COMMENTS ON NEW PSEMAS CONTRACT

ASSOCIATION NAME	**Namibia Private Practitioners' Forum (S21)**	
CONTRACT SECTION	**COMMENT/DESCRIPTION OF ISSUE**	**PROPOSED AMENDMENT/SOLUTION**
Def: Admininstrato r	PSEMAS will have no room to appoint different service providers for 1) Processing of Claims 2) Conduct investigations / audits 3) conduct clinical investigations, if the definition defines one entity to provide all those services. History has shown that one entity will unlikely have all-round capacity to provide all these services.	Separate the definition of services providers. Then PSEMAS can decide to appoint one firm to conduct all such services, but also it can decide to appoint multiple capacitated entities to perform such services.
Def: Healthcare Service Provider (HSP)	The contract requires that both a professional person (i.e. GP) and the facility he/she practices in (i.e. his consulting rooms) obtain a practice number. This will cause confusion as to which number can be used for claims. If the intention is to "lock" one professional into one facility, this is not practical and may cause severe disruption of healthcare service delivery. Healthcare providers very often "locum" for other providers at different practices. This is a long standing and ethical practice aimed at improving the continuity of service delivery at a facility. A doctor going on leave usually obtains a "locum" to ensure continuation of services. Prohibiting this may cause substantial disruption in provision of healthcare services.	Several clauses will need to be amended, and the issue of "locums" need to be specifically addressed to ensure that healthcare services are not disrupted beyond this current, accepted and ethical practice.
Def: Annexure A1 and A2	Defined as the application forms. The application forms are now B1 and B2.	Correct numbering of application forms.
Def: Tariff	See submission contained in cover letter. Also, a range of 0% to 7.5% for a levy may cause confusion. Who should pay what percentage and when will different levies be applicable? Many service providers are only able to calculate the levy contribution at the end of the of service provision, i.e. after a person was in hospital for several days, and same cannot be attached to the first claim. It also makes no sense that a tariff can be "agreed" and at the same time "calculated by the Minister". It appears there will again be a unilateral setting of tariffs, with no input from service providers. Tariffs should be set taking into account the cost of service delivery, and the contract should make annual review compulsory.	Set a fixed percentage contribution. Proof of payment of the levy should under certain circumstances only be requested at a later stage. Tariffs should be agreed upon, and should be available at the first signing of the agreement. Insert a clause that review of tariffs will be done annually.
2.3	Even if the Minister only determine "WHAT" services shall be provided, but not "HOW" they are	We understand there was substantial abuse and

ASSOCIATION NAME	**Namibia Private Practitioners' Forum (S21)**	
CONTRACT SECTION	**COMMENT/DESCRIPTION OF ISSUE**	**PROPOSED AMENDMENT/SOLUTION**
	provided, this may still interfere, and in fact prohibit a healthcare professional from exercising his/her professional, clinical best judgment.	overtreatment in the past. But further consultations are required to find a balance between protecting the fund against this abuse, without interfering with the clinical judgement of a healthcare professional.
2.8.2	The inclusion of "disciplined" is too vague. A professional may go through a disciplinary hearing and be found innocent, but it could still be said he was disciplined.	Revise the wording to state: have been found guilty after disciplinary proceedings instituted by the relevant statutory regulator.
2.8.2	If a person was found guilty at a disciplinary hearing, and it was decided he/she is <u>suspended</u> for a period of time, then the PSEMAS contract will continue to punish him even after he legitimately returned to practice.	The validity of continued punishment after complying with a regulatory sanction (but still /again being allowed to practice) is questionable. These prohibitions should be deleted and a person allowed by the regulator to practice should not face other obstacles to provide healthcare services to government employees.
2.9	Obstetrics insurance is prohibitively expensive (600,000 to 1,000,000 per year), and most providers will not be able to take out such insurance. Government employees will be left without sufficient healthcare professionals to deliver babies. Risk will differ substantially from one discipline to another and a flat benchmark may by prejudicial for low risk providers (example obstetrics vs optometrists)	
2.10	See the comments under "DEF: Healthcare Service Provider" above. This prohibition will cause a substantial interference with the longstanding and ethical practice of employing locums. It will not only cause major disruption in healthcare services, but also in healthcare practices. This will also prohibit providers to participate in outreach programmes, crucial in a country with Namibia's vastness and poverty levels. Many providers see patients at remote places, such as mining towns. This clause (duplicated later on) will prohibit this necessary outreach and stifle service delivery.	Remove this prohibition and consult on possible alternative controls to curtail abuse. Perhaps a written notification (not request for approval) to the administrator of temporary relocation (temporary locum in other practices) can be considered.
3.5, 3.6, 3.7,	These provisions are far reaching and any	State that a healthcare provider

COMMENTS ON NEW PSEMAS CONTRACT

ASSOCIATION NAME	**Namibia Private Practitioners' Forum (S21)**	
CONTRACT SECTION	**COMMENT/DESCRIPTION OF ISSUE**	**PROPOSED AMENDMENT/SOLUTION**
3.8	healthcare provider who truly understands its impact will not become a PSEMAS service provider. Those who have done so in the past did it out of ignorance. It is stated that no amount of reasonable care on the part of a healthcare provider can pass the risk of fraudulent claims to the administrator or PSEMAS; irrespective of how the fraud was committed, or even if the administrator or PSEMAS was negligent (or even assisted) in the fraud. It is now a public secret that persons are working inside PSEMAS / the administrator to defraud PSEMAS, yet only the healthcare provider takes the full risk. Healthcare providers are not private / criminal investigators. If for instance an ID is fake, the person using same has the intention not to defraud the doctor, but indeed PSEMAS. Whay must only a healthcare provider carry full liability, and in fact be punished for such fraudulent behavior if he/she acted with reasonable care. Many Namibians, especially children, don't have IDs and therefore will not qualify for treatment. How is membership verified at 03:00 in the morning for a person dying after a motor vehicle accident outside as small town? What will be the consequences for a healthcare provider if such patients are refused treatment?	may be held liable if it was found that he/she did not take reasonable care to establish the identify of a patient and the whether a patient is a member of PSEMAS. A healthcare provider must also have the explicit right to refuse treatment to any person if he/she is, in his/her sole discretion, for any reason suspicious / unsure of the identity or membership or level of remaining cover of a person. A clear onboarding procedure should be set out, and if followed, risk should pass to PSEMAS. There must be a clause setting out exceptions given certain circumstances. If this crucial matter is not addressed the NPPF will sensitize healthcare providers on this risk and advise them to refrain from contracting with PSEMAS to avoid this disproportionate financial (and legal and regulatory) risk.
3.9	"reasonable efforts" is a subjective term and can easily be abused by PSEMAS or the administrator to hold health professionals liable irrespective of their reasonable conduct.	Define reasonable conduct, i.e. requesting an original ID and agreed method proving membership should be sufficient. When this was done risk passes from the provider to the administrator / PSEMAS.
3.10	"peer reviews" should be clearly defined. There is already proof of person in one discipline of the healthcare professions providing opinions against others purely for financial gain.	The extent to which information of a healthcare provider may be distributed to third parties must be clearly defined. Client confidentiality must remain protected. A healthcare provider cannot enter into a contract which harms the client's confidentiality. It must be kept in mind that confidentiality belongs to the client, not the provider. The right of the healthcare provider to receive

COMMENTS ON NEW PSEMAS CONTRACT

ASSOCIATION NAME	**Namibia Private Practitioners' Forum (S21)**	
CONTRACT SECTION	**COMMENT/DESCRIPTION OF ISSUE**	**PROPOSED AMENDMENT/SOLUTION**
		such opinions and where necessary defend himself against adverse opinions must be specifically stipulated.
3.12 and "DEF TARIFFS"	It is impossible to contract with a party and then reserve the right to unilaterally, at any time in future, change any terms of such agreement. This is also applicable to the "tariffs" which may be set from time to time. Then it is not an agreement any longer but a prescription, which cannot be valid outside of statutory law.	Each provider must have the explicit right to cancel the contract with immediate effect if he or she is not in agreement / willing to accept such new amendments / changes in tariffs. Again, if this is not amended, the proposed contract exposed healthcare providers to unacceptable risk and it will be advisable not to enter into same.
4.2	The required information must be limited to information relevant to each claim. Where additional work is required, such as the writing of a report, provision must be made for additional remuneration for such additional work. This should also be applicable for any additional work required by any managed care entity.	Changes under comments should be incorporated.
4.3.1	If benefits were previously confirmed in writing, then the administrator should not be able to decline a claim on the basis that benefits were in fact insufficient. What systems will be in place to protect providers when limits have been reached? If a healthcare provider cannot access up to date limits within minutes on a 24/7/365 basis, then the providers (and members of the fund) must understand that healthcare services will only be available at such times as confirmation of limits can be obtained. A person in an accident at 03:00 in the morning will simply have to wait until benefits can be confirmed by the administrator.	
4.3.4	Note the previous comments on "tariffs".	
4.3.6	Many service providers are only able to calculate the levy payable at the end of a series of services and products provided, i.e. after a person was in hospital for several days. A levy payment can then not be attached at the initial claim. Proof of levy payment from "time to time" is contradictory to para 4.13.10.	Make provision for instances where levies can only become payable at the end of service delivery, while claims may be submitted in the interim (i.e. hospital stay with several procedures).
4.4.	It takes 30 days to assess a claim (4.3) and 30	Include that interest for late

COMMENTS ON NEW PSEMAS CONTRACT

ASSOCIATION NAME	**Namibia Private Practitioners' Forum (S21)**	
CONTRACT SECTION	**COMMENT/DESCRIPTION OF ISSUE**	**PROPOSED AMENDMENT/SOLUTION**
	days more to pay same (4.4). **Payment will therefore be made after 60 days only. This is not acceptable and payment should be made within 30 days of submission of a complete claim**. Also, if claims are not processed within the prescribed time, interest should be payable to the provider. Otherwise it serves no purpose (as is currently the case) to state that payment will be made within a minimum period. These payment terms can simply be ignored as they are currently.	payments to service providers will be calculated at 50% of the prevailing prime interest rate per annum, calculated daily compounded monthly. And this interest payment will be paid together with the payment of the claim.
4.6.2	It has happened that the administrator makes a mistake or becomes unreasonable. There must be recourse for health professionals. The administrator is ONLY and AGENT of PSEMAS and cannot become the judge, jury and executioner. The liability ultimately stays with PSEMAS and a review to PSEMAS must be possible. If such a process in not in place PSEMAS, as public entity, may find itself in contravention of Article 18 of the Constitution.	Include a clause to state that in any matter which cannot be resolved with the administrator, PSEMAS / MoF can be approached. This will then be in line with the arbitration clause as arbitration takes place between PSEMAS and the provider, and NOT between the administrator and the provider.
4.7	See previous comments on "tariffs". The current system whereby NAMAF controls codes and descriptors is simply wrong, and unlawful, and same should be in control of the healthcare disciplines. Funders are concerned about building reserves and cutting costs. Healthcare providers are concerned about treatment and health outcomes. The former cannot dictate to the latter on what procedures entail. NAMAF does not have the license to use the coding system which they copied from South Africa. These rights in fact belong to the NPPF. See also the previous comments on the Medical Control Board.	
4.10	See the previous comments on "locums". Will the current declaration form requirement fall away?	Was the declaration form requirement purposefully deleted?
4.11	In practice the full bill / statement of account can only be compiled once the healthcare professional has provided all information about the treatment and medicines to his/her admin staff. Instant billing, is therefore not always possible.	
4.12	See previous comments on levies regarding the percentage to be fixed as well as the time at which levies can be calculated and become payable. There are circumstances where very needing	

COMMENTS ON NEW PSEMAS CONTRACT

ASSOCIATION NAME	**Namibia Private Practitioners' Forum (S21)**	
CONTRACT SECTION	**COMMENT/DESCRIPTION OF ISSUE**	**PROPOSED AMENDMENT/SOLUTION**
	patients cannot afford the levy. The administrator must have the ability to waive same under deserving circumstances. Diabetic medicines for instance are often life-saving, but very expensive. A poorer worker can die because of the levy restrictions. And the healthcare provider again faces the legal / regulatory risk under these circumstances.	
4.13.7	See the previous comments on "locums". Also many practices process claims at a central location for branch practices outside the centrum, thus signature by the professional is not possible.	
4.13.9	Copying facilities not always available at places of treatment. Luderitz hospital does not even have a copy machine. What about patients with no ID, i.e. children; must treatment to them be denied? Who takes the risk of denying such patients treatment?	
4.13.10	See previous comments on levies which are not immediately calculable and only payable later during or after completed treatment. After hours admin staff are not available to provide this document. Practically healthcare providers should not be required to do any after hours work, as the PSEMAS agreement does not take into account after hours circumstances, while still placing complete risk in the hands of the service provider.	Insert a clause that providers may refuse to see patients after hours, or remove all obstacles to enable the provider to do after hours work without taking on total risk.
4.14	This cannot be an unlimited right. The information must be relevant to the claims and the provider's capacity to provide services for which claims were submitted. Surely consultation should again be a requirement. Again, a healthcare cannot contract out of privilege belonging to a patient.	
4.15	This is a very costly and time consuming exercise for providers. Numerous providers prefer to opt out of PSEMAS contracts for this reason alone.	Is it not more practical to state that hard copies will be provided within 48 after receipt of a specific request by the administrator relating to a specific claim ?
4.16 and 4.17	See comment under 4.14	
4.19	**Government wants to improve its current ailing tax collection system by potentially denying patients access to healthcare**. This should not be acceptable. Treat tax revenue problems through the proper channels at MoF and let healthcare service provision to government	

COMMENTS ON NEW PSEMAS CONTRACT

ASSOCIATION NAME	**Namibia Private Practitioners' Forum (S21)**	
CONTRACT SECTION	**COMMENT/DESCRIPTION OF ISSUE**	**PROPOSED AMENDMENT/SOLUTION**
	employees be dealt with in this agreement.	
4.20	See the previous comments on numbers being issued to both a provider as well as a facility. What number will be required for a claim? The contract is not clear on this. See also previous comments on "locums".	
5.1	See previous comments on tariffs. NAMAF does not have the powers to set tariffs. A clause must also allow providers to cancel the agreement with immediate effect should any amendment to a tariff not be acceptable. A unilateral amendment of tariffs at any future time causes this to be an ultra vires prescriptive instrument, instead of an agreement by consensus.	
6	See previous comments on "locums".	
7.3.4	This is a very onerous requirement and compliance will definitely disrupt service delivery from numerous providers very often. The purpose of the provision is also not clear, as every person claiming must undergo extreme vetting under the original application requirements. If a practice has been contracted with PSEMAS for many years and 10 healthcare providers work there, the appointment of just one additional provider causes the immediate lapse of the PSEMAS contract. This then necessities a new application, which process has in some cases in the past taken several months. Meanwhile patients wait for treatment and must resort to alternative providers, if available. This risk to healthcare provider practices alone is suffient to deter contracting with PSEMAS. Numerous practices have frequent staff turnover, making it impossible to be contracted with PSEMAS,	
8.3	This can easily result in a breach of confidentiality and the patient's consent will be required. They are not a party to this agreement and even if a provider signs this agreement, it cannot breach the confidentiality which ultimately belongs to the patient.	
8.6	There must be provision for the service provider to state his/her case (audi alterem partem) and for same to be properly considered, before the ministry can simply conclude that such conduct	

COMMENTS ON NEW PSEMAS CONTRACT

ASSOCIATION NAME	**Namibia Private Practitioners' Forum (S21)**	
CONTRACT SECTION	**COMMENT/DESCRIPTION OF ISSUE**	**PROPOSED AMENDMENT/SOLUTION**
	was committed. The constitutional right to fair administrative procedure and a fair trial will remain applicable to the ministry and cannot be erased by agreement (as this agreement attempts to do).	
8.9	The word "will" is not appropriate. It might be clear from the start that the member had no part in the fraud, yet he must be suspended.	Rather include "may".
9.2	The Receiver's office is currently very ineffective and mistakes are in the order of the day; especially the Oshakati office. Should government employees suffer for MoF's incompetence?	
9.3	Is the intention that all HSPs must reapply for a PSEMAS contact every year, and at least again upon the termination date of 31 March 2018? If so, will this not become an administrative nightmare that will again disrupt service delivery? We have now seen the involved process of cancelling and renewing contracts … and no application has even been filed in terms of the new contract. We envisage this process to take many months more.	
9.4 and 9.4.1	Will an" Application" lapse …. Or the agreement? Tax Certificates are not valid for six months, but must be submitted twice a year, they will automatically lapse in between submissions, causing the PSEMAS contract to be automatically cancelled.	Application must probably be changed to "agreement".
9.4	Insolvency does not cause a provider to be incompetent to provide medical services. Insolvency could be caused in a farming business but not affecting a farming doctor's abilities to provide medical services. This is an unfair and irrelevant punishment.	
9.5	The unilateral right of revocation, without a due process, a right audi alterem partem or fair process, will not pass constitutional muster. There is already a process of investigations. That should be sufficient. In a sorted list of claims there will always be a highest and a lowest ranking item / person. Such rank means nothing without investigations into facts. It could be that a doctor is in a unique position / location, providing a niche service crucial for PSEMAS members.	The right to cancel the agreement must follow the investigation described in paragraph 8. It cannot be as arbitrary as stated here. Remove the last sentence from this paragraph.
10.5	Is the intention that PSEMAS may refuse to pay past claims. The office of the Receiver is notorious	It must be clear if PAST payments due will be made once a tax food

COMMENTS ON NEW PSEMAS CONTRACT

ASSOCIATION NAME	Namibia Private Practitioners' Forum (S21)	
CONTRACT SECTION	**COMMENT/DESCRIPTION OF ISSUE**	**PROPOSED AMENDMENT/SOLUTION**
	for poor service and extremely slow to respond to enquiries, let alone fixing their own mistakes. No sensible healthcare provider can risk losing income due to the incompetence of this government agency. It is ironic that a PSEMAS (MoF) member can be refused a health service due to failure on the part of the Receiver (MoF).	standing is received. Also, there must be some safeguard built in for providers who suffer at the hand of poor service delivery (and downright incompetence) of the Receiver. We mention again, even the Special Tax Tribunal is defunct, so tax payers are at this point delivered into the abyss, and stand to be further punished from this untenable situation completely out of their control, and so also the members of PSEMAS.
10.6	See the crucial previous comments on locums. This impractical proposal will not only impede in the current, ethical practice of employing locums, but will substantially disrupt service delivery to government employees.	As stated before, there must be another model to mitigate the risk to PSEMAS. Disturbing a functioning, ethical practice which improved sustainable service delivery should not be the reaction. We also urge the ministry to consult the Honourable Minister of Health to better understand how the industry functions.
10.7	A professional that was temporarily suspended should not be punished for life. This will be unconstitutional.	
10.8	See comments on this issue state before.	
10.9	This will obstruct settlement agreements with claimants in civil matters, which will result in increased insurance premiums and increased cost of healthcare. It also negates from the new system of Court Directed Mediations aimed at settling disputes amicably and lessoning the burden on judges. The cost of legal services for claimants will increase substantially as doctors cannot afford the punishment for settling.	
10.10	This is far too vague. In fact, the paragraph as a whole makes no sense. Why reappointment and not just appointment. What if a doctor was refused because the hospital was overstaffed?	At least dishonesty must be the reason. And a guilty finding in such matter. Delete this paragraph.
10.11	If each HSP must be registered, each having a separate agreement with PSEMAS, it makes no sense to hold the employer-PSEMAS-contracted HSP responsible for employee-PSEMAS-	

COMMENTS ON NEW PSEMAS CONTRACT

ASSOCIATION NAME	**Namibia Private Practitioners' Forum (S21)**	
CONTRACT SECTION	**COMMENT/DESCRIPTION OF ISSUE**	**PROPOSED AMENDMENT/SOLUTION**
	contracted HSP. Either each HSP is responsible in person to PSEMAS, or ONLY the employer. But in the latter instance the employee cannot be required to also contract with PSEMAS.	
10.12	This is a duplication of 2.9.	
10.13	Duplication of 2.10. Dealt with before.	
10.14	Duplication of 2.11.	
10.15	Duplication.	
10.16	Duplication and dealt with before.	
10.17 to 10.27	All duplicated and dealt with before.	
11.1	This serves no purpose if the provider is prohibited from taking up any dispute directly with PSEMAS. As the administrator is not a party to the contract, disputes with the administrator does not fall within the arbitration clause.	
	A clause should be included to give the arbitrator the powers to make an award for costs of the arbitration.	
11.8	Email should be acceptable, and both parties should include an email address which both acknowledge as a means of receiving notices.	
	In several paragraphs the contract refers to "these Terms and Conditions" while the terms and conditions of PSEMAS is actually a separate document – the Rules.	
17.1	This is in contradiction to the fact that there are separate Terms and Conditions applicable to PSEMAS, i.e. the PSEMAS rules.	
GENERAL	There is no undertaking from PSEMAS to review tariffs regularly, i.e. annually	Include a mandatory annual review.
GENERAL	Providers should have the discretion to terminate services to problematic or defaulting patients.	
GENERAL	Many providers have no employees, and can therefore NEVER obtain a SSC good standing as they are not registered with SSC.	
GENERAL	The sheer admin liability on PSEMAS claims deters many providers from contracting with PSEMAS. Especially in light of the ease of claims procedures required by private medical aid funds.	
GENERAL	The administrator should never provide payment advices without payment.	
GENERAL	The administrator should never make a "global" payment as a percentage of outstanding claims as	

COMMENTS ON NEW PSEMAS CONTRACT

ASSOCIATION NAME	**Namibia Private Practitioners' Forum (S21)**	
CONTRACT SECTION	**COMMENT/DESCRIPTION OF ISSUE**	**PROPOSED AMENDMENT/SOLUTION**
	such payment makes per-patient reconciliation impossible at practice level and causes risk for the provider, the administrator and PSEMAS. One can simply never say what patient, in fact what batch, was paid, and which remain unpaid.	