NPPF
THE NAMIBIA PRIVATE PRACTITIONERS FORUM
Sec. 21 Non-Profit

7 December 2023

PRESS RELEASE

NAMAF: SETTING OF BENCHMARK TARIFFS AND ATTACK ON HEALTHCARE PROVIDERS

From the time of Asclepius and Hippocrates, the relationship between healer and patient has been acknowledged as a covenant, based on trust, between two unequal partners. Healthcare professionals (HPCs) are regulated by the Medical and Dental Act, Ethical Rules and Guidelines for Health Care Practitioners and the HPCN (Health Profession Councils of Namibia).

The HCP has to make decisions based on what is best for the patient, even when it is to his/her own detriment. This principle of taking responsibility for the patient without prioritising our own needs and without being influenced by possible financial gain, forms the basis for our acceptance to practice the art of medicine in an ethics driven environment.

In this environment our financial remuneration is controlled, and financially profitable endeavours are legally restricted. We, the healthcare providers, can only generate income by the giving our time, by medical procedure we personally deliver to a patient. No income can be generated from mark-up of appliances and prosthesis. We cannot receive income or discount for referral of a patient to a colleague or facility or requesting tests. We do not get subsidized by the state or receive a tax relieve for all our Pro Bono work.

In the last decades there has been an explosion of knowledge, diagnostic and treatment options brought to us by technology; it amplifies our ability to improve a patient's health. We endeavour to make this advantage accessible to all.

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The complexity of our field has necessitated rapid specialisation which brings about the biggest crisis in medicine namely the rise in medical input costs which we cannot contain. The complexity of navigating specialised care by many providers, the occasional failure to reach targets of treatment for major conditions, the sometimes, poor outcomes we have for groups of patients or individual patients in an imperfect system, are other matters of equal concern to us that need to be addressed by us. We are the healthcare providers dedicated to the improvement of our patients' health.

Because healthcare can entail large and unexpected expenses, our patients may use third-party funders to spread the risk. We as healthcare providers have no control over these funders and similarly the funding industry has no legal mandate to regulate us and influence our clinical decisions. As a convenient arrangement for us and our patients we accept direct payment from the funders but our first priority is always the provision of the necessary health care to our patients.

Medical Aid Funds (MAFs) are third party funders and do not form part of the Provider-Patient relationship. They are business entities, operating quasi-insurance schemes, based on assisting their paid-up members in funding unexpected and sometimes large medical expenses. This business model is based on pooling of contributions and risk sharing. Surpluses are not distributed to members. Technically the MAFs are not-for-profit business entities employing and remunerating a few people like a Principal Officer and some other staff members. Benefits of employment are the monthly salaries, paid holidays, sick leave, severance pay, training support and sometimes performance bonuses. With the help of a Board of Trustees (BOT) they hand the management of the pool of money received from their membership over to administrators who are equipped to account for premium income and pay claims.

Administrators are for-profit businesses selling their expertise in administering to MAFs. The large open funds remain administered, since their inception, by the same administrators who were the promoters of the funds in the first place. The owners or shareholders of administrators receive profits / dividends, and their employees receive regular salaries and other benefits. Administrators can also be involved in other for-profit endeavours, like insurance cover or owning their own healthcare facilities.

There are also other groups that are involved in health-related business endeavours, making vast profits out from the doctor-patient interaction; owners of facilities like hospitals, companies involved in the development of medical equipment, medicine and equipment merchants, and others. Many of these entities earn much more than the healthcare professional. We read the financial statements of NAMAF and MAFs. We hear first-hand of the remuneration packages of middle managers at the administrators, we are married to or socialise with representatives and so on.

In principle HCPs are not primarily focused on finances but are rather by nature, training and professional duty, focused on being of service to our patients.

The funding industry claims to be in a financial dilemma at present and claims that their existence is under threat. Dr Johann van Zyl, the advisor to the Namibian Association of Medical Aid Funds (NAMAF) is of the opinion that the main driver of the recent, largely unexpected increase in claims is due to the increase in utilisation of healthcare services by fund members, brought about by the sharp increase in both the number of healthcare providers as well as the type of healthcare services which are now available but which were not available previously in Namibia. In short, because we as healthcare providers are available to offer our services, members of MAFs do make use of the opportunities. This greater utilization of healthcare services assumingly sits behind the financial dilemma the MAFs find themselves in.

Despite their own analyses, they (the MAFs and NAMAF) naively (and perhaps maliciously) cling to, and as often as possible, repeat the narrative that it's not the mere existence of the healthcare providers that poses a problem, but that it is their "Waste, Abuse and Fraud" (WAF) that drives healthcare inflation. This fixed tunnel vision takes origin in an attitude of focusing solely on their own needs and refusing to engage in real dialogue, engagement and collaboration with others. They are not concerned with the sustainability of the private healthcare industry, only their won sustainability (from which the administrators will continue to profit). Their narrow-minded approach makes them cling to the fallacy that if they can control the behaviour of HCPs, they can control expenses.

Thus, the financial institutions operating on financial principles (only) now focus on "Provider Behaviour Management". They now try to ensure their financial survival by trying

to manage clinical care, in other words, by interfering with the discretion of healthcare professionals. NAMAF's chairperson, Ms Namoloh, declares in her 2022 annual report that NAMAF resolved to "*firm up its mandate as an effective and efficient clinical governance regulator….*" So, seemingly, "clinical governance", once instituted and regulated by NAMAF, will provide the golden solution to their claimed financial ills. She omits to mention how a proxy clinician, because that is what clinical governance means in practice, can practice medicine; how he/she can be licensed to, in effect, practice medicine.

How will the proxy clinician / MAFs take responsibility and accountability for clinical decisions? Perhaps the pinnacle of inappropriateness is their expectation that despite their clinical interference by way of their "clinical governance" or "Managed Care" programs, *"the final responsibility will remain with the healthcare provider*"(!). So they want to govern and they want to manage and they actually want to deliver healthcare themselves, through their managed care groups, but ultimately the healthcare professional remains legally liable for their, the financial sector's, decisions. This should not be acceptable to healthcare providers or the members of the MAFs.

In a seemingly rare moment of insight, it dawned on NAMAF that it could just be possible that the Medical Aid Funds Act (23 of 1995) do not provide enough powers for all of these endeavours. Ms Namoloh states further: *"…to ensure legal compliance raised by stakeholders, NAMAF obtained a legal opinion from Senior Council. To the extent that all the proposed changes could not be supported explicitly by Act 23 of 1995 NAMAF sought a different avenue to achieve the same goal by engaging the Funds to cater for some of the shortcomings through their Fund rules*." There seems to be no shame in declaring this underhand approach to gain control over the HCPs. As the Funds are not considered to be under the Competition Commission's control, they can sign "contracts" with the providers and in that way get the control over them which the law does not provide for.

NAMAF's clear duty as per its empowering statute (Medical Aid Funds Act of 1995) is to regulate funds. NAMAF denies this duty, despite it being expressly written in the law. Furthermore, NAMAF is merely an extension of the medical aid funds, as its Management Committee (responsible for all NAMAF's decisions and actions) are made up of representatives of the medical aid funds themselves. In effect, the MAFs have a duty to regulate themselves, and even that, they refuse to do. Looking closely at the entire construct,

it is an absurdity: The MAFs must regulate the MAFs and protect the members of MAFs against atrocities perpetrated by MAFs. They could perhaps be forgiven if they just tried, but they don't even try.

Instead of complying with their statutory duties they revert to underhanded tactics, mainly in the form of discrediting, and outright defaming healthcare providers. Mr Stephen Tjiuoro, CEO of NAMAF, is quoted in a newspaper article "NAMAF defends tariff decision" of 4 December 2023 to have claimed that: "*The decision as to whether most specific services are required is also invariably made by the provider who often stands to gain from the provision of those services* [with the patient / member] *not having adequate information or knowledge to make informed decisions as to the need for the nature of service*". The ignorance and maliciousness in this statement is glaring. What other relationship, can there possibly be between a professional and a client? Healthcare professionals do not accept kickbacks, nor are we receiving commissions or rebates. Apart from spectacles (optometrists) and medicines (pharmacists and dispending doctors), we only offer our time, for the benefit of our patients.

Mr Tjiuoro's biased and unfounded attitude that providers are unethical transgressors taints his opinions. If he has knowledge of individual provider's unethical behaviour, he should report this to the actual statutory regulator of healthcare professionals under the umbrella of the Health Professions Council of Namibia (HPCNA). Mr Tjiuoro effectively earns his salary from member contributions (although for close to two decades NAMAF unlawfully forced healthcare providers to contribute to NAMAF's income). His statements are slanderous and should be pointed out as such. As CEO of NAMAF he should be held accountable by his employer. Add to this Mr Tjiuoro's justification of the industry's decision not to increase tariffs going into 2024, citing "*asymmetry of information and consumer's inability to compare prices*" and his lack of understanding of an industry which is supposedly in survival mode, is staggering. No wonder that NAMAF's arrogance in its unlawful attempts to regulate healthcare providers knows no limits.

Further explanation may be warranted to avoid confusion. Of course, there is an asymmetry of information. The healthcare professional has, by the nature of his profession, more knowledge of anatomy, physiology, diseases, treatment regimes, medicine and a host of other, for some minds, un-discernible concepts. That is why a patient consults a HCP. The HCP evaluates the patient's problem and according to the best of his medical / professional

abilities, formulate a management plan on how to best address the problem. This is based on Evidence Based Medicine (this difficult word means: the value of it was confirmed by empirical research) knowledge of the individual circumstances of the patient and a set of ethical principles (as clearly set out in the "Ethical Guidelines" of the HPCNA.) The consultation is a process where the HCP (the expert on health matters - not NAMAF) meets with the patient (the expert on his/her personal requirements). It is a meeting of two experts. And together they decide on the management process to be followed. NAMAF and MAFs (more their administrators), operating in the financial services industry, increasingly wants to take control of, and dictate this process.

Information asymmetry does not imply that the HCP may or do autocratically enforce procedures and tests and treatment on the patient. Perhaps Mr Tjiuoro's remarks were not even meant to insult the integrity of the HCPs, but rather a display of ignorance, with the material potential of damaging the provider-patient trust relationship.

To add insult to injury, the "consumer's inability to compare prices" has in fact been brought about by Mr Tjiuoro and NAMAF themselves. NAMAF sets what is called the NAMAF Benchmark Tariffs ("NBT"). Mr Tjiuoro claims that the tariffs "*serve as a guide of what the reasonable costs of medical services are for the stipulated items*". In 2014 the NPPF commissioned a health cost study amongst GPs. The study was conducted by an independent South African firm of healthcare costing experts, called HealthMan. The purpose of the study was to assess all factors driving input costs and expenses (and other variables) to establish a fair and ethical tariff. The study also assessed the NAMAF tariffs. The study found that the methodology employed by NAMAF's (who unilaterally sets such tariffs in Namibia) is in many instances "*irrational, has no science behind it and is not cost based*".

Shortly after the publication of the HealthMan study, NAMAF locked public access to the NBT. Until today the members of the funds do not have access to the NBT. The trustees of the funds do not have access to the NBT. Not even the Registrar of Medical Aid Funds (i.e. NAMFISA), who must approve the benefits in all the rules of all the funds on an annual basis, have access to the NBT. The latter is extremely disturbing; the Registrar approves benefits without actually knowing what they are apart from "X % of NBT up to a limit of Y %". In other words, he does not know the actual benefit he approves. He has now way of assessing whether the benefits that he approves are fair, reasonable and market / cost related.

The NBT are now closed for any form of scrutiny by any third party. In this regard the NPPF lodged a complaint with NAMFISA, but no action was taken.

NAMAF has no express statutory powers to set the NBT (and this is currently challenged in the High Court). Mr Tjiuoro claims in his press conference of 5 December 2023 that the Supreme Court, in the landmark judgement of NAMAF & 8 Others vs the Namibian Competition Commission (NCC), acknowledges the purpose of the NAMAF Benchmark Tariffs. This is not a minor distortion of the judgment. It is simply false. The ruling was simply that the MAFs and NAMAF do not fall under the jurisdiction of the Competition Commission and thus the setting of the tariffs could not be faulted under the Competition Act. His (Mr Tjiuoro's) claim that this judgement confirms the mandate of NAMAF to set benchmark tariffs is disingenuous, and simply false.

In his press release he claims that: "*These tariffs are reviewed annually by actuaries as independent consultant …in order to determine whether the coded services and items cater for the latest medical developments and innovations*." The truth is that, by way of these tariffs, NAMAF dictates the description of any procedure/treatment (descriptors) and "advises" the funds on things (clinical matters) which he does not have a basic understanding of. In SA the item codes and descriptors are set by teams of independent healthcare professionals in every discipline, not by a single advisor / actuaries who, in Mr Tjiuoro's own explanation, make the most important decisions. In similar vein Tjiuoro explains that some input is expected from the providers, but that "*same is not a negotiated process*", an alarming admission coming from an administrative body such as NAMAF. This should be of great concern for members of the funds and HCPs alike, none of whom enjoy any regulatory protection against the conduct of MAFs, as explained in a previous press release by the NPPF.

Thus, the "*consumer's inability to compare prices*" is the doing of NAMAF and cannot be cited as one of the two main reasons not to adjust tariffs for 2024.

Surely, if patients had access to the tariffs, they could look up the NAMAF tariff code for instance "follow up 24- hour care" by a general practitioner for an in-hospital patient and discover that the tariff is N$272.10. They will comprehend that this is for a 24-hour period,

irrespective of how many times the practitioner visits the patient, how many calls he/she answers and whether the practitioner travels to the hospital at 02h00 am.

If patients (or "consumers" as NAMAF refers to them) did have access to the tariffs set by NAMAF, they would no doubt have difficulty believing Mr Tjiuoro's false claims that N$272.10 is a fair tariff based on cost and including the professional fee.

Mr Tjiuoro's statement that "*NPPF is a voluntary association of a handful private practitioners of medical services who conduct private practice……for personal profit* [and that] *….NPPF is attacking not only NAMAF but also the tools NAMAF is making available for the proper functioning of the medical aid funding industry which if they succeed could render the industry ungovernable*" is hardly worth commenting on because it simply illustrates another conceptual nebula. He clearly has no insight into the business of the NPPF, its objectives, and its membership, and also shows no interest to acquire some.

The NPPF can only advise Mr. Tjiuoro: Instead of attacking the NPPF, rather pay attention to the fact that there is no protection for any member of a MAF or provider of healthcare service against abuse by NAMAF or the MAFs – and this is solely because NAMAF refuses to execute its statutory mandate.

The NPPF has given substantial detail on this deplorable lack of regulatory protection in previous press releases, and it remains extremely important that the public be alerted to the fact that, contrary to popular belief, members of medical aid funds enjoy no regulatory protection against the conduct of their funds. Similarly, their healthcare providers, making claims on their behalf, also do not enjoy any regulatory protection. This places the members and their healthcare providers in a very precarious position, while the two entities, NAMAF and NAMFISA, who was meant to provide such protection, remain unconcerned. No wonder members of MAFs are fed misinformation and falsehoods, and that the financial sector continues to tarnish the reputation of private healthcare professionals, professionals that Namibia can truly be proud of, and who do not deserve to be abused in this fashion.

One last issue, which should be brought under the public's attention, is that the NPPF was recently informed that funds have unanimously decided to slash the in-hospital professional

fee benefit by 33%. This has not been officially communicated and fund members are unaware of this at the moment and are in any event unlikely to understand what it means.

Essentially this is a 33% reduction in the benefits payable for in-hospital treatment by medical practitioners. For example, a procedure that costs N$1,000 and was until now, for argument's sake, fully paid for by the fund, will as from 1 January 2024 only be reimbursed by the fund at N$670; the member will then have to pay the balance of N$330. This should be seen against the background of member contributions being increased by almost 10% as from next year.

We trust that this press release will better inform members of medical aid funds about the position of their MAFs (and their association – NAMAF), the regulatory vacuum for members and their healthcare providers, and why the funds find it "necessary" to tarnish the reputation of private healthcare professionals.

We also trust that members of funds will better comprehend their contribution to the "*looming financial crisis*" in the funding industry; that the abnormal increase in claims experienced in recent years is mostly attributed to increased utilisation of healthcare services by members.

Yours faithfully
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Note to Editor:

The Namibia Private Practitioners' Forum (NPPF) is a non-profit, Section 21 company. Its members are private sector healthcare providers from all healthcare disciplines.

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