Dear Ms Mbai,

Thank you for your response. I appreciate the opportunity to once again clarify the position of healthcare providers (HCPs) on this matter, as it requires a detailed explanation of the issues surrounding NAMAF's continued promotion of ICD-10 against the backdrop of the explanations received.

For over 12 years, the NPPF has consistently maintained that, under administrative law, NAMAF's mandate as per the Medical Aid Funds (MAF) Act is to regulate medical aid funds—not healthcare practitioners. ICD-10 falls within the clinical domain of healthcare provision. While the Namibian government may introduce ICD-10, NAMAF has no legal authority to enforce it. The principle was set out in a legal opinion by Senior Counsel, which was made available to NAMAF, NAMFISA, the Ministry of Health and Social Services, and the Ministry of Finance.

As such, NAMAF's authority is confined to the framework of the MAF Act, limiting fund rules to the provisions of Section 30 and Regulation 7 of the Act. Dictating ICD-10 requirements to practitioners as a condition for payment is neither supported within the ambit of Sections 30 nor is there any indication that such enforcement was the intention of the law.

NAMAF has publicly labelled HCPs—particularly hospitals, specialists, and pharmacists—as fraudsters who overcharge, using this claim to justify the introduction of ICD-10 coding. If practitioners choose to decline NAMAF's invitations to attend ICD-10 webinars, that decision must be respected, irrespective if they have a practice number.

Additionally, NAMAF's Memorandum of Understanding (MoU) with NAMFISA appears to embolden its erroneous belief that it is entitled to introduce clinical coding via the funds. NAMFISA is the statutory financial regulator of medical aid funds, while NAMAF has unilaterally assumed the role of clinical risk manager. This is a clear deviation from the MAF Act, which mandates NAMAF to regulate funds—not clinical governance. As a result, NAMFISA's apparent endorsement of ICD-10 coding as a payment precondition raises serious concerns about the circumvention of Regulation 7 and Section 30 of the MAF Act, as well as ethical HPCNA guidelines protecting patient confidentiality—a fundamental human right.

NAMFISA has echoed NAMAF's claim that ICD-10 is necessary to combat fraud, abuse, and waste (FAW). However, international healthcare coding specialists have indicated that ICD-

10, plays no significant role in reducing FAW. Moreover, the Namibian government transitioned to ICD-11 in December 2023, aligning with international standards. South Africa and other WHO member states are also adopting ICD-11, rendering NAMAF's insistence on ICD-10 outdated and misaligned with global best practices.

An internationally renowned coding expert has commented on NAMAF's involvement in coding and clinical risk management as follows:

"A coding structure defines the scope of practice of a profession, with codes added to facilitate funding. If funders start doing the coding, they have taken ownership of your scope of practice. The profession needs to give the interpretation of the codes, not the funder. This is totally unacceptable. Would they like it if healthcare providers started designing benefit structures?"

This statement underscores that when NAMAF imposes coding requirements and instructs funds to implement ICD-10, it oversteps its regulatory boundaries, infringing upon the professional autonomy of Namibian healthcare practitioners.

In response to NAMAF's actions—endorsed by NAMFISA—the NPPF made its position unambiguously clear in October 2024 to the General Manager: Insurance and Medical Aid Funds at NAMFISA (with NAMAF copied in), stating:

- Many practitioners will no longer participate in direct claims from medical aid funds that demand ICD-10 as a precondition for payment. Members of such funds will be required to pay upfront.
- Funds must provide financial security to ensure that members who cannot pay upfront still receive treatment in line with the fund's benefit guide.
- NPPF will perform a cost study and implement an alternative tariff model.

To substantiate this position, the NPPF has since secured user rights for the HealthMan and SAMA coding manuals in Namibia and is conducting a cost study to establish a separate coding system aligned with internationally accepted CPT-4 standards. This system will be harmonized with South Africa and Botswana, ensuring patient confidentiality, proper forensic fraud detection, and alignment with global best practices.

Healthcare providers have now lawfully assumed control of tariff coding in Namibia by obtaining the relevant user rights, in line with international practice. This effectively nullifies NAMAF's claim that its market relevance is based on its monopoly over the NAMAF Benchmark Tariff. Medical aid funds will be included in this new agreement. NAMFISA has

been requested to set-up a meeting with the funds to establish a Medical Control Board that deals with all relevant matters. While no one is obligated to follow the new tariff system, funds must justify to their members why they continue to support NAMAF's ***ultra vires*** actions—actions that unilaterally benefit funds and administrators (who still remain unregulated) at the expense of patients and healthcare providers.

NAMAF has failed to provide legally binding assurances that patient confidentiality will not be compromised through the release of clinical codes. Additionally, NAMAF has not cited any provision within Section 30 of the MAF Act that authorizes funds to demand ICD-10 compliance as a condition for payment. Thus, NAMAF and NAMFISA have failed to provide a legal basis for their actions to implement ICD-10 via the fund rules as a precondition of payment.

With coding now legally in the hands of HCPs, the issue of ICD-10 is effectively resolved. It is now up to NAMAF to reimburse practitioners who have requested refunds of fees wrongfully levied against them. Once this matter is settled, HCPs are willing to assist NAMAF in drafting conduct rules for medical aid funds as required by Section 18 of the MAF Act—something NAMAF has failed to accomplish for 30 years. This collaboration would enable NAMAF to fulfil its actual mandate of regulating medical aid funds, ultimately benefiting both fund members and practitioners. A step toward regulatory compliance and cooperation is necessary before the healthcare sector can become sustainable again.

It is trusted that this clarifies why the initial points were raised and highlights that your response seeks to legitimize an action without addressing NAMAF's initial violation of administrative law. This violation has no legal basis and renders the actions of both NAMAF and the funds in enforcing ICD-10 codes on practitioners as a precondition for payment ***ultra vires***.

Kind regards

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