NPPF: CEO REPORT JUNE 2024

EXCERPTS

Introduction:

This CEO Report is the first to follow the one submitted in November 2018.

Report on Activities:

As indicated above subjects of primary importance will be discussed here in alphabetical order. Because of the limitations of space each subject can be touched only very briefly but adequately for further exploration.

1. **Competition Commission**

It is quite important that private practicing healthcare providers perpetually be reminded not to form collusions which could be seen by Competition Commission as anti-competitive. Some cases may be difficult for instance entering into contracts with entities like hospitals or medical aid funds (for instance "independent practitioner associations" or "capitation agreements") where fixed fees are being paid for services. When there is doubt the golden rule is to ask Competition Commission directly what their approach would be in a particular (well explained) situation. Their legal department's written reply, although carrying a price tag, will be of some assurance, and when mediated by NPPF's legal adviser, will be of inestimable value to the NPPF member. One extremely difficult situation is the Namaf-Benchmark-"prescribed"- fees. NPPF members (and the entire private healthcare sector) have been warned repeatedly not to charge Benchmark fees slavishly because in reality it boils down to anti-competitive collusion. Never forget that in the court case Competition Commission vs Namaf/Medical Aid Funds the Namaf/Fund side argued very convincingly that the Namaf Benchmark fees are only recommended fees and not fixed fees. The findings of the court were that the Funds and Namaf are not subject to anti-competitive legislation but that healthcare providers are. They (healthcare

providers) seem not to be listening or they still do not understand!! The phrase "Namaf has not given us an increase" is still the order of the day. When authorization for a procedure or a particular medicine is refused by a patient's Fund the phrase "we are not allowed" to do such and such procedures is still being used regularly. Re-reminding to wipe out this employee mentality remains an important duty of NPPF leadership. "YOU ARE NOT EMPLOYED BY THE FUND; ASK YOUR FEE AND WHATEVER THE FUND DOES NOT PAY, THE PATIENT MUST PAY" needs to be drilled endlessly into healthcare providers' ears!! Because they do not know what to charge, two more actions on the side of NPPF is of critical importance. One is; a new cost study which will provide a formula to calculate fees for each profession should be done (see Healthman below). The second is to endlessly remind healthcare professionals that the Health Professions Council of Namibia (HPCNA) is not prescriptive at all in this field of healthcare provision. There is still an anxiety amongst healthcare providers that if their fees are not strictly "correct", HPCNA will strike and make a clamp down on their registrations.

2. **Covid**

In terms of the Covid pandemic NPPF enrolled itself in a countrywide cautionary action. First it cautioned members, medical aid funds and municipalities about the possibilities that the same or another episode may await us soon. Secondly it recommended to members that in line with basic scientific principles they should not allow themselves to be concentrated in healthcare facilities but should rather disperse so that the viral load can be contained. Thirdly municipalities were asked countrywide to (with the onset of a pandemic) immediately activate a Disaster Risk Management Team along the lines of the existing Disaster Risk Management Legislation. Support was also asked to timeously allot healthcare teams and equipment to manage and treat a dispersed patient population. Finally to medical aid funds our recommendation was that an "Emergency Committee" be brought into existence immediately with the onset of an epidemic by each fund so that authorizations for hospital admissions, transport and medicines could be obtained seamlessly in accordance with each Fund's rules.
During the previous pandemic NPPF's opinions were repeatedly called upon by healthcare providers across the spectrum. On legal issues such as the selling of practices which became vacant because of deceased owners as well as estate issues Mr. de Klerk became extremely busy. On the clinical side we had to mitigate anxieties over treatment regimes, availability of medicines and logistical delays demanding alternative treatments, overcrowded hospital facilities, medical aid funds being caught off guard and many others. On administrative level like communications amongst members; even issues like pharmacists selling rapid Covid self-test devises directly to the public, NPPF's capacity to talk to a huge

healthcare fraternity through its database proofed itself of outstanding value. With NPPF's present vision to extend its database to also include fund members, its (NPPF's) reach will be even wider and more useful also to the general public (see under Fund-member Associations below).

3. Forensic Investigations

The private healthcare sector has recently been subjected to a wave of forensic investigations and claw back operations by medical aid funds in their claimed struggle to survive of which a key ingredient is to overcome Fraud, Waste and Abuse (FWA). NPPF has been and still is at the forefront in fighting this. The main points of contention are that FWA being put exclusively before the door of the healthcare provider while the funds refuse to disclose the money that go to their administrators. Furthermore, checking the validity of each item on a claim is the duty of the administrator for which it is overwhelmingly funded. To claim back money which has already been paid out on claims that have met all the requirements of the administrators is actually an admission of a dysfunctional administration. In addition, Namibian Law does not legitimize claw back operations without proper mediation.

NPPF's position is that none of these would have taken place if NAMAF exercised its control duty over Funds. NPPF is in particular concerned about the legal relationships that exist mutually between the Fund which is obliged by law to pay the service provider and its administrator who practices the withholding of payment as part of the claw back operation. If the agency agreement between fund and administrator includes a claw back duty, the fund is operating beyond its lawful boundaries; if the agency does not include a claw back duty, then the administrator who is under no control in Namibia, pushes the fund towards unlawful operations.

Tragically this relentless drive of the shareholders of the administrator companies for bigger profits is playing itself out in the public domain. FWA accusations against the professions are made in the public press. The net result, if not actively guarded against by the health professions will be a loss of trust and confidence between the two most important players namely the patient and his healthcare provider. Third party payers do not seem to have even a minute sense of responsibility towards the basic pillars of the industry that sustains them until the collapse comes so close that even they can sense it. And then the blame is to be projected onto the other parties.

4. Friendly Society

The present CEO and writer of this text was for long (and still is) absolutely convinced that an alternative funding system for healthcare in Namibia with its low population can be worked out. If something entirely new cannot be worked out, a Friendly Society proofs to be the better option within the existing legal framework. Development of our own Friendly Society was thus driven a couple of years ago to the point where an actuarial company as well as an IT company for the software became enrolled and more than N$150,000 been paid out by NPPF. Further development was voted down at a Directors meeting dated December 07, 2018.

There are some crucial elements which will bring about the most important ingredient of any funding system namely that both member and service provider take ownership of it. They are:
*** Mutual cross subsidizing amongst members (also called horizontal cross subsidizing)**
*** Auto subsidizing of a member (when young subsidizing his own old age; also called vertical subsidizing.**
*** Carrying over (roll over) of net profits from one year to another to the benefit of the member per member. (Profits not disappearing into the pockets of shareholders of administrators)**
*** No profit driven administrators/third party payers**
*** Restricted benefits for members as per contribution**
*** Total transparency**
Such a system will prevent enormous amounts of money flowing out into the pockets of shareholders. These savings may allow access for the poorer members of the population who have a few dollars to spare and who are now entirely excluded from fund membership. The result will be a completely different configuration especially when large employers come on board.

5. Fund-Member Associations

After an NPPF struggle for twelve years with limited success against a, by now totally unregulated and actually corrupt by design funding model, the author of this text is convinced that only two ways remain. Either embark on a full competition with the existing funds by way of an alternative funding model like described under Friendly Society above, or start regulating the existing funds from below. The latter will have limited success but pinching these Fund/Administrator

coalitions at the source of their wealth will certainly make them rethink some aspects of their behavior. For this a well-organized fund-member- healthcare-provider organizational structure will serve. A purposely designed database which will enable NPPF to talk to fund members directly and/or via their healthcare provider is needed. Once this is in place meetings with individual healthcare providers together with their fund member patients can be arranged from practice to practice. Representatives of the funds may be invited to each meeting. All of a sudden there will be a platform where fund members (the ultimate carriers of the purse) can listen to both sides of the equation in a very size-limited gathering.
The weak point is that there is still no "axe over the neck" because common people will be afraid of losing their Fund membership and end up being uncovered for health costs. Blackmailing is most certainly not beyond the scope of the funds' ethics as was demonstrated a couple of years ago when they blackmailed the entire Bio-kinetics fraternity out of their NPPF membership.
This entire undertaking will ask for a lot of work and dedication. We (NPPF) have already started calling on healthcare providers to make patients sign permission to share their personal data and a limited database is already in place. No objections or resistance has as jet been encountered and the reason for slow progress is that healthcare providers need (as always) constant reminding to comfort them into action.

6. **Fraud, Waste, Abuse (FWA)**

FWA was already discussed under Forensic Investigations above. What needs to be added here is that the NHP/Medscheme entity (the foremost practitioners of claw back operations) did cave in to pressure from many sides which included NPPF. Amounts that have been clawed back were released again and paid to the lawful owners namely the health professionals who have worked for it.

7. **Health Industry Forum Namibia (HIFN)**

HIFN was initiated in April 2019 and I quote: The HIFN will provide a platform for representatives of healthcare industry stakeholders from all sectors and disciplines to discuss the challenges the industry is facing and find potential solutions to these challenges together. Your participation in this Forum will be greatly appreciated.
Despite some skepticism about their internal capacity, NPPF joined membership in May 2019. A number of communications were exchanged mainly in connection with the Covid pandemic. By August 2020 based on disappointments in the way in which they handled negotiations on behalf of all relating to the renewal of the

Psemas contract, NPPF informed them officially that we will in future go our own way again. After February 2022 there was no further involvement with them.

8. **Healthman.**

Healthman is a South African company specializing in cost studies for healthcare professionals. It means that they evaluate the costs of running a practice, add a reasonable income for the professional and then come up with a Rand-Conversion-Factor (RCF). In effect it means they give you a minute value for your work which is then easily converted into real money value depending how much time you have spent. For instance, for a Psychologist a RCF may be N$ 25.00. For a consultation or the writing of a report or whatever professional work he does, to be sustainable he has to charge 60 x 25 = N$1500 per hour (just an example). Although costly, it (the cost study) is the only scientific way by which healthcare professionals can determine their worth. It is done profession by profession and takes into consideration the time, the intensity, the skill requirements as well as the costs of running that particular type of practice. Dentists are excluded because of extreme difficulties with their materials in use.

It was done for NPPF in November 2014 at a cost of about N$300,000. Unfortunately only a few professions took part at that time.

The contact person is Casper Venter at email address casperv@healthman.co.za. A follow-up study has become indispensable.

9. **Heritage Medical Aid Fund (HMAF)**

HMAF was recently rescued from bankruptcy by a court decision. The intricacies of the salvage operation could only be deducted by healthcare providers. The program surely included withholding payment from healthcare providers for periods even longer than two years, while still receiving member contributions. Pharmacies quickly put a stop to it by demanding direct (out of the pocket) payment by members and thereby helped to further reduce the expenses bill of the fund tremendously. In doing so their (HMAF's) books must have shown enough profit to convince the judges about viability questions. Members, in particular the older group were trapped. Their choice was to either continue paying membership fees and thereby remaining "insured" or discontinue payment and sacrifice membership, never to be allowed again not only by HMAF but by the entire funding fraternity.

10. Health Professions Council of Namibia (HPCNA)

Five matters necessitated recent contact between NPPF and HPCNA.

a. **Split billing claimed by medical aid funds to be unethical conduct for healthcare providers. Refuted by HPCNA on direct inquiry by NPPF.**
b. **Much higher annual registration fees to be paid by healthcare providers with foreigner passports working in the country than by workers with citizenship. This concern still needs to be addressed.**
c. **Pushback from the private healthcare industry against unrestrained registration of healthcare workers by HPCNA. Medical aid funds claim that because of the high influx of healthcare providers into the country, especially medical specialists, an imbalance between supply and demand for services has come into being. Meeting this "supply-induced demand" they indicate as one of the ills causing their financial calamities. Irrespective of the truth content of this claim, in principle some form of pushback by a saturated industry should be in place and functional and this subject should be taken up with HPCNA.**
d. **Individual healthcare providers acting as advisers for medical aid funds. To run their "managed health care" programs, funds make use of single advisers who can on basis of their clinical background "authorize" on not, admission of patients in hospitals, emergency evacuations by air, clinical procedures by healthcare providers and even medicines to be dispensed to patients. Very probable these health professionals follow algorithms given to them by the overseers of expenses. This is an extremely dangerous position for the colleagues because foreseeing the outcomes of their advice is impossible. NPPF submitted a lengthy report in this connection to HPCNA but no reply was ever received.**
e. **NPPF had a meeting with the legal department of HPCNA on the unwillingness of medical specialists to write reports on patients that have been referred to them. Although there are no ethical rules or guidelines dealing specifically with this, their opinion was that it is part of the "good practice" requirements that are in place.**

   As in (d) above the net result is that we need more regular communications and updating in an ever changing environment between the regulator (HPCNA) and the regulated.

11. ICD10 coding:

ICD10 and its successor ICD 11 coding is a World Health Organization requirement for the implementation of which legislation is not yet in place in Namibia. Namaf has announced that it will be implemented and enforced in stages. Despite the fact

that it will not bring direct benefits for the healthcare provider, in a recent Monkey Survey conducted by NPPF amongst healthcare providers the majority indicated their willingness to cooperate without extra remuneration. It will not replace the "Namaf coding system".

12. Indemnity Insurance

As per the last renewal of the Psemas contract proof of (a vaguely specified) "professional" insurance is required of anyone who wants to enter a service agreement with Psemas. NPPF had an argument with the compilers of the contract but the vagueness of their description of what they want remained unchanged in the final draught.
This is a minefield for professionals. Clear distinction must be made between "malpractice insurance" and "professional indemnity insurance". The former is long term coverage of a wide range of liabilities which can befall the health professional and is expensive; the latter a short term insurance covering the consequences of short term decisions and is much cheaper. Because of the vagueness of the description in the contract, most professionals who were practicing without insurance for many years opted for the cheaper model.
The problem is that those who rushed into the cheap option may have a false sense of security and NPPF should from time to time warn all its members against it. Because of the intricacies in the choice of insurance it (choosing) should be based on professional advice, which is not the advice of the broker.

13. Legislation:

One issue that was raised some time back was whether the same person may have membership of both a private medical aid fund and Psemas simultaneously. The MAF-act prohibits membership of more than one private fund but practically spoken, Psemas is not a fund. The issue was never resolved.

14. Medical Control Board

It has been the policy of NPPF over the last twelve years that a single representative regulating body for the financial part of the entire private healthcare sector be brought into being. NPPF called it "Medical Control Board" and anticipations and ideals were discussed with the then Minister of Finance Callie Schlettwein as far back as 2013. By now with accumulating evidence that neither Namfisa nor Namaf accept regulatory responsibilities over the funds, it

boils down that neither the funds nor their administrators are regulated at all and that Namaf rather tries to regulate the healthcare professionals. Hampering the drive to call into existence this Board are:

a. **Administrators are profit driven entities and will not submit to such regulation. So for the Board to work, an entire change in structure of the present funding model will have to be established on authority of new legislation.**
b. **Overlap between the functions of HPCNA and the new Board in terms of the regulation of healthcare providers will have to be straightened out.**
c. **Overlap between the present functions of Namfisa, Namaf, Mafaf and the different Associations of healthcare providers and the new Board will have to be straightened out.**
d. **It will require a very dynamic drive to get it happen and the only authority to do so is the Minister with new integrating legislation.**

In the absence of such a drive a very difficult uphill road awaits the healthcare providers' side because "regulation" is at present totally dominated, in their own interests, by the funding side. The easiest (and perhaps only) way out will be to create a competing funding model as spelled out above under Friendly Society.

The newly created Namibia Healthcare Service Providers Forum driven by the Pharmacists and their legal authority Mr. Phillip Ellis, is a revival of the idea of an all- inclusive Control Board but those involved are still very naïve and seemingly chooses to walk the same way NPPF treaded upon 12 years ago. This delay is certainly in the interests of the funding industry.

15. Methealth

Methealth administrator proved itself the more accessible administrative company. Several complaints have been taken up with them, almost always with good results. Beth Venter proofed to be a reliable contact.

16. Ministry of Finance (MOF)

The following interactions with MOF need highlighting:

a. **The so-called Psemas contract between healthcare providers and MOF will not stand scrutiny in any court of law. It simply does not meet the legal criteria of a contract.**
b. **The contract with its deficiencies is enforced upon healthcare providers who do not have choices due to the demographic realities in their settings. It may**

therefore rather be considered a one-sided dictation of work conditions and not a contract.

c. **Remuneration which since 2014 is one-sidedly blocked at 2014 rates, impoverishes healthcare providers who invested in communities which would otherwise (without the Psemas contract) not have been viable and MOF knows it very well. These healthcare providers (who invested heavily in private infrastructure when the Psemas fees were reasonable with an expectation that fees will follow reasonable adjustments), find themselves now entrapped. This can be interpreted as unethical behavior/labor practices on Government's side the validity of which needs to be tested in court.**
d. **MOF's involvement in the Tax Good Standing Certificate issue is being dealt with below.**
e. **On 21 January 2022 MOF issued an unnumbered circular signed by Francois Brand, Acting Executive Director and addressed to Pharmacies that Psemas will not pay for prescribed medicines dispensed without doctor's consultations or visits. This had serious implications for all the practically difficult situations where Psemas patients ask for a doctor's script telephonically (without seeing the doctor). Instances include farmers living far from town, contractors who run out of medication but cannot reach a pharmacy in time, disabled people who cannot visit the doctor and so on. As a compromise NPPF recommended that doctors in these cases go through the entire procedure of making notes in the patient's folder, confirming the validity of the request and sending the script to the pharmacy and then charge for a follow-up visit under code 0108. Strictly speaking this advice called for not-honest behavior forced upon us by a poorly thought through rule. NPPF did not take it up with the authorities.**

17. Ministry of Health and Social Services (MOHSS)

NPPF /MOHSS interactions were mainly concentrated around four issues:

a. **The Tax Good Standing Certificate already mentioned and to be further discussed below.**
b. **The Psemas contract which is basically a MOF issue.**
c. **The Medicines Regulatory Council also to be discussed below.**
d. **The training of Interns.**
   There is a potential conflict between the qualification requirements for practicing healthcare providers set by HPCNA and the training facilities available. For medical clinicians the "clinical" year(s) usually depend on MOHSS facilities like hospitals where specialist/consultant oversight is available and who can "sign off" the student after completing the compulsory work. Some professions however (like the clinical psychologists) provide for "in service"

training in private healthcare facilities under supervision of the practitioner. Many issues arise of which payment is but one. Who should pay and how much should be paid? In principle these interns will end up working in both the private and public healthcare sectors under the ultimate umbrella of MOHSS and the quality will be supervised by HPCNA. Clinical psychologists have established an interaction with the funds because the work done by the intern amounts to quality (under supervision) service to members. NPPF although representing different sectors including Dentists, Occupational Therapists, Physiotherapists and other has not yet become officially involved in these processes but did take note through the intimate involvement of Dr. Jürgen Hoffman on behalf of the Psychologists.

18. Namaf (Namibian Association of Medical Aid Funds).

The NPPF/Namaf saga is a source of endless wonder and amusement and much too intricate to describe here. The following topics are of importance:

a. **Namaf is the medical aid funds and the medical aid funds are Namaf as per description in the medical aid fund Act 23 of 1995.**
b. **Namaf is a statutory body whose compilation, scope of functions and authority are determined (and limited) by law (Act 23 of 1995).**
c. **Namaf acted over the last ten years or so as if it has the authority to regulate the entire private healthcare sector, including the healthcare providers in Namibia. This was not based solely on arrogance but very fundamentally on a clause in the Act giving them authority to do "anything" to promote their interests.**
d. **There are multiple examples of its overreach, some of which will be mentioned below.**
e. **NPPF obtained Senior Council opinion (Adv. Totemeyer, SC) which implied that some clauses of Act 23 of 1995 including the "do anything" clause may be unconstitutional and a challenge in court may succeed.**
f. **Namaf, for years, has used the allotment of the so-called Namaf number as an axe over the necks of healthcare providers and as an instrument of coercion and made them pay an annual registration fee for the privilege of the number. The following quote comes from the 2022 Namaf Annual Report:** *Practice numbers are a means of identifying healthcare providers and are linked to a scope of practice.* ***Essentially, the information contained in PNs thus defines the procedures that a HCP is allowed to perform and bill patients for.***
g. **Much of its overreach is now being challenged in a court case set into motion by Dr. Jonathan Joffe and partners after having been refused a Namaf number**

for one of their facilities. Graciously they agreed to extend the challenge to include some aspects of the Act itself.

h. Namaf recently acknowledged that charging for practice numbers was beyond its statutory limits. Seemingly health professionals can now claim back at least three years' payments.

i. Because the court will decide upon key issues in the Act like for instance the "do anything" clause, a "New Namaf" is expected to appear after judgment.

j. One example of neglecting statutory duty by Namaf is the lack of exercise of "control" over funds. Added to a denial by Namfisa of authority to control funds, medical aid funds at the moment operate as totally uncontrolled financial institutions augmenting the already existing similar position of their administrators.

k. In consequence of this total lack of control and total freedom to do "anything" they want, to promote their interests all kinds of transgressions have become the order of the day. Some examples include claw back operations by Medscheme on behalf of NHP, the institution of "managed healthcare", usurping and hiding behind an electronic wall the entire Benchmark of codes and descriptors of clinical work, attempts to unilaterally change some of the wording of Articles to Act 23 of 1995, withholding Namaf numbers and using the allotment of numbers as instrument to enforce their will, not overseeing the amounts of money that drains out of the healthcare pool into the pockets of shareholders of administrators and many more.

There is no reason to think that even a New Namaf will refrain from enriching their ultimate masters the administrators. A watchful eye will therefore be incumbent until they can be driven out of existence by fair competition by an ethical funding system.

19. Namfisa

Of outstanding importance is to grab a clear insight into the role of Namfisa in the healthcare funding environment. Different from an ordinary contract between parties where the terms are spelled out on a piece of paper and both parties sign in the presence of witnesses, the contract between the Medical Aid Fund and its Member consists of the fund rules which describe the fund's promised performance in exchange for a variable monthly fee which is the performance of the member. These fund rules are registered with Namfisa as the obligations of one side (the Fund's side) of a contractual agreement and fall immediately upon registration under the protection of the Registrar of Medical Aid Funds at Namfisa. Changing the rules therefore is changing the essence of the contract and cannot be attempted and executed lightly. It is therefore Namfisa's role as statutory guardian

of these contracts to see to it that the rules are not arbitrarily changed and that the one party to the contract remains viable. The vulnerability of these rules is illustrated by the following abstract from the Namaf 2022 Annual Report showing how far Namaf's overreach is stretching:
"MC (Management committee of Namaf; my addition) approved the proposed wording for amendment of Fund Rules inclusive of Namaf coding structures as a valid requirement for claims or statement of account".

20. NHP Medical Aid Fund

NPPF became heavily involved with NHP in trying to protect its members against the unlawful claw back operations done by Medscheme.
Important points to be remembered:

a. **Claw back operations are outside of the Law in Namibia**
b. **There is a conundrum in the entire internal legal relationships not only of NHP but all Funds with their administrators. Funds stand under legal obligations as are prescribed by their regulating Act and its Regulations. One such obligation is that it must pay service providers who care for its members. If the administrator which is a profit-seeking but unregulated entity in Namibia under agency of the Fund does things illegally it can be prosecuted directly by the legal system. If however it does things which are not illegal but the results of which put the Fund outside of its legally prescribed obligations the exact legal situation may become unclear. If the agency agreement between Fund and Administrator includes a duty to claw back, the fund is to blame; if the agency agreement does not include such duty, the administrator itself acts outside the Law and also thereby traps the Fund in liability. Although the NHP/Medscheme construct has now stopped their claw back operations and repaid the affected professionals, it remains the duty of all parties involved with funds to dig deeper into these internal relationships to better understand actions and motivations in future. It is hard not to see the funders' entire modus operandi as being based on outwitting, trickery and cunning.**

21. Other Associations

NPPF never intended to oust any of the existing Associations/Societies of healthcare professionals and it was explained to them from the beginning and thereafter repeatedly. The author and present CEO had multiple meetings where he addressed these entities in person. A couple of these collectivities including

MAN (Medical Association of Namibia) and PSN (Pharmaceutical Society of Namibia) never offered such opportunity.
NPPF functions at another level enabled thereto by its legal capacity through the involvement of Mr. Eben de Klerk, NPPF's legal advisor. Quite a number of healthcare providers thus have membership of both NPPF and their own profession's Associations/Societies.
There are many examples over the years where these Associations/Societies made use of the help NPPF could offer, mainly in the form of advice. The main issue most of the time of course was Psemas and the Psemas contract. Other important examples were advice NPPF could provide to the Biokinetics during the Covid time and Life Link Ambulance Services. These advices have always been offered free of charge.

22. Prosperity Medical Aid Fund

Aside from occasional enquiries about individual problems encountered by members, formal contact between NPPF and Prosperity Administrator was in connection with "gap-insurance" for Psemas members. The need expressed by NPPF was for a gap-cover for Psemas members to compensate for the large shortfall between what Psemas pay compared to what is paid by private medical aid funds for the same service. The outcome was a proposal based on an insurance product, the benefits for members of which were not value for money at all. The issue was not pursued further.
<u>Directors should be aware of the technical differences between Health Insurance and a Medical Aid Fund!</u>

23. Psemas

The dilemmas which ended up on the NPPF desk in connection with Psemas were numerous and complex and cannot be dealt with in detail here. Fortunately they are well known to almost every healthcare provider including the entire new Directors team. The following need to be highlighted:

a. **Dealing with Psemas means dealing with its administrator Methealth who can almost never give a straight forward from the sleeve answer on any problem. A very reliable and accessible person at the Methealth desk is Ms. Beth Venter who never disappoints.**
b. **Under intense (and not even intense) legal scrutiny the validity of the so-called Psemas contract as a contract will not stand for even one minute for several reasons of which the one-sided annual extension is but one.**
c. **In most rural settings and even for not a few urban practices the availability of the Psemas agreement is an indispensable lifeline. There is simply not enough**

other private work available to sustain the country wide network of high quality private healthcare facilities for which Namibia is highly esteemed.

d. **With present Psemas fees the sustainability of this network is under serious threat and it is as if Government cannot care. Calls for improvement are not even answered and are therefore not pursued anymore.**
e. **There is a possibility to challenge Government of practicing unethical behavior. The basic premise is that on basis of Government having respected not so much the dictates of the agreement but the spirit thereof in the past, including the suggestions of reasonable pay for reasonable work, and the trust in general of citizens in their governments, many healthcare providers immersed themselves with limb and money in otherwise unsustainable communities but now find themselves trapped in inescapable situations of which government is well aware. Put differently; government is well aware that he enticed private investors and now have them trapped in inescapable situations which can be (and are) exploited further and further.**
f. **Seemingly the entire Psemas is in for reconstruction and a private consulting company has been allocated the contract. Until now no consultations have been conducted with those who are now caring under unsustainable conditions for the public service population.**

24. Survey Monkey

For an annual subscription "Survey Monkey" provides the software for conducting an unlimited number of surveys. This is a very useful tool which has been utilized several times over the last couple of years by NPPF.

25. Tax Good Standing Certificate

One of the extreme frustrations of healthcare providers when applying for registration of their healthcare facilities with Ministry of Health and Social Services (MOHSS) is that as a precondition they must deliver proof that their taxes have been paid. This is unique to the health professions in that paid taxes are a prerequisite for doing business and earning a living. One Ministry (Ministry of Finance) burdens another (Ministry of Health and Social Services) to enforce its determinants upon a single profession and if its members do not comply, to take them out of business. This is a legal absurdity which has been taken up with the relevant Ministers as well as the Ombudsman, but until now to no avail. The lion's share of this struggle goes to the credit of Dr. Jürgen Hoffmann, one of the newly elected Directors of NPPF.

26. Tele-Consultations

Tele-consultation and Tele-review will most certainly establish itself over time in Namibia. As a healthcare provider-patient engagement it has many benefits but also administrative caveats. It leaves the door wide open for corruption. Keeping record of what was said and done, is difficult and under some conditions impractical. Guarding over professionalism is extremely difficult. HPCNA's ethical guidelines will have to be reviewed and many other difficulties will have to be overcome. Fortunately there are other countries in the world with already advanced implementation from which we can learn.
Implementing will most probably go along with multiple trial-and-error experiments. A solid Association with members submitting to a code of conduct and identifiable by way of signposts in front of facilities and with names published in the press, as has been foreseen by NPPF many times, will be the way forward.

<u>Recommendations:</u>

Following from the above a few points of immediate importance should be highlighted:

1. **Interaction with HPCNA for redress of the much higher registration fees for foreigners and for implementing a system of push back for the prevention of overcrowding of the private healthcare sector. (See under HPCNA).**
2. **Claiming back moneys paid illegitimately for Namaf numbers (See under Namaf).**
3. **A new cost study (see under Healthman)**
4. **The establishment and further utilization of a fund-member database to exercise some regulation of the funds "from below" (See under Fund-Member Associations)**
5. **To investigate the internal legal relationships between Funds, their administrators and other entities appointed by them (See under NHP Medical Aid Fund and Forensic Investigations)**
6. **To rally financial support for the Joffe Court Case against Namaf.**

Conclusion:

The appearance of NPPF on the scene definitely made some difference for the previously vulnerable and defenseless healthcare providers. Although NPPF's approach has always been seen by its opponents as being "inflammatory" and "confrontational" it tried never to be unreasonable. It never tried to destroy but rather to create. A fair and sustainable foundation and platform for the professions who give so much to us have always been its destination. It did deliver some results. We now have a database with which healthcare providers can be reached and united. Medical aid funds and their Namaf have taken note not to mess with us. We have a solid "code of conduct" and "review" base enshrined in our Articles of Association whereby unruly and ethically questionable healthcare providers can be brought within limits. Importantly we have the trust of a large number of healthcare providers, some being members of NPPF but many still not. This trust and I want to dare say, fame, reach beyond single healthcare providers towards institutions like HPCNA, Namfisa, Fund administrators, other healthcare Associations and Societies, different Ministries, the Ombudsman and even beyond.

One person to be singled out in the entire effort is surely Eben de Klerk who never compromised morality and with his enormous knowledge often carried us through all sorts of legally troubled waters. Be saluted Eben de Klerk!!

It is my wish that those who follow will keep up inspiration and never to waver in doing what is right.

Dr JA Coetzee (aka Dr Dries Coetzee)

0811289029

drdriescoetzee@gmail.com

May 27, 2024

Dr Jürgen Hoffmann
CEO: NAMIBIA PRIVATE PRACTITIONERS FORUM
Cell: 081 1242884
Email: nppfmanagement@gmail.com