Psemas Reform: Forcing Faith in Public Healthcare

By Ndumba J Kamwanyah

I've been thinking about the government's decision to require state employees to use designated public hospitals.

Last year, president Netumbo Nandi-Ndaitwah announced that from April 2026, senior officials and all staff under the Public Service Employees Medical Aid Scheme would no longer be allowed to opt for private care.

On the surface, it sounds reasonable. If we want effective functional public hospitals, surely those who serve the public should also use them.

The move forms part of the ruling party's five-year N$85.7 billion development plan to upgrade public hospitals and clinics to match private standards.

I understand the intention. Namibia's public health system has struggled with service delivery and shortages of staff, equipment and medicines.

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Meanwhile, private hospitals have grown in reputation and resources.

The divide is visible and painful.

It's not wrong to want equality in healthcare. It's not wrong to expect public officials to share the same system as ordinary citizens.

In theory, it could create pressure to improve standards. If those in power must wait in the same queues, use the same wards and rely on the same doctors, perhaps reform would come faster.

But I cannot ignore the practical, legal and ethical concerns. Reform should be built on legal and ethical soundness, not hope.

We are told a readiness assessment has identified certain public facilities as suitable. That is encouraging but it's not the same as saying the entire system is ready to absorb thousands of additional patients.

Public hospitals are already stretched.

To suddenly direct all state employees to these facilities risks overwhelming them further. Good intentions do not automatically create capacity.

There is also the administrative side. Public hospitals will have to submit claims in a manner similar to private facilities. Psemas itself has admitted there is no proper billing system capable of processing such claims. This is not a small technical detail.

Billing systems are the backbone of medical aid systems. Without them, confusion, delays and disputes are inevitable.

If the system cannot process claims smoothly, hospitals may struggle with cash flow, and patients may face uncertainty about coverage.

Reforming healthcare financing without the necessary infrastructure is like building a roof before laying the foundation.

I also worry about the principle of choice. Medical aid schemes are built on the idea that members contribute and, in return, can access defined benefits.

If state employees contribute to Psemas, shouldn't they have some freedom in deciding where to seek care?

Removing private options assumes that compulsion is the best way to strengthen public services. I am not convinced.

Trust in public institutions is not created by forcing people into them. It is created by delivering consistent, high-quality care.

BROADER IMPACT

Supporters of the policy argue that the N$85.7 billion development plan will transform public facilities to match private standards. I hope this is true.

But transformation takes time. Infrastructure upgrades, staff training, equipment

The risk is that morale in public hospitals could decline if staff are blamed for systemic weaknesses beyond their control.

There is also a broader economic impact to consider. Namibia's private healthcare sector employs many professionals and supports related industries. A sudden withdrawal of Psemas members from private facilities could destabilise parts of that sector.

During a stakeholder meeting, private providers understandably raised concerns. Reform does not have to mean weakening one sector to strengthen another.

A balanced health system can allow public and private institutions to coexist, complement and even learn from each other.

If I were to suggest alternatives, I would start with gradual integration. For example, Psemas could introduce incentives for using public hospitals instead of outright prohibitions.

Lower co-payments, shorter authorisation processes, or enhanced benefits for public facility use might encourage voluntary migration.

BENCHMARKS

At the same time, strict quality benchmarks could be set.

Only facilities that meet defined standards on staffing, equipment and patient care should be designated. This would link policy to performance, not just political timelines.

Another option is phased implementation. Start with senior officials, as originally proposed for 2026, and monitor the impact carefully.

Collect data on waiting times, patient outcomes and financial sustainability.

Adjust the policy before expanding it to all state employees. Reform should be evidence-based.

A pilot approach allows mistakes to be corrected before they become national problems.

Most importantly, the billing and administrative systems must be fixed before claims

The new contract before the attorney general and the possible review of the annual contract renewal cycle are steps in the right direction. But these processes must be transparent and efficient.

Without strong administration, even the most noble healthcare reform will fail.

I believe in a strong public health system. I believe public hospitals should be places of dignity and excellence. But I also believe reform must respect reality.

Compelling state employees to use designated public hospitals may be bold, but boldness alone does not guarantee wisdom.

If the system is not fully prepared, the policy could strain facilities, frustrate patients and undermine confidence in both Psemas and the government's broader development plan.

Healthcare reform should unite us around shared improvement, not divide us through forced sacrifice. If we truly want public hospitals to match private standards, we must first build them to that level.

Then people will choose them willingly. And when choice aligns with quality, reform becomes sustainable, not merely symbolic.

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