Republic of Namibia

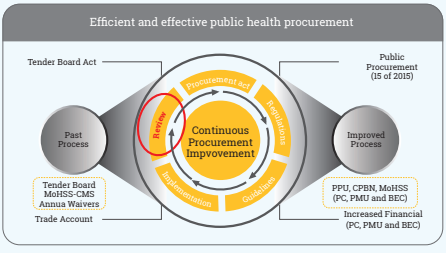
MINISTRY OF FINANCE

STRENGTHENING HEALTH PROCUREMENT FOR IMPACT: KEY RECOMMENDATIONS

BACKGROUND

The Health Sector Public Expenditure Review (2019) identified a number of inefficiencies in health procurement as significant bottlenecks that contribute to the mismatch between Namibia's health outcomes and significant health sector investments. The inefficiencies in pharmaceutical and clinical supplies procurement often result in sub-optimal purchase prices and stockouts of essential medicines, thereby disrupting service-delivery, particularly at the local level and for underserved communities. Procurement reforms have been ongoing in Namibia with the implementation of the Public Procurement Act of 2015, (Fig 1).

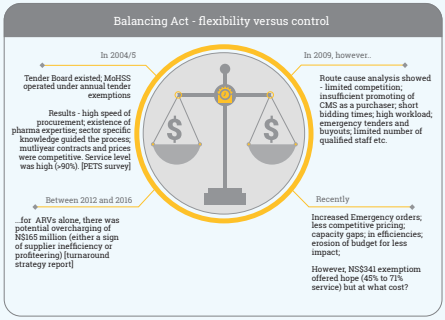
Fig 1: Efficient and effective public health procurement



PROGRESS TO DATE

Whilst noting the considerable improvements made (Fig 2), health sector procurement challenges remain. Some of these challenges includes: high number of emergency local tenders; limited international tenders impacting on value for money and increased frequency of stock-outs, hence, the need for continuous reforms.

Fig 2: Progress in health procurement



APPROACH

The Study led by the Ministry of Finance's (MoF) Procurement Policy Unit (PPU) and with technical support from hera, adopted a highly interactive bottleneck analysis and problem-solving dialogue approach with the key health stakeholders, including the Ministry of Health and Social Services (MoHSS), Central Procurement Board of Namibia (CPBN), Central Medical Stores (CMS) and development partners (UNICEF, UNDP, UNFPA, WHO, GFATM's PMU, USAID, I-TECH; GSCH-PSM). This approach provided opportunities for co-creation through document review, Key Informant Interviews (KIIs), meetings and a workshop with key stakeholders, with the aim of identifying solutions to improve efficiency in health procurement.

KEY FINDINGS AND RECOMMENDATION

1. Regulatory Framework. The Act and related Regulations and Guidelines for public procurement and public financial management are sufficiently supportive for the application of Good Practices in pharmaceutical procurement.

However, this could be further enhanced by adopting pooled procurement as another method of procurement under Part 5 of the Act, given the potential efficiencies it could bring, refer to Table1.

Table 1 Potential savings through pooled procurement

Mechanism	Potential savings (N$)
GDF facility	25,268,862.74
UNFPA mechanism	10,999,468.10
GFATM PPM mechanism	19,220,466.40
UNICEF SD mechanism	33,252,225.00

Whilst there are pre-financing challenges with pooled procurements, as this is not standard practice for Namibia, evidence from Route Cause Analysis Report (2009) show marked price differentials of 62-78%, compared to International and Regional pooled procurement mechanisms.

Recommendations:

1.1. Amendment of the Act, to add pooled procurement by third parties, as procurement method under Part 5 of the Act. **[PPU]**.

1.2. MoF in consultation with stakeholders and high-level policy makers to develop mechanism and regulations to facilitate advance payments for pooled procurement. **[MoF/ CMS/MoHSS]**.

1.3. Make additional instructions to Regulations and Guidelines capturing the outline of market analysis, the requirement of publishing bid prices per item, development and adoption of detailed multiyear procurement planning, adoption of a special threshold for procurement of pharmaceuticals and clinical supplies, and the use of freely convertible currencies such as USD or Euro, commonly used in international health procurement. **[PPU]**

1.4. Develop and adopt new Standard Bidding Documents (SBDs) and Procedures for 2-step tender process with pre-qualification of suppliers and products in pharmaceutical and clinical supplies procurement and use of Framework Agreements and related Purchase Orders **[PPU, CMS and CPBN]**.

2. Governance and Oversight. Governance and oversight structures for public financial management and public procurements are insufficient to support special arrangements for pharmaceutical and clinical supplies procurement. Decentralisation of MoHSS Procurement Management Unit is ongoing, and this is expected to reduce the workload. However, it is envisaged that a specialised Procurement Management Unit (PMU) based at CMS, Procurement committee (PC) and SBDs for pharmaceuticals and clinical supplies would alleviate the current challenges inherent in central PC and CPBN.

Recommendations:

2.1. In line with good standard practice, MoHSS to establish a special structural arrangement for PMU and PC for pharmaceutical and clinical supplies procurement whose membership should include representatives of the MoHSS central PC. **[CMS/MoHSS]**.

3. Human Resources. Human resource capacity (number and aptitude) gaps exist in all institutions involved in public procurement of pharmaceuticals and clinical supplies. There are delays at bid evaluation at CPBN; PPU is not sufficiently staffed (vacancy rate is 33%); and the CMS turnaround strategy phase 2 report states that 32 posts are vacant within CMS.

Recommendations:

3.1. Conduct an HR capacity audit for the institutions involved in public procurement and financial management of the pharmaceutical and clinical supplies within MoHSS-CMS, PPU and CPBN. This should include HR planning, staffing (number and skills), job analysis and recruitments. For CMS, this should be based on the recommendations and aspirations of the turnaround strategy already underway. [PPU, CPBN, CMS]

3.2. Develop and implement training for CMS and PMU on Public Procurement Act and State Finance Act and related regulations and guidelines **[CMS/ MoHSS]**.

4. IT Infrastructure for Procurement and Financial Management. IT Infrastructure for health procurement and financial

management exist but are not linked and are not used optimally. CMS has a well-developed SYSPRO system, which is being upgraded from V6 to V8, however gaps remain in terms of organisation of products in the system e.g., batch tracking, First Expired, First out (FEFO). An Integrated Financial Management System (IFMS) exists but needs to be linked with SYSPRO to allow for efficient financial planning, purchasing and budget monitoring.

Recommendations:

4.1. MoHSS to link IFMS with SYSPRO to allow for efficient financial planning, purchasing and budget monitoring, to avoid issuing manual purchase orders outside IFMS. **[CMS/MoHSS]**.

5. Procurement Planning and Financial Management. Annual planning for procurements is done and financial management systems exist, but execution is not optimal; availability of pharmaceuticals and clinical supplies is a concern, while overspending is observed each year. Financial certificates and purchase orders are issued by different offices and this creates a less transparent and effective financial planning process. This precipitates the current overspending against approved budget (average N$300 million annually). By using a pull system, CMS does not control ordering by facilities, this could be another reason for overspending.

Recommendations:

5.1. MoHSS to revise procurement planning for pharmaceuticals and clinical supplies to a rolling 3-year plan, in line with the MTEF. Annual update of the 3-year procurement plans should include the different MoHSS programmes to ensure changes in treatment regimens are taken into consideration. **[CMS/MoHSS]**.

5.2. MoHSS Accounting Officer to provide a finance certificate to ensure availability of funds over 3 years, to allow for establishing 3-year framework agreements under which purchase orders may be placed (reducing workload for Procurement staff by limiting the number of procurement cycles and decreasing procurement cycle times). **[MoHSS]**.

5.3. In line with the CMS turnaround strategy Phase 2 report, MoHSS to adopt provisions for health products tracking, improving storage infrastructure and introducing an essential clinical supplies list, all of which, will increase pharmaceutical procurement efficiencies considerably. **[CMS/MoHSS]**.

5.4. MoHSS to implement measures to control ordering by health facilities, including allocating budgets per District, inserting allocated budgets into FESC and assigning responsibility for monitoring pharmaceutical expenditure at District and Regional level. Move from the current pull system to an assisted pull system **[CMS/MoHSS]**.

6. Financial Resources and Management. In the recent past, resources approved for pharmaceutical and clinical supplies were not adequate for the country needs (51-85% of requested need was made available). This has inevitably resulted in overspending and accumulation of arrears of approximately N$370million. The budget release is less than optimal both in terms of frequency (monthly against the desired quarterly) and amount (N$75m against the desired N$100m).

Table 2: Pharmaceuticals and Clinical supplies funding gap

Description	2018/19 Billion	2019/20 Billion	2020/21 Billion
Need N$	1.33	1.30	1.26
Approved N$	0.68	0.90	1.07
%age	51.4%	69.3%	84.9%

In addition, there is weak cash flow management, emanating from lack of visibility of procurement activities by financial managers or budget control unit in the MoHSS. CMS have not conducted an internal financial audit in the past 3 years, a situation undesirable by financial management standards.

Recommendations:

6.1. In line with improvements in fiscal space, MoHSS to lobby for more resources for pharmaceutical and clinical supplies, whilst CMS should develop and implement a debt reduction strategy. [CMS/MoHSS]

6.2. Need to ensure timely release of budgets for purchase of pharmaceuticals and related supplies, through better cash flow planning and coordination between MoHSS and MoF. [CMS/MoHSS/ MoF]

6.3. MoHSS to conduct routine internal financial audits at CMS and ensure that recommendations are fully implemented. **[CMS/MoHSS]**.

7. Threshold. The introduction of the current threshold for pharmaceutical and clinical supplies procurements of N$25 million has presented some challenges to CMS, given the huge annual procurement value for pharmaceuticals and clinical supplies of approximately N$1 billion. Structural arrangements are yet to be agreed between MoHSS and CPBN on optimal threshold for health procurement. A more robust, evidenced-based analysis is required to ascertain the optimal threshold for MoHSS.

Recommendations:

7.1. PPU, informed by the on-going analysis, to consult with the Reference Group and agree on an appropriate threshold and attendant conditionalities to ensure efficiency. **[MoF/PPU]**.

8. Competitive procurements. There is limited involvement of international suppliers in bidding for pharmaceutical and clinical supplies, mainly due to the small quantities requested and bid currency fluctuations. There is also lack of evidence on additional value for applying local preferences to procurement of pharmaceuticals and clinical supplies.

Recommendations:

8.1. Put in place three-year framework agreements based on budgets from indicative MTEF estimates, consider the use of freely convertible currencies (USD or Euro) and item-price publication to attract international bidders. **[CMS/ MoHSS]**.

9. Coordination, accountability and oversight. It is noted that some of the current bottlenecks emanate from limited engagement and dialogue between the institutions involved. The importance of creating a platform to allow dialogue, consensus building on key challenges and accountability cannot be ignored, as it reduces inefficient back and forth that has been observed in the past years.

Recommendations:

9.1 Set-up a Reference Group to promote dialogue and consensus building on health sector procurement solutions. Membership to include PPU, CPBN and MoHSS (CMS, PMU, Finance) and accountable to the Accounting Authorities of the respective institutions. **[MoF (PPU), CMS** and **CPBN]**.

9.2. In line with the statutes, PPU and MoHSS need to undertake routine performance and compliance audits for pharmaceutical and clinical supplies procurements. **[MoF PPU]**.

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