, only about 316,000 Namibian people (18.6% of the total population) are covered by medical aid schemes, thus over 1.7 million Namibians did not have any health insurance. With respect to the total workforce in Namibia (530,000), over 200,000 employed Namibians were uncovered.[70] Thus, even a large number of formal workers do not have access to medical aid benefits. Even the current benefits of the SSC are going unheeded.

Taking Olivier into account, it is the responsibility to all employers to register their employees and not the responsibility of the workers themselves. The staff of the SSC carries out roadshows, open days, trade fairs and it also broadcasts on radio and uses print media to educate and sensitize their clients to the current benefits such as MSD. In 2011, they've acquired a mobile van, transformed it into an office (one-stop-service) and travelled to the remotest areas in the country to assist the informal workers with the registration. The result is that more people, who did not know that they should be registered, became aware of the Social Security Commission and its benefits. But a lot of employers neglect to inform and register their employees despite the fact that by law they must be registered if they work for one or more days during the week.[71] It is very difficult to get through to employers because some are not familiar with the SSC and some are just ignorant, as Olivier said.[72] According to Ngavetene, another factor could be the education of the informal operators and workers. For those people who are aware of the SSC it is kind of an elite institution only available for the formal sector. Furthermore, the issues of dealing with logistics and technicalities around the completion of forms are another challenge because not all informal operators and workers are literate in English. He also thinks that there hasn't been a deliberate effort to target informal workers and tell them about the possible benefits of SSC.[73] Ngavetene thinks that the SSC has to exert more

69 Ibid. 06:04-06:12 Min.

70 cf. Mbapaha, Gabriel 2011: Presentation - Facts & Figures pertaining to the Medical Aid Funds within the Healthcare Industry. Online: http://www.namaf.org.na/trusteetraining2011.html.

71 cf. Olivier, Anthea 2012: 01:48-05:10 Min.

72 cf. ibid. 17:50-18:03 Min.

73 cf. Ngavetene, Amon 2012: 13:58-15:52 Min.

efforts to inform the informal economy about the benefits of a registration. They should also make the registration process easier for them e.g. translating certain forms into certain languages.[74]

Tim Parkhouse, the Secretary General at the Namibian Employers' Federation (NEF), suggested the collection of the monthly subscriptions by going to each individual operation, explaining the SSC benefits to the staff and getting commitment from hopefully all informal sector operators. After that, a dedicated person from the SSC has to go to the operations and collect the contributions once a month. He thinks that “once the workers in the informal economy understand the benefits they would force their employers to enrol them”[75].

Taking Jauch into account, the SSC must rework their whole recruiting strategy. In his opinion, the SSC has no influence on the informal operators and workers at all.[76] Furthermore, the main incentive for informal businesses is mostly for survival so that they do not want to be a part of it and reject social security as irrelevant.[77] In addition he thinks that the SSC staff must contact the informal operators/employees individually and register them because in his opinion road shows, broadcasting etc. have no lasting influence on the informal economy.[78] But this begs the question: How would the SSC collect the social security fee every month. Setting up a bank or a post account could be one solution.[79] In this case the NISO could act as a national mouthpiece between the SSC and the informal sector.[80]

As mentioned above, the most potential problem of the high number of uninsured could be the medical aid premiums which are too high for low-income and unskilled workers. The typical products of the medical aid funds are 'high option' offerings which are only affordable for formal workers with a high or middle level income.[81] Even with the cheapest product for impatient and outpatient services, a “semi-skilled low-income worker would still pay 15% of his/her monthly income for family

74 cf. ibid. 16:15-16:56 Min.

75 Parkhouse, Tim – Secretary General of the Namibian Employers' Federation 2012: 08:02-08:16 Min.

76 cf. Jauch, Herbert 2012: 04:45-05:03 Min.

77 cf. ibid. 22:11-22:35 Min.

78 cf. ibid. 05:30-06:30 Min.

79 cf. ibid. 07:08-08:49 Min.

80 cf. ibid. 20:15-21:48 Min.

81 cf. Rinke de Wit, Tobias/ van de Gaag, Jacques: p. 24.

coverage and an unskilled worker 19-22%"[82], consequently the majority of insured workers are middle or high-income workers.
It would therefore be advisable to increase the number of people making use of health facilities in Namibia by enticing a fraction of uninsured workforce to register for a membership. Thus, the government and medical aid funds are challenged to create initiatives and find solutions to make the health care in Namibia affordable and sustainable. In other words, to decrease the number of the uninsured workers in Namibia, including the informal economy. The health care in Namibia hast to become cheaper.[83]

4.2 National Medical Benefit Fund

The Minister of Labour and Social Welfare, Immanuel Ngatjizeko, urged the SSC "to propose innovative ways in extending the coverage to operators in the informal sector"[84]. He called for the full implementation of the National Medical Benefit Fund (NMBF) and said that there is "a need to make social protection more accessible to more clients"[85], such as informal operators and workers. Even the Minister of Health and Social Services, Richard Kamwi, thinks that nobody should be excluded from the medical aid coverage and that Namibia needs "benefit designs and packages that appeal to all our employed"[86].

The National Medical Benefit Fund in Namibia is not implemented yet. According to Uahatjiri Ngaujake, the Manager of Research and Development of the Social Security Commission, they are still busy with research on how to establish a national health insurance for all Namibian people, including the informal operators and workers. The pivotal questions are: How is it going to be regulated and who is going to be covered? This research has been started in 2011 and will take around two or three years to bring the fund into place, so it is still in its early stages. The Head of Corporate Communications at the SSC, Rino Muranda, said that "Namibia will follow a thorough and

82 Ibid.

83 cf. Mbapaha, Gabriel 2011.

84 Namibian Broadcasting Coorporation 2012: SSC urged to expand coverage to informal sector. Online: http://www.nbc.na/news_article.php?id=6595&title=SCC%20urged%20to%20expand%20coverage%20to%20informal%20sector.

85 Ibid.

86 Mbapaha, Gabriel 2011.

comprehensive process in the establishment of the NMBF"[87]. The research report "will be studied and thoroughly reviewed in consultation with international bodies such as the International Labour Organisation"[88] and all relevant stakeholders to discuss the contents of the research report. "Only after the adoption of the report shall it become clear what form the NMBF will take, including when it will be implemented and how it will be funded"[89], Muranda said.
The NMBF is not designed especially for the informal economy because in the Social Security Act it was intended for employed people who have regular jobs in Namibia. But there are some elements of accommodating informal operators or workers in this medical aid fund, despite the nature of the informal economy. Because there are many challenges in view of the fact that e.g. the people in the informal economy do not have regular incomes to make contributions to the SSC on a monthly basis. But the SSC is trying to create a design bringing the informal workers on board, especially the self-employed people, as Ngaujake said. The SSC is considering what incentives they can provide to make the informal workers join given the problem they have in maintaining a regular income, which is a requirement for a contribution to the benefits. But the above-mentioned Social Security Act was not actually meant for these people. Nevertheless, the SSC is trying to include the uncovered low-income workforce into this fund by implementing an affordable health insurance. After the finalisation of the research work, the SSC has to start the consultation with other stakeholders, e.g. the government, unions, employers, employees as well as private medical funds so that these institutions can give input to the proposed design and the SSC can inform stakeholders about how this programme is going to affect them.[90]

The main challenge during the prospective implementation of a NMBF for informal workers is the rate of contribution for people who obtain only a (very) low income. Katjiuongua points out that, whatever the SSC does, "it must be a contributory kind of arrangement"[91] between the employer and the employee, although many of the informal workers do not have an employer. Ngaujake said that "once we are gone through the research, maybe we can come to a way to see how they can be

87 Nyaungwa, Nyasha Francis 2011: Namibia: National Health Insurance – Real or a Mirage?. Online: http://allafrica.com/stories/201110140943.html.

88 Ibid.

89 Ibid.

90 cf. Interview Ngaujake, Uahatjiri 2012: 02:38-09:41 Min.

91 Katjiuongua, Batseba 2012: 09:30-09:36 Min.

accommodated affordably"[92]. Ngaujake enhanced the fact that there is no classical national health insurance system in Namibia, just a few medical aid schemes which are mostly private. A national health insurance is what the SSC is trying to establish with the proposed National Medical Benefit Fund. So the SSC is "in support as an institution of moving towards national health insurance through universal health coverage which will [...] incorporate everybody in the country"[93], as Ngaujake said. According to Ngavetene, this kind of national health insurance could also mean that as long as you are Namibian and you find yourself within the borders of Namibia, you are covered. He said that it is not sure whether it applies to all Namibians or just to those employed Namibians who are registered for social security coverage.[94]

Given that the Social Security Act dictates that the NMBF will be financed by contributions and will cover all employees, it corresponds closely to a Bismarck Social Health Insurance (SHI), which is characterized by non-profit funds and contributions by employers and employees through payroll deduction, as Theophanides said. According to the policy objectives of the World Health Organisation (WHO), a SHI must generate sufficient and sustainable resources for health and ensure the financial accessibility to health services.[95]

The Namibian Informal Sector Organisation has made a proposal which includes the extension of the current product being offered by SSC like the MSD Fund as well as the Employee's Compensation Fund to the informal sector. Thus, the informal sector wants to benefit from social security, too. Ngavetene believes that the informal sector also wants to benefit from the planned NMBF.[96] All in all one key question and challenge is how the public health system or the SSC can get the private medical aid funds on board, because the latter want to stay independent.[97]

92 Ngaujake, Uahatjiri 2012: 09:42-09:52 Min.

93 Ibid. 18:42-18:54 Min.

94 cf. Ngavetene, Amon 2012: 08:51-09:12 Min.

95 cf. Theophanides, Ashleigh 2011: Presentation – The National Medical Benefit Fund – Where to next?. Online: http://www.namaf.org.na/presentations2011.html.

96 cf. Ngavetene, Amon 2012: 09:29-10:48 Min.

97 cf. Katjiuongua, Batseba 2012: 26:37-27:36 Min.

5. Prospects of a national health insurance in Namibia

5.1 Envisaged NMBF challenges

There are many challenges facing the implementation of a NMBF[98]: resistance by service providers as well as the resistance by employers to the extra contributions because they already face a high tax burden. Furthermore, the high unemployment rate could be another challenge and there is a very low base of people with low-income. Moreover, it is uncertain how government employees will be incorporated into the NMBF. It may well be that the implementation of a pension fund may take higher priority over NMBF.

As mentioned before, the administration of informal sector contributions might be a substantial challenge because (1) the self-employed informal sector is highly fragmented and the incomes are very low and irregular, (2) the size of the informal sector is not precisely known, and it is constantly changing, (3) the people of the informal sector avoid labour law and employment contracts do not exist and (4) the informal sector operators have a limited understanding of the SSC and insurance.
Another big issue is the so-called "hire-and-fire" mentality in the informal sector. If an employee becomes pregnant or seriously sick, the employer would lay her/him off and hire a new employee instead because, as mentioned above, there are no official contracts or agreements in many cases. Thus, for the informal operators there is no incentive to register their employees with SSC to provide long-term MSD or NMBF benefits.[99] Because of the policy stagnation, Jauch thinks that the implementation of a National Medical Benefit Fund would take longer than 15 years. Even the concept of a national pension fund system has still to be completed and you cannot see any attempts to implement such a system. With a NMBF it would be the same procedure because the costs would be much higher than the implementation of a pension fund. The only progress in the social security system within the last 5 years has been the increase of the MSD benefits, he thinks.[100] The capacity limit and the lack of awareness of SSC tends to result in the very low number of uninsured people in the Namibian informal sector.[101] Furthermore, many of the uninsured workers never became aware

98 cf. Theophanides, Ashleigh 2011: Based on interviews with various stakeholders.

99 cf. Jauch, Herbert 2012: 09:31-10:01 Min.

100 cf. ibid. 12:27-15:13 Min.

101 cf. ibid 24:07-25:20 Min.

of the benefits of SSC and they usually say: If they get sick, they can go to a public hospital and get free medical treatment, so why should they pay into the social security fund?[102]

5.2 Suggestions for improvement

The state has the primary role in providing a framework for delivering social security and health insurance. Thus, the state is responsible for ensuring the basic survival of its citizens. This could be realized through partnerships with the private medical aid funds.[103] An implementation of an affordable social security can be influenced by the political will, policy prioritisation as well as resource availability.[104] Furthermore, an effective social security or health insurance system "require[s] long-term planning, strategy and political commitment entrenched in the legislative and/or constitutional frameworks of the country"[105]. Due to the inherent nature of the informal sector, social security coverage in this sector is very low. This calls for innovative approaches to extend coverage, the introduction of multiple health insurance schemes for various categories of workers could be an option. For example, hawkers and street vendors can have their own scheme whilst farmers might have their separate ones. If such schemes are introduced, they should be flexible enough to cater for the specific needs of those members. For instance, the contributions by farmers should be structured in such a way to suit their farming operations, e.g. contributions to be paid during the breeding seasons when farmers sell some of their stock.[106]

In 5 years, Ngaujake hopes to have studies undertaken already which will point out how the SSC can achieve affordable coverage to everybody, including the informal workers and unemployed people. Although they know that "achieving national health insurance which covers the whole population is not an easy process, it's a very complex and long process"[107]. The SSC is foreseeing this process to take between 15-20 years to achieve a universal health coverage.

Daniel Motinga, a Namibian Economist, welcomes the government's effort to establish a NMBF but is sceptical of the government's ability to finance it "in a country where about 60% of the population

102 cf. Parkhouse, Tim 2012: 25:39-26:05 Min.

103 cf. OECD: Social Protection, Poverty Reduction and Pro-Poor Growth, p. 25. Online: www.oecd.org/dataoecd/45/63/43573310.pdf.

104 cf. ibid. p. 26.

105 Ibid. p. 27.

106 cf. Ngaujake, Uahatjiri 2012.

107 Ngaujake, Uahatjiri 2012: 20:30-20:46 Min.

operate in informal sector employment"[108]. The establishment is necessary because the current medical aid model "excludes the poor from accessing quality health services due to price"[109]. Due to the lack of fiscal space, the government is not able to fund the NMBF, as Motinga said. He suggested a sustainable tripartite funding mix, a combination of state, employers and employees to share costs. In addition, he thinks that "the revenue base for the insurance scheme should be as broad as possible in order to achieve low contribution rates"[110]. Taking Ngavetene into account, the contribution rate has to be tailor-made, so the SSC has to create a structured fee that will match the affordability of the informal sector. If the formal sector contributes N$54 per employee to social security, for the informal sector half of this amount is needed. Despite the difference in absolute payments, their benefit should not differ from the formal sector benefits. So there has to be an equal risk-sharing, as Ngavetene said.[111] The contribution rates should be asymmetric and based on the principle of solidarity in order to establish that the poor and needy people will contribute less but benefit more. One of the main questions is: How long will it take before the country establishes its own national health insurance? Economists predicted, with the current low GDP growth, the implementation of a national health insurance would take longer than 20 years. With a progressive introduction of the national health insurance, the establishment within 10-15 years could be realistic. Muranda also pointed out the challenge of making the new NMBF affordable to low-income workers such as the informal operators and workers.[112] According to the National Union of Namibian Workers (NUNW), formal employment creation can provide access to affordable quality health care in Namibia because only employed people can afford the contributions.[113] The OECD states that the costs of a national health insurance can be kept manageable by starting with a limited programme, e.g. micro-health insurance which can serve informal workers, and scaling up as effects are recognisable and the available resources expand.[114]

Jauch believes that a renewal and strengthening of the public health system combined with the implementation of the Basic Income Grant (BIG) would be the best solution to provide access to

108 Nyaungwa, Nyasha Francis 2011.

109 Ibid.

110 Ibid.

111 cf. Ngavetene, Amon: 11:58-13:44 Min.

112 cf. Nyaungwa, Nyasha Francis 2011.

113 cf. Kaaronda, Evilastus 2011: Presentation – Revolutionising private healthcare: Covering the uncovered. Online: http://www.namaf.org.na/presentations2011.html.

114 cf. OECD: Social Protection, Poverty Reduction and Pro-Poor Growth, p. 26.

health care services for the whole Namibian population. The BIG is a monthly cash grant (N$100) that would be paid by the state to every Namibian citizen regardless of age or income. The main aim of the BIG is its ability to improve everyone's life by alleviating poverty and inequality. With this grant, the people are able to use the local clinic much more regularly to improve their health status, as shown in the BIG pilot project in Otjivero. This would be more effective than the implementation of a national health insurance which could be too expensive for low-income workers in the informal sector.[115] Using the example of Venezuela, the BIG could be financed by the country's resource revenues, as Jauch said.[116] Jauch believes that in 5-10 years the SSC wants to broaden the framework of action (mobile office) and the number of covered formal workers could be increased to 90% and the number of informal workers to about 30-40%.[117] Katjiuongua also thinks that the BIG could be a good idea because "any small amount that you give to somebody who has got nothing can only help to sustain this person"[118] and it obviously made a difference to the people who benefited by the pilot project in Otjivero. She never had a problem with the implementation of the BIG and hopes that it will be a discussion at length, especially in terms of access to health services.

Basically, Ngavetene said that "the deliberations should stop being an academic debate and move towards being more kind of a practical […] framework"[119].

EXAMPLE

Taking Theophanides into account the NMBF should include the following characteristics[120]:

- The NMBF package should be a basic minimum benefit package, providing primary, hospital and emergency cover to Namibians
- It should allow minimally treatment for the most common diseases of the population
- The NMBF should match the health care needs of the population
- It should cover low frequency, very high severity health care events, which is a benefit gap not covered under PSEMAS
- The benefit definition should be clear and simple
- It should seek to keep costs low rather than provide a large number of services

115 cf. Jauch, Herbert 2012: 16:25-18:45 Min.

116 cf. ibid. 26:38-27:10 Min.

117 cf. ibid. 29:20-30:16 Min.

118 Katjiuongua, Batseba 2012: 15:54-16:04 Min.

119 Ngavetene, Amon 2012: 22:09-22:20 Min.

120 cf. Theophanides, Ashleigh 2011: Based on interviews with various stakeholders.

According to these characteristics the private medical schemes can act as a "top-up for more complex procedures"[121]. The administration could be conducted by the existing administration infrastructure. The NMBF should aim to increase access to health insurance by making it affordable, fair and sustainable to get more people registered. Another aim of the NMBF should be to increase the health system efficiency "to converge with public health, to reduce pressure on public hospitals, to upgrade public health facilities, and to equip and resource district services at clinics"[122]. The informal sector employment should also qualify for NMBF membership: The SSC should provide a discounted rate for upfront payment and lump sum contributions in preference to a regular collection of premiums for the informal sector operators and workers.[123]
If the NMBF operates like a medical aid, it should be regulated by Namibia Financial Institutions Supervisory Authority (NAMFISA). Another recommendation by Theophanides is the strengthening of a consumer education because the people only know the SSC under the name of MSD fund. The NMBF should be based on the principle of solidarity and the contributions should be tax-deductible "to provide incentives, especially for the informal sector"[124]. The government should provide subsidies and there should be a split of costs between the employer and employee. There should be a phased implementation and the membership should be compulsory to obtain constant funding. Furthermore, the "NMBF delivery should not focus only on either the private sector or public sector, but should rather contract with both sectors strategically where capacity exist"[125].

5.3 Positive example – Okambilimbili Health Insurance Project in Namibia

In 2004, the PharmAccess Foundation, a Dutch NGO, started a project "to increase access to affordable quality health care, including counselling and treatment for HIV/AIDS, for uninsured low-income workers in Namibia"[126] by creating and strengthening pre-paid health financing mechanisms

121 Ibid.

122 Ibid.

123 cf. ibid.

124 Ibid.

125 Ibid.

126 Rinke de Wit, Tobias/ van de Gaag, Jacques: p. 9.

and improving the quality of available healthcare. The Okambilimbili project was made possible by donors from various organizations and was based on the following principles[127]:

1. Using local potential and underutilized capacity in the private sector; 2. integrating HIV/AIDS treatment into general healthcare structures; 3. setting up partnership in order to link private sector initiatives to donor organizations. The basic strategy included the cooperation with local partners and service providers to develop affordable high-quality health insurance products. They also provided subsidies and insurance advocacy to the target group of previously uninsured low-income workers and employers to encourage enrolment in these health insurance products.[128]

At the beginning of this project, they focused on supporting Diamond Health Services (DHS) which created an affordable health care product including HIV benefits but excluding any inpatient care benefit. Compared to the cheapest products of the medical aid industry, which excluded HIV treatment, this product was an affordable offer indeed, but it did not meet the minimum value requirements and went unheeded. PharmAccess and the Project Okambilimbili partners "realized that the engagement of the wider medical aid fund industry was needed if the project objectives were to be achieved"[129]. They started to negotiate with open private medical aid providers to improve affordable health care options with good primary care benefits, including HIV/AIDS treatment, for low and middle-income workers. Because in 2004, only 40% of this target group had access to private health insurance, because only middle and high-income workers could afford the employee contribution of 50%.[130]

In 2006, PharmAccess created a "separated risk pool through the creation of a risk equalization fund for HIV"[131] called Health Is Vital Risk Equalization Fund (HIVREF). Two medical aid funds (RCC and Renaissance) removed HIV/AIDS risk from its individual risk pools and shared these financial risks with other open medical aid funds in a "separate vehicle across a larger risk group"[132] by contributing a monthly premium per individual to this risk pool.

The HIVREF was administered by the Prosperity Health Group, supported by a HIV/AIDS disease management organization (MyHealth) and included 'Vitality' (monthly premium of N$30 per

127 cf. ibid. p. 30.

128 cf. bid. p. 30-31.

129 Ibid. p. 32.

130 cf. ibid.

131 Ibid. p. 35.

132 Ibid.

member) and 'Vitality Day Care' (monthly premium N$146-306 depending on the members income). The “HIV/AIDS treatment benefit called 'Vitality' provided each beneficiary with N$100,000 for the care and treatment of HIV/AIDS per year, including private hospitalization, medication, pathology, radiology, counselling and doctor consultations”[133] for all members of a larger employer groups. The 'Vitality Day Care', a day-to-day primary health service, was designed for uninsured employer groups who were not a member of a medical aid fund. It included “limited outpatient care for general health conditions and in-patient care in the private wing of public hospitals for non-HIV related in-patient care”[134]. The 'Vitality Day Care' was limited to N$10,000 per year and was only available to people with an income of less than N$4,500 per month.[135] To support the initial start-up of HIVREF (and in addition to the premium subsidies), PharmAccess provided two lump sum contributions into the pool. At the same time NHP and DHS created a similar low cost product, the NHP Blue Diamond which “shared primary care risk with the service providers through a capitation agreement whilst incorporating the risk of HIV/AIDS treatment and hospitalization into the NHP risk pool on a fee for service structure”[136]. In 2006 three new affordable health insurance products became available, the HIVREF, NHP Blue Diamond and NHP Economic Plan. All subsidies ended in December 2008. The impacts of the Okambilimbili Project are as follows: These new products changed the health insurance industry. Three new low cost health insurance products were created (including various HIV/AIDS benefits such as treatment protocols, quality monitoring of ART which are affordable for uninsured low-income workers). By the end of 2008, 36,360 previously uninsured employees enrolled in one of these new affordable health insurance products.[137]

6. Conclusion

All in all “health protection increases labour productivity by improving people's health status”[138] and there is a need to better understand how effective social security/ health insurance for informal workers might promote access to sustainable decent employment. It creates opportunities to better use public institutions for their inclusion into society. Thus, it must be in the state's interest to provide affordable health care because it can have a positive impact on the economic growth and

133 Ibid. p. 36.

134 Ibid.

135 cf. Lush, David 2006: p. 8.

136 Rinke de Wit, Tobias/ van de Gaag, Jacques: p. 37-38.

137 cf. ibid. p. 47-51.

138 OECD: Social Protection, Poverty Reduction and Pro-Poor Growth, p. 23.

social development.[139] But the informal sector is highly fragmented and the incomes are very low and irregular.

Currently, there is no national health insurance that covers the whole Namibian population. With the National Medical Benefit Fund, the government is currently doing research on establishing an affordable national health insurance and how the Namibian workforce (formal and informal economy) and even the unemployed can be accommodated. In 2006, over 1.7 million Namibians did not have any health insurance, thus there is definitely a need because even the cheapest products of private medical aid funds are too expensive for (very) low-income workforce such as informal sector workers and unemployed people in Namibia. The public health system is understaffed and overrun (responsible for 85% of the Namibian population) because the majority is unable to pay for expensive private health services. Therefore, the NMBF, which shall be financed by monthly contributions, should be a basic minimum benefit package which includes treatment for the most common diseases of the population. It should seek the costs low rather than provide a large number of health services. The NMBF should also be associated with an improvement of the health system to reduce pressure on public hospitals and upgrade public health facilities. The NMBF should be based on the principle of solidarity, the government should provide subsidies and the contributions could be tax-deductible. The government should start to negotiate with the private medical aid industry to use spare capacity. Project Okambilimbili can serve as a positive example in respect of cooperation with private medical aid funds to provide low-cost health insurance to informal workers.

In summary, it can be stated that achieving national health insurance which covers all, formal and informal workers as well as unemployed people will be a complex and difficult process. It will probably take 15-20 years to establish the whole concept of an universal health insurance. But it was Henry Ford that said: "Coming together is the beginning. Keeping together is progress. Working together is success."[140]

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