THE HEALTH MARKET CONDUCT *INSIGHTS*

Namaf
Namibian Association of Medical Aid Funds

Key Industry Metrics & Trends

In The Spotlight with Charine Glen-Spyron Clinical Psychologist

Sustainability with affordability at the core: A Southern African perspective Dr. Katlego Mothudi

Regulatory/ Policy Update– Namibia 2nd quarter

Industry update from **Namaf**

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- Namaf coding structure
- Claims trends

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Health Market Conduct Insights | Second Edition | Q2 2026

By: Uatavi Mbai
Stakeholder Relations and Communication Manager

Section 1: Lead Message

From Dialogue to Meaningful Engagement

Welcome to the second edition of *The Health Market Conduct Insights.* Following the introduction of this platform in our first edition, Namaf continues its commitment to keeping the healthcare funding industry informed, connected, and engaged on developments that influence the sustainability and conduct of our market.

The healthcare funding environment continues to evolve, with increasing claims expenditure, changing utilisation patterns, regulatory reform, and ongoing efforts to strengthen the sustainability of the industry. These developments require more than regulatory oversight; they require continued dialogue and collaboration among medical aid funds, administrators, healthcare providers, professional associations, and other stakeholders. The industry trends highlighted in this edition demonstrate why it is important for all stakeholders to understand not only what is changing, but also how these changes affect the broader healthcare funding ecosystem.

At Namaf, we believe that meaningful stakeholder engagement is central to effective market conduct. Engagement must go beyond communicating decisions and requirements; it must create opportunities for stakeholders to share their experiences, raise concerns, and contribute to solutions. This principle informed the strategic decision to introduce the Namaf Roadshow, taking engagement directly to healthcare providers and stakeholders across the country. The Roadshow provides an opportunity to share updates on key initiatives, including ICD-10, the Namibia NAPPI Product and Price File, coding and benchmark processes, and the practice number renewal process, while giving stakeholders an opportunity to provide practical input.

The response from stakeholders has demonstrated the value of this approach. Following one of the engagements, a participant shared: "I hope you enjoyed a good weekend. Thank you again for Friday's engagement – you and your team's effort is really appreciated!" For Namaf, feedback such as this reinforces the importance of creating spaces where stakeholders feel heard and where engagement is a genuine two-way conversation.

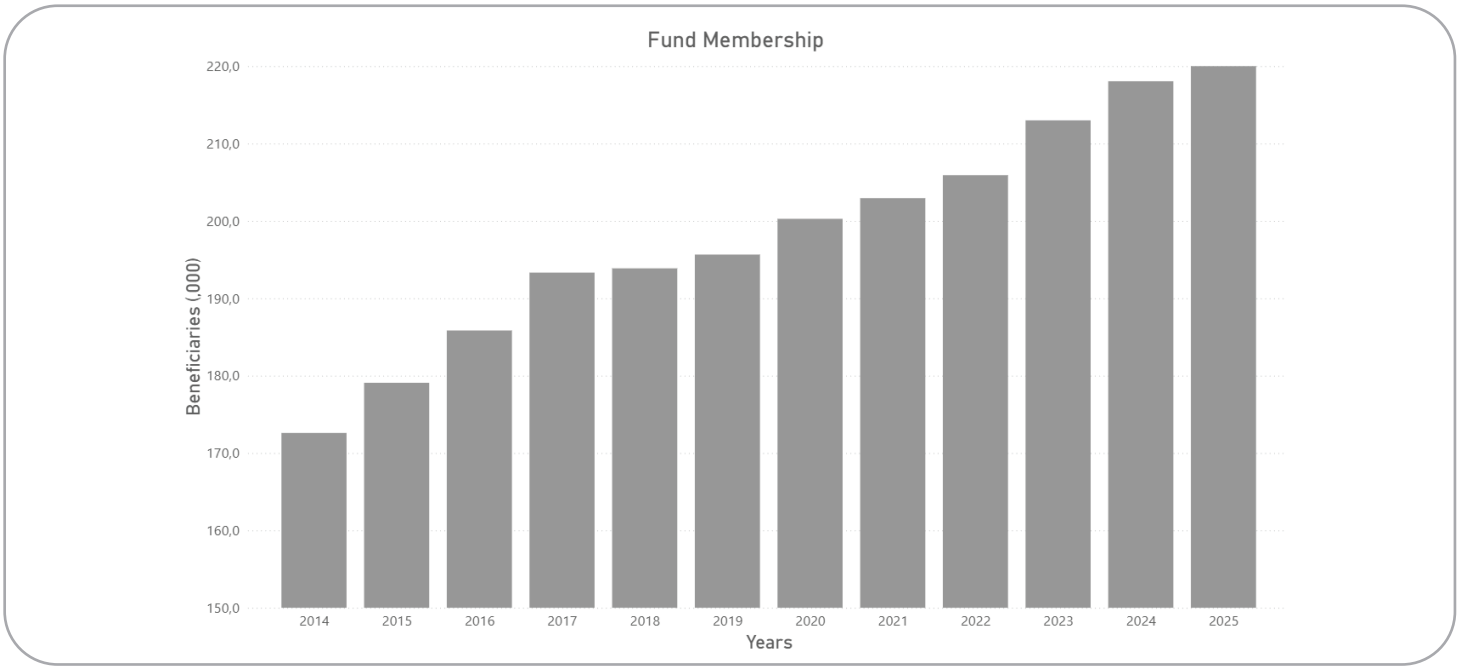
As we move forward, the focus must be on turning dialogue into meaningful outcomes. The Roadshow, stakeholder forums, PANC, regulatory consultations, and industry education initiatives are all part of a broader effort to strengthen collaboration and ensure that stakeholder perspectives are considered in shaping initiatives that affect the healthcare funding environment.

This second edition, therefore, continues the conversation started in our first edition: a sustainable healthcare funding industry requires transparency, informed participation, mutual accountability, and trust. Namaf remains committed to creating platforms that enable stakeholders to engage constructively, share perspectives, and work collectively towards a healthcare funding environment that is sustainable, responsive, and focused on the interests of the industry and its members.

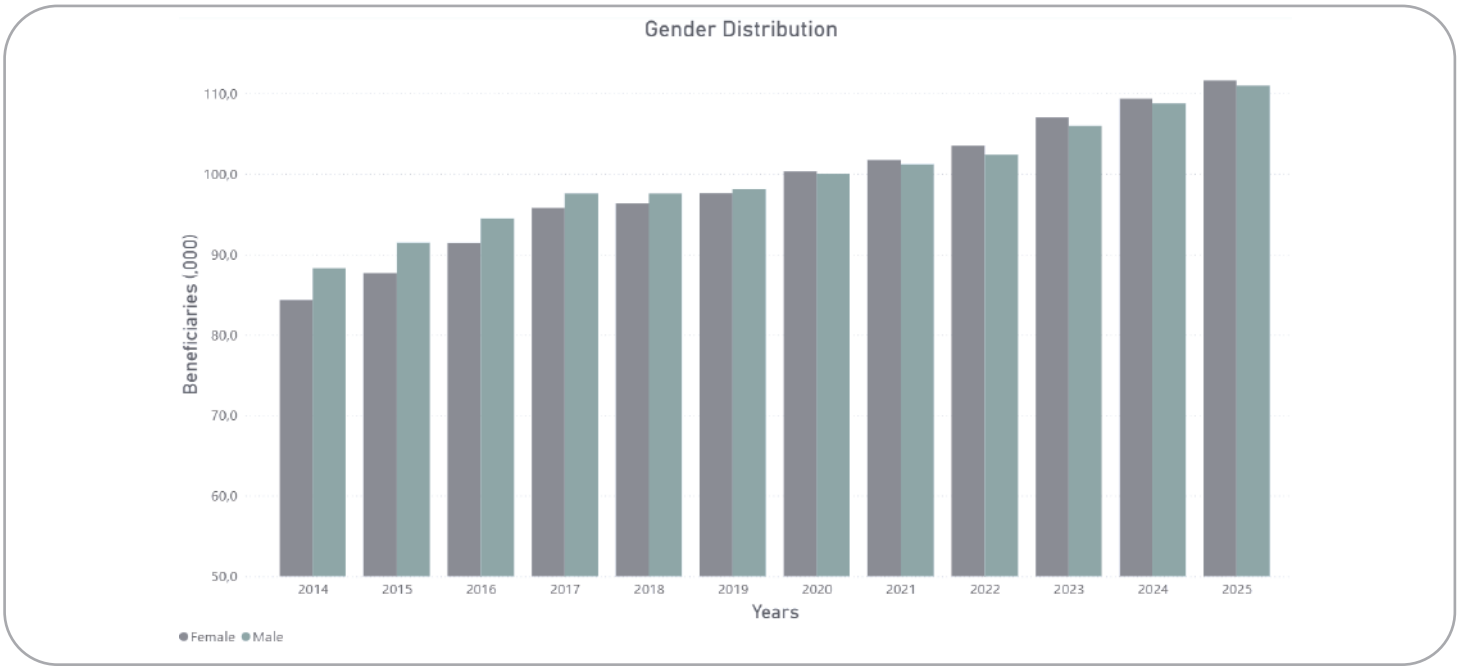
Section 2: Key Industry Metrics & Trends

1. Membership

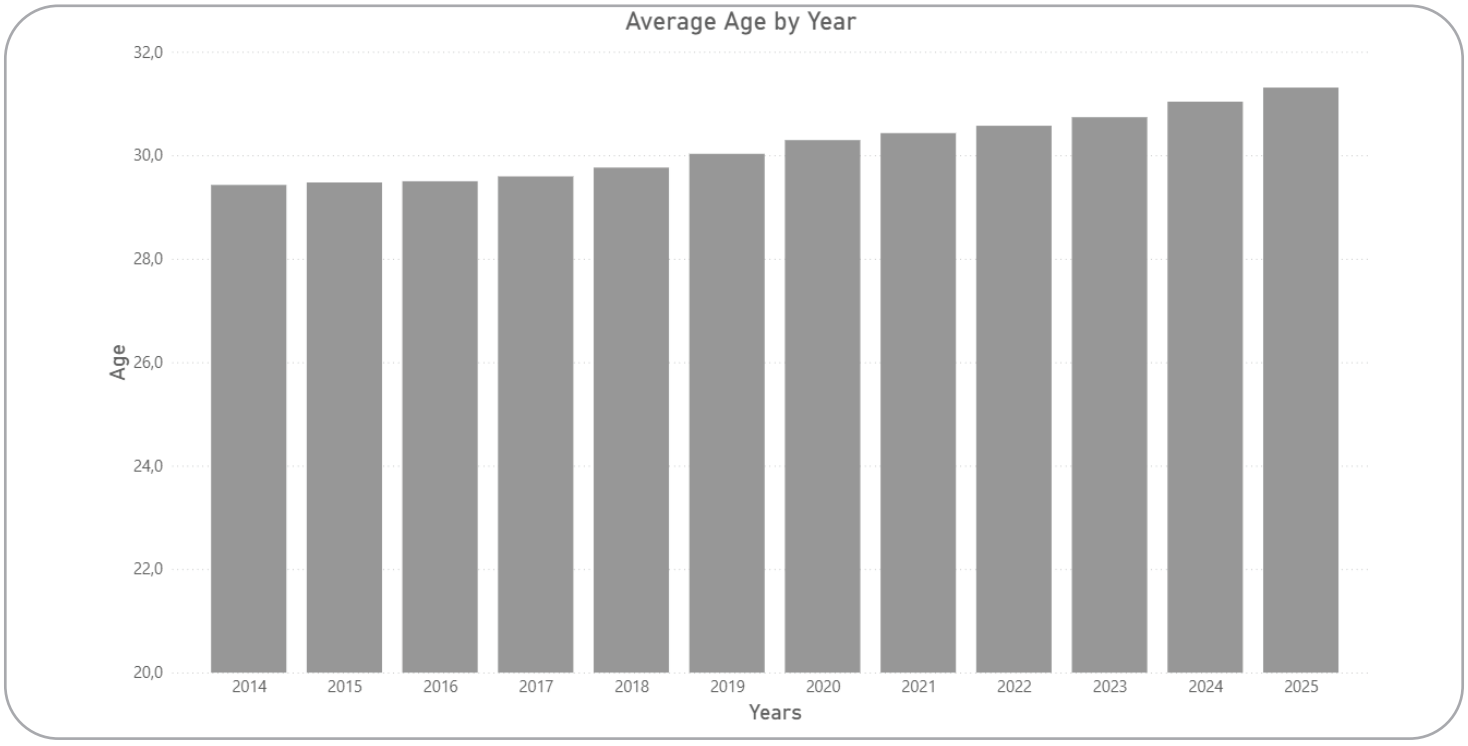
Membership in registered medical aid funds has grown steadily over time, reaching 220 000 beneficiaries by the end of 2025.



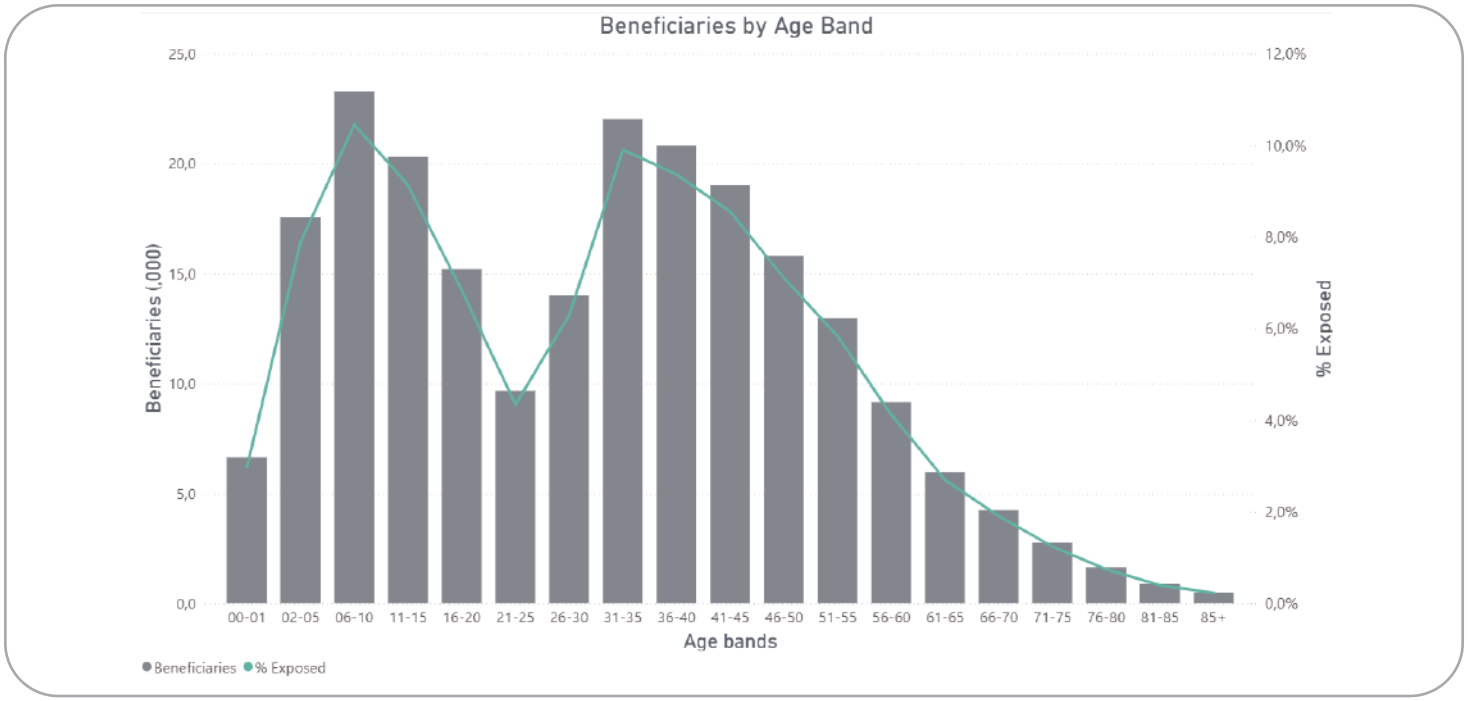
The proportions of male and female beneficiaries have remained similar over time.



Although ageing accelerated slightly in 2025, the average age of beneficiaries in registered medical aid funds has remained broadly stable over time, increasing by only 1.83 years over the past decade.

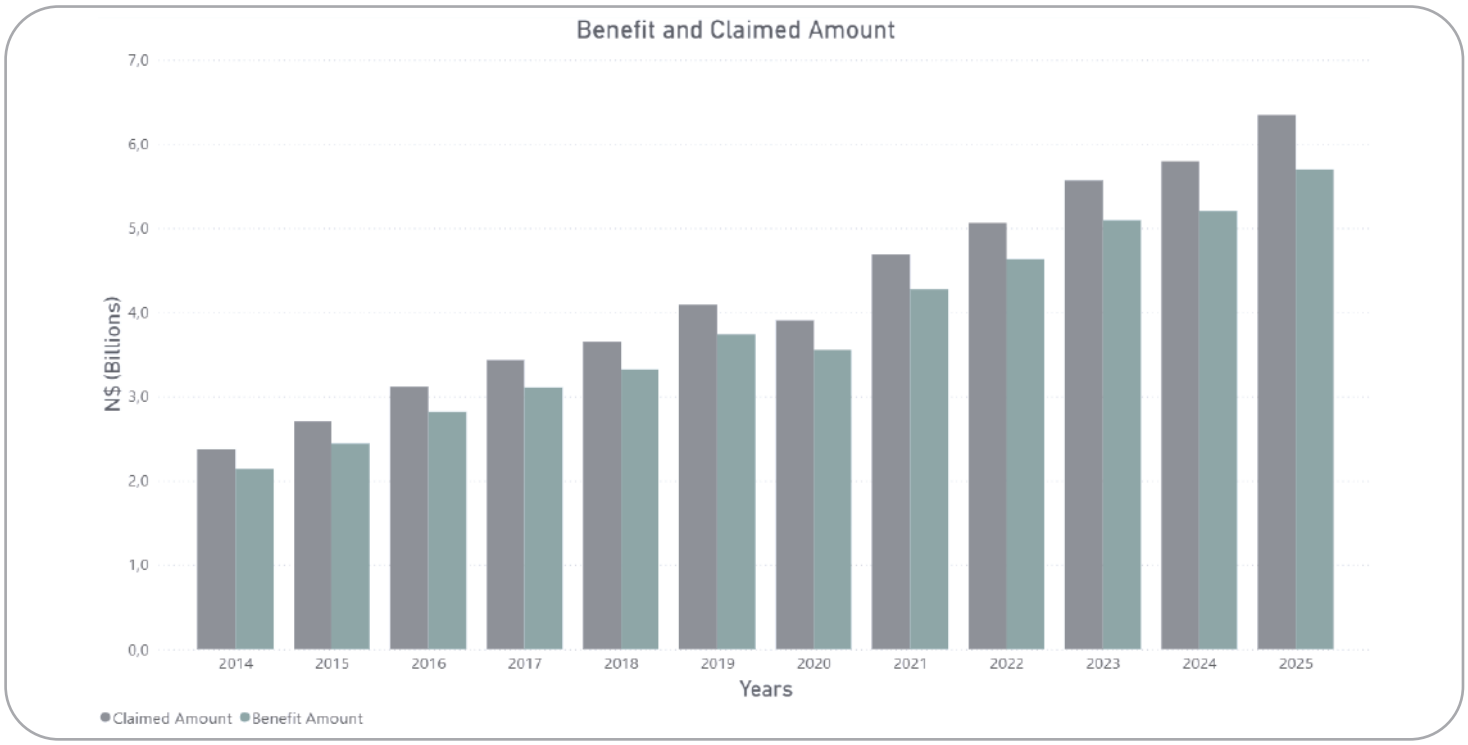


One reason the average age has remained relatively stable is that a large share of beneficiaries in registered medical aid funds falls within the younger age bands, while a smaller share falls within the older age bands.

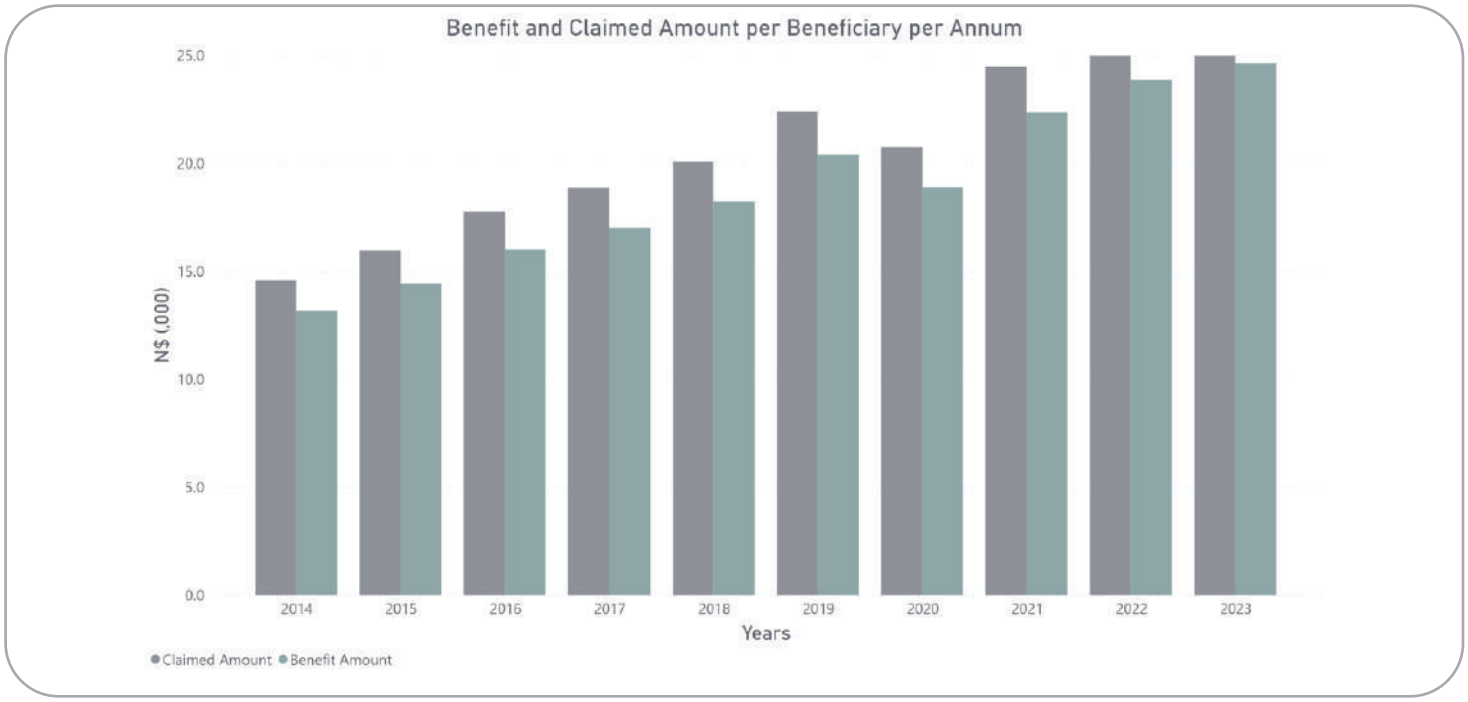


2. Claims Trends

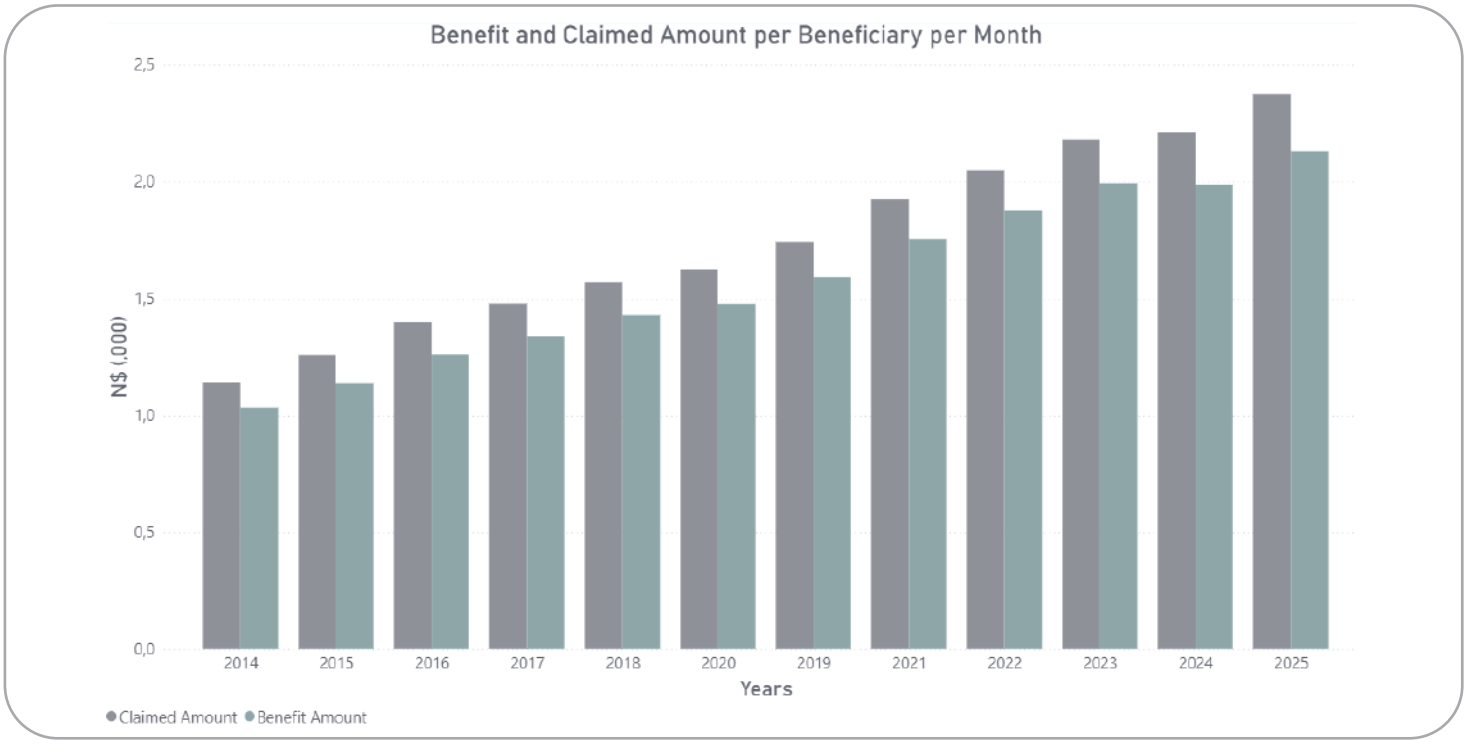
Total claims and benefits have risen steadily over time, with claims received by registered medical aid funds reaching N$6.34 billion by the end of 2025. The effects of the COVID-19 pandemic on the use of elective, or planned, healthcare services are evident in the 2020 claims and benefit figures. In nominal terms, both claims received and benefits paid declined in 2020 compared with 2018 and 2019 but recovered and exceeded pre-pandemic levels from 2021 onward.



The total value of claims received and paid by registered medical aid funds translates into N$28 500 claimed per average covered beneficiary for the 2025 benefit year and N$25 580 paid per average covered beneficiary per annum for the 2025 benefit year. These average amounts are significantly higher than the average claims per beneficiary received and paid in the pre-pandemic 2018 and 2019 benefit years, as well as in the post-pandemic years.

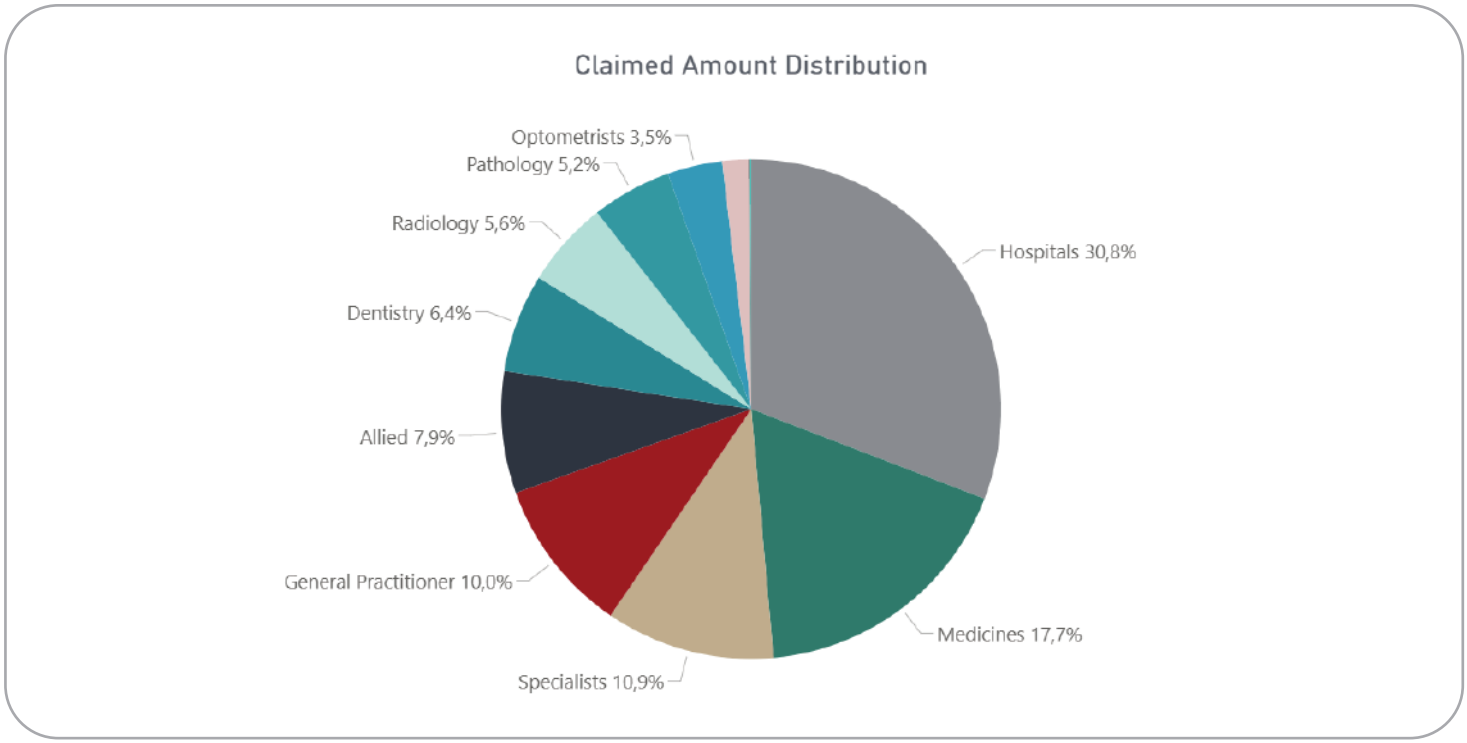


The above figures translate into a total claimed amount of N$2 370 per average beneficiary per month for the 2025 benefit year and a total benefit amount of N$2 130 per average beneficiary per month for the 2025 benefit year.

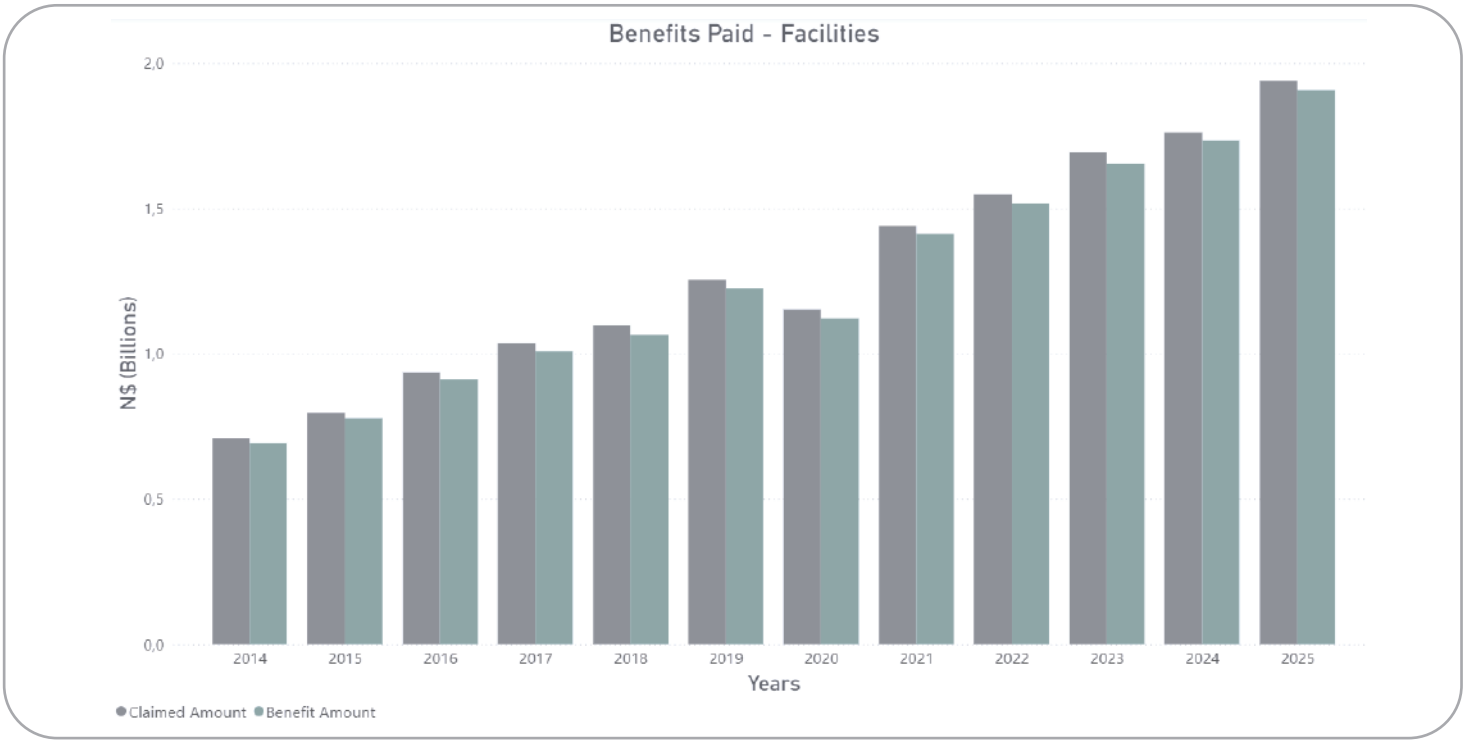


3. Claims by discipline.

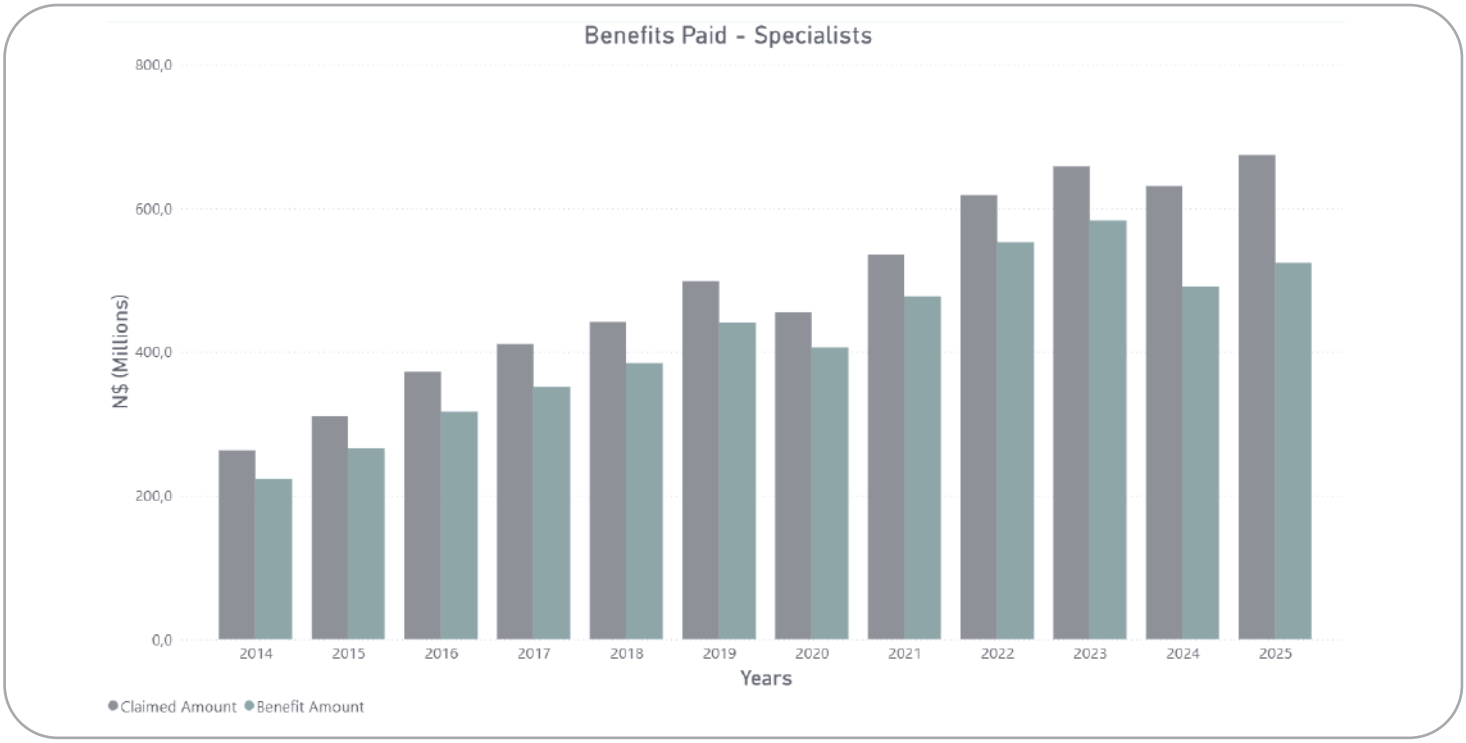
Private hospitals accounted for just under a third of the total claims paid in 2025 by registered medical aid funds, followed by medicines at 17.7%, specialists at 10.9%, and general practitioners at 10.0%. The proportions of benefits paid towards general practitioners, specialists, hospitals, and medicines decreased compared with prior years, while the proportion of benefits paid towards allied disciplines and optometrists increased.



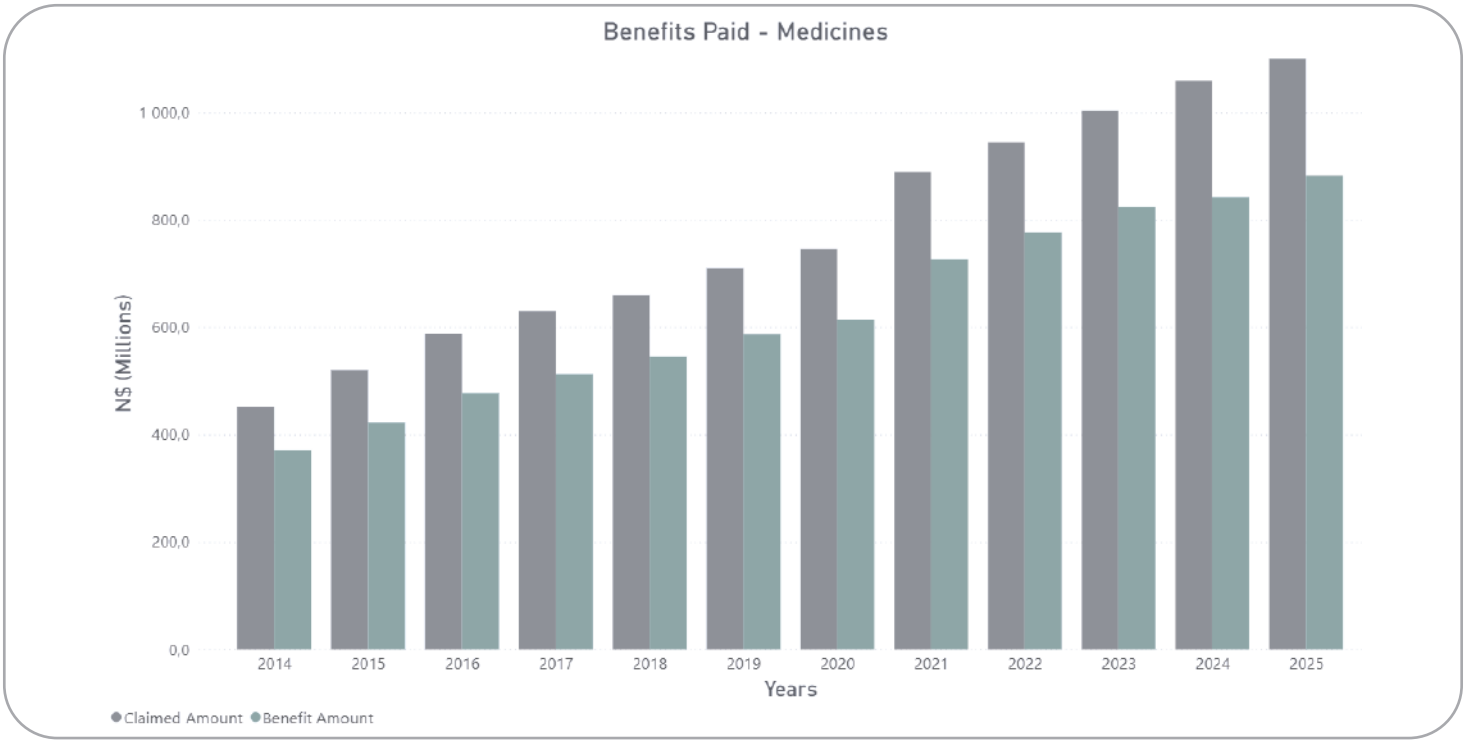
The total value of the claims paid to private hospitals in 2025 was approximately N$1.91 billion while about N$1.94 billion was claimed.



The total value of claims paid to medical specialists was about N$524.36 million in 2025, while N$674.35 million was claimed. It is important to note that a lower proportion of claims received was paid in respect of specialists compared with private hospitals.



An even lower percentage of claims received was paid in respect of medicines, with claims to the value of N$1.12 billion having been received and claims to the value of approximately N$882.3 million having been paid.



4. Key Drivers

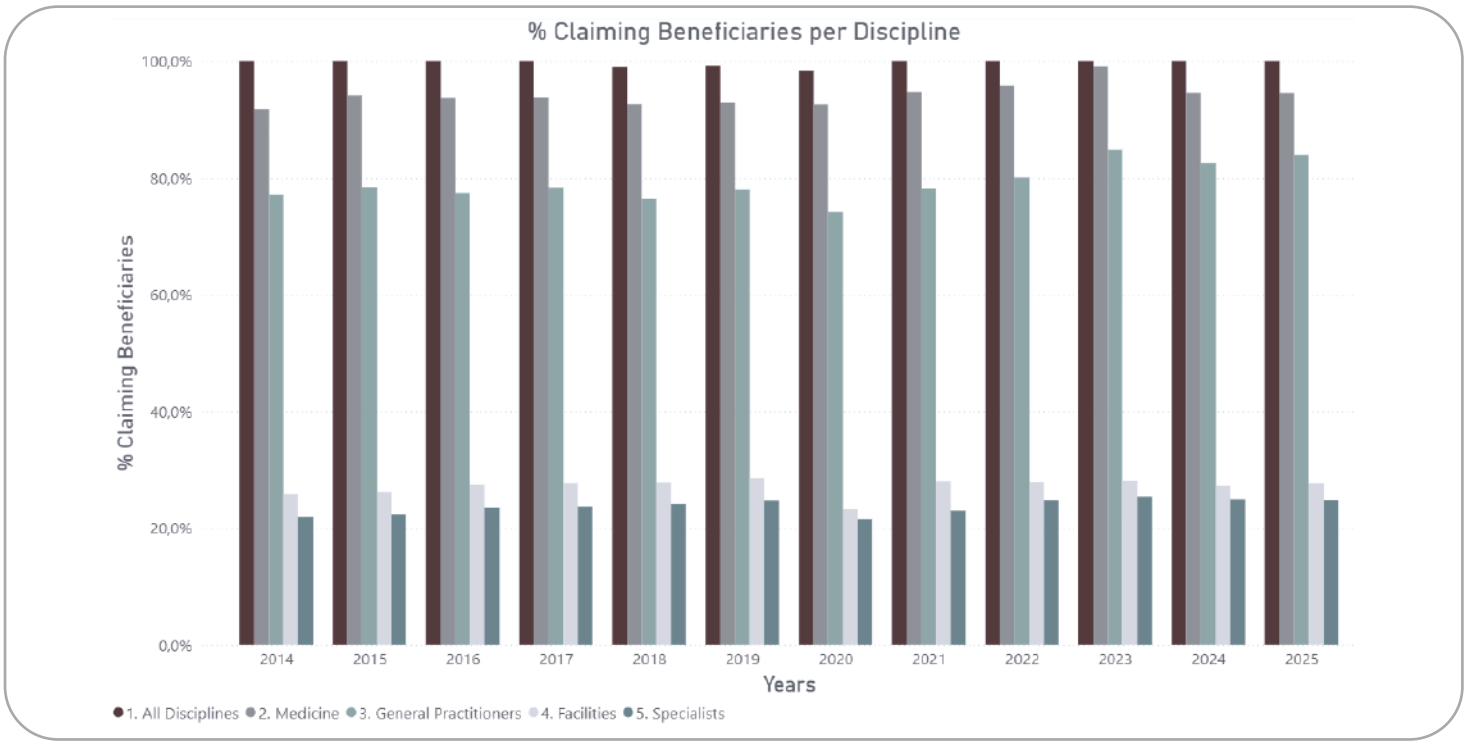
The total cost of claims received and/or paid by medical aid funds is typically determined by two factors:

- The volume of the claims which is known as utilisation of benefits and/or services in the medical aid funding environment; and

- The price per claim line or item.

The figure below shows that the overall utilisation of services at a discipline or provider type level has remained relatively constant over time. In 2025:

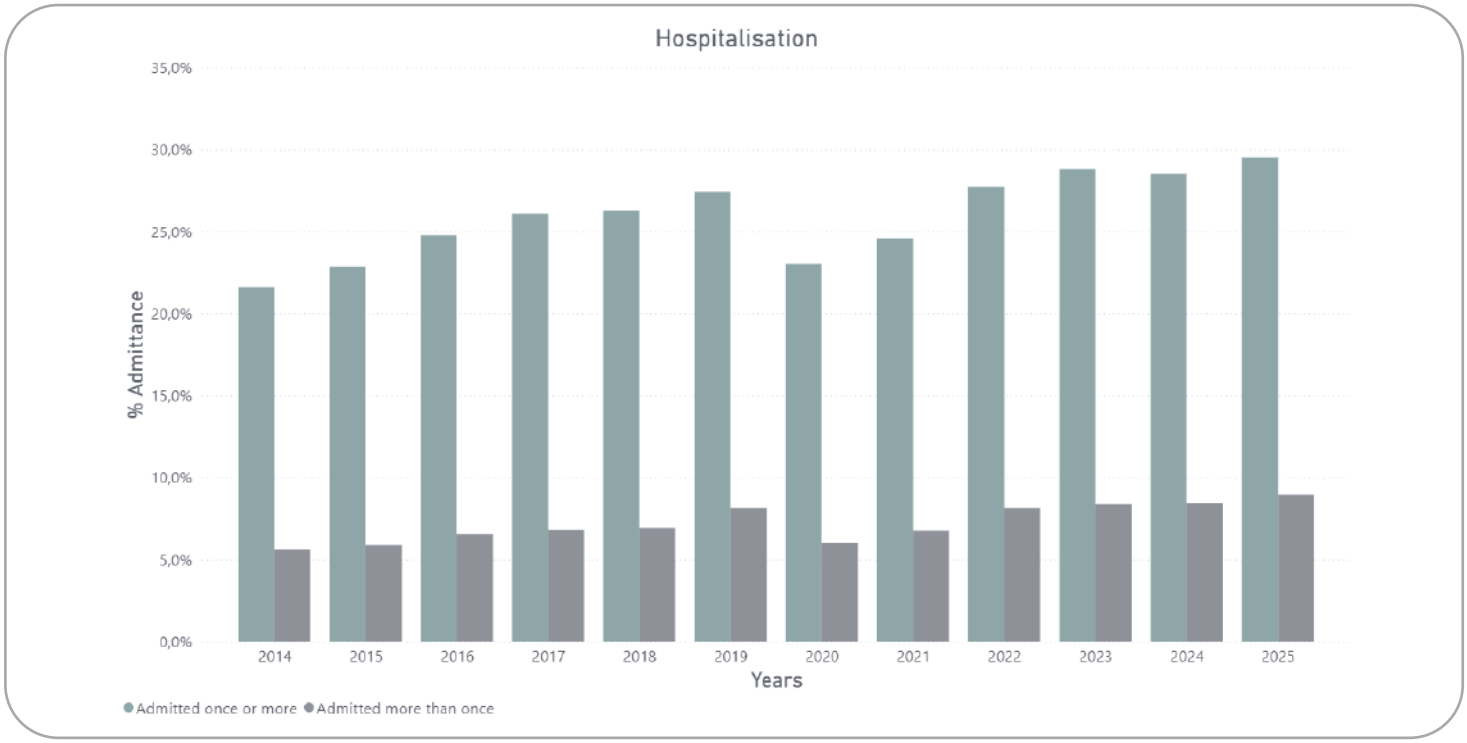
- All beneficiaries belonging to a registered medical aid fund submitted a claim of some description;
- 99.1% of beneficiaries submitted a claim for medicines;
- 77.2% of beneficiaries submitted a claim originating from an encounter with a general practitioner;
- 26.8% of beneficiaries submitted a claim originating from a hospital encounter; and
- 25.4% of beneficiaries submitted a claim originating from an encounter with a medical specialist.



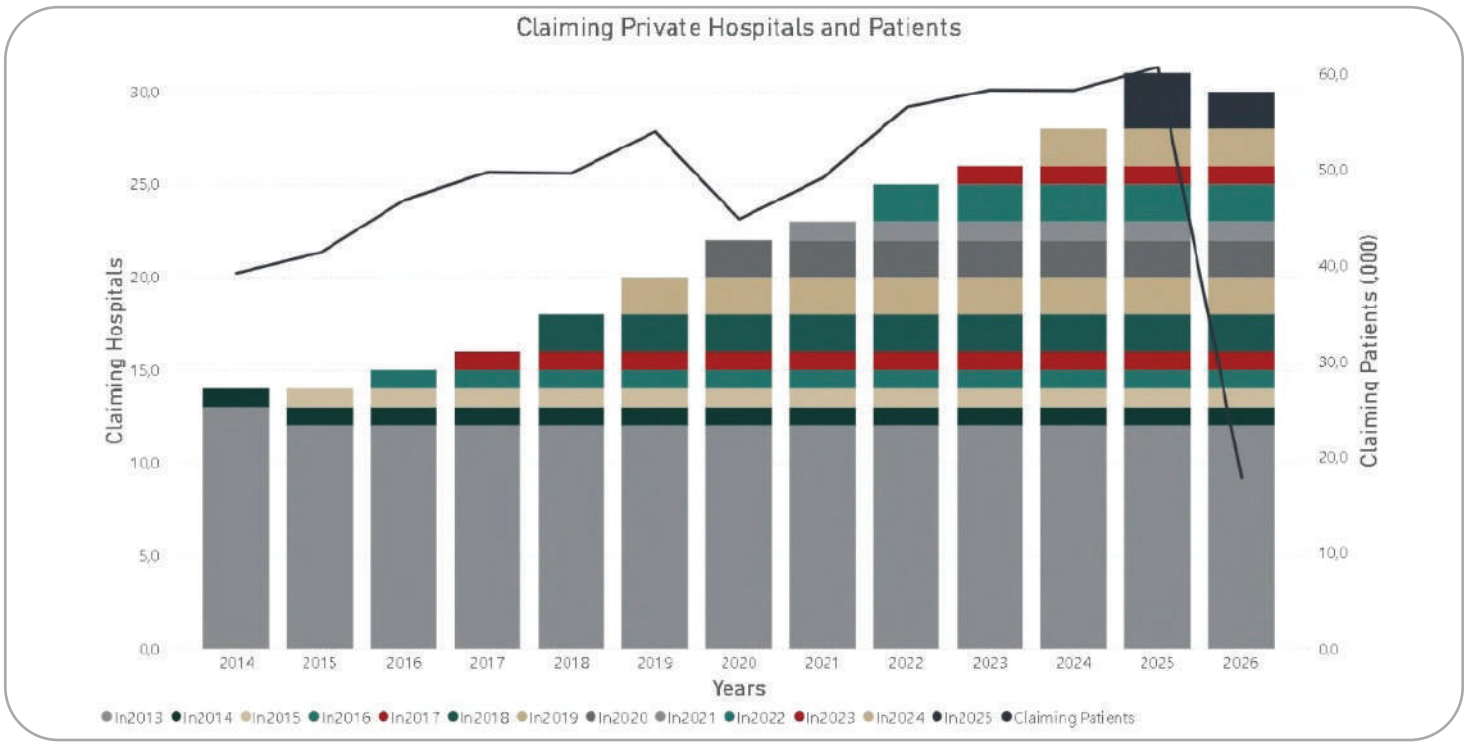
The trends in the figure above appear relatively constant over time, but this is because such a high percentage of beneficiaries submitted a claim. The impact of the COVID-19 pandemic on the utilisation of healthcare services is again visible.

The figure below shows trends over time in hospitalisation for beneficiaries who were admitted at least once and those who were admitted more than once, respectively.

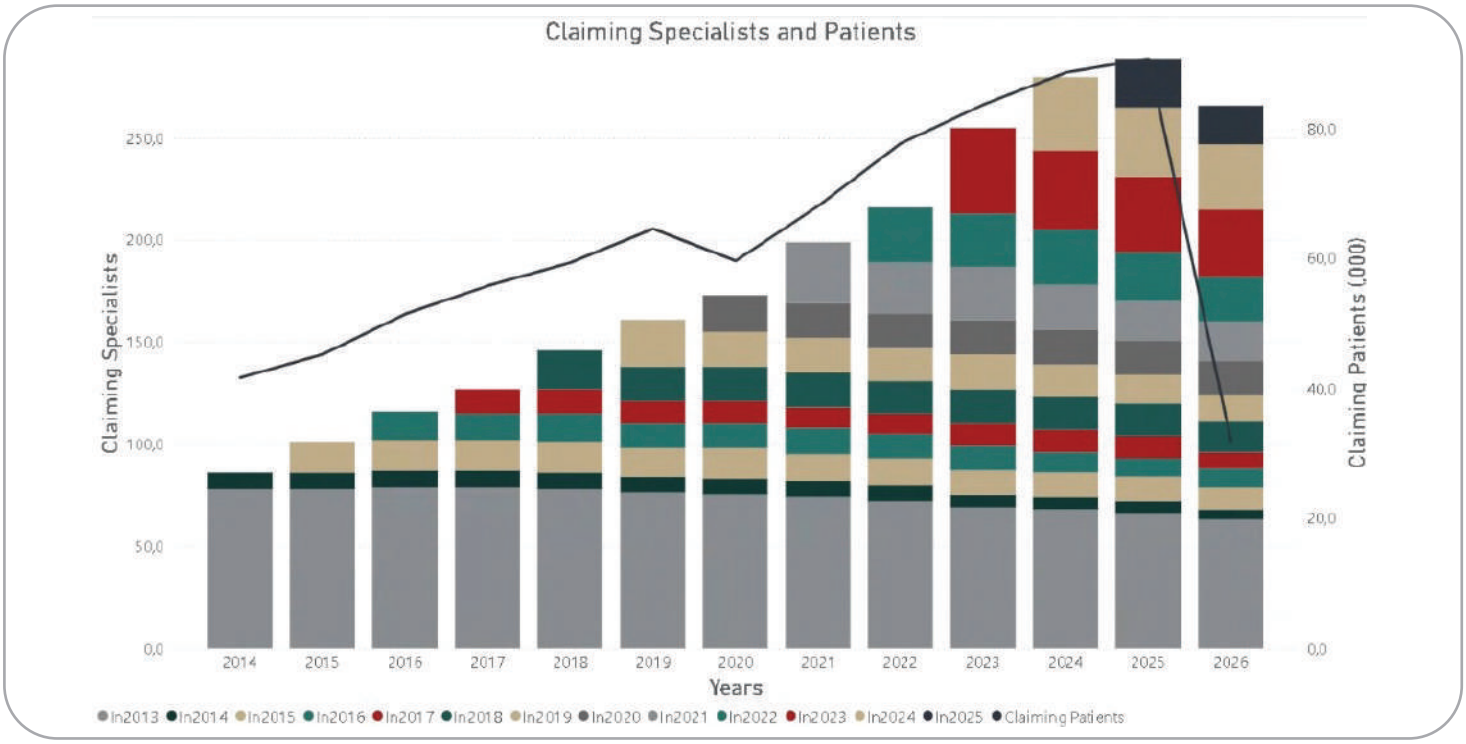
The figure shows that the rate of hospitalisation increased from 22.86% to 29.53% over the ten years to December 2025, while the proportion of beneficiaries with more than one admission per year increased from 5.88% to 8.96% of total covered beneficiaries. These increases should be read together with the observation above that the average age of covered beneficiaries remained relatively constant over the same period.



It is well known that the number of hospitals and hospital beds has increased significantly in recent years. The figure below shows how the number of admissions has increased as the number of hospitals has grown over time, confirming the view that access to care is one of the key drivers of service utilisation. In turn, this forms part of the principle of so-called supplier-induced demand.



The figure below shows the effect over time of increases in the number of specialists in Namibia on the utilisation rates of specialist services. The notion of supplier-induced demand is again applicable, but it is important to note that a proportion of the increased utilisation of specialist services reflects the fact that certain services were previously unavailable in Namibia. This suggests that increased utilisation of services is not always negative, although the pressure on the overall cost of funding healthcare will increase correspondingly.



It is again worth noting that the number of beneficiaries who accessed specialist services reduced significantly in 2020 and 2021, which can be attributed to the effects of the COVID-19 pandemic. In 2022 and 2023, the utilisation of specialist services returned to pre-pandemic levels.

The number of claiming specialists also increased markedly in 2022 and 2023.

5. Summary

The report analyses trends in the membership and claims experience of registered medical aid funds up to 2025. It notes steady beneficiary numbers, a balanced gender ratio, and a stable average age, while claims and benefits paid have increased significantly. The analysis suggests that these increases were driven primarily by improved access to healthcare services, such as hospitals and specialists, rather than by changes in the underlying healthcare needs of the covered population, with COVID-19 causing temporary reductions in utilisation that later returned to pre-pandemic levels.

6. Key Takeaways & Risks

- The central cost pressure experienced by medical aid funds is not explained by ageing alone. Beneficiary numbers reached 220 000 by end-2025 and the population aged by only 1.83 years over the past decade, yet total claims increased to N$6.34 billion, or N$28 500 per average beneficiary per year. This suggests that utilisation and/or price intensity, rather than demographic shift, is the more important driver of claims inflation.

- Hospital utilisation is the most material structural risk. The hospitalisation rate increased from 22.86% to 29.53% over 10 years, while beneficiaries with more than one admission per year increased from 5.88% to 8.96%. Because private hospitals account for just under a third of all claims paid and approximately N$1.91 billion in benefits, repeat admissions represent a disproportionate source of cost pressure.

- A supply-side utilisation effect requires active management. Rising admissions are linked to growth in the number of hospitals and beds, while specialist utilisation is linked to growth in the number of specialists. This creates a strategic tension, namely that better access improves care availability, but it can also expand demand and increase funding pressure even when underlying member risk has not changed materially.

- The gap between claims received and claims paid is significantly wider for specialists and medicines than for hospitals. In 2025, about N$674.35 million was claimed for specialists versus N$524.36 million paid, and N$1.12 billion was claimed for medicines versus approximately N$882.3 million paid. This may indicate tariff, benefit design, or affordability tensions that could affect member experience, provider relations, and future scheme behaviour.

- A key interpretation risk is that broad utilisation rates appear stable while intensity is worsening. Although nearly all beneficiaries submitted some claim and discipline-level utilisation appears relatively constant, the more important signal is the rise in hospital and repeat-admission rates.

Section 3: Regulatory / Policy Update – Namibia 2nd quarter

The implications of the Financial Institutions and Market Act 2021 (Act No. 2 of 2021) (commonly known as FIMA), on the Medical Aid Funds Act, 1995 (Act No. 23 of 1995)

Prior to 01 May 2026, registered Medical Aid Funds in Namibia were regulated by NAMFISA and NAMAF under the provisions of the Medical Aid Funds Act, 1995 (Act No. 23 of 1995). In terms of the MAFs Act, 1995, as amended, the Chief Executive Officer (CEO) of NAMFISA is also the Registrar of Medical Aid Funds and therefore responsible for regulating the financial component of Funds, commonly known as "Prudential Supervision. The health component of Funds is controlled by Namaf.

FIMA consolidated and modernised the regulatory framework of non-banking financial sector in line with the risk-based supervision framework. FIMA seeks to, amongst other objects, foster:

- The financial soundness and stability of financial institutions and financial intermediaries.
- The highest standards of conduct of business, financial institutions, and financial intermediaries.
- The fairness, efficiency, and orderliness of the financial institutions and markets;
- The protection of consumers of financial services;
- The promotion of public awareness and understanding of financial institutions and financial intermediaries; and
- The reduction and deterrence of financial crime.

The FIM Act, 2021, amends and impacts various provisions within Namibia's financial and regulatory sectors, amending provisions of the Medical Aid Funds Act, 1995, and does not completely repeal the Medical Aid Funds Act, 1995 (Act No. 23 of 1995). Instead, certain sections related to the Registrar are repealed, while the core statute of the 1995 Act remains active to govern medical aid funds alongside FIMA's supervisory framework, administered by NAMFISA. Put differently, provisions of the Medical Aid Funds Act, 1995, which relate to Namaf, remained intact. To strengthen its regulatory powers, Namaf, together with the Minister of Health and Social Services, as the steward, is in the process of amending the health and clinical components of Medical Aid Funds.

The above statutory contextual framework does not change how healthcare providers, health facilities, and private hospitals interact with Medical Aid Funds. The primary distinction however is that providers of healthcare services are undertakings subject to the control of the Namibian Competition Commission established in terms of the Competition Act, 2003 (Act No 2 of 2003) whilst Medical Aid Funds are not undertakings.

Section 4: In The Spotlight

Charine Glen-Spyron
Clinical Psychologist, President of the Psychological Association of Namibia (PAN)

Mental Health in Namibia: A National Priority for Health, Dignity and Wellbeing

Mental health is not a peripheral issue in Namibia. It is a fundamental component of our health, our families, our workplaces and the wellbeing of our communities. Yet mental health remains one of the areas of healthcare where stigma, limited access to services and delayed help-seeking continue to have significant consequences.

Available national data demonstrate the scale of the challenge. During the 2022/23 financial year, Namibia recorded 14,369 outpatient visits for psychiatric disorders and a further 96,192 psychiatric follow-up visits, alongside 9,782 psychiatric inpatient admissions. More recently, the Ministry of Health and Social Services reported 1,474 suicide deaths over a three-year period, highlighting the urgent need for effective prevention, early intervention, and accessible mental healthcare.

Namibia is also at an important turning point in how mental healthcare is understood and delivered. In September 2025, the Mental Health Bill 2025 was tabled as a landmark reform intended to modernise Namibia's mental healthcare framework and strengthen the dignity, rights, and wellbeing of people experiencing mental health conditions. The Bill has subsequently progressed through Parliament, with the National Assembly adopting it in June 2026 and the National Council subsequently considering the legislation. At the time of writing, it is therefore important to distinguish between the passage of the Bill and its formal promulgation and commencement as an Act.

The proposed legislation represents an important shift towards a human-rights-based, patient-centered, and community-oriented approach to mental healthcare. It provides for stronger protections against abuse and neglect, greater emphasis on community-based care, improved regulation of restraint and seclusion, suicide prevention and early intervention, and broader mental-health coverage through medical aid schemes. For Namibia's mental health population, this could represent a significant move away from responding only when people reach a crisis point towards prevention, early identification, treatment, rehabilitation, and recovery.

However, legislation alone cannot transform mental healthcare. We need investment in services, appropriately trained professionals, multidisciplinary teams, community-based interventions, and systems that make it easier for people to seek help before a crisis develops.

We must also recognise that mental health and physical health cannot be separated. Depression, anxiety, chronic stress, trauma, and other mental health conditions can affect sleep, energy, concentration, lifestyle behaviours and adherence to medical treatment. Conversely, chronic physical illnesses can significantly affect psychological wellbeing. The relationship is therefore not simply one-directional: our minds and bodies continuously influence one another.

This is why we should pay attention to changes in ourselves and those around us. Persistent changes in mood, sleep, appetite, behaviour, motivation, relationships, work performance or physical wellbeing should not simply be dismissed as "stress" or something that we must endure. Early support can prevent difficulties from becoming crises. As the Psychological Association of Namibia, we encourage every Namibian to view help-seeking as a strength rather than a weakness. Speaking to a psychologist, counsellor, social worker, doctor or another appropriate healthcare professional can be an important first step towards recovery.

The future of mental healthcare in Namibia must be built on prevention, early intervention, dignity, accessibility, collaboration and hope. The proposed legislative reforms provide an important foundation. Our responsibility as professionals, communities, employers, families and individuals is to ensure that this foundation translates into meaningful change in people's everyday lives.

Mental health is health. There is no health without mental health.

Section 5: Sustainability with affordability at the core: A Southern African perspective

Dr. Katlego Mothudi
Managing Director, Board of Healthcare Funders (BHF)

Across Southern Africa, medical aid funds and medical schemes face the same question: how do we remain financially sound while keeping cover within reach of the people who need it most? The answer will shape whether private healthcare financing remains relevant to the region's Universal Health Coverage (UHC) ambitions, or is slowly priced out of them.

Across Africa, progress towards UHC remains uneven, with high out-of-pocket healthcare costs continuing to undermine financial protection for millions of households. This challenge is not confined to the uninsured. Funding models also face the challenge of attracting and retaining younger, healthier members, particularly as conventional cover becomes increasingly unaffordable. When younger members remain outside the risk pool, costs become more concentrated among older and sicker members, placing further pressure on contributions. That, in turn, risks pushing the next tier of members out. It is a slow puncture, not a sudden failure, and one that threatens the long-term sustainability of healthcare funding.

Two levers matter most in breaking that cycle. The first is product design. For funds and schemes, this means designing structured, affordable entry-level options focused on primary care, GP consultations, essential medicines and basic diagnostics, while using data, prevention and more efficient care pathways to manage costs before they escalate. The second is regulatory pace: benefit frameworks need to evolve alongside changing disease burdens and care models. Where they do not, they can limit investment in the prevention and primary care interventions that help improve health outcomes and contain long-term costs.

Neither lever works in isolation, and neither belongs to funders alone. Sustainable, affordable cover depends on regulators, funders, providers and government moving at the same pace, toward the same goal. Namibia's own deliberations on the role of private medical aid within its UHC framework sit squarely within this regional conversation.

The resilience dividend, as we have called it, is the long-term return on investing now in more sustainable, more affordable systems. Southern Africa does not lack the evidence for what works. What the region needs, collectively, is the resolve to implement it before the next generation of members is priced out of the pool altogether.

Section 6: Industry Update from Namaf

Passing the Baton: *A Legacy of Progress and a New Chapter for Namaf*

The conclusion of the outgoing Management Committee's term marks an important moment in the journey of the Namibian Association of Medical Aid Funds (Namaf). Over the course of its tenure, the Management Committee navigated a complex and evolving healthcare funding environment, while laying important foundations for a more sustainable, transparent, and collaborative industry.
Under the leadership of Pieter Theron, the outgoing President, Namaf strengthened its strategic focus and confronted some of the most pressing challenges facing the medical aid fund industry. His tenure was characterised by a commitment to sustainability, evidence-based decision-making, and meaningful engagement with stakeholders across the healthcare value chain.

One of the defining achievements of the Management Committee was the development and implementation of Namaf's 2024–2026 Strategic Plan. Developed through consultation and informed by the industry's key challenges, the strategy provided a clear roadmap around four strategic themes: legislative and governance reform, sustainability of the healthcare industry, stakeholder participation and ownership, and institutional resources and support.

The Committee also demonstrated its commitment to the long-term sustainability of the industry through difficult but necessary decisions. In 2024, following analysis of claims data showing continued pressure on medical aid funds, the Management Committee resolved to maintain a zero percent increase in the Namaf benchmark tariff. While such decisions are never taken lightly, the approach reflected the Committee's responsibility to consider the sustainability of the broader health funding system and the affordability of healthcare for members.

Building the foundations for reform

Legislative reform remained a key priority throughout the Committee's term. Recognising that the existing legislative framework required modernisation to respond to the changing healthcare environment, the Committee pursued reform of the Medical Aid Funds Act.

The Committee secured important political support for this agenda, including the identification of stewardship for the reform process. Although changes in political leadership and ministerial appointments slowed progress, the Committee succeeded in keeping legislative reform firmly on the industry agenda and established the groundwork for continued progress.

This work was complemented by efforts to strengthen Namaf's technical decision-making structures. The revision and alignment of the Terms of Reference for the Clinical and Coding Committee and the Affordability Committee placed greater emphasis on the skills, experience and knowledge required to support evidence-based decisions affecting the industry.

Advancing transparency and modernisation

The outgoing Management Committee also oversaw significant progress on initiatives designed to improve efficiency, transparency and consistency within the healthcare funding environment.

A notable milestone was the delivery of the Namibia NAPPI Product and Price File in October 2025. The initiative represents an important step towards greater transparency in medicine pricing and improved information available to stakeholders within the healthcare funding system.

The Committee also continued to drive the implementation of ICD-10, recognising the importance of standardised diagnostic coding in strengthening claims data, healthcare information and evidence-based decision-making. While the implementation of Phase 2.2 experienced delays, the work undertaken during the term created a foundation for its eventual completion.

Collaboration became a strategic priority

Perhaps one of the most significant shifts during the Committee's term was the strengthening of stakeholder participation.

The implementation of the Stakeholder Engagement Plan (SEP) created more structured opportunities for Namaf to engage with healthcare provider associations and other industry stakeholders. Engagements with organisations representing pharmacists, medical practitioners, private practitioners, medical societies and psychologists provided platforms for stakeholders to raise concerns, share perspectives and contribute to solutions.

The establishment of the Principal Officer Administrator Namaf Committee (PANC) further strengthened this collaborative approach by creating a platform through which Principal Officers and Administrators could engage directly with Namaf on operational matters and industry challenges.

These structures have helped move stakeholder engagement beyond consultation towards greater participation and shared ownership of the industry's future.

A legacy of strong governance

The outgoing Management Committee leaves behind not only projects and policies, but also a strengthened governance foundation. The approval of a balanced FY2026 budget and the continuation of an unqualified audit opinion demonstrate the Committee's focus on responsible stewardship, financial discipline and institutional stability.
Importantly, the Committee recognised that sustainable healthcare funding cannot be achieved by Namaf acting alone. Its work reinforced the principle that government, medical aid funds, healthcare providers and members are interconnected participants in the healthcare ecosystem.
Passing the baton

As one chapter closes, another begins.

The leadership transition from Pieter Theron to Sam Kauapirura, who assumes the presidency of the Management Committee for the new term, represents more than a change in leadership. It symbolises the passing of the baton from one team to another, with the new leadership inheriting both the achievements and the unfinished work of the outgoing Committee.

Pieter Theron leaves the presidency having led Namaf through a period of significant strategic development, difficult industry decisions and institutional change. His contribution, together with that of the outgoing Management Committee, has helped position Namaf to respond more deliberately to the challenges and opportunities ahead.

For incoming President Sam Kauapirura, the task is therefore one of both continuity and renewal. The foundations have been laid; the next leadership must build on them. Completing the legislative reform agenda, advancing the implementation of ICD-10, strengthening industry collaboration, addressing affordability and sustainability, and preparing the private healthcare funding industry for a changing healthcare landscape will remain important priorities.

The baton is now in new hands, but the race continues.

The outgoing Management Committee's greatest legacy may ultimately be the structures, relationships and strategic direction it established to enable those who follow to go further. As Namaf enters the next chapter, the spirit of collaboration, sustainability and responsible stewardship that defined the outgoing Committee provides a strong foundation on which the new Management Committee can build.

From Pieter Theron to Sam Kauapirura, the baton has been passed with the responsibility of shaping a sustainable future for Namibia's healthcare funding industry firmly carried forward

NAMAF WELCOMES HIGH COURT JUDGEMENT AND REAFFIRMS COMMITMENT TO COLLABORATIVE SOLUTIONS FOR THE HEALTHCARE INDUSTRY

The Namibian Association of Medical Aid Funds (Namaf) notes the judgment delivered by the High Court of Namibia on 7 August 2026 in the matter of *Olympia Eye Institute Private Hospital v The Namibia Association of Medical Aid Funds and Others.*

The Court dismissed the application with costs and, in its alternative observations, confirmed that Namaf performs an evaluative function in administering the practice-number system. The Court further noted that this function must be exercised within the limits of the Medical Aid Funds Act, the applicable regulations, and Namaf's published requirements.

Namaf welcomes the clarity provided by the judgment regarding the regulatory framework within which the Association operates.

Working with the industry to address emerging disciplines

Namaf recognises that healthcare is continually evolving, with new medical disciplines, technologies, specialised services, and models of care emerging over time. The Association acknowledges that not every emerging or highly specialised discipline will necessarily fit neatly into existing coding, classification or practice-number structures.

Namaf therefore wishes to emphasise that its approach is not to create unnecessary barriers for legitimate healthcare services, but to ensure that the systems used by medical aid funds are consistent, transparent, clinically appropriate, and sustainable.

Where a legitimate healthcare discipline or service does not adequately fit within an existing coding or classification structure, Namaf remains committed to engaging with the relevant healthcare professionals and representative associations to understand the service, assess the appropriate classification, and work towards a practical solution.

"Our responsibility is to ensure that the systems supporting medical aid funds remain fit for purpose while recognising that healthcare does not stand still. Where a discipline or service does not fit an existing structure, the answer must be to engage, understand the unique circumstances, and find a workable solution within the regulatory framework," said Uatavi Mbai, Manager: Stakeholder Relations & Communication.

Collaboration remains central to Namaf's approach

Namaf believes that a sustainable healthcare funding environment requires ongoing collaboration between medical aid funds, healthcare providers, professional associations, regulators, and other stakeholders.

The Association has consistently used stakeholder engagement platforms to identify implementation challenges, clarify requirements, and develop practical solutions. These engagements are particularly important where technical frameworks such as practice numbers, coding standards, tariffs, and product classifications intersect with new or specialised areas of healthcare.

Namaf will continue to encourage healthcare providers and their representative bodies to engage with Namaf where they believe that an existing classification, coding, or administrative process does not adequately accommodate their discipline or service. This can be done through our annual process.

Such engagements allow Namaf to consider the clinical nature of the service, the applicable regulatory requirements, existing coding structures, implications for medical aid funds and members, and the broader sustainability of the healthcare funding system.

Protecting the interests of members while supporting innovation

Namaf's mandate also requires consideration of the interests of medical aid fund members. Any classification or recognition of a healthcare service must therefore take into account not only whether the service can be accommodated administratively, but also whether the approach supports appropriate access, transparency, affordability, and sustainable funding.

Namaf recognises that innovation and specialised healthcare services play an important role in improving health outcomes. At the same time, the medical aid environment must operate within systems that enable funds to assess claims consistently and members to understand the benefits available to them.

Namaf will therefore continue to seek a balance between supporting legitimate developments within the healthcare sector and maintaining appropriate governance and sustainability of medical aid funds.

A commitment to constructive engagement

Namaf remains committed to an open and constructive relationship with the healthcare industry.

Namaf encourages healthcare providers and associations to bring forward areas where existing structures may not adequately address new or specialised disciplines. Namaf will continue to use its established stakeholder engagement mechanisms to facilitate discussion and, where appropriate, develop workable solutions within the applicable legislative and regulatory framework.

"The healthcare environment is dynamic, and our regulatory and administrative systems must be responsive to that reality. Collaboration is the most effective way of ensuring that emerging disciplines are properly understood and appropriately accommodated, while protecting the integrity and sustainability of the health funding industry," Uatavi Mbai, Manager: Stakeholder Relationship & Communication, said.

Namaf remains committed to collaborating with the industry, listening to stakeholder concerns, and finding practical, sustainable, and workable solutions to challenges arising from the evolution of healthcare in Namibia.

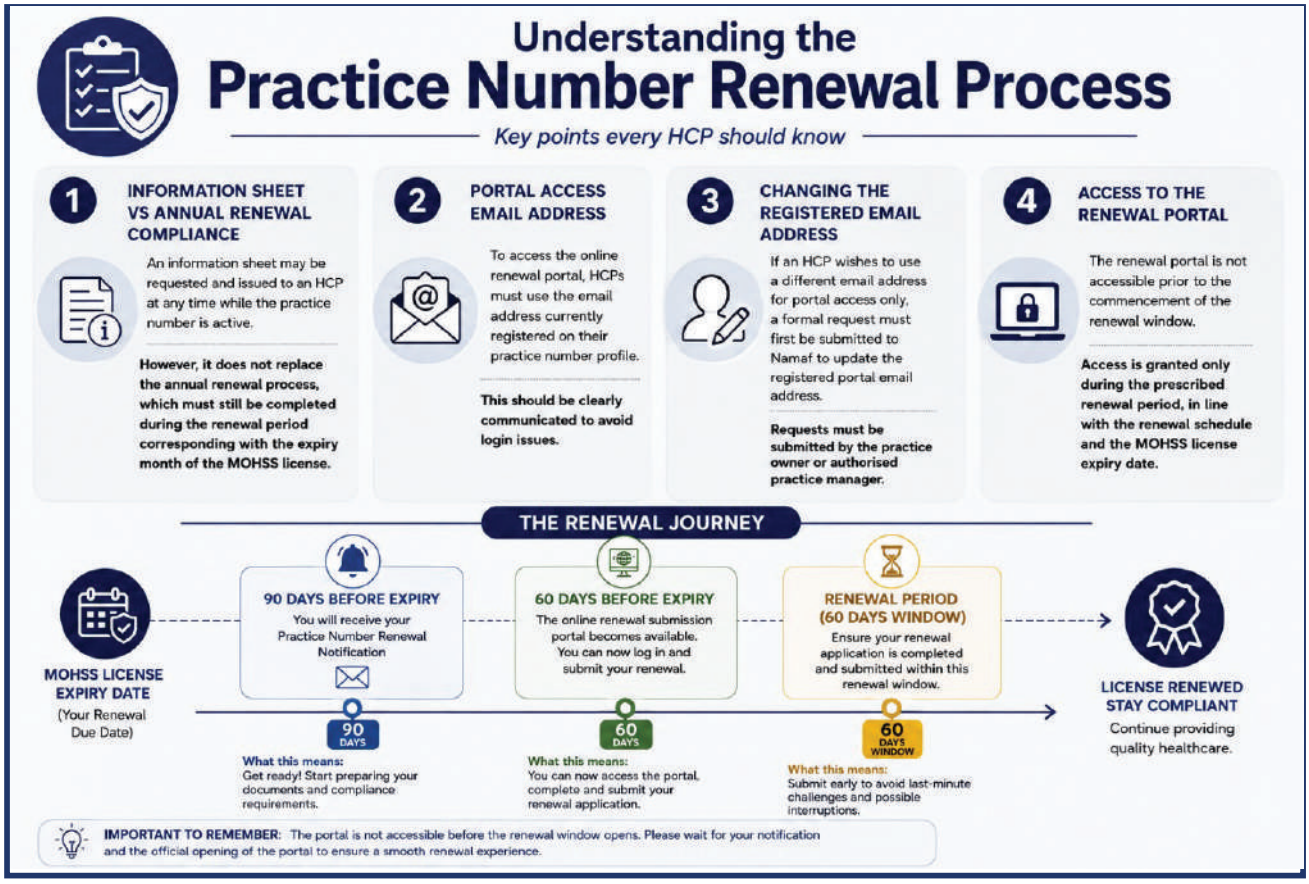
From Industry Standard to National Blueprint: Namaf Coding Structure Gains Wider Application

A significant development that further demonstrates Namaf's growing role as a blueprint for health funding in Namibia is the adoption and use of Namaf's coding structures within the Ministry of Health and Social Services. This development gains particular relevance in the context of the 30 April 2026 Presidential directive to expand the use of state health facilities to accommodate private patients, creating a greater need for common standards for coding, billing, claims processing and healthcare information across the public and private sectors. Namaf's coding framework, which provides a standardised basis for communication between healthcare providers and medical aid funds, offers an established platform that can support this integration and improve consistency, transparency, and efficiency in healthcare funding.

This represents an important validation of Namaf's strategic ambition to become a blueprint for health funding in Namibia extending its technical standards and industry expertise beyond medical aid funds to contribute to a more integrated, interoperable, and sustainable national healthcare financing

Improving awareness of practice number renewals

One of the key areas of stakeholder communication during the period was the **Practice Number Renewal Campaign.**



Namaf has adopted a structured and proactive approach to communicating annual coding submission and practice number renewal requirements. Monthly trigger emails are sent to associations and affected healthcare providers, while additional awareness initiatives, including videos and engagements with association administrators, are used to clarify the renewal requirements.

Targeted communication regarding upcoming renewals and suspension lists is also provided to allow providers and associations to address compliance matters before suspensions take effect. This approach is intended to minimise service disruptions while improving operational efficiency and strengthening communication between Namaf and healthcare providers.

Transparency at the Center of the 2027 Coding and Benchmark Tariff Review Process

The Namibia Association of Medical Aid Funds (Namaf) has officially commenced the review of submissions received for the 2027 Coding and Benchmark Tariff Review. We would like to thank all healthcare providers, professional associations, medical aid fund administrators, and other stakeholders who participated in the submission process.

The review process represents an important governance function that ensures Namibia's healthcare coding framework and benchmark tariffs remain relevant, evidence-based, and responsive to changes in healthcare delivery. It also reflects Namaf's commitment to transparency, accountability, and stakeholder participation in the governance of the healthcare funding industry.

A Governance Process, Not an Approval Process

It is important for stakeholders to understand that submitting a proposal does not automatically result in its adoption. Rather, each submission enters a structured governance process where it is evaluated against consistent criteria and supported by evidence before any recommendation is made.

Namaf's role is to facilitate a fair, impartial, and transparent review process that considers the interests of the entire healthcare funding ecosystem, including healthcare providers, medical aid funds, and ultimately, medical aid members.

Every submission is afforded the same opportunity for consideration, irrespective of the discipline or organisation/association from which it originates.

A Structured and Evidence-Based Review

To promote consistency and sound decision-making, all submissions are assessed against a common framework. This includes evaluating:

- the problem or gap the submission seeks to address;
- the desired outcome and expected benefit to the healthcare system;
- the motivation supporting the proposed change;
- the quality and relevance of supporting evidence; and
- benchmarking against recognised national and international coding systems where applicable.

Requests may relate to the introduction of new procedure codes, the deletion of obsolete codes, amendments to code descriptions, revisions to benchmark tariff values, or improvements to billing rules and guidelines. Regardless of the nature of the request, the same governance principles apply throughout the review process.

Independent Technical Assessment

Following receipt of submissions, Namaf undertakes a comprehensive technical review to determine whether the information provided sufficiently supports the requested change.

Where additional clarification or supporting evidence is required, submitters may be contacted during the review process. Subject matter experts and relevant stakeholders may also be consulted where specialised technical input is necessary.

This collaborative approach strengthens the integrity of the review while ensuring that recommendations are informed by clinical expertise, operational realities, and sound governance practices.

Ensuring Fairness and Consistency

A key objective of the review process is to ensure that similar submissions are evaluated consistently using the same principles and assessment criteria.

The governance framework helps minimise subjectivity by requiring decisions to be supported by evidence, documented rationale, and transparent evaluation. This ensures that recommendations are based on merit rather than individual interests.

Such an approach promotes confidence among stakeholders and supports a coding environment that is equitable, predictable, and aligned with evolving healthcare best practices.

Balancing Innovation with Sustainability

Healthcare continues to evolve through new technologies, changing clinical practice, and emerging models of care. While innovation is encouraged, proposed changes must also be assessed within the broader context of sustainability and their potential impact on the healthcare funding environment.

The review process, therefore, considers not only the clinical justification for a proposal but also its implications for consistency, claims administration, reimbursement practices, fair remuneration for healthcare providers, and the long-term sustainability of the medical aid industry.

Keeping Stakeholders Informed

Namaf recognises that transparency extends beyond receiving submissions. Throughout the review process, stakeholders will continue to receive updates on key milestones and progress where appropriate.

Once the review has concluded and the necessary governa

Consultation on regulatory reform

Regulatory reform continued to be an important area of engagement during the quarter. Namaf undertook consultations with a broad range of stakeholders to create opportunities for dialogue on proposed regulatory principles and amendments affecting the healthcare funding environment.

Engagements included statutory meetings, the Trustee Forum, the Principal Officers and Administrators Namaf Committee (PANC), the Association and Healthcare Provider engagement, as well as engagement with the Minister of Justice and Labour Relations.

The consultations provided stakeholders with an opportunity to share their perspectives, raise concerns and contribute to the refinement of the proposed regulatory framework.

Investing in industry education

Education remains an important component of Namaf's stakeholder engagement strategy. Continued training on rules, regulations, policies, procedures and industry responsibilities is intended to support compliance, good governance and more effective claims management and tariff benchmarking.

ICD-10 online training continued during the period, with discipline-specific sessions aimed at achieving a 95% compliance level. Training sessions covered general practitioners, physiotherapy, occupational therapy, biokinetics, dieticians, social workers and independent practice specialists across several disciplines.

Namaf Roadshow

The Namaf Roadshow was introduced as a strategic stakeholder engagement initiative aimed at bringing Namaf closer to healthcare providers and stakeholders across the country, recognising that effective regulation and industry development require meaningful engagement with those directly affected by decisions and processes within the healthcare funding environment. The 2nd

Roadshow provides an opportunity for Namaf to share updates on key industry developments while creating a platform for stakeholders to ask questions, raise concerns and provide practical input on issues affecting their day-to-day operations. Discussions covered key areas including ICD-10, the Namibia NAPPI Product and Price File, coding and benchmark processes, and the practice number renewal process, enabling Namaf to better understand how these initiatives are experienced in practice. The feedback received from participants has been encouraging, with one stakeholder expressing appreciation following an engagement: *"I hope you enjoyed a good weekend. Thank you again for Friday's engagement – you and your team's effort is really appreciated!"* Such feedback reinforces the value of direct engagement and supports Namaf's strategic decision to create more opportunities for stakeholders to be heard, ensuring that their experiences, concerns and recommendations are taken into account in shaping and improving initiatives within the healthcare funding industry. Ultimately, the Namaf Roadshow is an investment in collaborative market conduct, transparency and trust, strengthening the relationship between Namaf and the stakeholders it serves.

ICD-10 message for Provider Disciplines

This is an easy guidance note to assist the following disciplines in using codes relevant to their specific disciplines.

Proposed written communication

1. 044 Cardio Thoracic Surgery

Cardio Thoracic Surgery- Message to providers, the ICD-10 codes for discipline type will largely range from I00 to I99, J40 to J99, and chapter 19 (S & T) codes for thoracic and intrathoracic injuries with external cause codes from Chapter 20. To a lesser extent, some codes may be assigned from other chapters of ICD-10

2. 082 Speech therapy and Audiology

To use referral ICD-10 codes from diagnosing providers or to assign ICD-10 codes as per their scope of practice. Codes can be assigned from Chapter 5 (F80 to F89), Chapter 8 H90 to H95, Chapter 18: sign & symptom codes, and Chapter 21: Z codes.

3. 088 Registered nurses

Nurses to use sign & symptom, Z codes (R codes). Registered Nurses- to use codes from Chapter 18 R00 to R99 or Z00 to Z99. Where a diagnosing provider has a referral ICD-10 code, the referral code should be assigned.

4. 004 Chiropractors

To use ICD-10 codes from Chapter 13 (M codes) or chapter 21 (Z codes). 8 providers Send communication to providers informing them to work within their scope of practice and assign referral ICD-10 codes from diagnosing providers when available or assign ICD-10 codes from Chapter 13 (M00 to M99) and select the appropriate 5th character which indicates spine Chapter 21, Chapter 6 (codes for headaches-G44 range), Chapter 18: code for headache e.g. R51 and codes from Chapter 21 (Z50 range, if applicable)

5. 009 Ambulance Services

Use sign & symptom or injury codes. Chapter 18: Sign and symptom codes, Chapter 19: injury and poisoning codes, Chapter 20: External cause codes

6. 010 Anaesthetists

Providers to use the surgeons ICD-10 codes or use the ICD-10 code diagnosed by the anaesthetist if surgery was cancelled or medical condition was diagnosed & treated.

7. 012 Dermatology

Use code range L00 to L99.

8. 037 Medical Laboratory Scientist

Use Z00 to Z13, Z71, or referral doctors' codes. Medical technologists: non-diagnosing.

9. 038 Diagnostic Radiology

ICD-10 codes for conditions diagnosed or Z01,6 when no findings are reported. Radiology: Diagnosing.

12. 068 Podiatry

Use codes (M codes, E code for diabetic complications, L codes for nail & pressure ulcers, a few Z codes). 1 Provider: Podiatry

13. 075 Clinical technology

Use Diagnosing providers ICD-10 codes: cardiac, renal failure or perfusion (very limited ICD-10 codes).

14. 095 Dental therapy

Dental therapists with a range of codes for use (K codes-K00 to K13 & Z codes-Z01.2, Z46.3, and Z96.5).

15. 099 Psychological Counsellors

Use Z71,1 or the code supplied by the Psychiatrist/Psychologist

16. 006 - Open the ICD-10 MIT, select Column I, press Ctrl & F on the key board, a window pops up. Type the diagnosis in the window and click find. Range of codes will pop up, choose the code you are looking for.

17. 008 Homeopathy

Use Z71,8 or Z71,9, or the referral doctor's diagnosis when available.

18. 017 Pulmonology

Use J00 to J99, discuss MIT. Guidance on how to use the MIT, Open the ICD-10 MIT, select Column I, press Ctrl & F on the key board, a window pops up. Type the diagnosis in the window and click find. Range of codes will pop up, choose the code you are looking for.

19. 019 Gastroenterology

Use K00 to K99.

20. 020 Neurology

- Use G00 to G99. Some codes will come from other chapters. 2 providers: diagnosing. Examples of other chapters Chapter 18: R codes, e.g. R42, R55, R20.2

21. 021 Cardiology

- Use I00 to I99.

22. 022 Psychiatry

Use codes between F00 to F99.

23. 024 Independent Practice Specialist Neurosurgery

Use codeG00 to G99 and Chapter 19: S & T codes for trauma to brain & spinal cord with External cause codes from Chapter 20.

24. 025 Nuclear Medicine

Use code range E04 to E05,M80 to M85, C00 to C97, I20 to I25, G40 to G47 & some Z codes will largely be used.

25. 026 Ophthalmology

Use code will largely range between H00 to H48.

26. 028 Orthopaedics

Use codes will largely range between M00 to M99 and S00 to T98 with External cause codes from Chapter 20.

27. 030 Otorhinolaryngology

Codes will largely range between H60 to J95 and J00 to J44. 5 Providers: Diagnosing.

28. 033 - Proposed solution:

Codes will largely come from I00 to I99 & some codes from Q00 to Q99.

29. 035 Emergency Medicine Independent Practice Specialist

Providers of assigning emergency/trauma codes-discuss MIT/software. Guidance on how to use the MIT, Open the ICD-10 MIT, select Column I, press Ctrl & F on the key board, a window pops up. Type the diagnosis in the window and click find. Range of codes will pop up, choose the code you are looking for.

30. 036 Plastic and Reconstructive Surgery
Providers to assign ICD-10 codes for conditions for which they perform surgery-discuss. 3 providers: diagnosing. MIT/software, guidance on how to use the MIT, Open the ICD-10 MIT, select Column I, press Ctrl & F on the key board, a window pops up. Type the diagnosis in the window and click find. Range of codes will pop up, choose the code you are looking for.

31. 040 Independent Practice Specialist Radiation Oncology

Providers to use codes largely ranging between C00 to D09.

32. 047 Drug & Alcohol Rehab

Use Z71,5, Z71,4, Z72,0, A72,1 or doctor's referral; codes ranging between F10 to F19.

33. 049 Sub-Acute Facilities

- Proposed solution: Message to providers to use doctor's referral code or Z codes for rehab (Z50 range of codes), counselling, 1 Provider: non-diagnosing.

34. 050 Group Practice

- Proposed solution: Message to providers to assign codes for conditions diagnosed & treated, discussion on MIT & software, guidance on how to use the MIT, . 1 provider. Open the ICD-10 MIT, select Column I, press Ctrl & F on the key board, a window pops up. Type the diagnosis in the window and click find. Range of codes will pop up, choose the code you are looking for.

35. 052 Pathology Independent Practice Specialist

Providers to assign ICD-10 code Z01.7 on claims

36. 054 General Dental Practice

Providers ICD-10 range of codes for dentists (K 00 to K14 codes).

37. 055 Mental Health Institutions

Providers to use code range F00 to F99.

38. 056 Provincial Hospitals

Providers are requested to submit ICD-10 codes. Public sector hospital. They should submit codes already indicated by the treating doctor or assign codes from the diagnosis documented by the doctor in the patient's file.

39. 057 Private Hospitals ('A' - Status)

Providers requesting the providers to submit ICD-10 codes, providers must use software vendors for compliance.11 providers. They should submit codes which are already indicated by the treating doctors or assign codes from the diagnosis documented by the Dr in the patient's file. Where clinical information or the diagnosis if not clear, legible or incomplete, the case manager or hospital personnel must consult with the treating doctor for the correct information.

40. 058 Private Hospitals ('B' - Status)

Providers to assign ICD-10 codes using clinical information documented in the patients' healthcare records. Where clinical information or the diagnosis is not clear, legible or incomplete, the case manager or hospital personnel must consult with the treating doctor for the correct information. ICD-10 is a phased approach. Phase: 2.1: current phase, voluntary submission of ICD-10 codes (preparatory phase). Phase 2.2: Mandatory phase, all claims require ICD-10 codes form 01/07/2026 Minimum of 3 characters from ICD-10 Master Industry Table (MIT) and ICD-10 codes must appear on every claim line that has a tariff code and Failure to submit a claim with ICD-10 code/s will result in a rejection of the claim/claim line.

41. 060 Pharmacies

Providers to assign ICD-10 code Z76,9 or Chapter 18 sign & symptom codes (R codes).

42. 062 Maxillo-facial and Oral Surgery

Providers to use codes jaw/facial disorder codes Chapter 11: K00 to K14, Chapter 19: S00 to S09 & Chapter 17: Q10 to: diagnosing.

43. 064 Orthodontics

Providers very limited set of ICD-10 codes (K00 to K14codes).

44. 069 Medical Scientist

Providers to assign Z codes (screening/preventive), E codes (E10 to E 14 diabetes), B codes (B20 to B24 HIV/ADIS), D68-coagulation defects, etc.

45. 070 Optometrists

Providers ICD-10 code range available (H codes). Limited sets of ICD-10 codes, optometrists.

46. 077 Unattached / Day Theatres

Providers to use a software package that is compliant. Guidance on how to use the MIT, Open the ICD-10 MIT, select Column I, press Ctrl & F on the key board, a window pops up. Type the diagnosis in the window and click find. Range of codes will pop up, choose the code you are looking for.

47. 078 Blood transfusion services

Providers to use Z51,3 on all claims.2 providers:

48. 079 Hospices

Providers to use Z51.5 on claims.

49. 080 Nursing Agencies/Home Care Services

Providers to use sign & symptom codes Chapter 18: (R codes).

50. 083 Hearing Aid Acoustician

To use H90 to H93, R42, H81 range, H93 range, Z97.4

51. 087 Orthotists & Prosthetists

Providers, limited sets of Z ICD-10 codes. M20 to M24, Q66.0, L97 with E10 to E14 (referral codes) Z44 range, Z89 range, R26 range, and G81 range.

52. 089 Social workers

Providers to use the ICD-10 Z codes range. 6 providers: Code ranges F00-F99 to be supplied by the diagnosing provider; or use codes from Chapter 21 (Z codes).

53. 093 Dental Technician

Providers to use Z46,3 on claims.

54. 101 Naturopathy

Providers to use Z71 to Z74 codes.

55. 118

Codes to claims as per scope of practice, sign & symptoms codes/injury codes, etc. Adv life support: 1 provider. Codes are widespread in different chapters. Some common chapters for use will be Chapter 19 with external cause codes from chapter 20, Chapter 18: sign and symptom codes.

56. 120 Stand-Alone Oncology Units

Use ICD-10 codes from range C00 to D09.

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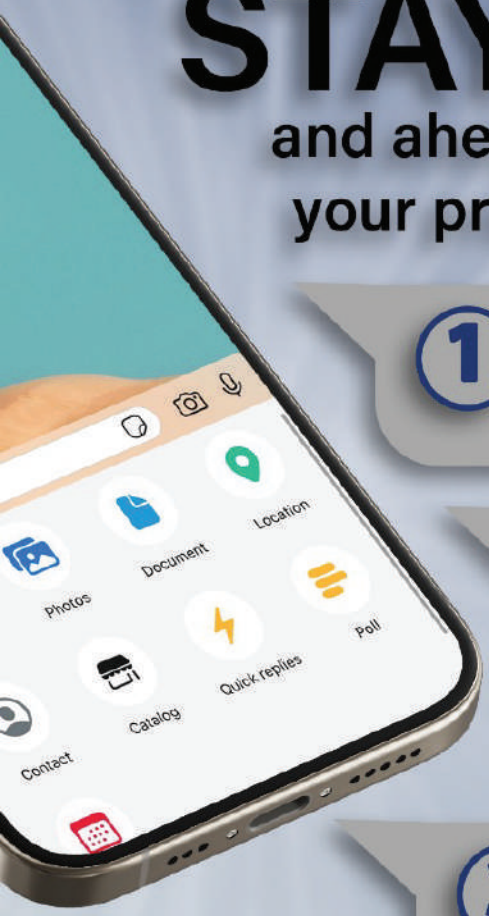

1. Important notice on Practice Number Renewal.
2. Updated on ICD-10, procedure codes and benchmark tariffs and the Namibian NAPPI Product & Price File
3. Regular insights from industry claims data reports

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Namibian Association of Medical Aid Funds

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