09/04/2025

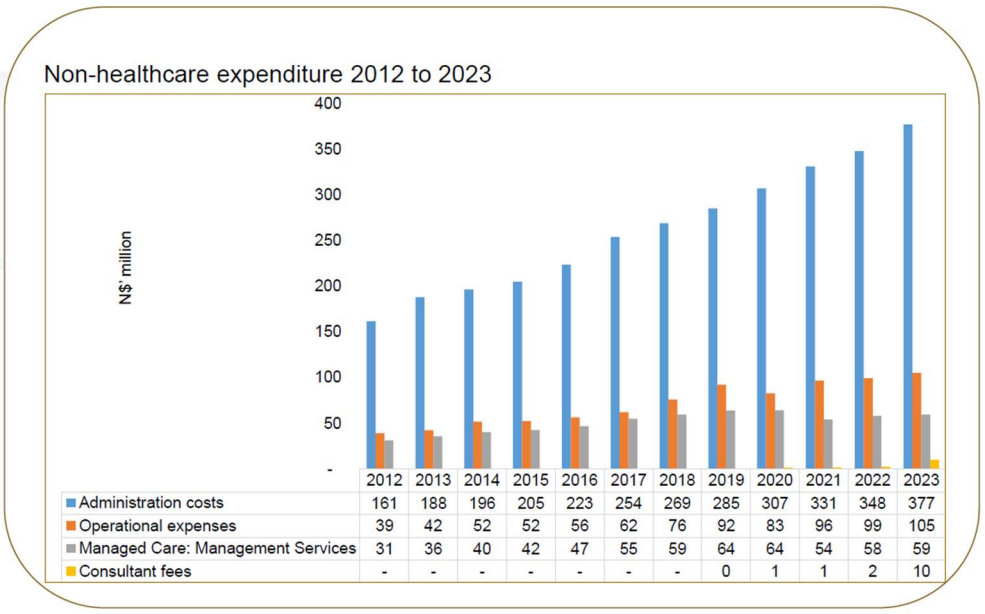
MOVING FROM A FUNDER-CENTRIC TO A VALUE-BASED, PATIENT-CENTRED FUNDING MODEL

1. NAMAF-Based Funding System Dominated by Administrator Profits

The current medical aid funding system is structured to favour funders and medical aid administrators, with insufficient accountability to patient outcomes or provider sustainability. Administrators operate with minimal oversight, resulting in cost inflation and fragmented healthcare delivery that undermines long-term value.

Over the past decade, administrative and non-healthcare-related costs have escalated disproportionately—exceeding both the inflation rate and the rate of increase in actual medical claims. Despite increasing member contributions, benefits have steadily declined, while administrative overheads and consultancy fees have grown exponentially.

This trend has become particularly evident since 2019, when NAMAF significantly expanded its regulatory overreach, as documented in the 2019 NAMAF CEO Report. This coincided with a sharp increase in non-healthcare spending—most notably on consultant fees—raising serious concerns about systemic misallocation of funds and the erosion of value for medical aid members.



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Administration costs	161	188	196	205	223	254	269	285	307	331	348	377
Operational expenses	39	42	52	52	56	62	76	92	83	96	99	105
Managed Care: Management Services	31	36	40	42	47	55	59	64	64	54	58	59
Consultant fees	-	-	-	-	-	-	-	0	1	1	2	10

Diagram 1: Non-healthcare expenditure (Source: NAMFISA)

The June 2023 NAMAF Strategy reaffirms a disturbing trend: higher patient contributions, fewer benefits, and continued reliance on outdated benchmark tariffs—all reinforcing a cost-containment

approach at the expense of care quality. Most recently, the enforced use of ICD-10 coding as a payment condition, without proper confidentiality safeguards, marks yet another overreach into the clinical autonomy of healthcare providers.

We, as practitioners, are trained to heal, to diagnose, to treat, and to comfort. Yet we find ourselves trapped in a system where health funds are diverted into bureaucratic structures, with little regard for the fact that clinical outcomes are deteriorating. This is compounded by the denial of bona fide claims, arbitrary pre-authorization refusals, down-coding of legitimate services, clawbacks, and bureaucratic interference in clinical decision-making.

For over 13 years, the NPPF has consistently advocated for systemic reform, including:

- Regulation of administrative companies whose profit-driven practices reduce patient benefits.
- Protection against the entry of unqualified or non-compliant practitioners.
- Fair, evidence-based coding and reimbursement mechanisms, such as those using SAMA codes, Healthman, or other established independent tariffs.
- Shifting regulatory focus toward medical aid funds—rather than practitioners—by enforcing conduct codes as contemplated by the Medical Aid Funds Act.

All efforts to align the existing system with fundamental principles have failed. It is now imperative for the industry to take responsibility and address these shortcomings meaningfully—by reducing administrative bloat, restoring practitioner dignity, and safeguarding patient care through the replacement of the NAMAF-centric system with a transparent, equitable alternative.

Healthcare providers must now redefine their allegiance—united not as subcontractors to a third-party entity, but as equal partners in a system that truly serves both professional integrity and patient welfare.

2. NPPF Vision

To build in partnership with all healthcare professions a credible, ethical, and sustainable healthcare funding alternative. The following principles must guide its design and implementation:

- **Provider and patient co-governance**
- **Transparent tariffs** based on actual care costs
- **Timely and fair practitioner payment**
- **Governance without opaque boards or unnecessary consultants**
- **Ethical practice and financial sustainability**

3. The Solution: A Cooperative Model

A lawful, **FIMA-** and **Namibia Competition Commission (NaCC)**-compliant healthcare funding system must be **conceptualized and implemented collaboratively**—one that is **by and for healthcare professionals and their patients**, ensuring **ethical, transparent, and sustainable** access to private healthcare.

While the **Friendly Society** model was previously explored, it revealed critical limitations, including **significant financial exposure** and **non-alignment with forthcoming FIMA requirements**, rendering it unsuitable as a long-term solution. The current effort is therefore **exploratory**, aimed at assessing **feasible alternatives** that avoid the legal and regulatory pitfalls of past proposals. This should not be seen as a final solution, but rather as part of a broader review of options to establish a **resilient and accountable system**

a) Two Arms of the Co-op

The **Co-operatives Act of 1996** offers an alternative framework that aligns with existing legal provisions and emerging regulatory requirements. This structure consists of two distinct but complementary arms:

Arm	**Function**	**Regulated By**	**Key Points**
Medical Funding Co-op (MFC)	Collects contributions, pays claims, manages risk	FIMA / NAMFISA	Independent board, non-provider led, cooperative governance
Provider Cooperative (PC)	Negotiates tariffs, ensures quality, restricts rogue access	Co-operatives Act	Advisory role only, no influence over funding decisions

b) Shared Services Administrator (SSA)

- Jointly owned by MFC and PC
- Manages claims, IT, fraud control, and tariffs
- Keeps admin costs low by limiting outsourcing
- Staffed by professionals, not subject to FIMA conflict

c) Governance to Avoid FIMA and NaCC Conflict

- MFC board includes employers, patient reps, legal/financial experts, and **one non-voting HCP advisor**
- PC elects internal committee to propose fee schedules, vet practitioners, and ensure clinical integrity
- **Tariff authority lies with MFC** to maintain regulatory compliance

d) Tariffs & Utilization Control

- Use **Healthman/SAMA etc codes** and cost study results to create an alternative Benchmark tariff for use in Namibia without violating anti-competitive principles
- Establish coding committees for fairness

- Deploy **data analytics** to prevent and detect fraud or misuse

e) Creating a NAMAF-Free Zone

- NAMAF derives control from practitioner dependency and fund gatekeeping
- An **independently licensed MFC** and **direct negotiation with employers/PSEMAS** bypass NAMAF entirely.

f) Patient-Centric Design

- Patient representation on MFC board
- Transparent benefit designs based on **affordability and clinical value**
- Surplus returns as **benefit top-ups** or **premium reductions**

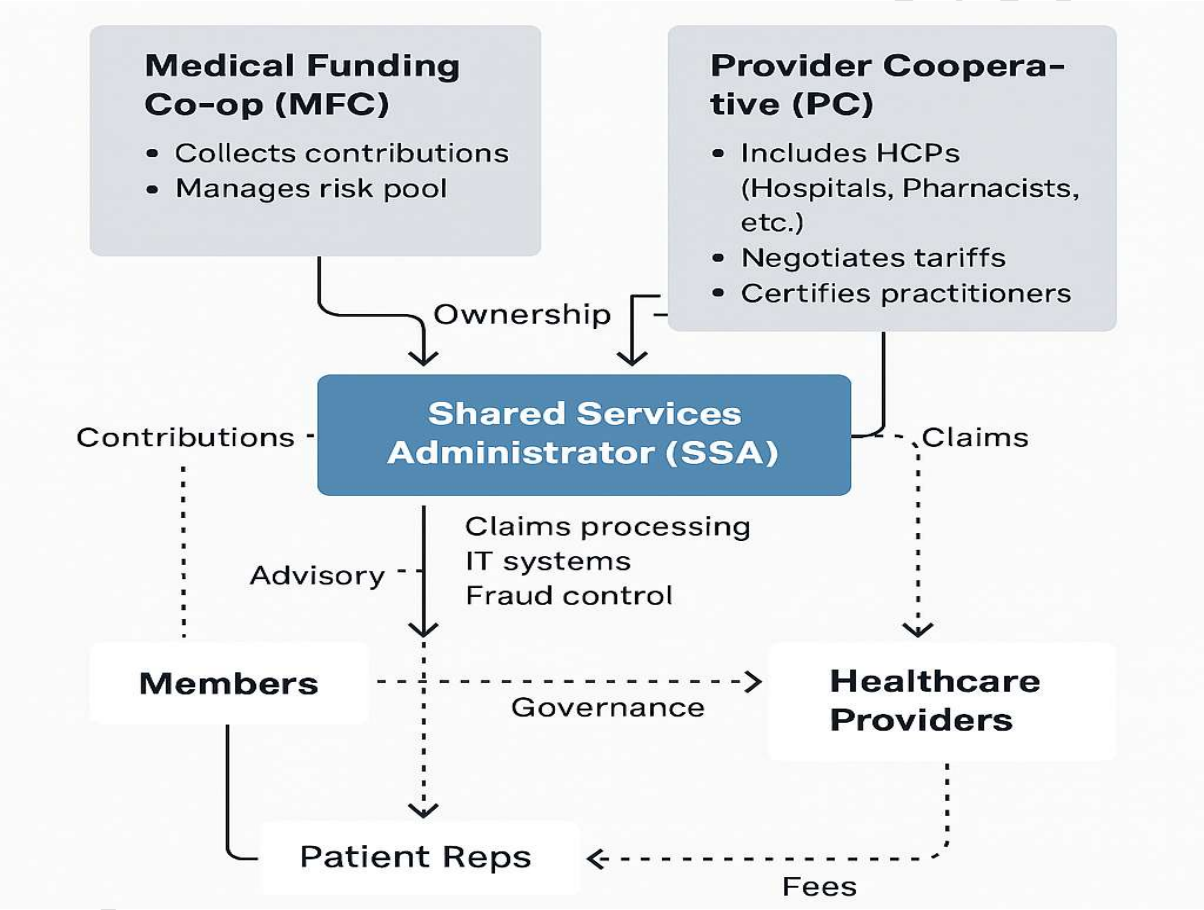


Diagram 2: Operational Structure of the Alternative Funding Model

4. Inclusive Care Delivery

The model includes all health service providers (doctors, dentists, specialists, allied professionals, pharmacies, hospitals etc) under a locally governed umbrella. The Co-operatives Act allows for example all professions or entities not represented by **NPPF** such as **Namibian Association of Private Hospitals, (NAPH) and Pharmaceutical Society of Namibia (PSN)** to unify and:

- Negotiate fair tariffs across all healthcare sectors

- Co-govern the SSA
- Provide services independently of NAMAF influence

5. Comparative Models

The difference between NAMAF and the proposed model is as follows:

	Status Quo (NAMAF Model)	**Proposed Model (Co-op + SSA)**
Fund Management	Central funds managed by third-party administrators	Member Contributions flow into co-op
Surplus Use	Goes to reserves or profits	Surplus returned to members as investment/savings
Member Benefit	No return to members	Encourages prudent utilization and ownership
Utilization Trends	Encourages overutilization – **non-sustainable**	Promotes responsible care and system trust - **sustainable**

a) Key Benefits

- **Incentive Alignment:** Members act responsibly
- **Ownership:** Patients and providers own the system
- **Trust & Transparency:** No hidden costs or admin abuse
- **Long-term Sustainability**
- **Provider Autonomy & Fair Remuneration**

b) Enticing Younger Members

- Allow unused benefits to **grow wealth**
- Increase buy-in and **stabilize the risk pool**

c) Buffer Reserve Fund

- Protects the system from shocks (epidemics, economic crises)
- Enables **continuity** and **benefit stability**

d) Aligning Provider Incentives

- Shift from **volume to value**

- Encourage efficient, effective care with **fair remuneration for practitioners**

6. Design Risks & Solutions

To ensure the cooperative model remains effective, sustainable, and resilient, potential risks must be proactively addressed. The following strategies offer practical solutions to key design challenges:

Risk	Solution
Moral Hazard	Mitigate over-saving with **preventive care bundles**
Complexity	Use **simple visual dashboards/apps**
Provider Resistance	Start with **early adopters**
Economic / Epidemic	**Build a reserve fund** to mitigate cashflow threats
Reverse Misuse	Enforce **strong governance with fiduciary oversight**

The Mutual Health Investment Fund is designed to hold and grow **member surplus contributions and cooperative reserves** through prudent, low-risk investment strategies. This ensures long-term sustainability of the health platform while offering members collective security and potential financial returns in times of surplus.

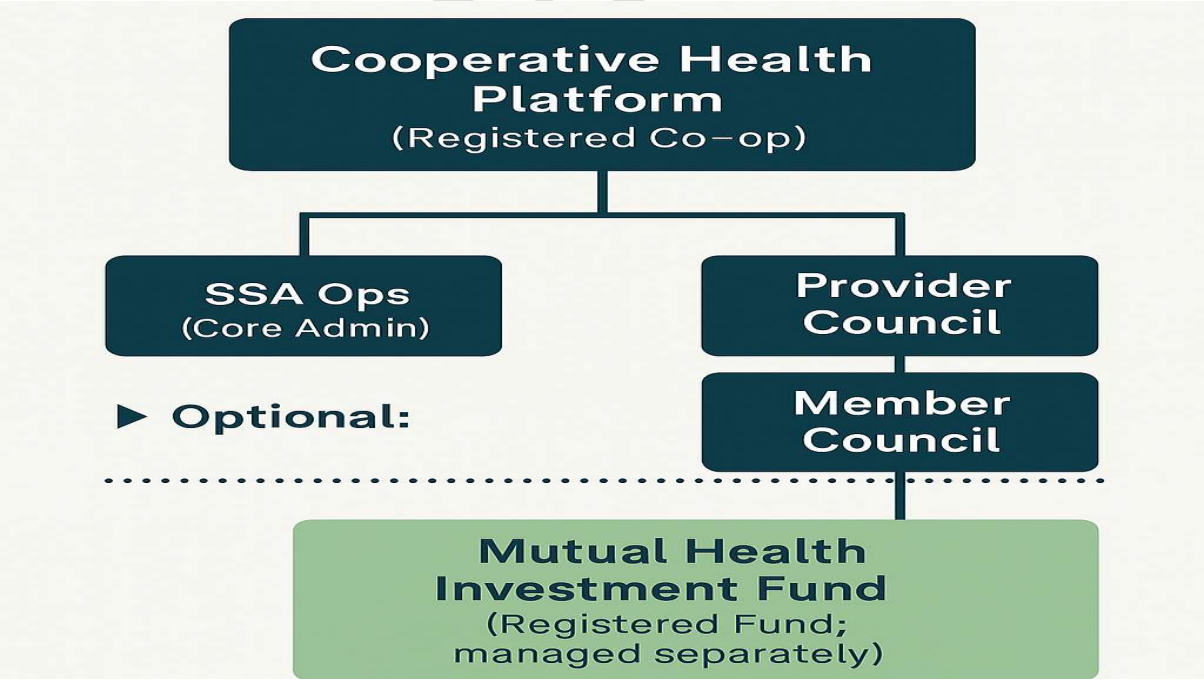


Diagram 3: Co-operate extension grows member wealth through a Mutual Health Investment Fund

7. A Cultural Shift

The Co-op model is more than a technical solution; it is a **paradigm shift** from transactional, profit-

centric healthcare to a **mutualistic, value-based model.**

- **Members become shareholders**, benefiting from surplus rather than subsidizing inefficiencies of NAMAF and Administrators.
- **Providers earn fairer tariffs**, reduce burnout, and are incentivized to focus on care quality, not volume.
- **The system evolves** from a reactive, hospital-based model to a proactive, prevention-focused approach, with continued s**upport for high-quality specialist care and hospitals** as integral components of the healthcare landscape.

8. Name Suggestions

The brand should reflect the unity and shared ownership that support authentic, community-driven marketing efforts and can select a name from the following (or any other) suggestions:

- **NamHealth Alliance**
- **Ubuntu Health Co-op** *("I am because we are.")*
- **OmweCare (***Omwe means "unity" in Oshiwambo***)**
- **Namibian Health Cooperative (NaHeCo)**
- **HealthLink Namibia**
- **NamCare Collective**
- **MediUnity Namibia**

9. Implementation Phases

a) Legal & Regulatory Setup: Establishing first the PC under appropriate Acts (Co-operatives Act, NaCC Act). Establish the MC under the appropriate Acts (FIMA, Banking & Co-operatives Act etc)

b) SSA Pilot Project: Launching a small-scale Shared Services Administrator to process claims, test IT systems, and refine governance protocols.

c) Employer Engagement: Signing on progressive employers and sectors (e.g., Formal Sector, SMEs, public sector partners etc).

d) Progressive Rollout: Gradual expansion to other patient pools while ensuring risk buffers and service quality.

e) Sustainability Plan:

- A Reserve Fund will be established from contributions and surpluses to manage initial
- claims, shocks, and transitions.
- Operational efficiency will be achieved by minimizing outsourcing, using open-source tech, and leveraging in-house professional expertise.

We acknowledge that change requires both vision and caution. Our implementation framework is designed to ensure **no patient is left behind**, **no practitioner is exposed**, and **every cent is accounted for**.

10. Funding and Implementation

To ensure a sustainable transition, the implementation of the Co-op Model will be guided by a phased, cost-conscious approach:

a) *Start-Up Capital*: Initial funding will be raised through a combination of:

   i. Seed contributions from aligned healthcare associations

   ii. Crowdfunding among healthcare professionals

   iii. Strategic partnerships with patient advocacy groups (employers) and social impact investors

   iv. Application for technical assistance from development agencies supporting health reform

11. Conclusion

There is room for all healthcare providers to stand together and take control of the future. The **cooperative model** represents just one example of a **lawful, sustainable, and ethical alternative** to the current **NAMAF-dominated system** explored so far. It honours **professional integrity**, empowers **patients**, and ensures that health contributions fund **healthcare—not bureaucracy**.

This is the key message. The **NPPF**, with the assistance of **Healthman**, is actively investigating alternative models that offer **synergy**, provide **clear operational frameworks**, and can be assessed for **legal and statutory compliance**, **robust governance**, and the **accurate interpretation of a new coding system**.

Sincerely,

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On behalf of the NPPF TEAM