MINUTES OF MEETING

Joint Meeting between IPO Forum & HCP's

Location: MEDICLINIC BOARDROOM

Date: 7 SEPTEMBER 2023

Time: 18:00

Attendance

Esther McLeod, RMA
Elize Fahl, Bankmed
Valeria Muchero, Heritage Health
Dantago Garosas, NHP
Callie Schäfer, Gemhealth
Ronnie Skolnic, Medscheme
Tiaan Serfontein, Prosperity Health
Karl Weyhe, Paramount
Getrud Basaku, Telecom
Alison Begley, NMC
Beth Clayton, Methealth
Eben De Klerk, NPPF
Dr Sophia van Rooyen, GP- NPPF
Dr Armid Azadeh, CE - MAN
Dr David Weber, Chairman - MAN
Dr Steffen Bau, Paediatric Society
Dr Erich Mansfeld, GP - NMC
Dr Michael Jario, Neurosurgeon
Dr Nura Afshani, ASN
Dr Vaja Zatjirua
Dr H Ndjabo, Psychiatrist – Psychiatric Association

Opening & Overview on Private Healthcare – Callie Schäfer, IPO Forum Representative

The Independent Principal Officers (IPO) Forum was established during August 2022 due to different opinions between Funds, PO's & NAMAF, as to the role of NAMAF.

The IPO Forum represents all 8 Funds:
Open Funds - NHP, RMA, NMC, NAMMED & HERITAGE HEALTH
Closed Funds - BANKMED, GEMHEALTH & NAPOTEL

- Private Healthcare (PHC) faces major threats
- It is imperative to restore TRUST amongst role players
- Ensure dialogue and engagement with stakeholders to secure the future of PHC
- Promote collaboration in order to protect the PHC industry
- According to NAMFISA the Fund reserves must remain at 25% of total annual contributions
- When reserves fall below 25%, the Fund needs to restore the reserves and submit a business plan to NAMFISA
- Less than 50% of the Namibians employed and contributing to the SSC, are actually covered by a medical aid fund. The rest are uninsured.

Information/Statistics from NAMFISA quarterly (Q4 - 2022) report ending Dec 2022

- Total members/beneficiaries = 209 545
- Impact of COVID resulted in accumulated costs during 2021/22
  Total COVID expenses 437 519 million
- On average, the expenditure/claims of all Funds amounted to 1 billion per quarter
- Highest cost drivers identified: Hospitals 35%, Pharmacies 15% & Specialists 13%
- Non healthcare expenses amounted to 128 million (11.3% for open funds & 5% for closed funds)
- A total amount 1.23 billion per quarter was collected from member contributions during 2022
- At the end of 2022, the reserve funds of all MAF's dropped with 10%
- The 2022 spike in claims became the new trend

Challenges identified by IPO Forum

- Addressing distrust amongst stakeholders, breaking the silo's and working together
- Healthcare inflation & utilization
- New trend in claiming
- Influx of practitioners, specialists & pharmacies
- Members/Groups pressurizing MAF's to reduce premiums, co-payments and premium increases
- Identify and address abuse, wastage and fraud

Current IPO projects

- Understand trending
- Consider alternative reimbursement models
- Compulsory referral system
- Speeding up payment cycles
- Ways & means of ICD-10 coding
- Address inter-hospital treatments
- Contracting network providers

Medical Insurance Landscape – Namibian Culture evolving over last 2 decades – Dr David Weber, MAN

- HCP's becoming heavily policed and over administrated, resulting in reduced earnings.
- Associations & organizations representing HCP's, historically being the custodians of the billing structures.
- NAMAF previously regarded as being the filter and bridging entity between MAF's and HCP's.
- MAF's currently in a crisis and are 'not for profit' cross subsidized insurers of their membership.
- The Administrators (IPO) and stewards of the Funds, now performing the gatekeeper function, but with little/no insight into clinical medicine.

The origin of AHB (In-hospital Benefit 225%)

- Many specialists in Namibia moved to SAMA plus 20% from 1999.
- Their SA counterparts were claiming SAMA or SAMA plus 20% at that stage.
- The NAMAF (Namibian) tariffs lagged between 50-150% behind when compared to RAMS (Representative Association of Medical Schemes – later named BHF tariffs).
- GP tariffs also lagged behind when compared to BHF tariffs.
- Around 2001 the NAMAF tariffs for GP's were adjusted by 50% upwards to correct the gap, provided that GP's should act as gatekeepers.
- The process was monitored by NAMAF but around 2004 no savings could be measured.
- The increased tariffs for GP's were not adjusted downward.
- Specialists refused to claim directly from the Funds for in-hospital procedures, due to the tariff difference.
- Those specialists claiming from the Funds, did balanced-billing, which left the patients with payments and co-payments.
- Funds had to deal with many Ex-Gratia applications. They then increased the specialist tariffs to SAMA plus 20% for in-hospital procedures, provided that the specialists will no longer do balanced-billing, which resulted in less Ex-Gratia applications and removed the financial burden on the patient.

SAMA/MAN Guide to Billing 2007 vs NAMAF Tariffs 2007

- The SAMA/MAN Guide to Billing was approved as a reference price list by the SA Council for Medical Schemes.
- Differences existed in terms of coding, technology and procedures between the SAMA/MAN Guide to Billing and NAMAF tariffs.
- A principle of 2 Scale Structure was adopted… on the basis hereof service providers determine charges according to the NHPRL 2007 SAMA/MAN Guide to Billing rules and medical aid funds determine payment contributions in terms of NAMAF 2007 Tariff rules.

GAP cover to Benefit including 225%

- Up to 2009 the Fund took out re-insurance which was applicable to GAP cover as well as Excess Over Limit (EOL).
- The GAP cover basically covered the difference between the BHF (the NAMAF tariffs were linked to the BHF tariffs) and SAMA tariffs.
- This, however, was cancelled at the end of 2009 and the Fund took on that liability.
- Instead of calculating the GAP as NAMAF +180%, all MAF's decided to pay 225% for GP's and Specialists for in-hospital procedures.

Eben De Klerk (representing NPPF)

We have sympathy for the Funds' position and have to find solutions in a collaborative way.

1. Have to understand different perspectives and get common narratives on certain issues i.e. Health 'inflation' is caused by the members who started utilizing more = increase in claims. The narrative must change as everyone is made to think the HCP's are the culprits; and that the HCP's must start earning less to save the Funds.

2. Position of NAMAF
   - They do not have statutory powers.
   - No member of an MAF has access to the NAMAF Benchmark Tariffs, even though it is the members who are paying the premiums (this was addressed with NAMFISA but nothing can be done about it).
   - NAMAF is an association of MAF's AND a regulator of MAF's and should have made rules to regulate the MAF's which has not been done since 1995.
   - Instead NAMAF became a regulator of HCP's and set up Benchmark Tariffs for the benefit of cost saving for the MAF's.
3. Trust Deficit
   - Caused by numerous attempts to address problems and lodge complaints with either NAMAF, MAF's and/or NAMFISA over the past years, with little or no reply.
   - It is very important that issues causing friction must be addressed in an honest way and not be ignored.
   - Information was quoted from the NAMAF Chairman's report (2022) which again triggers the issue of distrust.

General Comments

- Communication is vital.
- MAF's to consider having HCP's on their board for clinical decisions.
- HCP's are regulated and are bound to a code of ethics which makes is difficult to point out 'bad apples' (ethical dilemma).
- MAF's have data on HCP's which can be used as an outline to identify wastage, abuse, etc.
- ICD-10 codes are helpful but cannot rule out mismanagement.
- Influx of HCP's – what attracts them? Easy entry, mark-up medicine model, free for service model.
- Approach Ministry of Health & Ministry of Home Affairs to introduce a possible 6 month moratorium on foreign HCP's.
- Benchmark Tariff system encourages waste.
- Some practices subsidize patients.
- Release statement to the public regarding HCP's image and MAF's image.
- MAF's - possible increase in membership by accepting foreign nationals (SADC)
- Reduced membership premium for lower income groups / attract uninsured

Action Points (short to medium term)

- Identify and list differences/issues to be prioritized and addressed.
- Follow-up meetings / discussions.
- Form a group for cost, peer review, etc.
- Next NAMFISA report will be released mid-September from which trends can be compared, between Dec'22 and Jun'23, and necessary interventions can be identified.