HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS

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LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT

1. Please provide a bird's eyes view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).

Namibia's healthcare system operates as a dual structure, comprising the public and private sectors. The Ministry of Health and Social Services (MoHSS) manages and provides public healthcare services, overseeing a four-tiered healthcare system which includes primary healthcare sites, district hospitals, intermediate hospitals, and a referral hospital. Clinics (Class E) are staffed by nurses and pharmacy technicians or assistants and serve as the first point of contact for many patients. When a patient's needs exceed a clinic's scope, they are referred to health centres (Class D), which have doctors, pharmacists, and nurses. For more advanced care, district hospitals (Class C) handle cases beyond primary care capacity. If a specialist is required, district hospitals refer patients to intermediate hospitals (Class B). The most medically complex cases are sent to Windhoek Central Hospital (Class A), Namibia's national referral hospital. The country also operates outreach mobile clinics (Class F), which provide rural healthcare services to underserved populations.

Public healthcare is tax-funded and serves 85 per cent of the population, primarily lower-income groups. The private sector, which caters for 15-17 per cent of middle- and high-income individuals, offers specialised services through private hospitals and clinics. However, only 18 per cent of the population is covered by medical aid funds, meaning that 82 per cent rely on public healthcare or pay directly for private services themselves. The MoHSS oversees government funding allocation, with higher-level hospitals receiving more financial resources due to their broader service capacity. Budget prioritisation and facility upgrades depend on hospital classification, ensuring an equitable distribution of healthcare funding.

The Namibian government is the largest healthcare funder, contributing 62 per cent of total health expenditure, followed by the private sector (31 per cent) and international donors (seven per cent), with the majority of donor funding supporting HIV and antiretroviral therapy programmes. The MoHSS formulates national healthcare policies, while regional and local municipalities oversee healthcare service delivery. The government collaborates with international organisations such as World Health Organization (WHO) to improve infrastructure, regulate pharmaceuticals, and support specialised medical programmes aimed at expanding universal health coverage.

Healthcare insurance in Namibia is not compulsory and operates under a mix of public and private schemes. The Public Service Employee Medical Aid Scheme (PSEMAS) is a

government-funded insurance plan covering civil servants and their dependents, granting them access to both public and private healthcare. A significant portion of health expenditure (28.9 per cent) is directed towards the PSEMAS, which serves only 12 per cent of the population. Namibia has seven medical aid funds: Renaissance Health, Nammed, Namibia Health Plan (NHP), Namibia Medical Care (NMC), Heritage Health, Napotel, and Namdeb Medical Scheme. Tyhese function as not-for-profit entities based on social solidarity and cross-subsidisation, making private healthcare more accessible.

Private medical aid providers, offer private insurance plans that provide access to better-equipped private hospitals, reducing strain on public healthcare facilities. Private hospitals, offer specialised medical care, often exceeding public hospital standards in infrastructure and service delivery. Employers also contribute to healthcare financing through corporate health insurance schemes, ensuring that employees receive adequate medical coverage. Additionally, private pharmaceutical companies play a crucial role in supplying medication and medical equipment to both public and private healthcare providers.

2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.

Namibia's healthcare financing is primarily governed by the Medical Aid Funds Act 23 of 1995, which regulates medical aid funds and establishes the Namibian Association of Medical Aid Funds (NAMAF) to oversee their operations. The NAMAF's role includes promoting medical aid funds, ensuring financial stability, and standardising healthcare financing practices. Financial oversight is further strengthened by the Namibia Financial Institutions Supervisory Authority (NAMFISA), established under the NAMFISA Act of 2001, which ensures that medical aid funds operate within a sound financial and legal framework to protect members' interests.

While the PSEMAS plays a significant role in healthcare financing, it operates under specific government policies rather than the Medical Aid Funds Act. This distinction means that the PSEMAS is subject to government oversight rather than NAMAF or NAMFISA regulations, highlighting the dual nature of Namibia's health insurance system, which blends public and private sector elements.

To standardise medical billing and claims processing, the NAMAF administers a structured coding system that includes practice numbers, diagnostic codes, procedure codes, and the National Pharmaceutical Product Index (NAPPI) codes. These coding standards help ensure uniformity in claims processing, reimbursement, and risk management. As of 1 January 2025, the NAMAF has mandated that all medical claims include International Classification of Diseases (ICD-10) codes, with a targeted 70 per cent compliance rate, backed by training programmes for healthcare providers.

The NAMAF also sets benchmark tariffs, which serve as advisory pricing guidelines for medical services. However, these tariffs are not mandatory, meaning medical aid funds and healthcare providers retain discretion over reimbursement rates, leading to variability in coverage and costs across different providers. Due to limitations in the Medical Aid Funds Act, the NAMAF's regulatory authority is restricted: it cannot dictate benefit designs, coverage amounts, or mandatory service inclusions for medical aid funds.

Negotiations between medical aid funds, healthcare providers, and government bodies play a crucial role in shaping reimbursement rates and service agreements. These negotiations establish payment structures, provider participation criteria, and service coverage terms. This aims to balance cost containment for payers while ensuring fair compensation for providers.

The NAMAF serves as a facilitator in these discussions, helping coordinate agreements between medical aid funds, healthcare providers, and regulatory authorities such as the MoHSS and the Health Professions Council of Namibia. However, the lack of statutory authority over benefit designs limits the NAMAF's ability to enforce standardisation, making reimbursement negotiations complicated and sometimes inconsistent.

3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?

The MoHSS is the principal government agency responsible for formulating healthcare policies, coordinating public health programmes, and supervising both public and private healthcare providers. Established in 1990, the MoHSS operates through a three-tier system (national, regional, and district levels), ensuring that 85 per cent of the population, primarily lower-income groups, have access to healthcare services. Notably, Namibia allocates 16.6 per cent of its total budget to health, surpassing the 15 per cent benchmark set by the African Union's Abuja Declaration.

Namibia Financial Institutions Supervisory Authority (NAMFISA)

Established under the NAMFISA Act, 2001, this autonomous body regulates and supervises financial entities, including medical aid funds, ensuring that they operate within a sound financial and legal framework to protect members' interests.

Namibian Association of Medical Aid Funds (NAMAF)

Created under the Medical Aid Funds Act, 1995, the NAMAF oversees the operations of medical aid funds, promotes their development, and manages a standardised coding structure for claims processing. It also sets benchmark tariffs for medical services, though adherence by medical aid funds and providers remains voluntary, leading to potential variations in healthcare costs and coverage.

Namibia Medicines Regulatory Council (NMRC)

This statutory entity is responsible for the registration and authorisation of medicines for both human and veterinary use. It ensures that all pharmaceuticals meet safety, efficacy, and quality standards before being made available to the public.

Namibia's health funding sector faces two primary risks: financial prudential risk and clinical risk, requiring oversight by separate regulators. The NAMFISA oversees financial prudential risk, ensuring medical aid funds operate legally and financially sound. The NAMAF regulates clinical risk, managing the standardised coding system that facilitates claims processing, reimbursement, and cost management within the healthcare sector.

The judicial system in Namibia plays a critical role in interpreting and enforcing healthcare laws. Courts adjudicate disputes between medical aid funds, healthcare providers, and patients, ensuring compliance with legal and regulatory frameworks. Their rulings contribute to case law development, shaping healthcare financing policies and regulatory enforcement over time.

4. Has there been a change with healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?

The Covid-19 pandemic significantly reshaped healthcare financing in Namibia, leading to increased government spending, budget reallocations, and emergency fast-track funding. These adjustments were necessary to strengthen healthcare infrastructure, procure essential medical supplies, and support socio-economic relief programmes.

In response to the crisis, in 2020/21 the Namibian government allocated an emergency budget of N$727m (approx. US$40.25m) to the MoHSS, focusing on procuring personal protective equipment (PPE), increasing hospital capacity, expanding testing and contact tracing, and securing vaccines. Additionally, the WHO contributed US$1.73m in emergency medical supplies, ensuring that procurement prioritised Namibia's most pressing healthcare needs. Public hospitals, particularly Windhoek Central, Katutura, and regional referral hospitals, required increased funding for ICU expansion, oxygen supply, and medical equipment procurement to manage the surge in Covid-19 cases.

To prioritise the Covid-19 response, Namibia redirected funding from other healthcare programmes, focusing resources on ICU expansions, ventilator purchases, and vaccine distribution. Health centres and clinics (Class D & E) adapted to increased community healthcare needs, particularly for vaccine rollouts and outpatient Covid-19 treatments. In addition to healthcare spending, funds were also reallocated to socio-economic relief programmes, including rental deferrals, tax reductions, and financial support for struggling businesses. However, despite the initial rise in public healthcare spending, UNICEF reported a decline in real healthcare expenditure after 2020, raising concerns about Namibia's ability to sustain long-term pandemic recovery efforts.

To accelerate response efforts, Namibia implemented fast-track funding mechanisms in collaboration with WHO, United Nations Development Programme (UNDP), and the Global Fund. These emergency financial measures enabled rapid procurement of essential medical supplies, vaccine distribution, and financial relief for healthcare institutions. The government also relaxed procurement regulations to expedite spending on critical medical services, while the Bank of Namibia introduced liquidity relief measures to maintain financial stability in the healthcare sector. The hospital classification system helped structure government budget reallocations, ensuring priority funding for hospitals handling Covid-19 patients.

5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are

the conditions of admission?

Healthcare access in Namibia is determined by residency status, financial capacity, and regulatory policies, with the MoHSS overseeing the public healthcare system, which serves 85 per cent of the population, primarily low-income groups. Public healthcare is subsidised, making it affordable for citizens and permanent residents, while non-citizens, including foreign workers and tourists, must pay directly unless covered by private insurance. The Namibian Constitution guarantees equitable healthcare access, ensuring no individual is denied care due to financial hardship, and 76 per cent of Namibians live within 10 km of a health facility, significantly improving healthcare accessibility. However, rural and remote areas continue to face challenges due to limited medical infrastructure and personnel shortages.

The Hospitals and Health Facilities Act, 1994, guarantees every person in Namibia the right to access state hospitals and state health facilities to receive treatment and benefit from healthcare services (section 11(1) Hospitals and Health Facilities Act, 1994). However, the superintendent of a state hospital has the authority to deny access to any individual, including healthcare practitioners, if they contravene hospital rules, refuse to comply with a hospital authority's order, or for any other sufficient reason (section 11(2) Hospitals and Health Facilities Act, 1994).

The private healthcare sector caters to middle- and high-income individuals, serving 15–17 per cent of the population, with only 18 per cent of Namibians enrolled in medical aid funds, which grant access to private hospitals and specialised services. Although private healthcare offers high-quality treatment, it remains inaccessible to most citizens without insurance. Medical service providers in both public and private sectors must comply with licensing and regulatory standards under the Hospitals and Health Facilities Act of 1994, ensuring strict operational and quality requirements for private hospitals and clinics. The NMRC oversees pharmaceutical and medical equipment safety standards, ensuring compliance with national and international regulations. Unlike integrated public-private healthcare models, private healthcare providers in Namibia do not receive direct government funding, relying instead on patient fees and insurance reimbursements.

Patients requiring specialised medical treatment not available in Namibia may receive government-sponsored treatment abroad, typically in South Africa, with funding subject to medical board review and financial approval. Some private medical aid schemes cover international medical referrals, but pre-authorisation is required. Namibia also ensures emergency healthcare access for all individuals, regardless of nationality or residency status. Public hospitals are required to provide life-saving treatment to all patients, including foreigners and non-residents, although foreign patients are billed after stabilisation. Additionally, Namibia collaborates with neighbouring countries for cross-border emergency medical transfers, although billing and reimbursement policies remain complex.

These policies reinforce Namibia's commitment to universal healthcare access, ensuring that citizens and permanent residents can access essential healthcare services, while balancing financial sustainability and regulatory compliance within the healthcare system.

HEALTH INSURANCE FINANCING AND COVERAGE

6. How are health insurance carriers financed? How are premiums determined?

Health insurance in Namibia operates under a voluntary system, with financing primarily derived from member contributions (premiums), employer subsidies, and investment reserves. The PSEMAS is government-funded, providing coverage for civil servants and their dependents, while private medical aid funds rely on monthly premiums paid by individual members or employer groups according to their approved Medical Aid Fund Rules.

Premiums for private medical aid funds are determined by actuarial risk assessments, taking into account demographic profiles, claims history, and financial reserves. Monthly contributions vary based on the age of the principal member, with age categories set in January of each financial year, dictating premium amounts for the remainder of the year. Contribution tables outline premiums for employer groups, pensioners, and private members, ensuring risk-adjusted pricing for each category. In return for monthly contributions, members receive coverage for hospitalisation, medical consultations, prescription medication, and specialised treatments.

While judicial review of premiums is limited, courts can intervene in cases of unfair pricing, discriminatory practices, or regulatory disputes. The NAMFISA also has the authority to review complaints related to excessive contributions, although most disputes are resolved through internal regulatory frameworks rather than litigation. Ultimately, premium pricing remains market-driven, influenced by risk pooling, regulatory oversight, and employer contributions, ensuring a balance between affordability and financial sustainability in Namibia's health insurance sector.

7. How is coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in person medical appointments and telemedicine appointments?

Health insurance coverage in Namibia is regulated by a combination of statutory laws, industry standards, and government oversight. While medical aid funds have discretion in defining coverage, they operate under the Medical Aid Funds Act of 1995 and are regulated by the NAMFISA. The NAMAF plays an advisory role in setting benchmark tariffs and standardised coding systems for claims processing, but adherence is voluntary. The government influences coverage through its PSEMAS, which subsidises healthcare for public servants and their dependents. However, the PSEMAS faces sustainability concerns, with government subsidies covering 85 per cent of its costs.

Regarding telemedicine, Namibia has taken steps to integrate digital health solutions through its National eHealth Strategy (2021-2025). This strategy supports remote consultations and digital health record management to improve healthcare access in rural areas. However, disparities exist between in-person medical services and telemedicine in terms of insurance coverage and reimbursement policies. While private insurers may cover telemedicine services selectively, public sector policies on telemedicine reimbursement have yet to be developed. Special cases, such as orphan drugs and off-label medication use, are evaluated individually by medical aid funds and subject to approval processes, often requiring additional clinical justification.

The Namibia Medicines Regulatory Council is a statutory body established in terms of Medicines and Related Substances Control Act, 2003, to regulate scheduled substances including registration of medicines. Medicines are registered for approved indications and any use of a medicine outside its registered indication is considered to be 'off-label' use. Given the above, healthcare providers are reminded that if any prescriber uses any medicine including ivermectin 'off-label', they will be responsible for any outcome of the usage outside its registered indications. Consequently, the use of 'off-label' medication is not subject to insurance.

HOSPITAL SECTOR

8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?

Hospital services in Namibia are financed and reimbursed through a combination of models depending on whether care is provided in a stationary (inpatient) or ambulatory (outpatient) setting. Public hospitals primarily operate under a fixed/flat pricing model, where government funding is allocated based on specific treatment categories, often using a bundled payment system like Diagnosis-Related Groups (DRGs). A DRG system categorises patients with similar clinical diagnoses to help control hospital costs and determine payer reimbursement rates. For example, Medicare pays out a set amount per DRG rather than reimbursing total hospital costs, which incentivises cost-efficient care. In contrast, private hospitals primarily use an individualised/specified pricing system or fee-for-service model, where each consultation, procedure, and treatment is billed separately, with medical aid schemes reimbursing costs based on predetermined tariffs set by the NAMAF. While fee-for-service models remains dominant, alternative pricing structures such as capitation payments, pay-for-performance incentives, and global budgets have been discussed to improve efficiency and contain rising healthcare costs.

Government contributions play a significant role in financing public healthcare, with hospitals receiving budget allocations from the MoHSS to cover operational costs, staff salaries, and essential medical supplies. Additionally, subsidised care is provided to low-income individuals, while the PSEMAS funds healthcare for government employees. International aid and donor funding further supplement the healthcare budget, particularly for disease-specific programmes like HIV/AIDS, tuberculosis, and maternal health. State hospital admissions are regulated to ensure equitable access to care, with admission determined by a medical practitioner based on the urgency of treatment needs (section 12(1) Hospitals and Health Facilities Act, 1994). However, the hospital superintendent has the authority to deny admission or discharge patients if admission is unnecessary, if the patient's behaviour justifies discharge, or for other sufficient reasons (section 12(2) Hospitals and Health Facilities Act, 1994). Once admitted, the patient is assigned a ward, section, and bed by the superintendent or an authorised official, with the possibility of being transferred if needed (section 13 Hospitals and Health Facilities Act, 1994). Additionally, state patients may be transferred to other hospitals for treatment at no cost, with the state covering all transfer expenses (section 14 Hospitals and Health Facilities Act, 1994).

Patients admitted to public hospitals must choose between being classified as state patients or private patients (section 18(1) Hospitals and Health Facilities Act, 1994). State patients

receive subsidised or free care, while private patients are responsible for covering the full cost of services received. To ensure financial protection, public facilities maintain minimal or no user fees, preventing denial of care due to financial constraints. Programmes such as the Special Fund for Uncommon Illnesses and the Motor Vehicle Accident Fund provide additional financial protection for patients facing catastrophic healthcare costs. Notably, only eight per cent of healthcare expenditure in Namibia is paid directly by patients, well below the WHO concern threshold of 15 to 20 per cent, which indicates a relatively low financial burden on households.

In addition to hospital financing, pharmaceutical pricing and economic efficiency are regulated through government policies, legal frameworks, and cost-control mechanisms. Section 57 of the Pharmacy Act, 2004, bans pharmacists from overcharging or engaging in price-fixing agreements, ensuring pricing fairness and preventing consumer exploitation. The Pharmacy Council of Namibia, under Section 67 Pharmacy Act, 2004, has the authority to establish and enforce pricing regulations. Any pharmacist breaking these rules may face disciplinary action under Section 50 Pharmacy Act, 2004, which includes fines, suspension, or licence revocation. The National Drug Policy further introduces pricing reforms to eliminate incentives for price inflation in Namibia's current percentage mark-up system, which favours higher-priced medicines. To replace this system, fixed professional fees for retail pharmacists and a fee-for-service model for wholesalers will be implemented, ensuring cost transparency and affordability.

To control pharmaceutical costs, the government actively monitors drug prices at all levels: manufacturer, wholesaler, and retailer. It also negotiates with the private sector to prevent price inflation. International price comparisons (reference pricing) are used to ensure that pharmaceutical prices remain competitive and fair. The policy also promotes transparency in drug pricing, reducing reliance on confidential rebates and increasing public awareness of medicine costs. Additionally, generic drugs are being prioritised as a cost-saving measure, ensuring affordable alternatives to brand-name medications and reducing overall pharmaceutical expenditure. These combined strategies of legal oversight, structured pricing reforms, government intervention, and transparent market regulations aim to enhance pricing fairness, improve economic efficiency, and ensure that essential medicines remain accessible and affordable to the Namibian population.

9. How are the prices of such services determined? How is economic efficiency controlled?

The pricing of hospital services in Namibia is determined through a mix of government regulation, negotiations with insurers, and independent pricing structures in the private sector. In the public healthcare system, the government sets prices for services through the MoHSS, which determines tariffs for state hospitals and health facilities (section 19(1) Hospitals and Health Facilities Act, 1994). These tariffs are based on patient classification (state versus private), the type of hospital, and the nature of the treatment provided (section 19(2) Hospitals and Health Facilities Act, 1994). The Minister also has the discretion to exempt certain patients or categories from payment or reduce fees when necessary (section 19(3)). This price-setting mechanism helps ensure that healthcare remains affordable and accessible for the majority of the population while controlling costs in the public sector.

In the private sector, prices are generally determined through negotiations between hospitals and medical aid schemes, which operate under the guidance of the NAMAF. The NAMAF plays a crucial role in standardising medical tariffs by setting recommended fee schedules that medical aids follow when reimbursing hospitals. While these tariffs provide cost benchmarks, private hospitals are not legally bound to adhere to them and may set their own prices, leading to variation in costs depending on the facility. This allows free pricing within the private sector but also contributes to rising healthcare costs for uninsured patients.

To maintain economic efficiency, Namibia employs various cost-control measures, especially in the public healthcare sector. Bundled payments (eg, DRGs) are used to limit unnecessary spending by ensuring hospitals receive fixed payments per treatment category, rather than billing itemised services. The government also subsidises healthcare services through annual budget allocations, ensuring that state hospitals operate within predefined financial limits. Additionally, medical aid schemes regulate healthcare expenditures by setting reimbursement limits and negotiating service costs with private hospitals to prevent excessive pricing. The introduction of alternative reimbursement models, such as capitation payments and pay-for-performance incentives, is under discussion to enhance economic efficiency further by aligning provider incentives with quality care rather than service volume.

HEALTHCARE PROVIDERS IN PRIVATE PRACTICE

10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?

In private practice, services provided by physicians, therapists, laboratories, and other healthcare service providers are primarily financed through medical aid schemes and direct payments from patients, with limited government contribution in specific cases.

Some private healthcare services, particularly those related to diagnostic procedures, imaging, and pathology tests, may follow a fixed pricing model, where service providers charge predefined rates for specific treatment categories or medical indications. In certain cases, medical aid schemes negotiate standardised tariffs with healthcare providers, ensuring predictability in costs for covered treatments.

Most private healthcare services operate on a fee-for-service basis, where physicians, therapists, and laboratories charge separately for each consultation, test, or procedure performed. The NAMAF sets benchmark tariffs, which serve as guidelines for medical aid reimbursements; however, private providers are not obligated to follow these tariffs and may charge above the recommended rates. Reimbursement varies by medical aid fund: some funds fully cover NAMAF-tariffed services, while others apply co-payments or limit coverage to certain procedures.

The government has minimal direct financial involvement in private healthcare, as public funds are primarily allocated to state hospitals and clinics. However, government employees covered under the PSEMAS can access private healthcare providers, with reimbursements processed through the scheme. In some cases, subsidies or special funding may be allocated to private providers offering specialised care (eg, HIV/AIDS treatment programmes or maternal health services funded through government partnerships).

11. How are the prices of such services determined? How is economic efficiency controlled?

The pricing of private healthcare services in Namibia is influenced by a combination of free pricing, insurer negotiations, and government-regulated reimbursement structures. Unlike the public sector, where prices are set by the government, private healthcare providers have the flexibility to set their own fees, leading to variations in costs depending on the facility and type of service provided. While the government does not regulate private healthcare pricing directly, it does impose reimbursement limits for services covered under public medical aid schemes such as the PSEMAS. This ensures that state-funded medical aid programmes do not overpay for private medical services.

In the private sector, insurers and healthcare providers negotiate service costs, often using NAMAF benchmark tariffs as a pricing guide. These tariffs are not legally binding but provide a standardised pricing framework used by medical aid funds to determine reimbursement limits. Some private providers charge within the NAMAF's recommended rates, while others exceed these benchmarks, requiring patients to pay directly for the difference unless a specific agreement exists between the provider and the insurer. This negotiation-based pricing system allows insurers to control healthcare costs while ensuring that private providers receive fair compensation for their services.

The NAMAF plays a key role in standardising medical tariffs for private healthcare services, including hospitals, physicians, radiologists, therapists, and laboratories. These benchmark tariffs are reviewed periodically and guide medical aid funds in determining reimbursement rates for covered medical services. Private hospitals, such as Lady Pohamba Private Hospital, adhere to NAMAF tariffs for standard accommodation and medical services, but they also set their own additional charges for consumables, medications, and specialised procedures.

Medical aid funds use the NAMAF's benchmark tariffs to negotiate reimbursement agreements with healthcare providers. Some medical aid funds fully cover NAMAF-based tariffs, while others impose co-payment structures, requiring patients to cover a portion of the cost themselves. In cases where a private provider charges above NAMAF rates, the patient is responsible for the excess amount unless there is a direct billing arrangement between the provider and the insurer. This system helps to maintain financial balance between affordability for patients and financial sustainability for healthcare providers.

Tariffs refer to standardised pricing structures used by the NAMAF and medical aid funds to regulate reimbursement rates for private healthcare services. These tariffs apply to a wide range of hospital and medical services, ensuring transparency in billing and predictable healthcare costs for insured patients.

To maintain economic efficiency, private healthcare providers and insurers use several cost-control measures. One of the most important mechanisms is pre-authorisation by medical aid funds, which ensures that admissions and treatments are medically necessary before costs are incurred. This prevents unnecessary hospitalisations and the overuse of medical services, reducing the financial burden on both insurers and patients.

Additionally, NAMAF benchmark tariffs serve as reimbursement caps, limiting the amount that medical aid funds will cover for specific services. This prevents excessive billing by providers while ensuring that patients are aware of potential out-of-pocket expenses in cases where service charges exceed the standard tariff rates. Furthermore, billing structures based on time (eg, ICU rates charged per day or by duration of stay) help ensure that patients only pay for the level of care they receive, promoting cost efficiency in hospital resource allocation.

Hospitals also implement separate billing for consumables, medications, and specialised equipment, which allows for cost transparency and accurate tracking of medical expenses. Unlike fixed-price services, where patients are charged a flat rate for a package of treatments, itemised billing ensures that patients only pay for what they use, reducing unnecessary costs.

PHARMACEUTICALS AND MEDICAL DEVICES

12. How are pharmaceuticals and medical devices financed and reimbursed?

In the public healthcare system, pharmaceuticals and medical devices are primarily financed through government funding, ensuring that state patients receive essential treatments free of charge or at subsidised rates. The MoHSS is responsible for centralised procurement and distribution, maintaining stock levels in state hospitals, clinics, and primary healthcare centres.

The PSEMAS provides medical aid coverage for government employees, offering reimbursement for prescription medications obtained from public pharmacies. Certain medications, such as HIV/AIDS antiretroviral therapy, tuberculosis treatments, and malaria drugs, are fully covered by government programmes or international donor funding, ensuring access for vulnerable populations.

In the private healthcare sector, pharmaceuticals and medical devices are financed through private medical aid schemes or direct patient payments. Medical aid funds follow the NAMAF benchmark tariffs, which provide standardised reimbursement rates for prescription drugs and medical devices. However, private pharmacies and hospitals are not legally bound to adhere to these tariffs, allowing them to charge above the benchmark rates, requiring patients to cover the difference themselves through direct payments.

Patients without medical aid coverage must pay the full price for medicines and medical devices, which can lead to high costs, especially for specialised or imported drugs. Some medical aid funds provide additional coverage for chronic conditions, ensuring that long-term medication costs for diseases such as diabetes, hypertension, and asthma are partially or fully reimbursed. Medical devices, including prosthetics, wheelchairs, and hearing aids, are covered under specific insurance policies, but patients often need to co-pay for advanced models.

13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?

The pricing of pharmaceuticals and medical devices in Namibia is regulated through government policies, legal frameworks, and economic efficiency mechanisms to ensure fair

pricing, transparency, and affordability. Section 57 of the Pharmacy Act, 2004, bans excessive pricing by pharmacists and prevents collusion or price inflation, with the Pharmacy Council of Namibia authorised under Section 67 to define and enforce pricing regulations. Violations of these regulations constitute unprofessional conduct and may result in fines, suspension, or licence revocation under Section 50.

Additionally, Namibia's National Drug Policy introduces pricing reforms to address inefficiencies in the current percentage mark-up system, which encourages higher-priced medicines. This system is set to be replaced by a fixed professional fee for retail pharmacists and a fee-for-service model for wholesalers, eliminating incentives for price inflation. The government also plays a key role in monitoring drug prices at all levels (manufacturer, wholesaler, and retailer) and negotiating with the private sector to prevent unreasonably high costs. International price comparisons (reference pricing) are used to maintain competitive pricing, and public awareness initiatives promote greater transparency in the pricing of medicines. Furthermore, the policy prioritises the use of generic drugs as a cost-saving measure, ensuring affordable alternatives to brand-name medications and reducing pharmaceutical expenditure. Through legal oversight, structured pricing reforms, and market regulation, Namibia seeks to enhance fair pricing.

LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

The cases *Heritage Health Medical Aid Fund v Registrar of Medical Aid Funds* 2022 NASC 42 and *Heritage Health Medical Aid Fund v The Registrar of Medical Aid Funds and Others* 2019 NAHCMD 535 are critical precedents in Namibia's healthcare financing landscape. These cases arose when Heritage Health implemented increased contribution rates in 2019 without obtaining prior approval from the Registrar of Medical Aid Funds, leading to regulatory intervention and judicial review. The courts upheld the Registrar's authority to regulate contribution changes, emphasising that medical aid funds cannot unilaterally adjust premiums without state approval.
The Medical Aid Funds Act, 1995, particularly section 30(n) and section 31, forms the legal foundation for regulating healthcare financing in Namibia.

Section 30(n) requires that all medical aid funds establish rules specifying membership fees, the amount payable, and the basis for calculating contributions. This provision ensures transparency in fund operations and prevents arbitrary premium increases. Section 31(1) and (2) mandates that any amendment, rescission, or addition to a fund's rules is only valid if approved by the Registrar and duly registered. This provision ensures that all contribution adjustments undergo regulatory scrutiny, maintaining financial stability and protecting members from sudden or excessive cost increases.

By applying these legal provisions, the courts in the *Heritage Health* cases reinforced the regulatory authority of the Registrar and the NAMFISA, ensuring that medical aid funds operate within a structured legal and financial framework.

The case *Pharmaceutical Society of Namibia v Namibian Competition Commission* 2023 NAHCMD 776 indirectly affects public and private healthcare financing by challenging the pricing structures used in the pharmaceutical industry, which have a direct impact on medical aid funds and reimbursement policies. The NAMAF, which sets benchmark tariffs for medicine pricing, was cited in the case as the entity that established the 50 per cent mark-up formula. The ruling clarifies that pricing agreements within the industry must comply with competition law, affecting how medical aid funds determine reimbursement rates for pharmaceuticals.

RECENT DEVELOPMENTS AND TRENDS

15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes, or trends for healthcare financing and reimbursement and briefly indicate how these may foreseeably affect the medical sector in the near future.

Namibia's healthcare sector is undergoing major regulatory reforms to improve governance, leadership, and coordination. The *Hospitals and Health Facilities Act, 1994*, has been amended on several occasions and is set partially to be repealed by the *National Health Act, 2015,* which remains unenforced. The *Health Professions Act, 2024*, yet to be implemented, establishes the Health Professions Council of Namibia, responsible for setting professional standards, accrediting educational programmes, and ensuring ethical conduct in healthcare. The *Health Professions Act, 2024*, also introduces new registration, licensing, and disciplinary procedures for healthcare professionals, ensuring high-quality healthcare services. While officially promulgated, full enforcement depends on the development of supporting regulations and administrative structures.

As part of its universal health coverage initiative, Namibia is working to expand access to essential healthcare services without financial hardship. The *National Health Act, 2015*, proposes revised healthcare financing models, standardised hospital reimbursements, and clear eligibility criteria for subsidised healthcare services. These reforms seek to reduce disparities in healthcare access while encouraging public-private partnerships to improve service delivery. Strengthening pharmaceutical supply chain management is another key focus, with the *Pharmacy Act, 2004,* and the *Health Professions Act, 2024*, introducing new procurement regulations, digital inventory tracking, and stricter oversight to prevent medicine shortages and distribution inefficiencies.

Namibia is also investing in digital health data systems to modernise healthcare services. The *National Health Act, 2015*, mandates routine health facility reporting, the creation of a centralised digital health records system, and expanded data-sharing policies between public and private healthcare providers. These improvements will enhance healthcare coordination, support evidence-based decision-making, and improve patient outcomes. In parallel, Namibia continues to strengthen human resources in healthcare, addressing staff shortages and capacity-building needs to ensure a well-trained workforce.

In 2022, the Namibian Cabinet approved the universal health coverage framework, prioritising affordable healthcare access for marginalised populations. The expansion of

primary healthcare services remains a cornerstone of this initiative, although a definitive rollout timeline has yet to be confirmed. In December 2023, the MoHSS introduced new measures to track and optimise healthcare expenditure. The National Health Account monitors total health spending, while the National AIDS Spending Assessment focuses on HIV/AIDS resource allocation, helping guide policy decisions and strategic planning. These tools reinforce Namibia's commitment to equitable, sustainable healthcare financing, particularly benefiting vulnerable populations, high-risk individuals, and maternal health programmes.

As Namibia moves forward with these reforms, the government's commitment to universal healthcare, financial sustainability, and data-driven policymaking remains central. While challenges in funding, regulatory enforcement, and service delivery persist, the introduction of stronger governance frameworks, digital health initiatives, and public-private partnerships help bring into place a more equitable and efficient healthcare system.

Namibia's Pharmaceutical Pricing Policy Initiative, led by the MoHSS with support from technical advisors, aims to evaluate and develop a structured pharmaceutical pricing policy to ensure equitable, transparent, and affordable medicine pricing. The initiative involves a comprehensive situational analysis of current pricing strategies in both the public and private sectors, with a focus on identifying gaps and inefficiencies. Through stakeholder consultations, the policy framework will be shaped to align with Namibia's healthcare needs and financial realities. If necessary, the initiative will outline a roadmap for policy development, integrating international best practices and evidence-based pricing models. This effort supports Sustainable Development Goal (SDG 3.8), promoting universal health coverage by ensuring that essential medicines remain financially accessible without imposing undue financial hardship on patients.

In Namibia, patient records are currently mostly recorded manually on paper-based medical cards or health passports. Namibia's National eHealth Strategy 2021-2025 represents a significant shift towards digital healthcare services, which will affect financing and reimbursement models. The strategy focuses on implementing electronic health records, telemedicine, and digital data management systems, all of which can improve efficiency, reduce administrative costs, and streamline reimbursement processes. By digitising patient records and billing systems, insurers and government health agencies will have more accurate data for claims processing, reducing fraudulent claims and ensuring more rapid reimbursements. A key priority under the National eHealth Strategy 2021-2025 is the review of existing policies and laws governing eHealth to identify regulatory gaps.