Namaf
Namibian Association of Medical Aid Funds

CLINICAL GOVERNANCE
services

Namibian Association of Medical Aid Funds

INTERVENTION PRIORITISATION WORKSHOP

Clinical Governance Services (Pty) Ltd

July 2023

TABLE OF CONTENTS

1 INTRODUCTION

1.1 Background

The medical aid funding industry in Namibia is experiencing unprecedented pressures on their solvency margins due to the contribution income being lower than the benefits paid on average across the industry. This is not sustainable and Namaf decided to host a workshop amongst industry decision-makers to determine and prioritise interventions to address the situation.

The workshop was held on 12 and 13 June 2023 and the purpose of this report is to summarise the workshop in-and outputs.

1.2 Professional Brief and Scope

Clinical Governance Services (Pty) Ltd ("CGS") collaborated with Prof Marius Ungerer to plan and facilitate the workshop.

The scope of the workshop was to facilitate discussions between the medical aid funding decision-makers, namely Namaf Management Committee members, fund trustees and principal officers, to:

- Formulate a universally acceptable definition of the problem/s experienced,
- Decide on appropriate interventions and assign roles and responsibilities, and
- Develop an action plan.

The workshop was planned to be based upon factual data and, to this end, a survey was conducted before the workshop to obtain the inputs of all the funding industry stakeholders, including medical aid fund trustees, principal officers, and administrators on:

- Whether a problem existed,
- What the potential solutions are,
- Whether there is scope for collaboration,
- Who should be taking responsibility for the design and implementation of the solutions, and
- Which interventions should be prioritised.

The results if the survey were used as a starting point for the workshop and attendees were required to build upon that during the workshop.

1.3 Purpose of the report

The purpose of this report is to provide a summary of the:

- Survey results,
- Supplementary information provided during the workshop,
- Interventions decided upon, and
- Action plan developed.

The actual survey results and the slides used during the workshop form part of the report and have already been distributed.

1.4 Confidentiality

The data which underlies this report is confidential to Namaf and the registered medical aid funds and the report is addressed to the Namaf Management Committee and Secretariat.

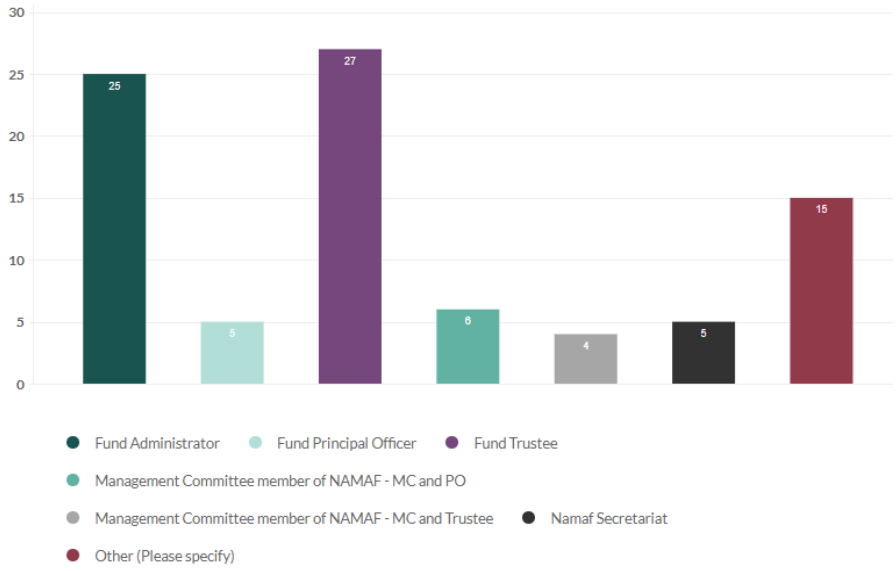
The report should only be distributed in an unabridged format and at the discretion of the Namaf Management Committee and/or Secretariat.

2 SURVEY RESULTS

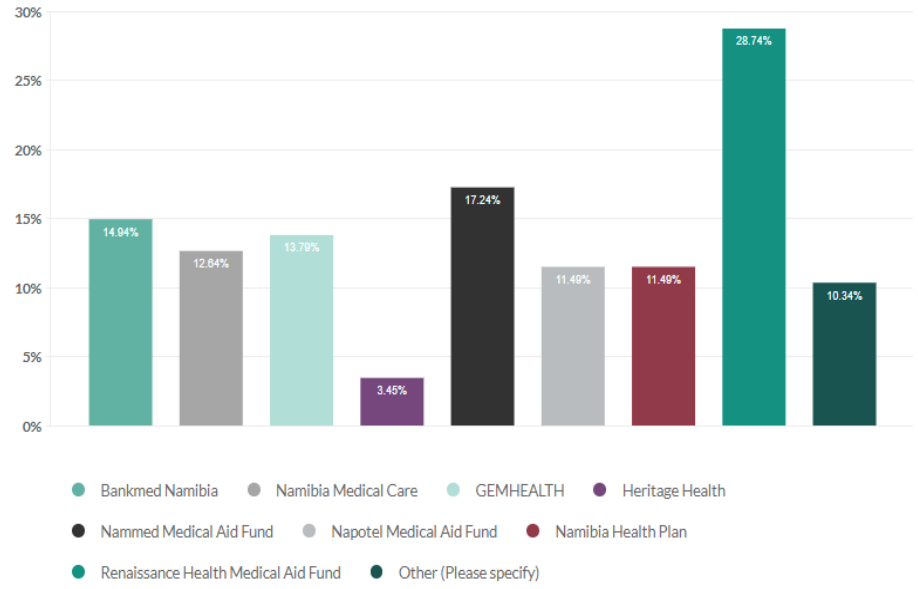
2.1 Respondent Profiles

Individuals from all sectors in the medical aid funding industry were invited to participate in the survey and fifty-seven responses were received.

The figure below shows that the most responses were received from medical aid fund administrators followed by fund trustees.

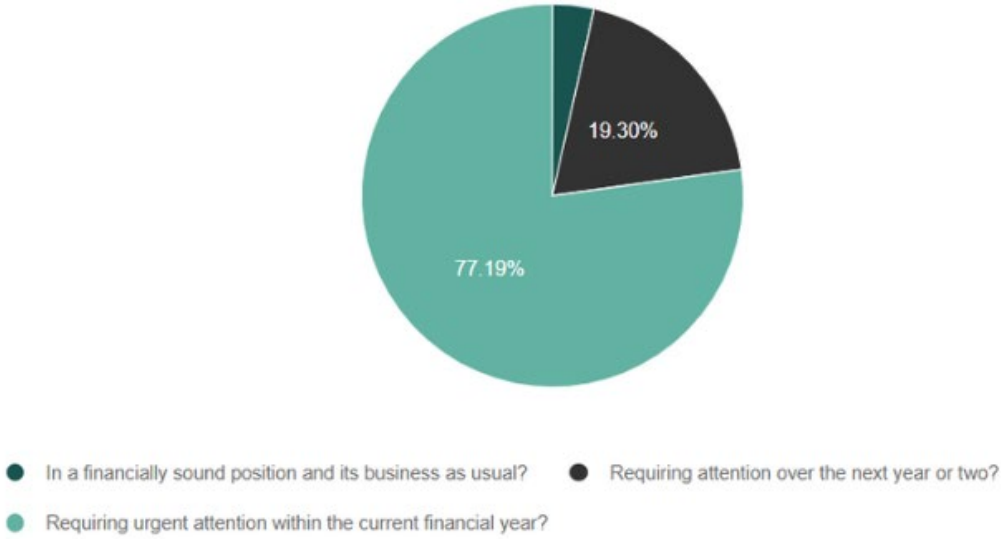


The next figure shows the proportion of responses received from each of the registered medical aid funds.



2.2 Problem identification

The respondents were requested to offer an opinion on whether the medical aid funding industry is facing a problem. The figure below shows that 96.49% of respondents believed that the medical aid funding industry in Namibia is requiring urgent attention.

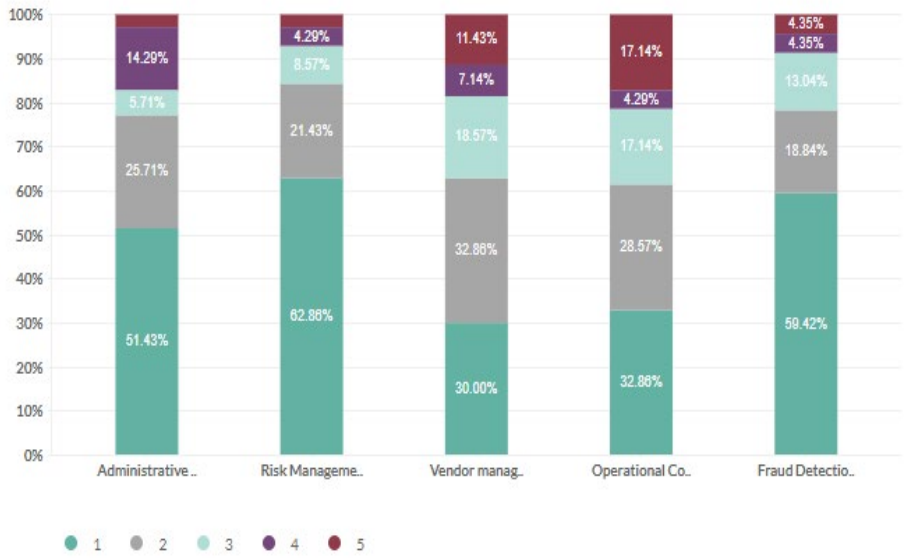


2.2.1 Focus areas

The results of a literature review revealed five areas upon which any medical aid fund must focus:

- Administrative efficiency,
- Risk management,
- Vendor (Provider) management,
- Operational cost control, and
- Fraud detection and prevention.

Respondents were asked to prioritise the areas in which attention is required and the responses are summarised in the figure below where a score of 1 indicates the highest priority and a score of five the lowest.



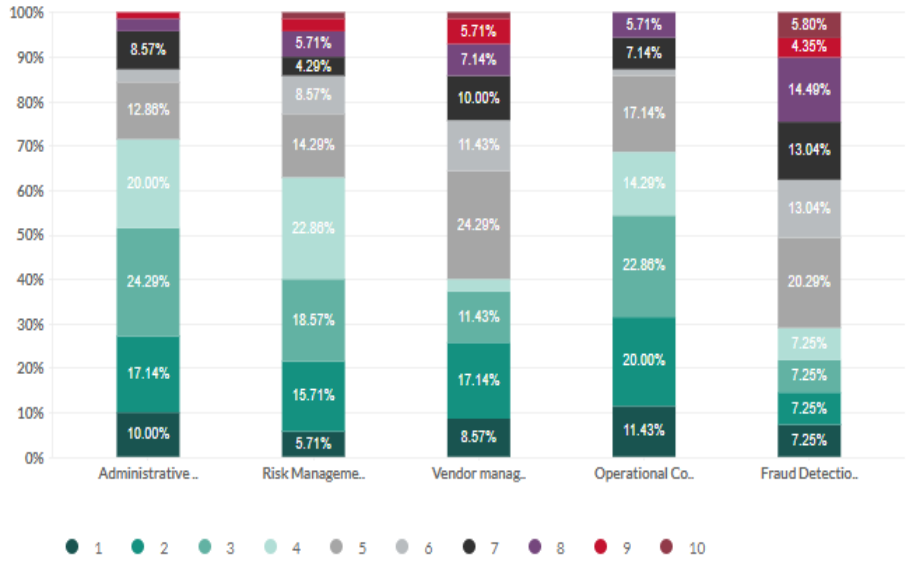
From an interpretive perspective we regarded scores of 1, 2 and 3 as indicating a high priority and scores of 4 and 5 as lower priorities. Using this approach, the figure above shows that the respondents believed that clinical and financial risk management is the focus area with the highest priority followed by fraud, waste and abuse detection and management and improved administrative efficiency.

It is to be expected that the different sectors in the medical aid funding industry will have varying opinions on the priorities of focus areas. The table below summarises the responses received from the different sectors.

	Overall	NAMAF	MC	PO's	Trustees	Administrators
Administrative efficiency	1.93	3.25	1.25	1.25	1.71	2.37
Risk Management	1.70	2.25	1.50	1.25	1.82	1.63
Vendor Management	2.42	3.50	3.13	2.25	2.29	2.32
Operational cost control	2.53	3.75	1.38	1.63	2.24	3.00
Fraud Detection and Prevention	1.75	2.00	1.86	1.38	1.59	1.95

In the table the cells highlighted in red indicate the highest priority and those highlighted in green the lowest priority. The table shows that there is consensus amongst funding industry stakeholders on the three priority areas identified.

Having established the prioritised focus areas, it was necessary to assess the respondents' views on the industry's current performance on the areas identified. The figure below shows a summary of the responses received. A score of 1 indicates a superior performance and a score of ten represents an inferior performance.



The figure shows that the respondents believed that the industry is performing best on administrative efficiency and operational cost control, followed by clinical and financial risk management. The respondents rated the performance on fraud detection and prevention the poorest, while it was believed to be the second highest priority.

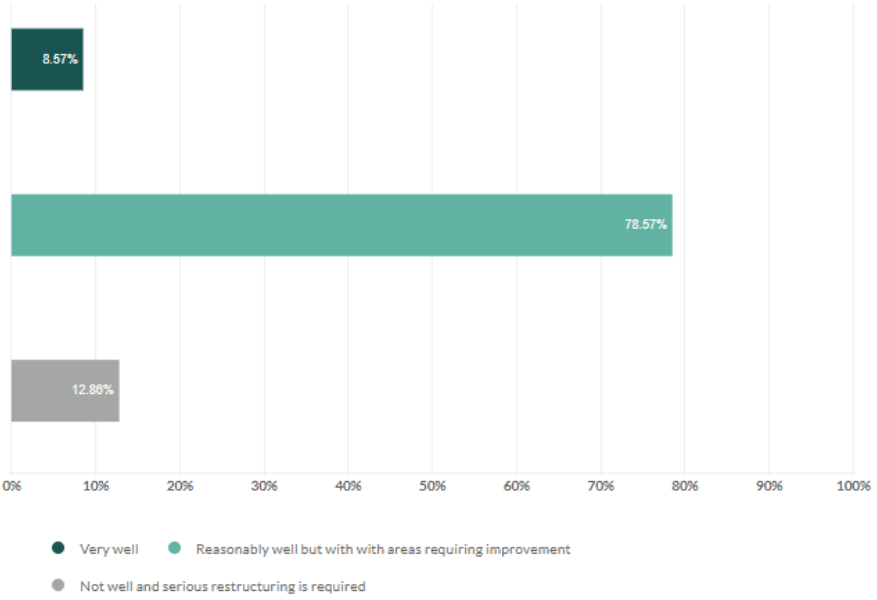
The table below shows the responses on the industry performances by sector.

	Overall	NAMAF	MC	PO's	Trustees	Administrators
Administrative efficiency	3.81	3.75	3.25	3.13	3.82	2.37
Risk Management	4.30	5.75	3.75	3.63	3.94	1.63
Vendor Management	4.67	4.75	5.13	5.75	4.29	2.32
Operational cost control	3.63	4.00	3.25	3.00	3.47	3.00
Fraud Detection and Prevention	5.61	5.25	5.25	6.38	5.18	1.95

In the table above the cells highlighted in green indicate good performances and those highlighted in red indicate inferior performance. The opposing views expressed by the administrator responses are likely due to misinterpretations of the questions asked.

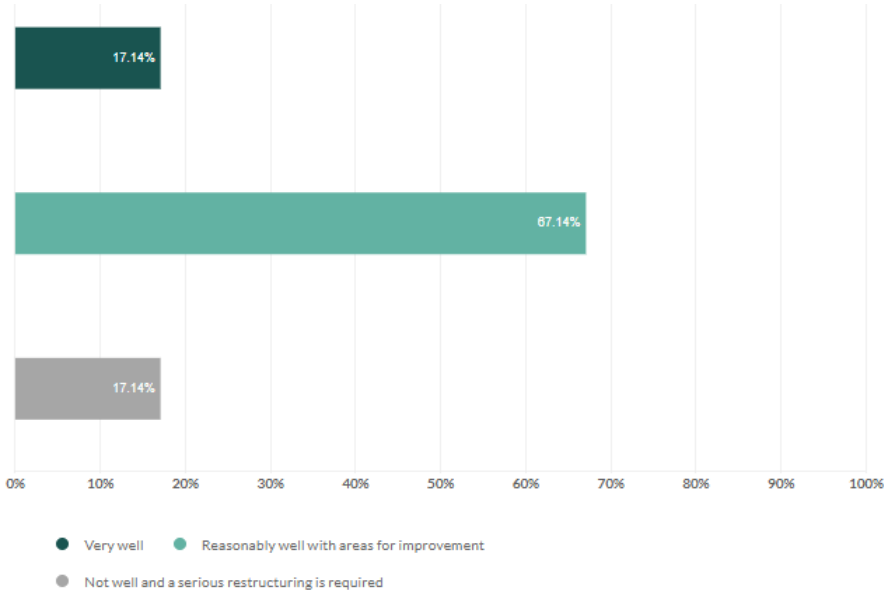
2.2.2 Management effectiveness

Respondents were requested to rate the effectiveness of the management of medical aid funds by the funds themselves and the funds' administrators, respectively. The figure below shows a summary of the responses received with respect to the effectiveness of the management of the funds by the funds themselves (i.e., the funds' trustees and principal officers).



The figure shows that 91.43% of respondents believe that the management of medical aid funds by the funds themselves can be improved upon.

The next figure shows a summary of the respondents' views on the effective of the management of medical aid funds by the funds' administrators.



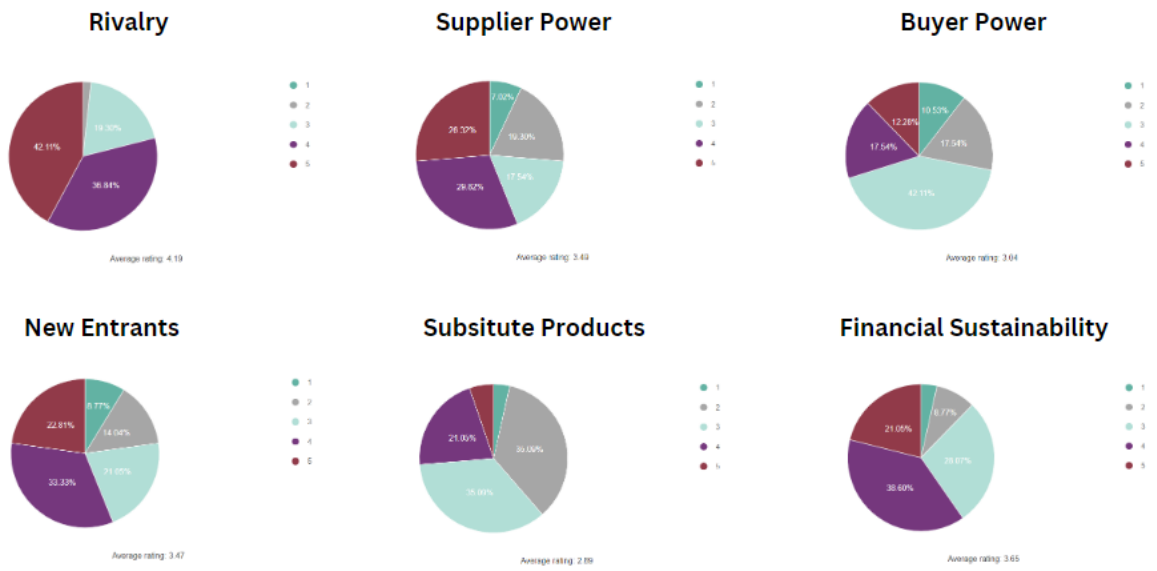
The figure shows that 82.86% of respondents believe that the management of medical aid funds by the funds' administrators can be improved upon.

2.2.3 Competitive forces

Respondents were also requested to rank the following competitive forces being faced by registered medical aid funds:

- Rivalry amongst existing competitors due to a small market and good supply of medical aid fund choices.
- Bargaining power of suppliers/providers to the medical aid funding industry is high due to a perceived lack of supplier competition.
- Bargaining power of buyers of medical aid funds (members) is high because of the availability of various medical aid funds and lenient application of rules (many exceptions).
- The threat of new entrants into the medical aid funding industry is low due to the unattractiveness of the industry.
- The threat of substitute products (insurance products, capitation arrangements, digital healthcare) are high due to emergence of viable alternative substitutes.
- Considering the trend in the above industry forces the attractiveness of the long-term financial sustainability medical aid funding industry is low.

The figure below shows a summary of the responses received.



The figure shows that the top three competitive forces experienced by registered medical aid funds are:

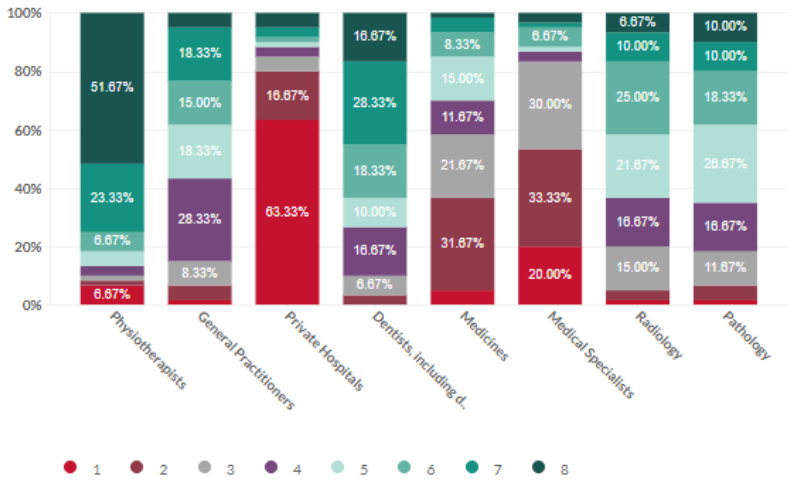
- Rivalry amongst existing competitors due to a small market and good supply of medical aid fund choices.
- The attractiveness of the long- term financial sustainability medical aid funding industry is low.
- Bargaining power of suppliers/providers to the medical aid funding industry is high due to a perceived lack of supplier competition.

2.2.4 Detail issues identified

The respondents were requested to rank a series of potential cost drivers by their order of importance:

- Physiotherapists
- General Practitioners
- Private Hospitals
- Dentists, including Dental Specialists
- Medicines
- Medical Specialists
- Radiology
- Pathology

The figure below provides an overview of the responses received where a score of 1 indicates the highest priority and a score of ten the lowest.



The figure shows that the respondents regarded Private Hospitals the most important, followed by Medical Specialists and Medicines.

The table below shows that there is consensus amongst the industry sectors regarding the relative importance of the financial stress factors.

	Overall	NAMAF	MC	PO's	Trustees	Administrator
Physiotherapists	6.58	4.25	6.14	7.25	6.40	7.00
General Practitioners	4.96	4.75	4.43	5.63	4.47	5.58
Private Hospitals ★	2.15	4.50	2.00	1.25	2.07	1.95
Dentists, including dental specialists	5.87	4.25	5.57	6.50	5.80	5.84
Medicines ★	3.49	4.50	2.86	2.13	3.60	3.63
Medical Specialists ★	2.84	4.50	3.29	2.63	2.60	2.63
Radiology	5.09	4.75	6.14	5.25	5.60	4.68
Pathology	5.02	4.50	5.57	5.38	5.47	4.68

Respondents were also asked to rank the following potential drivers of healthcare inflation by severity or potential impact:

- Namaf benchmark tariffs are too high.
- Healthcare service providers are charging more than the Namaf benchmark tariffs.
- Medical aid fund beneficiaries are misusing their funds and accessing too many benefits (Consumer induced demand).
- Healthcare service providers are driving utilisation (Supplier induced demand).
- Healthcare providers are not adhering to the Namaf billing rules and guidelines.
- Clinical best practice and evidence-based standards that are not adhered to.

The figure shows that the top three drivers identified by the respondents are:

- Healthcare service providers are driving utilisation (Supplier induced demand).
- Healthcare service providers are charging more than the Namaf benchmark tariffs.
- Healthcare providers are not adhering to the Namaf billing rules and guidelines.

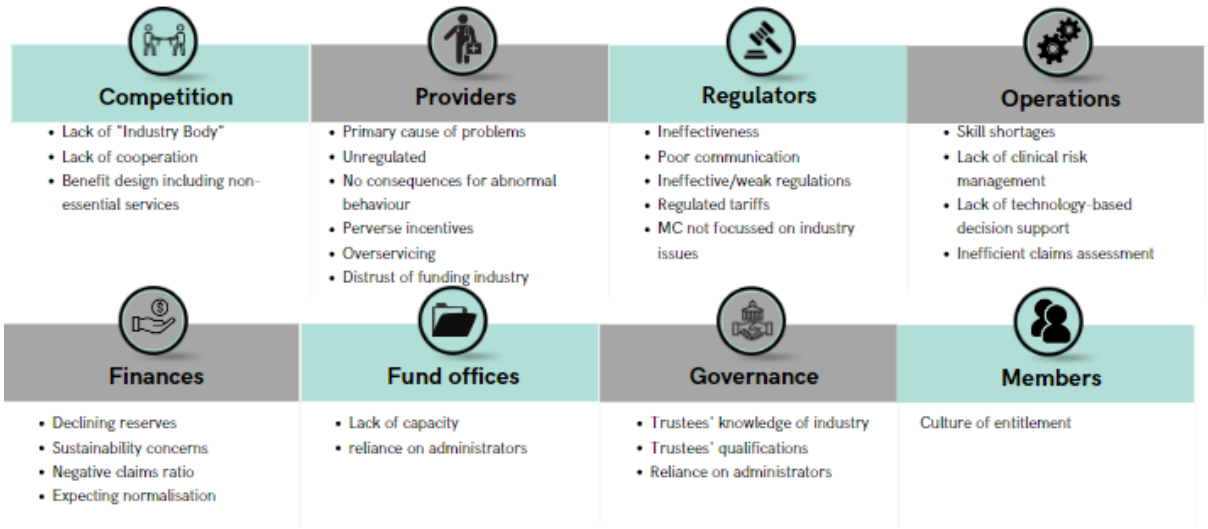
The table below shows again that there is consensus amongst the industry sectors regarding the top three drivers.

	Overall	NAMAF	MC	PO's	Trustees	Administrator
Namaf benchmark tariffs are too high	2.53	1.50	2.13	2.25	2.59	2.74
Healthcare service providers are charging more than the Namaf benchmark tariffs	4.21	4.00	4.25	4.38	4.18	4.21
Medical aid fund beneficiaries are misusing their funds and accessing too many benefits (Consumer induced demand).	3.70	3.75	3.25	4.00	3.71	3.74
Healthcare service providers are driving utilisation (Supplier induced demand).	4.56	5.00	4.25	4.88	4.41	4.68
Healthcare providers are not adhering to the Namaf billing rules and guidelines.	3.97	4.75	3.88	4.25	3.65	4.05
Clinical best practice and evidence-based standards that are not adhered to.	3.91	4.75	3.50	4.25	3.94	3.68
Other	3.82	3.25	3.50	3.38	4.00	4.16

2.2.5 Narrative responses received

The structure of the survey allowed respondents to submit narrative responses where they wished to add to the responses provided, or where they wanted to motivate the answers provided further.

The pictogram below provides a summary of the verbal responses received, noting that the unedited versions of the responses are attached to this report as an annexure.



2.2.6 Summary of problem definition

According to the responses received, the problem definition can be summarised as follows:

- The medical aid funding industry is in financial distress.
- The main cost drivers are:
    - Private Hospitals
    - Medical Specialists,
    - Medicines.
- The main drivers of healthcare inflations are:
    - Providers driving utilisation.
    - Providers claiming higher than Namaf Benchmark Tariffs.
    - Non-compliance to Namaf billing rules and guidelines.
    - Sub-optimal application of clinical best practice and evidence-based medicine principles.
- Poor detection and management of Fraud, Waste and Abuse.
- Management Committee sub-optimally focussed on industry issues.
- Sub-optimal management of funds by funds themselves and the fund administrators.

- The top three competitive forces are:
  - Rivalry amongst medical aid fund,
  - Financial sustainability of medical aid funds,
  - Supplier power.
- A need for member and trustee education.
- Sub optimally structured and managed medical aid funding ecosystem.

2.3 A new context

Following the problem definition, the survey assessed respondents, views on potential solutions.

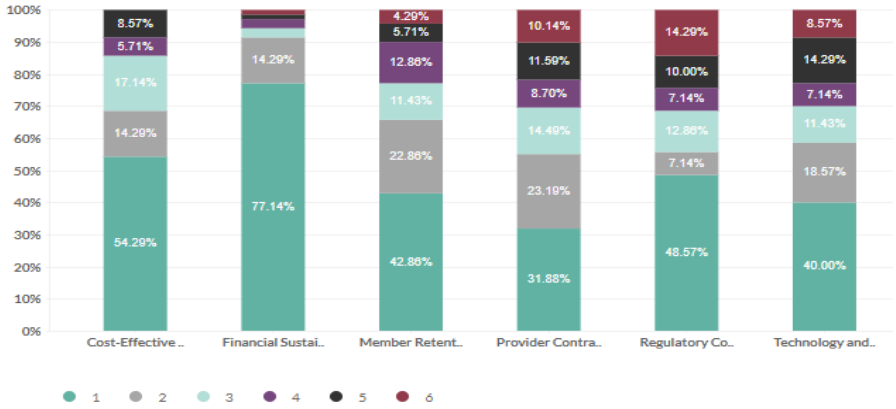
2.3.1 Critical success factors

The results of a literature review suggest that a positive performance by the medical aid funding industry and the medical aid funds themselves is dependent on the following success factors:

i. **Cost-Effective Operations**: Medical aid funds need to operate in a cost-effective manner to keep their contributions affordable for members. This includes efficient administrative processes, effective cost controls, and strategic investments.
ii. **Member Retention**: Medical aid funds must focus on member retention to maintain a stable and sustainable membership base. This requires providing high-quality services, good customer service, and regular communication with members.
iii. **Financial Sustainability**: Medical aid funds must have a sustainable financial model to ensure that they can meet the healthcare needs of their members over the long term. This requires effective risk management, prudent financial planning, and ongoing monitoring of financial performance.
iv. **Provider Contracts**: Medical aid funds need to establish and maintain strong relationships with healthcare providers to ensure that members have access to quality healthcare services. This includes negotiating favourable rates with providers and ensuring that adequate numbers of providers are contracted and accessible.
v. **Regulatory Compliance**: Medical aid funds must comply with regulatory requirements set by the Regulators. Compliance is important for maintaining the trust of members, ensuring fair competition among medical aid funds, and protecting the financial stability of the industry.
vi. **Technology and Innovation**: Medical aid funds must embrace technology and innovation to remain competitive and meet the evolving needs of their members. This includes investing in digital platforms for member engagement, data analytics

for better decision-making, and telemedicine solutions for improved access to care.

Respondents were asked to rank the statements by importance and the results are shown in the figure below with a score of 1 indicating the highest importance and ten the lowest.



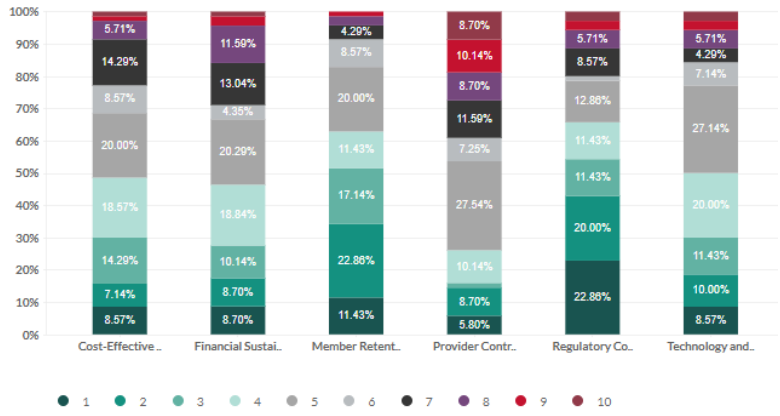
The figure shows that the top three critical success factors are:

- The financial sustainability of the medical aid funds,
- Cost-effective operations of the medical aid funds, and
- Member retention.

The table below shows that there is consensus amongst between the industry sectors on the critical success factors for the industry.

	Overall	NAMAF	MC	PO's	Trustee's	Administrators
Cost-Effective Operations	2.02	2.50	1.25	1.88	1.71	2.26
Member Retention	2.35	4.00	2.25	1.88	2.12	2.16
Financial Sustainability	1.47	2.25	1.13	1.00	1.35	1.63
Provider Contracts	2.75	3.50	2.25	1.88	2.47	3.32
Regulatory Compliance	2.67	2.25	3.13	1.88	2.47	3.05
Technology and Innovation	2.56	3.25	3.25	2.00	2.12	3.21

Then, respondents were requested to provide their views on the current performance of the industry against the critical success factors identified. The figure below shows a summary of the responses received with a score of 1 indicating a superior performance and a score of 10 an inferior performance.



The figure shows a malignment between the critical success factors identified and the adjudged levels of performance.

The table below again shows consensus amongst industry sectors.

	Overall	NAMAF	MC	PO's	Trustee's	Administrators
Cost-Effective Operations	4.60	3.50	3.75	4.00	4.76	5.16
Member Retention	3.75	3.00	2.88	3.00	3.76	4.58
Financial Sustainability	4.95	5.00	4.75	5.86	4.12	5.11
Provider Contracts	5.88	4.25	5.50	7.00	4.82	6.42
Regulatory Compliance	3.84	4.25	3.13	2.75	3.35	4.47
Technology and Innovation	4.61	4.75	4.38	5.00	4.24	4.58

2.3.2 Critical Success Factor Summary

In summary, the survey results pertaining to the industry critical success factors show that:

- There is consensus on the detail critical success factors.
- The current performances are not matching the critical success factors identified.
- There are differing views regarding the current performance on the critical success factors:
    - Most agree that the current performance on financial sustainability is poor, but the degree of poorness varies, and
    - The trustees and administrators responded that the current performance of cost-effective operations is poor, while the MC members, principal officers and Namaf staff though that the performance is above average.
- All respondents responded that the performance on member retention is good.

2.4 Mandate for Decision-making

Prior to planning interventions with respect to problems and critical success factors identified, it was necessary to assess the respondents views the need to cooperate as an industry and, secondly, whether such cooperation will be legally viable.

All respondents indicated that there is a need to cooperate and, even though there was some variability in the strength of agreement, not a single respondent indicated that there is an absolute legal prohibition against cooperation.

2.5 Potential solutions

Having identified the problems, the industry is facing and critical success factors for the industry, the survey assessed the respondents' views on potential solutions.

2.5.1 Potentially controversial solutions

The respondents' views were assessed on two potentially controversial solutions:

- 57.89% of respondents indicated that out-of-pocket expenditure is inevitable in a medical aid environment, but it must be noted that a distinction was made between co-payments and out-of-pocket expenditure arising due to providers charging more than the Namaf benchmark tariffs, as an example.
- 61.82% of respondents indicated that lowering Namaf benchmark tariffs as a cost-reduction strategy is not an option.

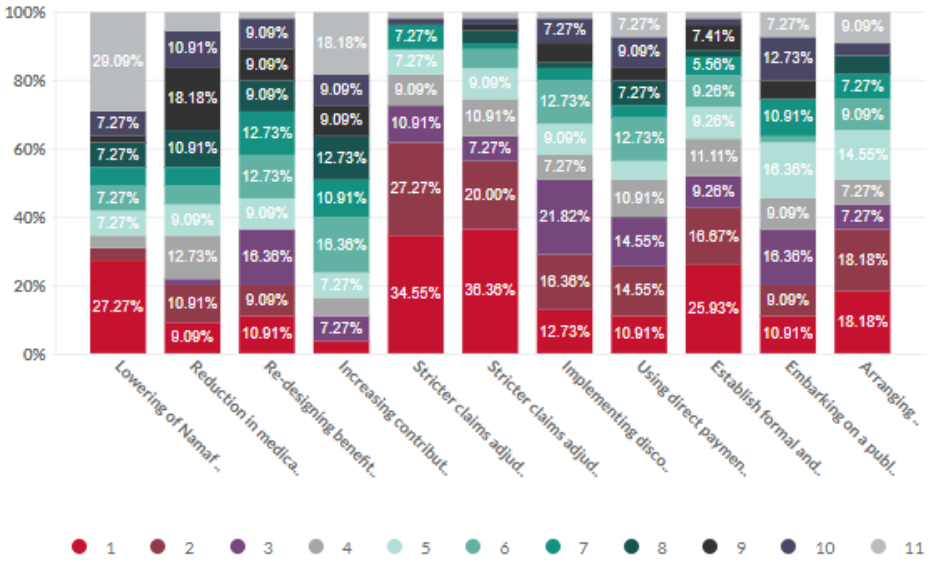
2.5.2 Feasible interventions

Respondents were asked to prioritise the following potential interventions to address the financial situations funds are finding themselves in:

- Lowering of Namaf benchmark tariffs.
- Reduction in medical aid fund benefits.
- Re-designing benefits and introducing co-payments to create member disincentives.
- Increasing contributions (Applying interim contribution increases).
- Stricter claims adjudication with rejection of claims that do not comply with clinical best practices.
- Stricter claims adjudication with rejection of claims that do not comply with the Namaf billing rules and guidelines.
- Implementing discount arrangements (e.g., discounts in return for shorter payment cycles).

- Using direct payments to members as a mechanism to manage provider behaviour.
- Establish formal and legally binding industry arrangements between medical aid funds (as a collective) and healthcare service providers (with associated incentives and disincentives).
- Embarking on a public relations campaign and appealing to medical aid fund members to claim less.
- Arranging provider meetings and appealing them to help reduce expenditure.

The figure below shows a summary of the priorities chosen where a score of 1 indicate the highest priority and a score of the ten the lowest.



The figure shows that the top four priorities chosen were:

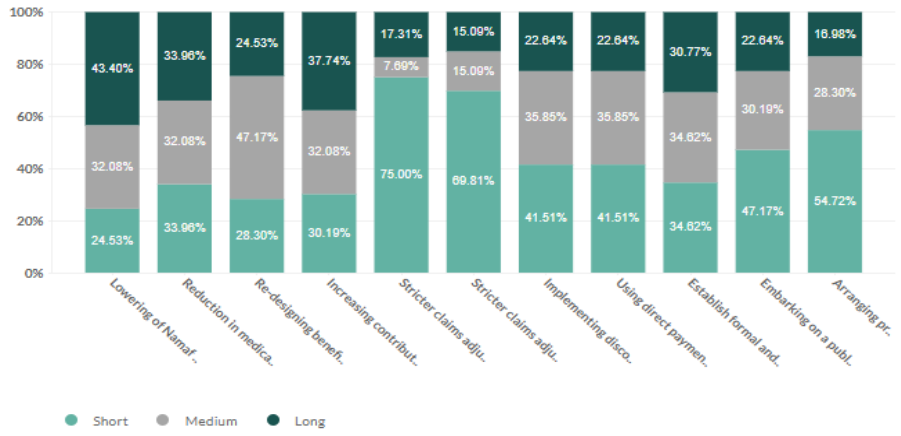
- Stricter claims adjudication based on Namaf billing rules and guidelines,
- Stricter claims adjudication based on clinical best practices,
- Establishment of formal relationships (contracts) with healthcare service providers, and
- Establishing formal communication channels with healthcare service providers to *inter alia* facilitate education.

The table below again shows consensus amongst industry sectors regarding the interventions that must be implemented.

		Overall	Namaf	MC	PCFs	Trustees	Administrators
	Lowering of Namaf benchmark tariffs	6.35	11.00	7.83	8.25	5.40	5.74
	Reduction in medical aid fund benefits	6.24	7.75	7.67	7.50	6.33	5.37
	Re-designing benefits and introducing co-payments to create member disincentives	6.24	7.75	7.67	7.50	6.33	5.37
	Increasing contributions (Applying interim contribution increases)	7.33	5.75	7.50	7.50	6.75	8.32
1	Stricter claims adjudication with rejection of claims that do not comply with clinical best practices	2.94	1.75	2.83	2.25	3.13	3.00
2	Stricter claims adjudication with rejection of claims that do not comply with the Namaf billing rules and guidelines.	3.35	1.25	3.00	2.38	3.47	3.37
3B	Implementing discount arrangements (e.g. discounts in return for shorter payment cycles)	4.44	5.50	5.67	3.88	4.20	5.37
	Using direct payments to members as a mechanism to manage provider behaviour.	5.18	4.75	7.33	3.75	5.53	6.21
3A	Establish formal and legally binding industry arrangements between medical aid funds (as a collective) and healthcare service providers (with associated incentives and disincentives).	3.85	2.50	3.50	3.50	3.53	4.84
	Embarking on a public relations campaign and appealing to medical aid fund members to claim less.	5.49	5.75	5.67	5.00	4.07	6.32
	Arranging provider meetings and appealing them to help reduce expenditure.	4.64	6.50	4.00	3.88	4.87	4.79

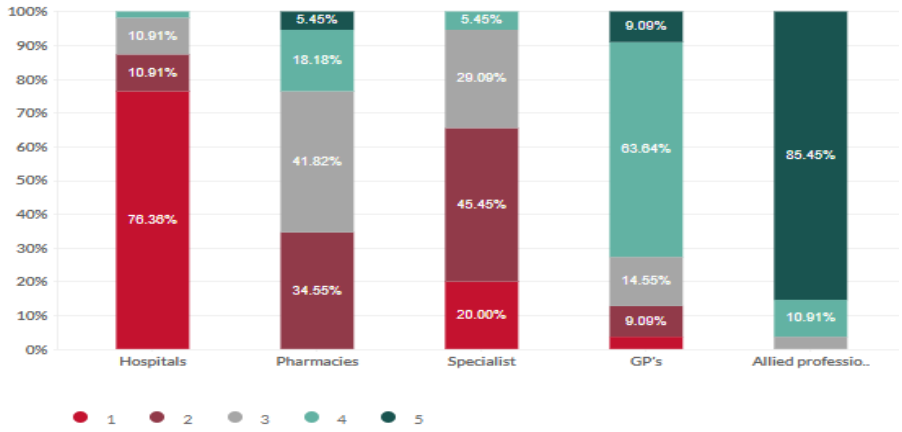
2.5.3 Prioritisation of interventions

The figure below shows a summary of the responses received with respect to the prioritisation of the interventions identified.



The figure shows that the top two priorities identified are stricter claims adjudication according to the Namaf billing rules and guidelines and clinical best practice principles.

With respect to establishing formal relationships, or contracts, with providers, respondents were asked to prioritise the main disciplines. The figure below shows a summary of the responses received, with a score of 1 indicating the highest priority.



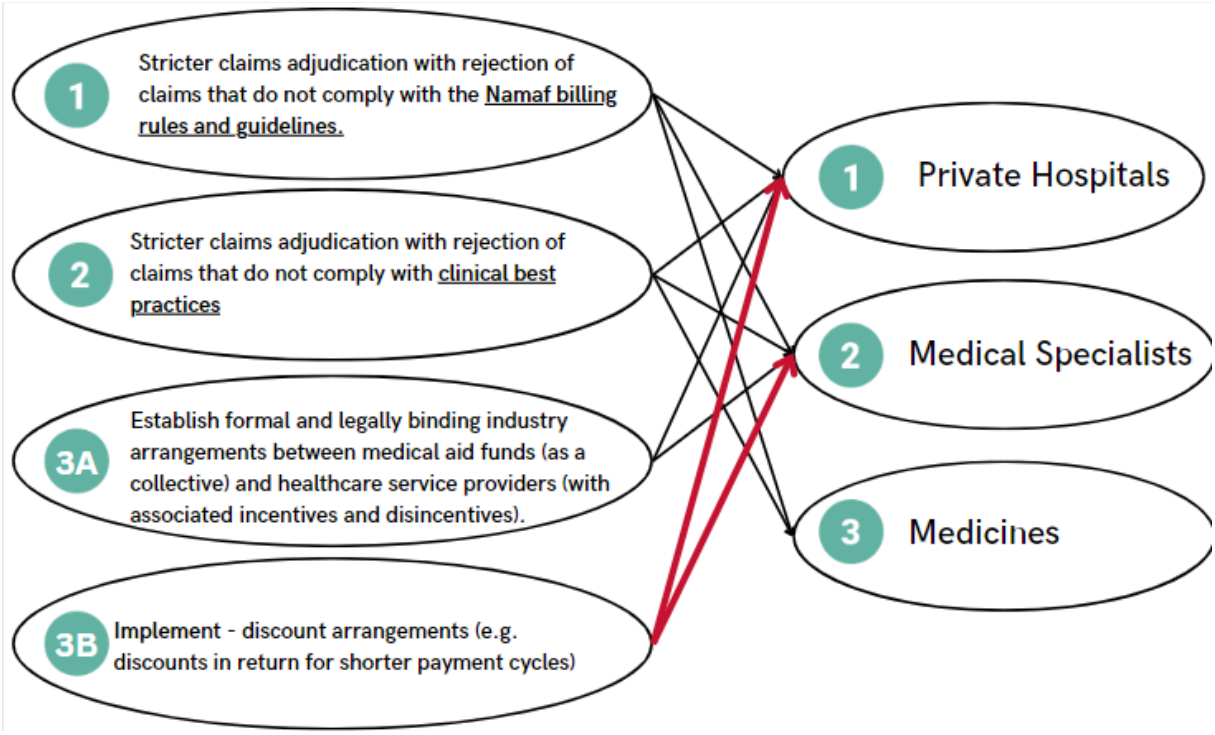
The figure shows that Private Hospitals must receive the highest priority, followed by medical Specialists and pharmacies.

The table below shows consensus by all industry sectors on the overall prioritisation.

	Overall	NAMAF	MC	PO's	Trustees	Administrator
Hospitals	1.38	1.00	1.17	1.25	1.53	1.26
Pharmacies	2.95	2.50	2.50	2.63	3.27	3.05
Specialist	2.20	2.75	2.33	2.38	1.93	2.05
GP's	3.65	3.75	4.00	3.75	3.67	3.63
Allied professions	4.82	5.00	5.00	5.00	4.60	5.00

2.5.4 Intervention mapping

The figure below shows a mapping between the interventions identified, and prioritised, against the key focus areas identified during the problem identification phase.



The figure shows that the interventions identified will address all three priority areas, if implemented.

2.5.5 Intervention mobilisation

Regarding the implementation of interventions respondents were requested to indicate who they believed must take responsibility for the design of the interventions required. The table below shows a summary of the responses received.

	Overall	NAMAF	MC	PO's	Trustees	Administrator
Funds individually	3.07	3.25	2.29	3.25	2.33	3.58
Fund actuaries	3.58	2.75	4.43	4.88	3.60	3.42
Funds as a collective (Outside of NAMAF)	2.95	4.50	2.43	2.75	2.93	2.63
Administrators	4.18	3.00	4.14	5.13	4.27	4.16
Namaf	3.15	4.50	2.43	1.63	3.53	2.84
NAMFISA	5.27	5.50	5.57	4.13	4.80	6.00
HPCNA	5.80	4.50	6.71	6.25	6.53	5.37

The lower scores in the table indicate the more preferred options. Even though there are variations in the views expressed between the sector representatives, the aggregate view is that the funds individually, funds as a collective and Namaf must assume the responsibility for the design of the interventions.

The next table below summarises the responses received when respondents were asked to indicate who should be responsible for the implementation of the interventions identified.

	Overall	NAMAF	MC	PO's	Trustees	Administrator
Funds individually	2.84	3.75	2.00	2.00	2.20	3.26
Fund actuaries	3.87	4.50	4.43	4.25	3.87	3.89
Funds as a collective (Outside of NAMAF)	3.04	5.25	2.43	2.63	3.13	2.42
Administrators	3.49	2.25	2.72	3.63	3.47	3.63
Namaf	3.65	4.00	4.00	3.63	3.73	3.42
NAMFISA	5.22	4.25	5.86	5.25	5.00	5.74
HPCNA	5.89	4.00	6.57	6.63	6.60	5.63

The table shows that on average the respondents believe that the funds individually and as a collective, together with their administrators must be responsible for the implementation of the interventions identified. Importantly, the respondents indicated that Namaf must assume a lesser role in the implementation of the interventions than the design thereof.

The next table shows a summary of the responses received with respect to the who should take accountability for developing, maintaining, and communicating clinical best practices.

	Overall	NAMAF	MC	PO's	Trustees	Administrator
Funds individually	42.86%	75.00%	71.43%	50.00%	66.67%	26.32%
Fund actuaries	12.24%	0.00%	14.29%	12.50%	13.33%	10.53%
Funds as a collective (Outside of NAMAF)	46.94%	75.00%	42.86%	50.00%	33.33%	52.63%
Administrators	57.14%	75.00%	57.14%	25.00%	60.00%	68.42%
Namaf	75.51%	50.00%	100.00%	87.50%	80.00%	68.42%
NAMFISA	14.29%	0.00%	14.29%	12.50%	13.33%	15.79%
HPCNA	46.94%	25.00%	28.57%	37.50%	33.33%	63.16%
Specialist service provider	40.82%	25.00%	28.57%	25.00%	46.67%	52.63%

The table shows that 75.51% of respondents believed that Namaf must assume the responsibility and 57.14% of respondents responded that the administrators must assume the responsibility.

3 INTERVENTIONS

Three interventions could be identified and prioritised from the survey results:

1. Design and implementation of clinical best practices,
2. Stricter claims adjudication based on Namaf billing rules and guidelines, and
3. Design and implementation of provider contracts, including payment arrangements such as discounts.

Twelve additional initiatives were listed during deliberations in the workshop:

1. Medicine dispensing fee review,
2. Review of fund rules to align with the model rules in the standards to the Financial Institutions Management Act (FIMA), bearing in mind that FIMA has not yet been promulgated,
3. Development and implementation of appropriate monitoring mechanisms,
4. Refine trustee training,
5. Refine member education and training,
6. Investigate alternative reimbursement models, including risk sharing,
7. Larger medical industry transformation – current legislation,
8. Larger medical industry transformation – improved access to care,
9. GP Referral systems,
10. Management of Fraud, Waste and Abuse,
11. Implementation of electronic health records, and
12. Design and implementation of aligned communication processes and content.

The table below provides an overview of the projects identified, time horizon allocated, the implementation agent/s, whether the project is in support of the focus areas and whether the initiative has already been initiated.

Project	Name	Phases	Short Term	Long Term	Implementation Agent		Support Focus Areas			Already Initiated
					Namaf/MC/Funds as collective (Outside Namaf)	Medical Aid Funds	Hospitals	Specialists	Medicines	
1.	Clinical Best Practices	Design	X		Namaf/MC		X	X		No
		Implement	X	X		X	X	X		No
2.	Billing Rules and Guidelines	Refine	X		Namaf/MC		X	X	X	Yes
		Implement	X	X		X	X	X	X	Yes
3.	Provider Contracts, incl. discounts	Design, negotiation, finalisation (Incl. signature)	X		Namaf/MC		X	X	X	No
		Implement				X	X	X	X	No
4.	Medicine Dispensing fee review 1. Revise current medicine price file approach. 2. Replace current 50% markup with differential markups to incentivise generic utilisation and for NAMAF publish a benchmark dispensing fee. 3. Design a new Pharmacy reimbursement Model - End Game 4. Alignment with desired behaviour (Tiered dispensing fee)	Design	4.1	4.2	Namaf/MC				X	No
		Implement	4.1	4.2		X			X	No
5.	Refine Model rules in line with Act 23 1995 as supplied by Namfisa to include the scope of the initiatives. Define principles in support of fund specific rule changes with respect to clinical best practices, Billing rules,	Design		Dependent on Achievement of the design phase of 1-4	Namaf/MC		X	X	X	No
		Implement		X	Namaf/MC		X	X	X	No

Project	Name	Phases	Short Term	Long Term	Implementation Agent		Support Focus Areas			Already Initiated
					Namaf/MC/Funds as collective (Outside Namaf)	Medical Aid Funds	Hospitals	Specialists	Medicines	
	Provider contracting guidelines and Medicine dispensing fees									
6.	**Appropriate monitoring Mechanisms -** Indicators and system for Compliance with clinical best practice indicators, Namaf billing rules and guidelines, Provider contracts and Medicine dispensing fees Practice profiling template included	Design		Dependent on Achievement of the design phase of 1-4	Namaf/MC		X	X	X	No
		Implement		X	Namaf/MC		X	X	X	No
7.	**Refine Trustee Training**	Refine		X	Namaf/MC		X	X	X	Yes
		Implement		X	Namaf/MC	X	X	X	X	Yes
8.	**Refine member retention and education**	Design	X	X		X				Yes
		Implement	X	X		X	X	X	X	Yes
9.	**Investigate alternative reimbursement models (incl. risk sharing)**	Design		X	Namaf/MC		X	X		No
		Implement		X		X	X	X		No
10.	**Larger Medical Industry Transformation** Regulatory reform in support the efficacy of the medical aid industry: • Licensing of facilities/Practice number issuing • Exploring opportunities in the FIMA act • Improve regulatory conduct: • Healthcare service providers - HPCNA • Medical aid funds - Namfisa			X	Namaf/MC		X	X	X	No
11.	**Larger Medical Industry transformation** Increasing access to medical aid cover: Low-cost solutions			X	Namaf/MC		X	X	X	No
12.	**GP Referral** system to eliminate direct use of Specialists - investigate feasibility			X	Namaf/MC					No

Project	Name	Phases	Short Term	Long Term	Implementation Agent		Support Focus Areas			Already Initiated
					Namaf/MC/Funds as collective (Outside Namaf)	Medical Aid Funds	Hospitals	Specialists	Medicines	
13.	**Fraud, waste, and abuse** • Mechanisms for reporting when cases are found. • Statement on stand on Fraud waste and abuse • Re engage with regulator (NAMFISA) to create a forensic unit for all non-banking units. • If no NAMFISA appetite NAMAF should take over	X			Namaf/MC		X	X	X	No
14.	**Electronic health record** Specifically coupled to referrals		X		Namaf/MC					No
15.	**Design and** implement an aligned communication process and content that support the above projects and support timely communication to stakeholders related to milestone achievements in the fourteen projects	X	X		Namaf/MC	X	X	X	X	No

3.1 Funding of initiatives

The table below is a repeat of the previous table with the only difference being an indication on which entity must be responsible for the funding of the projects identified.

Project	Name	Phases	Short Term	Long Term	Funding		Support Focus Areas			Already Initiated
					Namaf/MC/Funds as collective (Outside Namaf)	Medical Aid Funds	Hospitals	Specialists	Medicines	
1.	**Clinical Best Practices**	Design	X		Namaf/MC		X	X		No
		Implement	X	X		X	X	X		No
2.	**Billing Rules and Guidelines**	Refine	X		Namaf/MC		X	X	X	Yes
		Implement	X	X		X	X	X	X	Yes

Project	Name	Phases	Short Term	Long Term	Funding		Support Focus Areas			Already Initiated
					Namaf/MC/Funds as collective (Outside Namaf)	Medical Aid Funds	Hospitals	Specialists	Medicines	
3.	**Provider Contracts, incl. discounts**	Design, negotiation, finalisation (Incl. signature)	X		Namaf/MC		X	X	X	No
		Implement				X	X	X	X	No
4.	**Medicine Dispensing fee review** 1. Revise current medicine price file approach. 2. Replace current 50% markup with differential markups to incentivise generic utilisation and for NAMAF publish a benchmark dispensing fee. 3. Design a new Pharmacy reimbursement Model - End Game 4. Alignment with desired behaviour (Tiered dispensing fee)	Design	4.1	4.2	Namaf/MC				X	No
		Implement	4.1	4.2		X			X	No
5.	**Refine Model rules in line with Act 23 1995 as supplied by Namfisa to include the scope of the initiatives.** Define principles in support of fund specific rule changes with respect to clinical best practices, Billing rules, Provider contracting guidelines and Medicine dispensing fees	Design		Dependent on Achievement of the design phase of 1-4	Namaf/MC		X	X	X	No
		Implement		X	Namaf/MC		X	X	X	No
6.	**Appropriate monitoring Mechanisms -** Indicators and system for Compliance with clinical best practice indicators, Namaf billing rules and guidelines, Provider contracts and Medicine dispensing fees Practice profiling template included	Design		Dependent on Achievement of the design phase of 1-4	Namaf/MC		X	X	X	No
		Implement		X	Namaf/MC		X	X	X	No

Project	Name	Phases	Short Term	Long Term	Funding		Support Focus Areas			Already Initiated
					Namaf/MC/Funds as collective (Outside Namaf)	Medical Aid Funds	Hospitals	Specialists	Medicines	
7.	**Refine Trustee Training**	Refine		X	Namaf/MC		X	X	X	Yes
		Implement		X	Namaf/MC		X	X	X	Yes
8.	**Refine member retention and education**	Design	X	X		X				Yes
		Implement	X	X		X	X	X	X	Yes
9.	**Investigate alternative reimbursement models (incl. risk sharing)**	Design		X	Namaf/MC		X	X		No
		Implement		X		X	X	X		No
10.	**Larger Medical Industry Transformation** Regulatory reform in support the efficacy of the medical aid industry: • Licensing of facilities/Practice number issuing • Exploring opportunities in the FIMA act • Improve regulatory conduct: • Healthcare service providers - HPCNA • Medical aid funds - Namfisa			X	Namaf/MC		X	X	X	No
11.	**Larger Medical Industry transformation** Increasing access to medical aid cover: Low-cost solutions			X	Namaf/MC		X	X	X	No
12.	**GP Referral** system to eliminate direct use of Specialists - investigate feasibility			X	Namaf/MC					No
13.	**Fraud, waste, and abuse** • Mechanisms for reporting when cases are found. • Statement on stand on Fraud waste and abuse • Re engage with regulator (NAMFISA) to create a forensic unit for all non-banking units. • If no NAMFISA appetite NAMAF should take over	X			Namaf/MC		X	X	X	No
14.	**Electronic health record** Specifically coupled to referrals		X		Namaf/MC					No
15.	**Design and** implement an aligned communication process and content that support the above projects and support timely communication to stakeholders	X	X		Namaf/MC	X	X	X	X	No

Project	Name	Phases	Short Term	Long Term	Funding		Support Focus Areas			Already Initiated
					Namaf/MC/Funds as collective (Outside Namaf)	Medical Aid Funds	Hospitals	Specialists	Medicines	
	related to milestone achievements in the fourteen projects									

4 NEXT STEPS

The following next steps were agreed to:

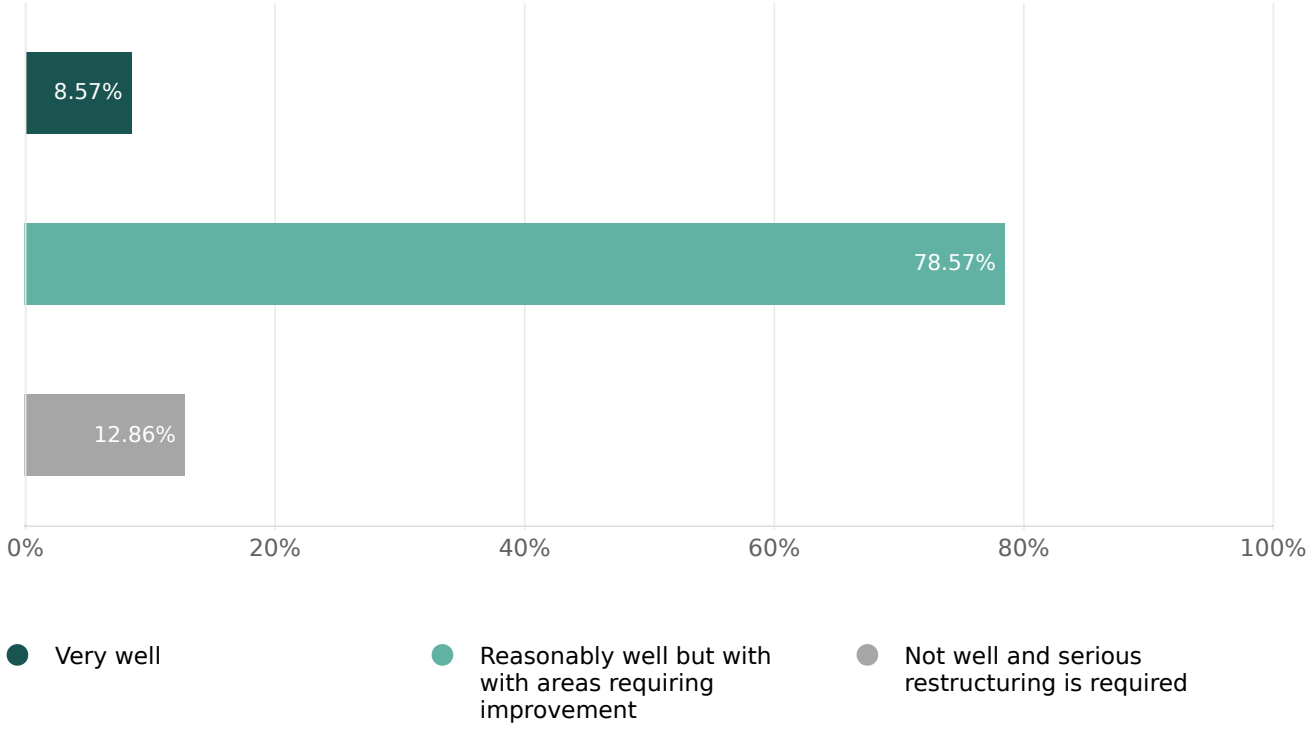
1. Identified projects to form part of NAMAF, MC and PO Forum agenda to mobilise and monitor progress on (At least Monthly a forum Interaction)
   - Approve a project scope description,
   - Resource allocations,
   - Budget allocations,
   - Evaluate progress feedbacks,
   - Approve next steps per project.
2. After NAMAF AGM there needs to be a set date for reporting on progress of these initiatives.
3. NAMAF to consider the appointment of a project manager to ensure implementation of the initiatives.
4. Commitment forms from all workshop participants saved on NAMAF secure files for future reference and usage.
5. Make sure your newly elected MC representative support the execution of the identified projects.
6. The identified projects will be an input into NAMAF September 2023 strategy workshop.
7. NAMAF to prepare appropriate communication to stakeholders about the intent and outcomes of this workshop.

ANNEXURE

The verbatim responses that were received to the questions where provision for such responses were made are included in this Annexure.

How well do you think Medical Aid Funds are being managed by medical aid funds **themselves** at the moment?

Answered: 70 Skipped: 17



Choices	Response percent	Response count
Very well	8.57%	6
Reasonably well but with with areas requiring improvement	78.57%	55
Not well and serious restructuring is required	12.86%	9
Please motivate your answer?		53

Please motivate your answer?

1. The Trustees of Funds should, in the event of fraudulent billing being identified authorize and approve backdated reversals of incorrect billing and over-servicing. Doctors / service providers should not be allowed to keep money for claims that was incorrectly billed. For example a Radiology Practice over-servicing / submitting incorrect claims (maybe for years), when this is identified, the money should be reversed and the provider should be blocked from getting direct payment from the Fund for at least a year.
2. Trustees not motivated, lack insight into Industry, Regulatory bodies control without insight into Industry matters. regulator does not have sufficient practical knowledge of how a Fund works, too much concentration on strategy not enough attention to operational issues. operational level of stakeholders ie Principal Officers concerns and suggestions not receiving sufficient attention by stakeholders.
3. Currently there are rules in place, but the constant drive to grow membership and each fund trying to outshine the other, makes it difficult to grow and the only way to stay attractive is to provide nice-to-have benefits. On the other hand funds try to please HCP's way too much and are not strict enough, they allow HCP's to control them, by this offering less support to their team, but rather to please the HCP to not put the fund in a bad light.

4. In my view, as a front-line worker that deals critically with cost control/management functions, the healthcare industry is now very commercialized and this puts the medical aid industry under pressure, and this contributed to the nonalignment of current administrative goals. The funds are operating in a way that rules and benefits design leaves room for grey areas and challenges by the health care providers. It appears that funds are operating in a very outdated manner and are service providers driven. With a lack of effective legislation, cost management/ control strategies in a commercialized healthcare industry are not existent. Additionally, the current competition between the private medical aid funds in Namibia is unhealthy and there is also a huge need for collaboration between the Private medical aid funds and the government especially in terms of service providers' regulation with support from the law makers.
5. None of the Medical Aid Funds are administered by themselves. Board members are elected by members, but these Board Members all have day jobs and serving as a Board Member is not their primary responsibility.
6. Manage potential fraud and abuse by service providers and members.
7. I think they should find strategies to apply the information shared in the claims data report.
8. Boards with less human capital practitioners and more business owners or operational managers would be more effective.
9. Role clarification of regulator and association needs to be outlined. Administrators tend to "rule" . Principal Officers not seen as conduits between member, Industry and Trustees. much more power needs to be handled by the Funds as opposed to regulators and HCP's
10. The Board of Trustee are not effectively controlling MAF. POs seem to be controlled by the Administrators who are not held to account for efficient management of risk-mitigating aspects of the Funds - mainly clinical risk governance
11. Need to equip themselves to understand the medical aid industry
12. High level of legal compliance and corporate governance principals.
13. Medical Aid Funds are managed by Administrators.
14. Medical Aid Funds do not have the necessary human resources to manage the Fund. Staff are employed by the Administrators. Equally, Funds do not have access to the administrative system. where contributions are collected, and claims are processed.
15. Do the boards of trustees have the necessary skills, experience and times to pro-actively manage their medical aid funds?
16. Private medical aid is unaffordable for members and providers with fraudulent related cases are not penalised on industry level and/or MoHSS termination of licenses.
17. It is important to find more appropriate risk management methodologies along with the associated cost management/funding strategies.
18. MAF are being managed by Administrators.
19. Trustees should be better informed about their clients' operations and accounts. You can not take decisions when you are not knowledgeable about the industry.
20. 1. The competition amongst the funds is one of the biggest deterrent for the funds to be managed properly for the betterment of the fund. Funds at the moment are chasing numbers and are stealing each other's members, which is not healthy . 2. The application of the relevant laws are not applied uniformly by all funds e.g. some funds apply discount to employer groups to attract members which is against NAMFISA. 3. The funds decide on certain issues to be implemented by all and yet, some funds are are not abiding by these decisions. 4. Investing in technology is one of the areas where the funds need to look at that can assist them in managing the funds. However, given the size of the funds and costs involved to invest new technology, the funds do not have the financial means to invest in new technology and innovations. 4. NAMAF at the moment is not as effective as it should be. The PO's of the funds have to have their own forum to be able to make decisions for the sustainability of the funds as NAMAF is not fulfilling this role. 5. NAMFISA also plays a role in the mismanagement of the funds specifically in terms of the benefits. The benefit reductions is part of managing the funds and ensure its sustainability and yet NAMFISA, in most cases decline approval of benefit reductions.
21. Implementing protocols, strategies for cost control, clinical auditing of hospital accounts are some of the important areas, which need attention.
22. Board of Trustees should always ensure that Funds decisions are balanced to benefit both members and the fund but should always innovate to remain relevant.

23. POSITIVES: 1 Given the retention of members during the past 3 years funds have generally succeeded in maintaining a base of membership that should provide sufficient risk pooling capacity to achieve sustainability. 2 The recent establishment of the Independent PO Forum to represent Funds is a positive action although not formally organised and lacking in a resourced secretariat. NEGATIVES: 1 An extended period without a functional representative body that can lobby and engage with other important stakeholders who impact the private funding industry in Namibia. Specific stakeholders that impact the private funding industry who should be engaged with include but are not limited to the MOHSS, HPCNA, the Medical Associations, the NMRCC and the two direct regulators NAMFISA and NAMAF. 2 The collective expertise of individual Boards is impacted by the ability to commit sufficient resources (time) to their fiduciary role of being a trustee which is limited. 3 Trustees are frequently employees who are placed on Boards as employer representatives to represent employer interests or are volunteers with skills that are useful. 4 Trustee remuneration is inadequate to attract upper level executive expertise to join Boards and is also inadequate to reimburse trustees for the liability that they accept as trustees.

24. The ability to manage is proportional to the relevance of the expertise and experience that a Board of Trustees Collectively bring to the management of a medical aid fund. Current remuneration does not reward sufficiently for the risks and responsibilities of being a trustee and as a consequence high calibre commercial or corporate leaders are not generally associated with medical aid fund boards of trustees. The nonexistence of a medical aid fund representative body that can lobby and engage as the voice of the funds with stakeholders such as HPCNA, MOHSS, medical associations, and the 2 regulators NAMAF and NAMFISA is a significant constraint on the ability of the funds to manage their environment In their collective interest.

25. The funds manage as well with the exception that over excessive HP claiming unreasonable 3x more tahn the guideline need to be identified and funds need to address them harshly.

26. Please motivate your answer? - The ability to manage is proportional to the relevance of the expertise and experience that a Board of Trustees Collectively bring to the management of a medical aid fund. Current remuneration does not reward sufficiently for the risks and responsibilities of being a trustee and as a consequence high calibre commercial or corporate leaders are not generally associated with medical aid fund boards of trustees. The nonexistence of a medical aid fund representative body that can lobby and engage as the voice of the funds with stakeholders such as HPCNA, MOHSS, medical associations, and the 2 regulators NAMAF and NAMFISA is a significant constraint on the ability of the funds to manage their environment In their collective interest.

27. Administrators have been allowed to assume too much authority and power in managing Funds. PO's need to actively take up full responsibility of their roles and provide the required support and expertise to empower Trustees to effectively fulfill their fiduciary duties.

28. Information, data and all relevant information are at one place and quick retractable. Problem solving is very quick.

29. At the moment is a singular person decision and most is left at hands of the administrator. The Principal officers are man decision makers from what i have observed.

30. The Trustees and the PO are honestly doing their best put all factors in in place.

31. There is proper governance in the Medical Aid Industry and up to the minute checks and balances at all times.

32. Not restructuring but the way in which decisions are taken without conflict of interest. The lack of skill and expertise in terms of how to identify solutions and interventions and how these are to be implemented. Urgent review of how things are done have to be considered as it is not working

33. Lack of industry collaboration in addressing common challenges i.e. code and rules, FWA, provider engagement, ICD-10 code implementation.

34. N/A in Namibia

35. * Don't understand the question. None of the medical aid funds in Namibia are under self-administration. * Management of MAF's need to serve in the best interest of their members. * There is a big responsibility to guard against potential conflict of interest. * Funds are currently relatively well managed but their financial stability and solvency are exposed to the impact of external decision makers such as MoHSS, HPCNA and NAMAF in providing registration and licensing of a multiple of new facilities and providers before a thorough needs analysis or impact analysis for additional new facilities have been done. * Trustees are not industry experts, yet they are expected to make (and do make) decisions and are part of decisions that hold significant unintended and unforeseen consequences. * Trustees length of time on a Board of Trustees is normally of a limited duration. * Their principal responsibility lies in their normal day-to-day jobs from which they derive their normal income. * The relationship between Medical aid funds and their administrators should be that of a partnership - not an "us" and "them" relationship. * Tendency by NAMAF and NAMFISA to exclude administrators from participation in discussion forums not constructive or conducive. *

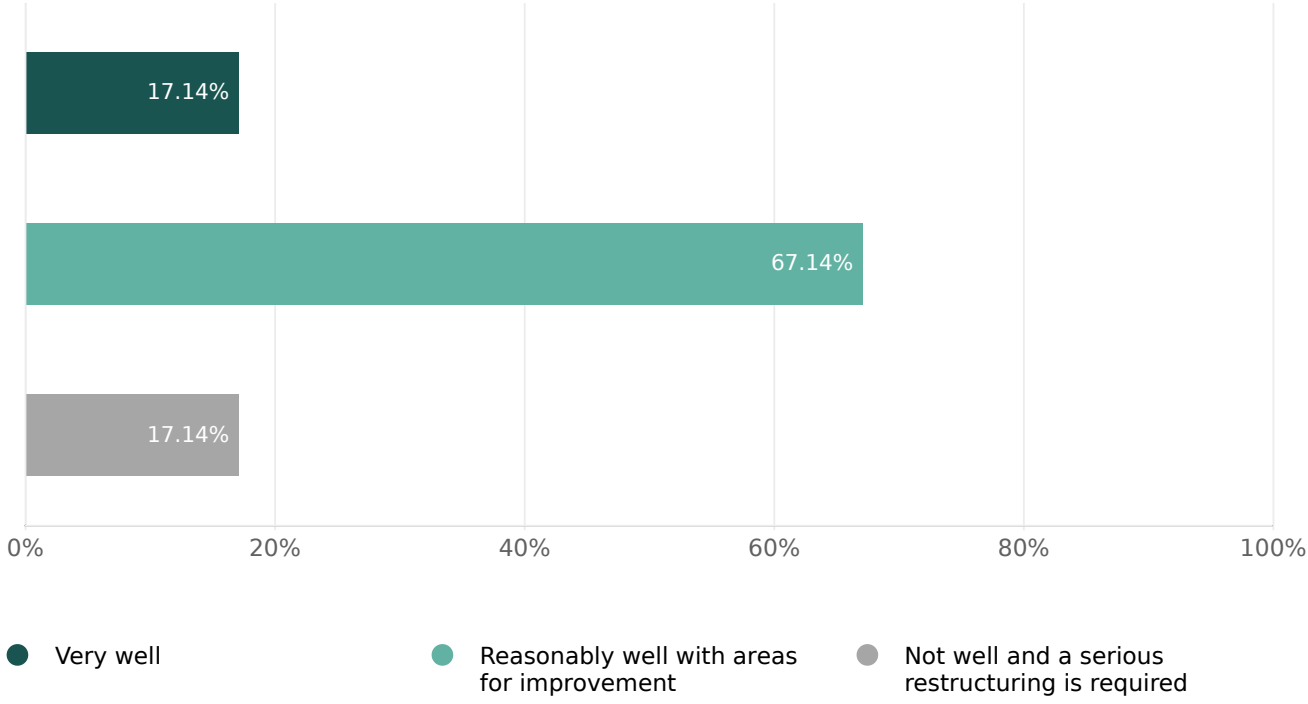
36. the Board of Trustees and PO's rely on the administrators for knowledge, advise and support, systems and skill - as it should be.

37. There is a lack of understanding of roles of Funds as the agents are managing and driving their own agendas through PO's.

38. The reliance on the administrators put the Trustees and PO at huge risk, as they don't prescribe to the administrators which systems to purchase or use, recruitment of competent staff yet they administer the fund's affairs on a daily basis. FIMA puts that responsibility back to the trustees and PO.
39. All funds are at risk at the moment, claims are still very high.
40. Funds are overall managed well by capable people who understand the industry.
41. The Administrators have to much say and I think often the trustees on the boards do not know enough. There is too much reliance on what the administrator is saying.
42. No misappropriation of funds or behavior that is contrary to Corporate Governance Principles has been reported or that I am aware of. I far as I know Funds have been receiving clean NAMFISA inspection reports YoY, with very minimal comments for correction recommendations from NAMFISA. Very high standards of ethical leadership are applied wherever i have been involved and possible red flags are pro-actively raised and aadressed before impacting the funds negatively. The financial performance in terms of reducing reserves is mostly due to unregulated providers in Namibia and in my opinion, it cannot be used as a yardstick to judge Funds in terms of good governance.
43. Fiduciary compliant and most are solvent at best.
44. Due to some tome higher turn over of qualified staffs and experience staff are costly and hard to find
45. Co-payments should be capped and a law to control medical costs should be implemented to prevent specialist from overcharging.
46. ADMINISTRATORS ARE NOT COMPLETELY MANAGEMENT BY THE FUNDS
47. Funds are relatively well managed and in compliance with regulatory requirements.
48. Agreements and management of high-claim areas should be better addressed as an industry.
49. Information shared with the Trustees are detailed and comprehensive for them to make informed decisions. The only dilemna currently being faced is that the claims costs are spiraling out of control due to increase in Specialists and increase in lines per claim from HCP's.
50. I think Medical Aids are trying their utmost best to manage the funds to the best of their ability.
51. The board of trustees of the funds does not have adequate knowledge of the medical aid industry.
52. Medical Aid Funds started to engage with each other through the IPO which is successful as it is a forum where POs engage with HCP and it is a focused driven forum and deliver results.
53. Look at benefit restructuring options to suit various income brackets.

How well do you think Medical Aid Funds are being managed by Medical Aid Funds' **administrators** at the moment?

Answered: 70 Skipped: 17



Choices	Response percent	Response count
Very well	17.14%	12
Reasonably well with areas for improvement	67.14%	47
Not well and a serious restructuring is required	17.14%	12
Please motivate your answer?		47

Please motivate your answer?

1. Administrators should block fraudulent practices where specific fraud / over-servicing is identified and DIRECT PAYMENT to such practices must be blocked/stopped. Payment to go to the member.
2. Case managers and claims assessors need much more training and understanding of diagnoses' as well as coding. Client advisors need education on Fund Rules as well as ensuring correct claiming information is given. Marketing needs to concentrate on benefits more than cost. Funds should compete on benefits not premiums.
3. I think we all need to improve in various fields, this is a sustainability issue and one need to look at ways to sustain the industry without making funds unaffordable for the future. Funds are already so expensive. The legislation of the country needs to change to support the medical aid fund act the same way it is done in SA. This allows for claw-backs and other forms of punishments the funds can use to get money back from past offenders.
4. Technology is very poor, current systems are very manually driven and outdated. The administrator should be there to oversee and manage the rules of the fund, however, the case seems to be different. The personal relationships between the fund managers and the administrator’s managers have the potential of blurring accountability and excellence in matters concerning decision-making from the administrators. It appears that the administrators are left to make the rules.
5. All Medical Aid Funds have proper service level agreements in place. NAMFISA puts a lot of responsibility on Boards to make sure that the day to day administration is done well.

6. strengthen capacity to detect potential fraud and double claims by service providers. Improve communication between Trustees and Administrators.
7. Competence is lacking in the administration. The identified errors, and fraud are mostly coming from the administrators side.
8. Greater emphasis needed on technology-based decision support systems enabling improved healthcare cost management.
9. Inefficient claims assessing, lack of knowledge of diagnosees and medications by Managed health care staff. lack of communication between Funds PO,s Trustees. lack of training of client services
10. Lack of capacity to manage the clinical risk of funds. Lack of skills to adjudicate claims in compliance with procedure coding guidelines and managed care organization protocols. Tanking ownership about the state of affairs covered by their responsibilities - more seeking to blame others for the state of affairs the funds they are managing is finding themselves in
11. Cost-efficient administration. Progress is made with the implementation of clinical risk programs and pro-active FWA management tools
12. Administrators are agents of Funds/service providers and as such should not manage Funds.
13. Based on information provided to the Funds.
14. Are administrators really doing all they can to identify fraud, waste and abuse? Are their systems geared to identify fraud, waste and abuse?
15. Administrators comply to the Fund Rules and NAMAF guidelines but from an operational and internal control management there will always be areas to improve or to keep up with technology
16. Administrators who ought to be the gate keepers are only processing claims.
17. Administrators should understand their role = they are contracted to fulfill the medical aids' administration functions, not trying to be the PO's or the decision makers, that's the trustees & PO's function. Their fees should also be looked at.
18. There are concerns on the way administrators are managing the funds that require urgent attention: 1. Uniformity in the application of the NAMAF billing rules and guidelines. 2. Correct interpretation and application of the NAMAF billing rules and guidelines. 3. Improved management of FWA, stricter approach and collaborative on the FWA. 4. Improved clinical management aspects in fund administration.
19. Administrators should work together in combating hospital costs and over billing from most HP.
20. Administrators will generally ensure that Funds and members' interests are considered but should always strive to improve administrative offering/operations
21. To the degree that administrators are engaged in the management of the Fund they contribute to the success of the Fund. This various from Fund to Fund but no Board has the expertise to manage their Fund without the input and participation of the administrator. Without knowing whether this aspect is addressed later, the third leg of the management "triumvirate" is the PO function. Again the relationship between the PO and the Administrator impacts the level of responsibility in managing the Fund that the Administrator is delegated. Effective management of a Fund depends on the quality of interaction and understanding of the various roles of the Board, the PO and the Administrator to create joint and several accountability for the performance of the fund.
22. The degree to which administrators participate in the management of Namibian medical aid funds is known to vary. Frequently the technical expertise necessary to manage their medical fund is largely provided by the administrator and so their participation In guiding and steering the operating decisions of the fund is important. The nature of a medical aid fund with volunteer trustees (not representing a shareholder interest), a Fund employee (The PO) in the role of "company secretary" and a paid administrator (manager/employee) creates a unique triumvirate that need to function in unison and in an aligned fashionIn order to achieve effective management. Not one, nor 2 of the 3 pillars are sufficient to ensure proper effective management, all 3 need to work together and this creates a challenge in answering the question either in relation to the Board or to the administrator.
23. Administrators contribute to the inability for funds to create affordable options within each scope. If the costs of processing claims can be minimized we have already moved into the right direction.
24. Please motivate your answer? - The degree to which administrators participate in the management of Namibian medical aid funds is known to vary. Frequently the technical expertise necessary to manage their medical fund is largely provided by the administrator and so their participation In guiding and steering the operating decisions of the fund is important. The nature of a medical aid fund with volunteer trustees (not representing a shareholder interest), a Fund employee (The PO) in the role of "company secretary" and a paid administrator (manager/employee) creates a unique triumvirate that need to function in unison and in an aligned fashionIn order to achieve effective management. Not one, nor 2 of the 3 pillars are sufficient to ensure proper effective management, all 3 need to work together. The Interdependency of the 3 parties Makes it difficult to provide an answer focused on one of the 3 parties. Without A question on the performance of the PO's Only 2 of the 3 Parties are considered as instrumental in the management of the fund.

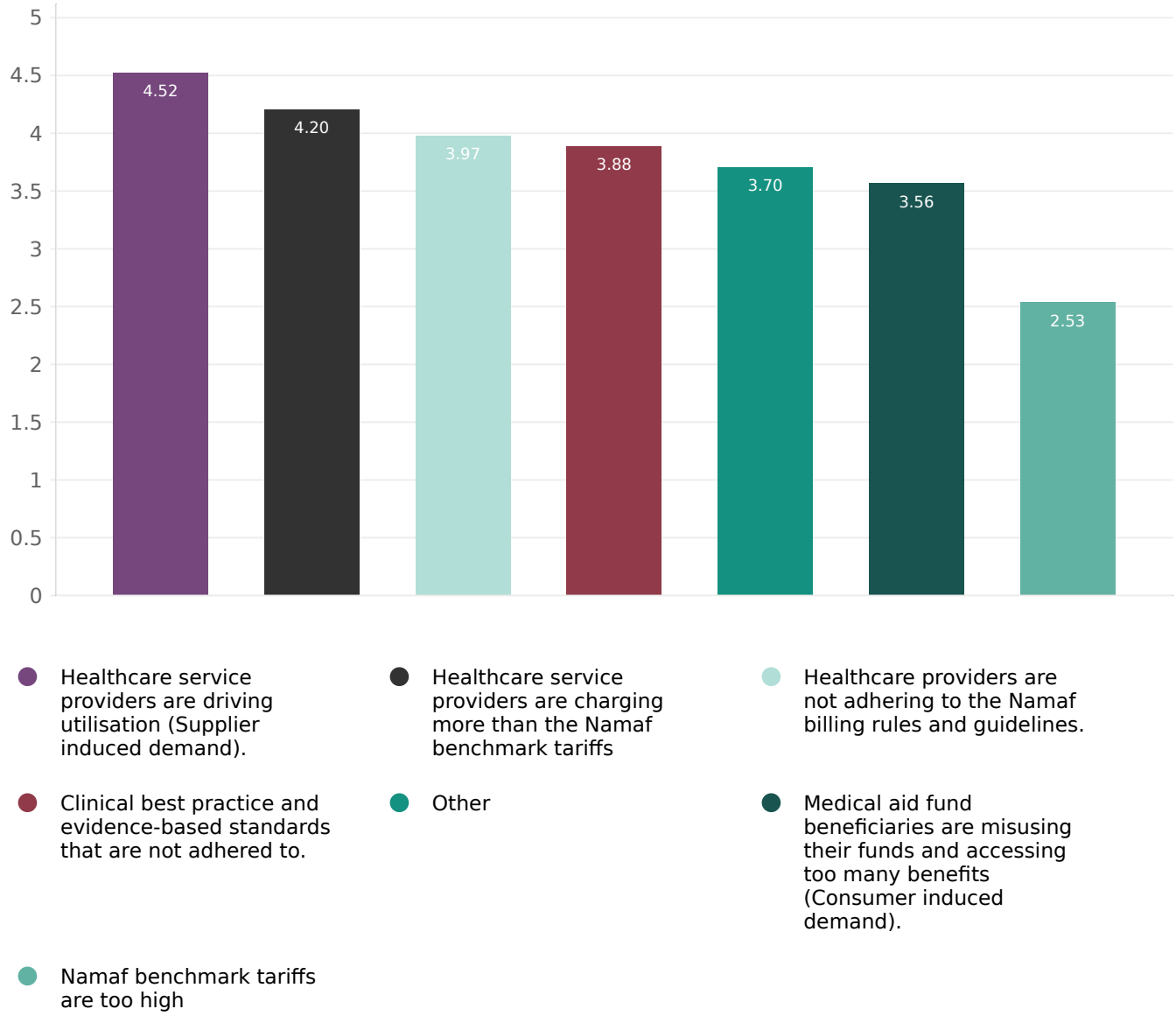
25. A medical aid fund is not supposed to be managed by an administrator. The administrator should only execute the operational functions and management should rest fully on the PO's, with oversight by Trustees.
26. It becomes the system good quality control each one quid one for proper management.
27. This is highly an innovation and technology driven function. The administrator is at the hands of one person to make the most critical cost management decisions for the fund which is a huge risk. Being so long in the industry and made relationships with service providers as an administrator does affect the cost management decisions for the fund as an administrator that is left to control some measures.
28. The Administrator still requires more improvement
29. Good work done by the Administrators but there are some certain areas they need to improve for example sharing some of their systems with the fund trustees.
30. Maybe not restructuring per se but serious improvement is required in terms of internal processes, including decision making, more investment in development of skill and systems. Trust needs to be rebuild with the HCP's. The above at question 8 is also applicable here.
31. 1. Changing technology 2. Lack of industry FWA and provider engagement 3. No common application of Namaf coding and billing rules. 4. Industry decision making to slow 5. Lack of communication/consultation between Namaf and funds
32. The industry needs to stand together, we need to use technology and manage providers better.
33. * Administrators are experts in their field of operations and knows the industry quite well. * Administrators, have a defined scope of operations within which to operate but with limited decision-making powers.
34. FWA can be improved. Industry needs to collaborate on spikes in utilisation and spikes in healthcare cost
35. The Administrators that are agents of Funds are managing them and a profit driven.
36. same views above apply.
37. Same as above.
38. the Administrators dictate how the medical aids work
39. No reported unhappiness or underperformance raised needing Trustee or any other stakeholder involvement.
40. Solid relationships are place, independence and separation required with certain funds and their administrators.
41. some time administrators are not easy controlled by the Funds and as they can manipulate the system to suit them
42. THEY ARE INDEPENDENT AND ARE PROFIT DRIVEN WHEREAS THE FUNDS ARE MEMBER DRIVEN
43. No major issues with administrator even though there is room for improvement especially regarding use of technology and artificial intelligence.
44. Administrators see the real impacts daily and do data analysis to understand the reality better. Controls are excellent that are implemented and the only issue is the claims costs that cannot be controlled due to increased number of Specialists and increased lines per claim from HCP's.
45. The Administrators are doing a reasonably good job, although I thing there is room for improvement with fraud and wasting from both members and service providers
46. The administrators definitely need huge improvements to mitigate the risk of errors, fraud, and abuse.
47. There are areas which require improvement especially claims data analysis to both detect high claims, incorrect coding and detect FWA and overservicing..

What do you think are the main drivers of healthcare inflation in the medical aid funding industry in Namibia?

Rate severity of impact on healthcare inflation.

Highest Score has biggest impact.

Answered: 66 Skipped: 21



Row	1 (Not severe)	2	3	4	5 (Very severe)	Average rating	Response count
Healthcare service providers are driving utilisation (Supplier induced demand).	0.00% (0)	3.03% (2)	6.06% (4)	27.27% (18)	63.64% (42)	4.52	66
Healthcare service providers are charging more than the Namaf benchmark tariffs	3.03% (2)	3.03% (2)	15.15% (10)	28.79% (19)	50.00% (33)	4.20	66
Healthcare providers are not adhering to the Namaf billing rules and guidelines.	1.52% (1)	4.55% (3)	24.24% (16)	34.85% (23)	34.85% (23)	3.97	66
Clinical best practice and evidence-based standards that are not adhered to.	0.00% (0)	4.55% (3)	27.27% (18)	43.94% (29)	24.24% (16)	3.88	66
Other	9.09% (6)	3.03% (2)	30.30% (20)	24.24% (16)	33.33% (22)	3.70	66
Medical aid fund beneficiaries are misusing their funds and accessing too many benefits (Consumer induced demand).	4.55% (3)	6.06% (4)	33.33% (22)	40.91% (27)	15.15% (10)	3.56	66
Namaf benchmark tariffs are too high	19.70% (13)	33.33% (22)	25.76% (17)	16.67% (11)	4.55% (3)	2.53	66
Please motivate your answer							46

Average rating: 3.76

Please motivate your answer

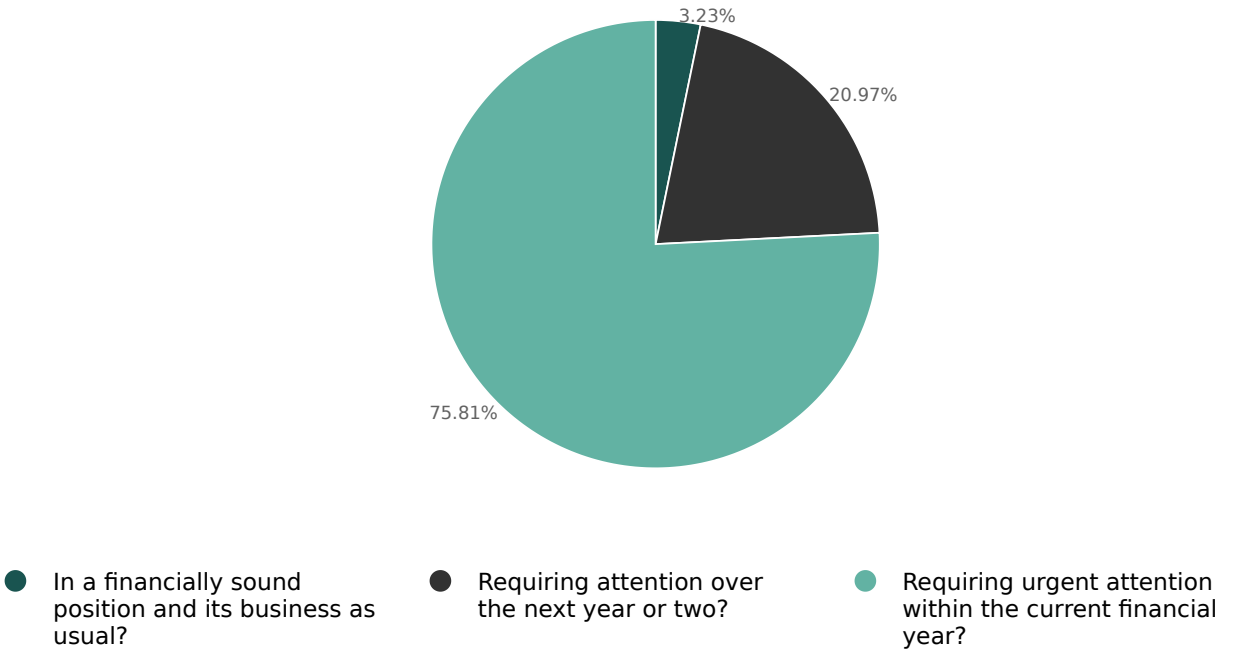
1. The absolute greed for money. A single GP making 15 million in one year shows greed to the next level. The industry seems to be scared to take on Doctors/ Health Professionals and continue to pay such practices directly. Providers such as these in Namibia should be in jail. Namaf needs to stop issuing practice numbers for example a discipline 037 if there are already 10 of these practices in one town. This is bankrupting the schemes. Nothing is being done about these greedy fraudsters, so obviously they continue with over-servicing and conveyer- belt medicines, seeing up to 85 patients per day. Unacceptable.
2. All of the listed issues are of great concern, we are all fully aware that if these trends continue the Industry will not last. Education is the key to addressing member abuse as well as overclaiming. Increase in hospitals and service providers needs to be curtailed, government intervention is desperately needed
3. Specialists and the influx of more and more HCP's in a small country makes the services of patients a necessity to survive. This drives procedures to sustain this the level of previous years income.
4. Too many HCP's that provide services to the Namibian population. The ratio is not ideal and for this reason the rate at which services are provided should be lower because of this huge supply of spesialized servives.
5. In addition - technological advances drives med CPI
6. Good medical insirance products on the market, far less costly than Medical Aod which appeals to the young and healthy
7. Medical aids should challenge providers who contribute to the above and get them out of the system
8. The influx of healthcare providers across various specialities are a key contributing factor for supplier induced demand
9. Hospitalisation is on the increase due to medical practices that has interests in pvt hospitals. Therefore some procedures that should be conducted from Day to Day benefit may now be billed to Hospital benefit.
10. Fraud waste and abuse
11. Medicine markup of 50% for pharmacies should be reduced to be affordable for members and the public in general

12. It is important that NAMAF certify that NAMAF rates are reflective of reasonable costs and medical aids have no need to pay in excess of these NAMAF tariffs.
13. Too many healthcare service providers with too few members; Administrators are too lenient towards misuse and rules and regulations. not being adhered to
14. 1. Service providers are milking the medical aid industry and this is unfortunately a fact. They only think of short term (quick way to gain financially) but not the long term sustainability of the funds. 2. NAMAF benchmarks tariffs need to be reviewed that will not be subject to misinterpretations and argument between service providers and funds. 3. Review of other alternative re-imbursement model requires e.g medicine, global fee instead of fee for service, 4. Member education should be the funds and NAMAF's main drive. 5. Service providers continuously not adhering to the NAMAF billing rules and guidelines due to lack of punitive measures.
15. Unbundling of codes, over billing, over utilization of benefits, e.g. consultations, pathology testing etc. drains the medical aid industry.
16. Lack of education amongst the Members with regards to benefit management and understanding about the impact of misuse by themselves and by service providers.
17. It seems as if the healthcare providers are driving the utilization and increasing the item lines per claim.
18. Providers in some specialty groups have the monopoly as there are only 1 or two, and they charge whatever they want, way above the benchmark tariff. in some cases, members have to pay before the provider treat the patient.
19. Members want to claim every cent the contribute.
20. The HPCNA is an ineffective vehicle through which to to challenge HCPs in respect of FWA incidents. NAMAF does not have an efficient and effective means of dealing with fund complaints and acting against HCPs so FWA initiatives are limited to what individual funds do. This affects the ability to sanction HCPs who may engage in FWA activities.
21. The member are left with no alternative to settle a HP claiming excessively due to lack of knowledge and the administrator / fund advisors conveying that it is out of their hands. Urgent attention need to be given to sustain our medical industry.
22. Important drivers were not identified
23. The increase in the number of facilities and specialists who have entered the market over the past 4 years has contributed to more services being utilised in a classic supply induced demand. At the same time, potential inefficiencies in the assessing processes of funds that contribute to an environment that by allowing Incorrect claiming encourages code farming. The failure of the HPCNA to be and be seen to be a regulated that is able to properly regulate hcp's and is successful in applying sanctions further probably encourages a laissez faire nonchalance to the NAMAF billing guidelines which also contributes to over claiming.
24. The specialist service providers are not control. There must be a regulator to that effect.
25. Poor fraud and theft management systems leading to abuse of funds by service providers and incorrect claims payments. Most cost effective management or control measures are left to clinical decisions that allows room for inconsistencies or easy payments when threatened by service providers.
26. Healthcare providers are milking the cow that feeds them.
27. Health care costs are increasing faster than the cost of goods and services.
28. Claims in general which are not coded correctly, addition of additional claim lines without administrators picking it up / identifying the waste, abuse and potential fraud. Administrators and the industry lack the necessary skill for proper claims adjudication inline with billing rules and guidelines and fund rules. Lack of knowledge on how to identify and manage the above.
29. 1. Lack of communication between Namaf/funds and providers 2. Lack of understanding of providers how funds work, sustainability, drive utilisation 3. Principle of ''use it or lose it'' from providers and members that drive utilisation. 4. Lack of collaboration and joint action on FWA to change provider behaviour
30. 225% for in-hospital services - must be 90 - 100%. The cost of products and services are too high.
31. * Lots of new facilities being registered. * Everybody is in there for a quick buck. * * In some cases there is a conflict of interest between Hospitals and shareholding of referring clinicians. * Lack of ethics in the manner services are provided. * Unnecessary tests and investigations being done. * Member's annual benefits are being viewed as a target to profit from instead of assisting the member to get the best health outcome. Once the benefits are exhausted the treatment also stops. * Provider efficiency is a big issue - poor outcomes are reimbursed at the normal NAMAF tariff. Providers need to be reimbursed according to their effectiveness up to a max. of 100% of tariff. Thereafter external insurance can kick-in. * Peer review and high ethical standards are critical for the continued existence of MAF's.

32. Too many specialist in a very small private healthcare market.
33. Administrators as gate keepers should be interpreting the correct billing rules and guidelines.
34. We need a policy influence with the Minister of Health/Finance for service providers to be regulated or else medical aid members will end up using public funds. The economy is declining and people are experiencing hardship with disposable income. They will choose to exit private funding.
35. Tariffs are high and Healthcare providers are not adhering to NAMAF tariffs.
36. Its at moment a demand and supply environment. If something new could be tried or something more expensive advertises better, then the service providers or members want to use it.
37. Too many specialist sharing a small cake
38. regulators fines have sever impacts on funds financial sustainability
39. No laws perhaps to regulate overcharging.
40. HEALTH PROVIDERS HAVING SHAREHOLDING IN HOSPITALS
41. Members do not understand medical aids and the concept of medical aids not making profits, therefore use their benefits to the maximum and then surprised by the fact that contributions need to increase. I am further of the opinion that benefits are still designed to cover non-essential benefits rather than essential benefits and that need to change. I am further of the perception that healthcare services in Namibia are much more expensive compared to south Africa. A market survey would be interesting to see what for example a physio session costs in SA or dental procedure costs in South Africa compared to Namibia.
42. no further comments
43. Increased supply in the medical market due to influx of specialists and increase in hospital beds. Providers charge in excess of NAMAF tariffs and expect members to pay the out of pocket amounts. Low control over supplier rates for example medicines and now proper NAMAF benefit tariff control over the medicine costs. Providers are getting clever and claiming additional lines per patient thus increasing the claims cost to Funds. FWA is very difficult to combat and providers are not open to understand that they might be claiming incorrectly. Providers overbill frequently either due to a lack of understanding or to obtain additional funds.
44. The absolute majority of service providers are charging more than the Namaf tariffs pushing medical inflation very high
45. Cost of living
46. Although Namibia have too many health care providers in the Country it does not result in competitive pricing in health care costs. It remains high as it could be as a result of agreeing on pricing amongst NCP.

What do you think of the financial position of the medical aid funds in Namibia as a collective? Is it:

Answered: 62 Skipped: 25



Choices	Response percent	Response count
In a financially sound position and its business as usual?	3.23%	2
Requiring attention over the next year or two?	20.97%	13
Requiring urgent attention within the current financial year?	75.81%	47
Please motivate your answer.		37

Please motivate your answer.

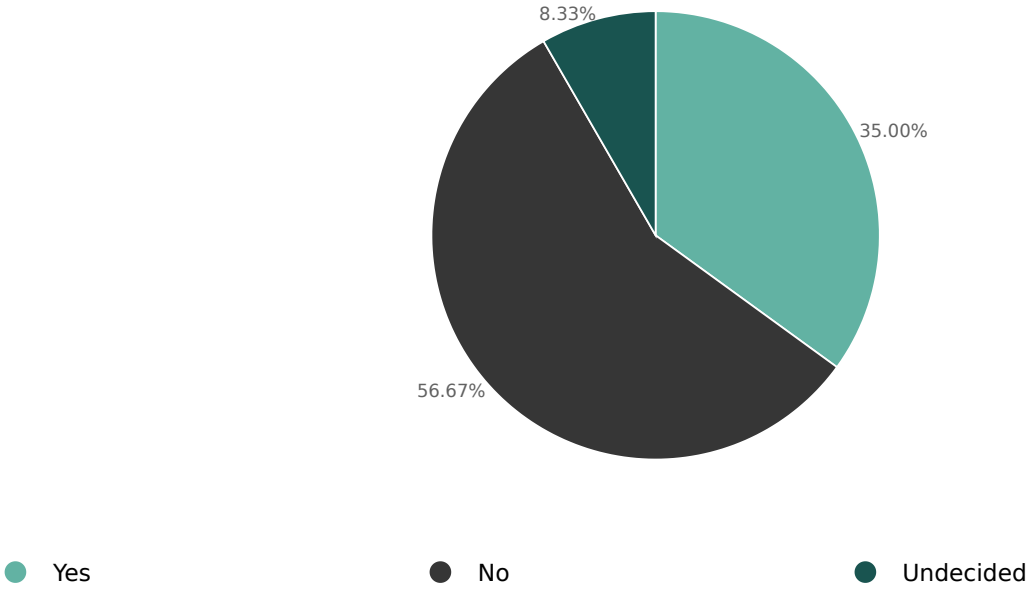
1. Currently some Funds in Namibia are already starting to pay from their Reserves, which is of great concern. If current claiming patterns continue, there will most likely not be Funds in the next 3 -4 years.
2. Claims ratio at 110% accross the board thus exceeding income, reserves being depleted, can only spell disaster
3. There are a lot of things that need to be addressed. Benefits and the reduction of certain costs, cost drivers should be reviewed from the HCP's side and the NAMAF guidelines, with this a law should be implemented to allow for contracted in providers that will only charge Namaf fees, if not, they are not paid.
4. Reserves are build over a long period, but can also be depleted over a very short period and this is what is currently happening. The reserve position of Funds have been fairly good, but given the current scenario, these reserves are depleted at a high rate.
5. 1. Current utilisation a direct result of a post Covid pandemic. Utilisation will normalize during 2024 / 2025 to historic CPI plus 3% increases YoY. 2. NAMF benchmark tariffs are low in certain disciplines and thus, "code farming & manageering" take place as HCP's also faces high cost increases i.e. HR, technology etc
6. Being affected by high claims
7. Increase in claims decrease in reserves No ministerial control over increasing Hospitals and HCP's increase in CPI

8. Latest reports are indicating that medical aid funds are drawing 10% of their claims payments funds from their investments
9. Low reserve levels and high medical cost
10. The rate at which the industry reserves are declining is a severe concern and threated the sustainability of funds in Namibia.
11. Financial stability of the industry is under threat.
12. Medical aid benefits decrease although contributions increase therefore the member gets fewer cover because of financial difficulty of funds that will most probably get even worse in future
13. The claims that resulted following the Covid-19 pandemic has been crippling. Financial sustainability is almost impossible without severe measures being implemented in the short term.
14. Funds are already using their reserves to settle claims. This a red light.
15. The industry is in a crisis and this must be attended to as a matter of urgency
16. There benefits cost control measures that require implementation now and not next year.
17. Claiming vs member contributions is totally out of control.
18. Over the past 2 years the financial position of the funds has been challenged by high claims, affecting sustainability of funds, if this issue is not addressed now, funds will cease to exist.
19. If the 2022 loss ratio occurs again in 2023 then drastic action will be required for funds to avoid dramatic and unaffordable contribution increases. The risk of a spiral of losses, increasing contributions and membership losses if the industry does not achieve break-even in 2024 is extremely high.
20. The culture nursed within our industry to allow practices to abuse the system and the administration process thereof not proactively blocking / rejecting such behavior will result in an entire downfall within our Healthcare industry.
21. Clear indication that claims ratio is following the pattern before Covid with exponential increase
22. The absence of a industry representative body that can effectively enlighten and therefore influence policymakers since independence has contributed to a situation where The industry requires urgent collaborative action to prevent "a perfect storm" of increasing claims ratios, forcing increases to contributions above CPI and resulting in a loss of members ultimately reducing the size of the risk pool and potentially triggering a death spiral.
23. The health care industry in Namibian is highly commercialized and current regulations are weak. Not, fully sure how the funds reserves are but by learning from Bankmed serious attention is required.
24. Claims are extensively high and this influence the Funds financial position.
25. Because hospital utilisations are very high and the fund reserves are diminishing speedily.
26. The rate at which utilization and healthcare inflation is increasing, immediate action is required (for which there are various interventions that can be implemented immediately) but will also require ongoing intensive attention over the next 3 to 5 years.
27. Considering the change in claims trend post Covid lock down, utilisation and influx of providers the ''run'' in the bounce back in 2021, 2022 and YTD 2023 cannot continue.
28. We need to bring medical cost and utilization down to stay in the game.
29. * The issues that have caused the problems are extensive and has been created over a number years and cannot be solved in the current year. * Be carefull of knee jerk reactions and the law of unintended consequences. * Important thing is to communicate with members and providers and explain the problem. * Identify realistic solutions which is in touch with reality - not a pie in the sky or make believe solutions.
30. a loss of more than 20% of reserves in a very short period of time required urgent interventions
31. Same views above apply
32. Claims are getting out of hand and reserve levels of the industry are fast reducing whereby the sustainability of the Funding industry is at risk.
33. Reserves under sever strain at the moment, claims are very high at the moment.
34. Reserves are in a decline, and if it is not paused or turned around, the future seems quite bleak.
35. Funds have already used in excess of 10% of their Reserves to cover the claims ratios of 110% in 2022. 2023 shows the same trends, thus if something is not done urgently, the MAF's will have +-3years to exist before reserves are depleted.
36. Funds are bleeding, utilization has surpassed revenue collection. I don't think the funds are financially sound.

37. The sustainability of the Private Medical Aid Funding industry is under threat and if it continues as currently, there might not be a Private Funding Industry in the next 4 to 5 years or earlier.

Do you think that lowering the Namaf benchmark tariffs is a feasible option to address the medical aid funding industry's financial position?

Answered: 60 Skipped: 27



Choices	Response percent	Response count
Yes	35.00%	21
No	56.67%	34
Undecided	8.33%	5
Please motivate your answer.		42

Please motivate your answer.

1. It will definately help. For example : decrease tariff 0119 from R707. to R300 . R300 is more than enough to drive from your house in Ludwigsdorf to Kleine Kuppe. Doctors and other HP's are spoilt in Namibia. Getting rich should not be your number one focus, the care of the patient should be.
2. Yes yes yes!!!
3. Currently the supply of HCP's is large and based on economies of scale, prices should come down, but this is not the case in Namibia. Due to the large demand for these services uitelisation drives this increasing costs.
4. Will certainly lead to a. provider induced usage. Fraud & abuse. b. member dissatisfaction. c. Potential litigation against Funds
5. NAMAF fess are not the cause of the high claims and cost
6. HCP's will simply increase claims lines and adjust co payment from member
7. We need to limit coding available to Providers because up coding is a big concern and Medical funds should lower % payment based on Namaf tariffs
8. The lowering of the NAMAF benchmark tariffs is an important short-term measure to ensure funds sufficient time to implement utilisation interventions to ensure the longer term sustainability of funds.
9. If the NAMAF tariffs are lowered, the members will have to settle the difference because the service providers will not lower their prices, If NAMAF tariffs are made compulsory, then it might work
10. At least in the short term it is expected to bring down costs.

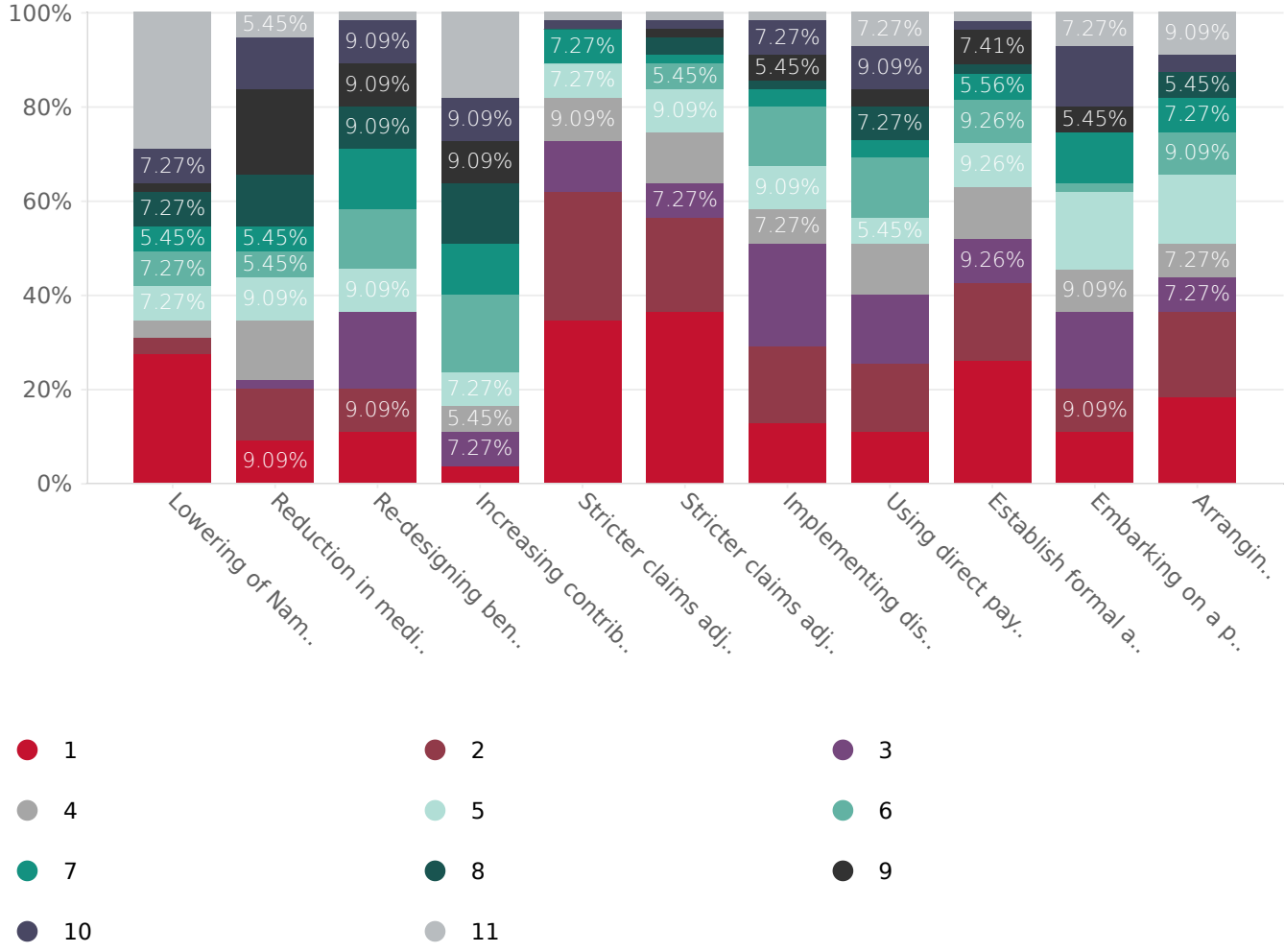
11. NAMAF Tariffs are just benchmarks.
12. Providers will still bill whichever they want despite lower tariffs as they are complaining with the current tariffs as it is. Very few will accept lower tariffs therefore contracted providers is the future willing to accept a lower tariff
13. But only if it is informed by adequate research and that suggested tariffs represent a cost reflective tariff.
14. Namaf benchmark tariff are a mere guide and not mandatory.
15. That will just cause more out-of-pocket and co-payment challenges.
16. However, this is not going to work 100% if the service providers will just add item lines on their accounts.
17. There are far more factors involved than NAMAF tariffs only.
18. This will not solve the over utilization but will additionally harm the member who at most time is left with no choice but to pay, because he/shee needs the medical service. This member is already exposed to the financial strains brought about by the increasing cost of living. I believe that one thing that will have an impact ultimately to the industry financial position is member education, funds and NAMAF need to teach the members how they can reduce their medical aid utilization unnecessarily as well as questioning the service providers on overutilizing. Red flagging and warning those service providers and eventually revoking their licenses.
19. the provider will just inflate the fees more, and the members will have higher co-payments.
20. reviewing tariffs to avoid tariffs encouraging cost inflationary behaviour (hospitalisation) is a potential action that could assist in containing costs. Reducing tariffs is likely to lead to increases in co-payments which will impact members so may be counter productive.
21. It is not the tariff but rather the lack of adherence to stick to the prescribed tariff guideline.
22. The Health Care Professionals' tariffs are not the cost driver
23. The most probable consequence is that members will face greater copayments If tariffs for services are reduced. If the financial performance of funds requires improvement and there is little scope to increase contributions by more than CPI and operating costs of funds are relatively well managed then the 3rd element of the equation namely claims paid needs to be addressed as the only significant variable with leverage to improve the industry performance. To reduce claims without increasing co-payments the industry may need to reduce benefits so that benefit limits are reached by more members more quickly. The probable consequence will be more funds receiving more ex-gratia applications but the nature of the ex-gratia applications is that they can be managed albeit with more effort and judgement than normal monthly claims.
24. I think cleaning the house from the inside is the best option to start with. In my view abuse and misuse is biggest threat. Strengthen the fund rules, put proper regulations in place (registration of service providers by NAMAF), uni-formal reimbursement protocols across funds. Improve technology and innovation
25. collectively the Funds can work out a suitable position
26. alternative tariff setting organization - representative of providers, GRN, Namaf and Funds
27. The lower the Namaf tariffs the better the Medical aid industry can be controlled because even specialists should adhere to the approved Namaf tariffs.
28. The funding industry will receive a huge backlash from HCP's given the current prevailing economic circumstances. Further, this might worsen access to healthcare which will negatively affect the member. The HCP will pass the shortfall to the member as a co-payment and might cause inappropriate billing practices and overservicing. Maybe one should consider not to increase the benchmark tariffs than to rather reduce it, but intensive stakeholder engagement (1 0r 2 letters or webinars will not be enough and can't be seen as proper stakeholder engagement - a lot more must be done in this regards) will be required where trust is build and where the HCP and the member understands why the decisions are taken. Collaboration between Funds and HCP's will be required in this case. If claims patterns and utilization does not improve then one might have to consider decreasing the benchmark tariffs. HCP's might be more willing to cooperate at no increase than a decrease in benchmark tariffs.
29. It will only increase the co-payment carried by members. At the current Namaf benchmark rate it is already one of the main reasons for the increase in co-payment/out-of-pocket expenses carried by members
30. The providers have to lower their fees as a small % of members can afford to pay the members portions.

31. * It is a benchmark tariff - individual MAF's can reduce their rate at which they are willing to reimburse. * If MAF's collectively reduce their benchmark tariffs then it will be tantamount to collussion or an unfair business practice. * A tier-based reimbursement rate based on effciencies and outcomes based treatment would be much better. Higher reimbursement rate for first time problem identification and solution - and providers who have less return patients.
32. Definately on in hospital treatment and services
33. The difference will either be recovered from the members through out of pocket payments or the service providers will over service and claim more on the invoices for procedures not done.
34. This will bring about only more out of pocket expenses for the medical aid members
35. Current NAMAF Benchmark tariffs are high because they are not evidence-based but only based on previously set tariffs as agreed by Funds.
36. It’ll change behaviors
37. the cost of service provider are very high and continue increasing on annual basis.
38. It may not change behaviour, migh make it worse
39. IT MIGHT HAVE A IMPACT BUT IT SHOULD BE A HOST OF INTERVENTIONS TO ADDRESS THE CURRENT FINANCIAL POSITION OF THE INDUSTRY
40. with measures in place to limit out of pocket to members.
41. However this might create out of pocket expenses for members which one must be cautious towards. But this will be a first step, especially for hospitals and medicines. One must thereafter keep track that the HCP's do not continue or start billing additional lines to make up for the deficit.
42. The benchmark tariffs are already at minimum. I think addressing utilization will help lower the financial position. The year 2020 is a true reflection of the above statement. MAF recorded savings because utilisations was low due to lockdowns & covid.

Prioritise the following potential interventions to address the financial situation that the medical aid funding industry is finding itself in, in order of priority (Rank 1= most important, 11 = least important) and indicate the time period of implementation (Short/Medium/Long).

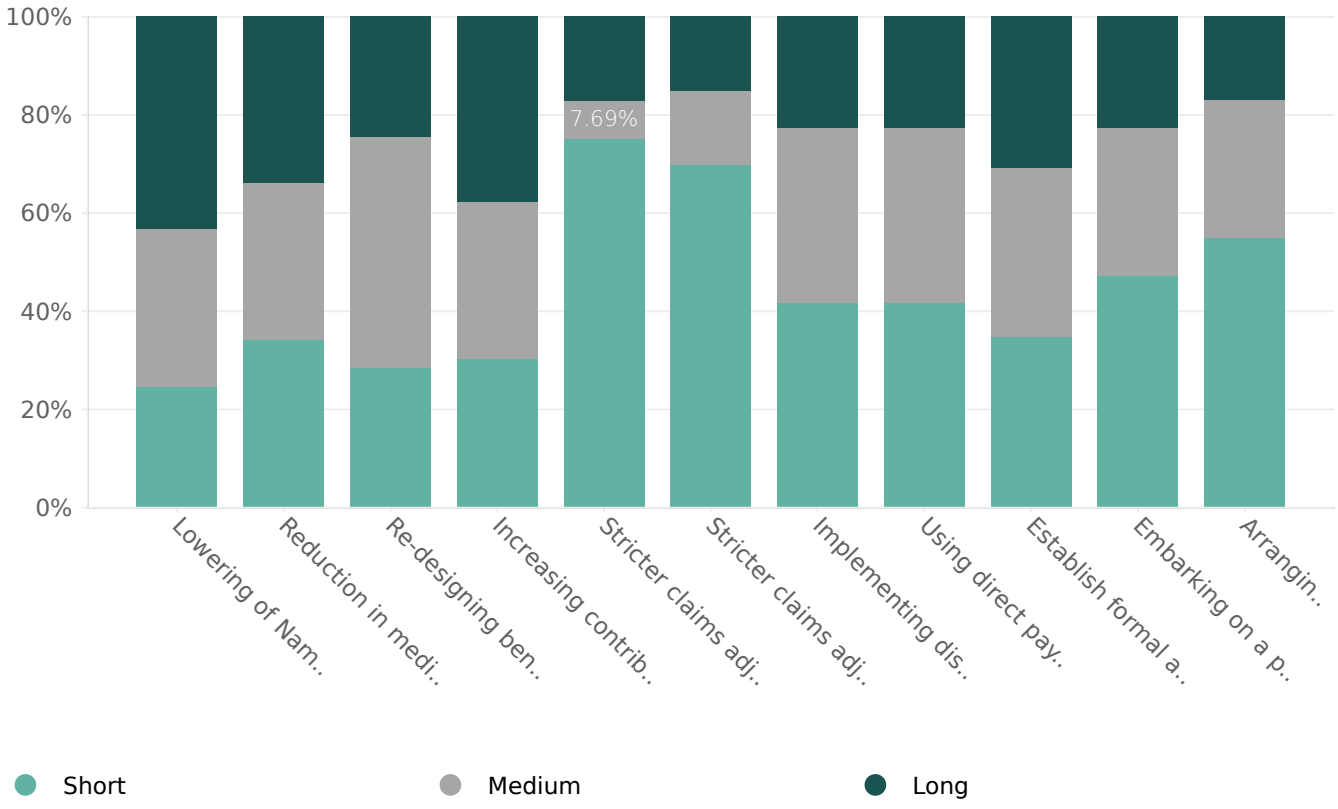
Answered: 55 Skipped: 32

Rank Importance



Row	1	2	3	4	5	6	7	8	9	10	11	Response count
Lowering of Namaf benchmark tariffs	27.27 % (15)	3.64% (2)	0.00% (0)	3.64% (2)	7.27% (4)	7.27% (4)	5.45% (3)	7.27% (4)	1.82% (1)	7.27% (4)	29.09 % (16)	55
Reduction in medical aid fund benefits	9.09% (5)	10.91 % (6)	1.82% (1)	12.73 % (7)	9.09% (5)	5.45% (3)	5.45% (3)	10.91 % (6)	18.18 % (10)	10.91 % (6)	5.45% (3)	55
Re-designing benefits and introducing co-payments to create member disincentives	10.91 % (6)	9.09% (5)	16.36 % (9)	0.00% (0)	9.09% (5)	12.73 % (7)	12.73 % (7)	9.09% (5)	9.09% (5)	9.09% (5)	1.82% (1)	55
Increasing contributions (Applying interim contribution increases)	3.64% (2)	0.00% (0)	7.27% (4)	5.45% (3)	7.27% (4)	16.36 % (9)	10.91 % (6)	12.73 % (7)	9.09% (5)	9.09% (5)	18.18 % (10)	55
Stricter claims adjudication with rejection of claims that do not comply with clinical best practices	34.55 % (19)	27.27 % (15)	10.91 % (6)	9.09% (5)	7.27% (4)	0.00% (0)	7.27% (4)	0.00% (0)	0.00% (0)	1.82% (1)	1.82% (1)	55
Stricter claims adjudication with rejection of claims that do not comply with the Namaf billing rules and guidelines.	36.36 % (20)	20.00 % (11)	7.27% (4)	10.91 % (6)	9.09% (5)	5.45% (3)	1.82% (1)	3.64% (2)	1.82% (1)	1.82% (1)	1.82% (1)	55
Implementing discount arrangements (e.g. discounts in return for shorter payment cycles)	12.73 % (7)	16.36 % (9)	21.82 % (12)	7.27% (4)	9.09% (5)	12.73 % (7)	3.64% (2)	1.82% (1)	5.45% (3)	7.27% (4)	1.82% (1)	55
Using direct payments to members as a mechanism to manage provider behaviour.	10.91 % (6)	14.55 % (8)	14.55 % (8)	10.91 % (6)	5.45% (3)	12.73 % (7)	3.64% (2)	7.27% (4)	3.64% (2)	9.09% (5)	7.27% (4)	55
Establish formal and legally binding industry arrangements between medical aid funds (as a collective) and healthcare service providers (with associated incentives and disincentives).	25.93 % (14)	16.67 % (9)	9.26% (5)	11.11 % (6)	9.26% (5)	9.26% (5)	5.56% (3)	1.85% (1)	7.41% (4)	1.85% (1)	1.85% (1)	54
Embarking on a public relations campaign and appealing to medical aid fund members to claim less.	10.91 % (6)	9.09% (5)	16.36 % (9)	9.09% (5)	16.36 % (9)	1.82% (1)	10.91 % (6)	0.00% (0)	5.45% (3)	12.73 % (7)	7.27% (4)	55
Arranging provider meetings and appealing them to help reduce expenditure.	18.18 % (10)	18.18 % (10)	7.27% (4)	7.27% (4)	14.55 % (8)	9.09% (5)	7.27% (4)	5.45% (3)	0.00% (0)	3.64% (2)	9.09% (5)	55
Any other suggestions?												19

Time period of implementation


100%
80%
60%
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7.69%
Lowering of Nam..
Reduction in medi..
Re-designing ben..
Increasing contrib..
Stricter claims adj..
Stricter claims adj..
Implementing dis..
Using direct pay..
Establish formal a..
Embarking on a p..
Arrangin..
Short
Medium
Long

Row	Short	Medium	Long	Response count
Lowering of Namaf benchmark tariffs	24.53% (13)	32.08% (17)	43.40% (23)	53
Reduction in medical aid fund benefits	33.96% (18)	32.08% (17)	33.96% (18)	53
Re-designing benefits and introducing co-payments to create member disincentives	28.30% (15)	47.17% (25)	24.53% (13)	53
Increasing contributions (Applying interim contribution increases)	30.19% (16)	32.08% (17)	37.74% (20)	53
Stricter claims adjudication with rejection of claims that do not comply with clinical best practices	75.00% (39)	7.69% (4)	17.31% (9)	52
Stricter claims adjudication with rejection of claims that do not comply with the Namaf billing rules and guidelines.	69.81% (37)	15.09% (8)	15.09% (8)	53
Implementing discount arrangements (e.g. discounts in return for shorter payment cycles)	41.51% (22)	35.85% (19)	22.64% (12)	53
Using direct payments to members as a mechanism to manage provider behaviour.	41.51% (22)	35.85% (19)	22.64% (12)	53
Establish formal and legally binding industry arrangements between medical aid funds (as a collective) and healthcare service providers (with associated incentives and disincentives).	34.62% (18)	34.62% (18)	30.77% (16)	52
Embarking on a public relations campaign and appealing to medical aid fund members to claim less.	47.17% (25)	30.19% (16)	22.64% (12)	53
Arranging provider meetings and appealing them to help reduce expenditure.	54.72% (29)	28.30% (15)	16.98% (9)	53
Any other suggestions?				19

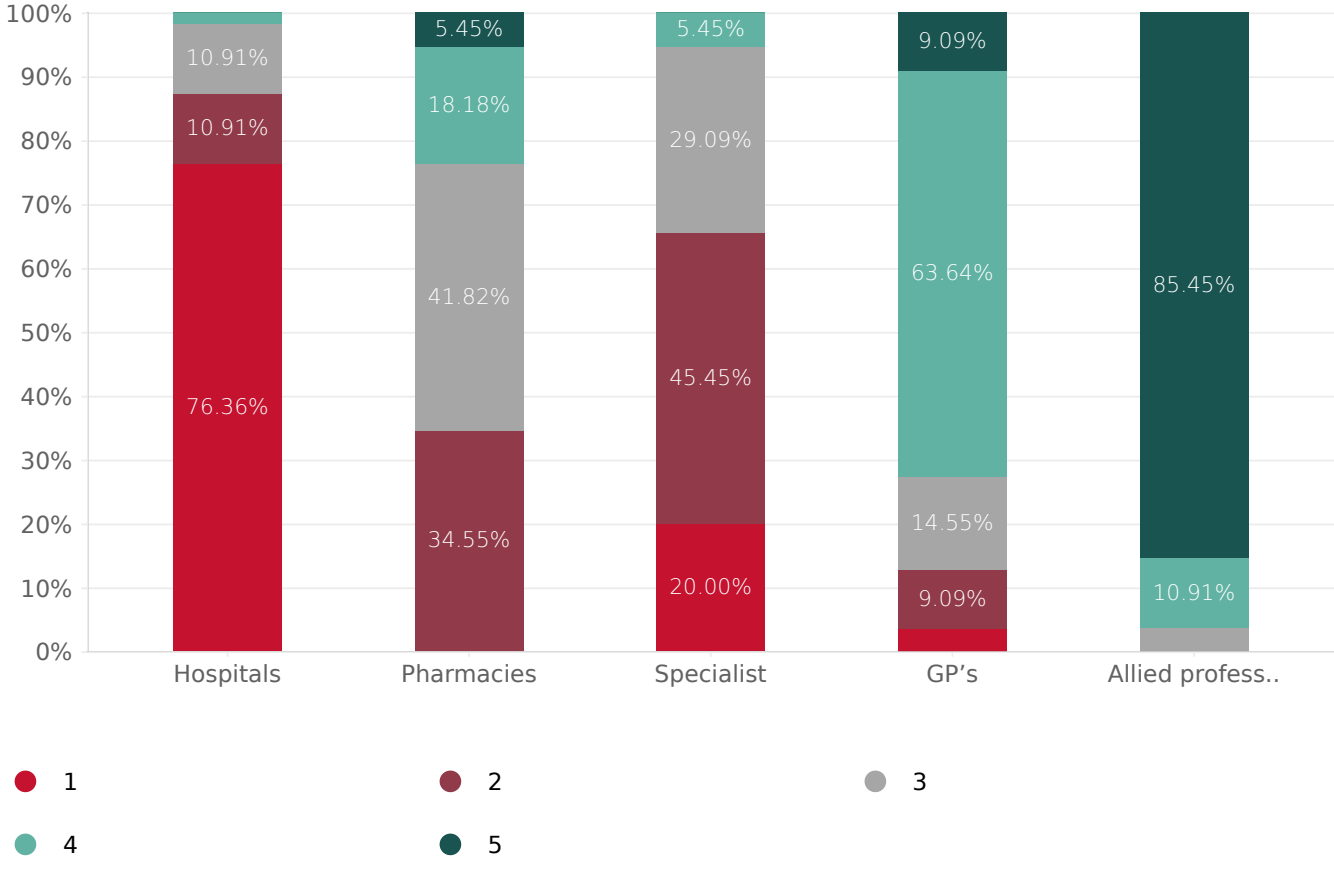
Any other suggestions?

1. None
2. Impose a law directive to allow for medicine price fixing and Namaf fee fixing for HCP's..
3. No
4. Limit Provider registrations in Namibia
5. Consider only registering practices with a PCNS number/NAMAF practice number following a period working at a suitable state health facility.
6. Turn the focus away from facilities towards the admitting HCSP. Prevent accounts, instead of trying to sort it out after it has already been submitted. A facility can't claim without a patient (being admitted by dr.). Identify outliers and convince these individuals to correct their claiming patterns. Do not pay doctors' accounts before hospitals' accounts have not been received - evaluate and correlate the 2 accounts. Enforce better case management. Provide more and better education to members.
7. remove licenses of the service providers that are not changing behavior
8. Minimize costs of processing claims and increase payment cycles will also motivate the industry to comply and adhere to tariff guidelines ultimately allowing the funds to motivate a possible decrease in Tariffs
9. Establish ANMAF (Association of Namibia Medical Aid Funds) as a representative body for Namibian medical aid funds. Use this body to formally reach out to medical associations, the HPCNA and MOHSS and position the low Road & highroad scenarios for the industry. On the basis of these 2 scenarios promote the need for an interagency work group that will encourage and support collaboration in pursuit of sustainable private healthcare (not necessarily private healthcare funding).
10. Improve technology and innovation -Fraud and theft detection systems

11. constant member education
12. Non.
13. We have to revisit/rethink how the funds and members interest will be best served i.e. Namaf's role as a ''regulator'' versus that of a ''member association'' as envisaged in the Medical Aid Funds Act
14. None
15. Active and robust engagement is needed for immediate implementation.
16. None
17. N/A
18. no
19. the public relations campaign should rather aim at educating the public and members to take charge of their visits to HCP and review and question their bills. Members should be made aware of their rights receive statements (consolidated incl copayments from their HCP)

When establishing formal and legally binding industry arrangements between medical aid funds (as a collective) and healthcare service providers (with associated incentives and disincentives), please prioritise the order of implementation of the following disciplines (1 = First and 5 = Last)

Answered: 55 Skipped: 32



Choices	1	2	3	4	5	Score	Rank	Response count
Hospitals	76.36% (42)	10.91% (6)	10.91% (6)	1.82% (1)	0.00% (0)	4.62	1	55
Pharmacies	0.00% (0)	34.55% (19)	41.82% (23)	18.18% (10)	5.45% (3)	3.05	3	55
Specialist	20.00% (11)	45.45% (25)	29.09% (16)	5.45% (3)	0.00% (0)	3.80	2	55
GP's	3.64% (2)	9.09% (5)	14.55% (8)	63.64% (35)	9.09% (5)	2.35	4	55
Allied professions	0.00% (0)	0.00% (0)	3.64% (2)	10.91% (6)	85.45% (47)	1.18	5	55
Any other suggestions?								17

Any other suggestions?

1. None
2. Law driven behavior forced to claim correctly. Introduce the Claw-back system for 20 years.
3. No
4. Incentivize members who claim less, if regulator would approve

5. Note hospitals billed Namaf tariff therefore rated 4 but if lower rates could be agreed, hospitals is a high priority
6. Again the industry is going about this from the wrong way: a hospital can not and does not have a claim without a patient being admitted by a doctor. Start focusing on admitting doctors. Then hospital claims will decrease.
7. We have the capability to implement rule in the forefront before del7vering the claim in real time to our administrators including contributing to the reduction pertaining to the costing aspect for the administrators. We are also willing to partake in discussions with the forum to play our part in ensuring that we do have a medical industry for years to come.
8. Very small chance of success for arrangements with HCP, due to mistrust and non communication historically. Careful to try and manage medicine when the big driver was cleary in Oncology medication.
9. Issue a general background paper to support an invitation for any organised discipline to engage with the collective on proposals to manage healthcare costs in pursuit of the sustainability of private healthcare. The reason for the invitation must be promoted as protecting private healthcare and as a consequence having to protect private healthcare funders.
10. Hospitals and GP as well as Specialist should be implemented hand in hand.
11. Non.
12. If the Specialists and GPs as a first step can change their 'behaviour'' in admitting or treating patients out-of-hospital it will reduce hospital costs
13. None
14. GP are gate keepers Specialists should also try and control costs by looking at what procedures get done in hospital, hospital stay duration and prescribed meds. Pharmacy and Hospital can only do as prescribed by the Drs
15. None
16. N/A
17. None

Please fee free to suggest any other interventions that you would like the workgroup to consider.

Answered: 34 Skipped: 53

1. Doctors involved in conveyer -belt medicines where they are seeing between 70 and 80 patients per day (which is seeing a patient every 7 minutes) should not be allowed to claim directly from any Fund in Namibia. Very easy to identify these doctors / hospitals in Namibia.
2. Look at the future of sustainability from a members perspective that pays a lot of money, what they want, need and what can be offered and a t what price...what is affordable healthcare???
3. None
4. Alternative reimbursement models. Per diem Capitation
5. None
6. Government needs to have a broader understanding of the damage being done to the country by allowing influx of HCP' s and hospitals being built. criteria for Ministry licensing needs to be far stricter
7. Agreed actions should be implemented immediately.
8. Focus should be what we can do in the short term to ensure sustainability.
9. The questionnaire does not touch on fit and proper requirements of governance and managing a medical aid fund.
10. Get the facilities onboard to assist with case management and identifying overutilizers. Prevent unnecessary admissions and ER visits, etc. Correct wrong billing practices. Talk to the individuals that seem to over-service. Create a centralized "collective data bank" from where the whole industry can receive information for planning and correcting. Implement ICD-10 coding as a matter of urgency. It will help with data, planning, FWB, etc.. Run a united education and information drive to inform all members regarding rules, etc. The industry needs regulating (numbers of HCSP's, etc.) We should look at a referral system - members should not be able to go to a specialist directly. Re-introduce PHC as well.
11. 1. Review the MC members of NAMAF that can provide meaningful input in the sustainability of the funds. 2. Go ahead with the project that identifies level of accountability (remember the meeting with each NAMAF committee?) 3. Identify as soon as possible Maggie successor. At the moment, no one at NAMAF staff can fulfill her shoes and all NAMAF billing rules clarification go to Dr Van Zyl. NAMAF should fulfill this role.
12. Standard billing codes per procedure per healthcare professional (GP/Specialists)
13. Prioritize member education
14. Designated FWA unit with teeth within the Namaf secretariat
15. Remove the manual submissions or manual processing of claims, in return advocate 3 day payment cycle thus curbing the HP forum to argue that due to slow payment they are forced to increase tariff fees on own accord. We as a Service provider for real time have all the meganisms (specifications) in place including relationships with vendors to drive the move in return minimizing the costs occurring on the vendor side as well.
16. Reconsider the Benchmark tariffs’ monetary values. If the industry wishes to implement this, the false claims that tariffs are based on “cost plus professional fee”, the tariffs are “negotiated”, “updated regularly after consultation” must be addressed. Inflation adjusted increases are applied. Very rarely anything else. If this forma the basis of negotiations for payment, the foundation must be much stronger and appropriate to be defendable.. There must be a reconsideration whether the point of departure that all HCP’s are “misbehaving”, up to “mischief”
17. To the degree that NAMAF has a role in the private healthcare funding industry it is important that all stakeholders outside NAMAF should provide some input on the degree of faith or confidence in NAMAF as an effective private healthcare industry leader capable of driving and delivering outcomes from the workshop. It may be useful for the stakeholder participants to understand to what degree there may be a lack of confidence or credibility in the process that is going to carried out. A little self reflection on and about NAMAF could be important to provide a rounded perspective for the workshop participants. The establishment of ANMAF as a purely representative body has been referred to already. The reason that this needs to be considered is the fact that serious questions can be asked whether NAMAF has a sufficiently positive reputation and the credibility to engage with other stakeholder groups in a constructive manner. The negative perception of NAMAF by HCPs is widespread and with disillusionment frequently comes distrust so there will have to be careful thought how to present any collaborative proposals to ensure a probability of cooperation and success. It is recommended for the first 2 day workshop that it is imperative to have some data or information providing a profile of the: 1 Level of understanding HCPs have of the current situation of the healthcare industry. 2 An indication of any recommendations that the HCPs may have. 3 an indication of the level of trust/ambivalence/distrust the HCPs individually or by association have in NAMAF.

18. 1. Rebuilding a collaborative relationship between NAMAF and Funds to work together towards the sustainability of the industry.
19. Health care is critically in the hands of the Service provider. It is a very challenging issue for funds to control. Therefore, this should be done hand in hand with the lawmakers. The lack of support from the government, and lack of national policies to regulation of Health care providers within the industry is the biggest problem. Only if engagement in State-private funds- conversation is not a dream, the related regulatory framework can be achieved. Most of our leaders belong to the public service medical aid and this does not affect them at all. Members education is highly underestimated, having an experience in community engagements and education - Do not underestimate members' education. There is a need for more youth attractive packages within the existing funds. I hope the above does not sound more like politics.
20. Nothing for now
21. Non.
22. It will be to the advantage of Namaf and funds if we have an open discussion on the engagement between Namaf and medical aid funds, Namaf recognising the role and consulting with funds/administrators on critical matters,
23. The HPCNA is not fulfilling their role and therefore we have a lot of practices scope creeping, no peer reviews in place.
24. None
25. The workshop should have been inclusive of all relevant stakeholders. Trustees might not have the day to day experiences of the industry's activities.
26. Price of medicine needs to be looked at urgently and not only implement next year
27. Put pressure on the Ministry of Health for the Medical Aid Industry prices regulation.
28. None
29. to come up with the numbers and types of medical aid funds in Namibia that can be sustainable and mark sound
30. N/A
31. None, but critical that urgent action needs to follow. We have sufficient tools available and now need to get the role players together to implement.
32. Consider a different model such as construction of medical facilities which will benefit funds in a longer term. Sponsoring of medical students' studies with binding contracts to provide services to medical aid.
33. nothing at the moment
34. NAMAF should support the IPO Forum as this is aiming at creating focus drives on the engagements with HCP. It is not intended to replace NAMAF but POs works closely with each other and bring about quick solutions.

The facilitators of the workshop are committed to a completely transparent process. Considering this, please provide any advice that you may have to ensure that (1) the interventions that will be decided upon will gain support by the majority or stakeholders and (2) ensure successful implementation. (All responses will be anonymized)

Answered: 34 Skipped: 53

1. Nothing to add.
2. Namaf engagements takes way too long. Needs to be costed correctly, show a positive outcome for savings and sustainability and remove funds from Namfisa as a regulator, wrong entity for the job. They are dumb and doesn;t look at the medical side only the financial side. This regulator does not know what they are doing, and they handle cases in a strange way.
3. Proper communication and collaboration amongst Funds, HCP's and Members are key in this process. NAMAF should earn the trust of both the funding industry and the HCP industry.
4. 1. Engage providers & members. 2. Be cognisant of effect on members iro implementation of co-payments. Will influence access and result in more severe illness cum hospitalisation utilisation. 3. Be aware of reducing an already low benchmark tariff schedule - will lead to "managering of claims, code farming etc.
5. None
6. ensure legally binding documents with penalties for non-compliance.
7. Should a fund suspect irregularities from a service provider, the support from the authorities is null? We can discuss the sustainability and the actions until we are blue, but no cases in Namibia (to my knowledge) of one Dr. suspended due to fraud.
8. The process should involve funders and providers, resulting in constructive dialogue, to see how the various parties can support each other and create a sustainable healthcare industry.
9. Open communication with all involved parties is critical.
10. Important to recognize every participant as a significant contributor in finding workable solutions.
11. We are all in this together and we should now form a united front to get through this crisis. We should take hands and not work against each other. Involve the HCSP's - the vast majority are here for the long run and would like to work with the funding industry to ensure sustainability. The small minority that is bleeding the industry should be identified and corrected.
12. 1. Get the buy in of the Board of Trustees. 2. Implementation should be made by all, no exemptions. 3. Communicate immediate to affected service providers and members.
13. noted
14. Include at least some representatives of the administrators in the workshop
15. Relook at the processing meganisim in place together with the idea to increase frequent payment cycles bi-weekly and allow us to place in advance rules to verify claims according to industry standard to ensure both ends (HP and Administrators) submit / receive clear and valid data to process including maximize the fraud intervention capabilities post to payment instead of current practice after payment.
16. Better consultation with service providers imperative as there is very poor grasp of the problems they are grappling with. Decisions should be well communicated. A perfect example of what should not happen, is the onesided panick driven lowering of AHB and no communication with affected HCP. This demonstrates total disrespect of Industry to stakeholders
17. NAMAF as workshop organisers should immediately issue invitations to the newly appointed NAMFISA general manager for medical aid funds. This must be a personal invitation and not for a staff member from NAMFISA.Even if the invitation is only for the introduction session and possibly the wrapup session at the end of the workshop the value of being inclusive and broadening the awareness of this effort will be valuable. At the same time similar invitations could be issued to the CEO of the HPCNA and the executive director of MHOSS.
18. Establish realistic timelines and ensure that they are adhered to, through effective implementation of a robust project plan.
19. Public Private partnership or consultation is key. Political support is the language of Africa Do not underestimate the power of those in rural areas. If it can be implemented in the city, it is implementable anywhere in Namibia.
20. More informative engagements
21. Non.
22. Communication and progress updates and including all stakeholders to work in a collaborative way cannot not be overemphasized. Sharing the results of the workshop with the all stakeholders (hcp's and members included)

23. 1. Allow for an equal playing field, respect and for an open and frank discussion. 2. That the any discussion is focussed, and any decision should be what ''will be in the best interest of the member and fund'' and no other interest focus. 3. Limit industry/Namaf politics to play a role and or to influence the openness of discissions. 4. Realise that there may be party(ies) with a conflict of interest. 5. Don't allow Namaf MC to influence the spontaneous discussions or decision making. 6. Ensure that all parties and Namaf accept openness of the discussions and not defend their position. 6. Ensure that Namaf accept responsibility for carrying out tasks and not only delegate it to the consultant. 7. Confirm the commitment of all attendees to any decision making. 8. Realise that implementation may be hampered by the absence of the administrator's management, - conclusions of the meeting will have to be provided to the respective Boards of Trustees - administrators' system and programming that may be required could cause a delay in implementation and or come at a cost? Wish you well with the project!
24. Everybody needs to know that the goose that lays the golden egg is nearly dead.
25. None
26. The implementations of the recommendations could easily be adopted and accepted by all if they could have a stake in the workshop it self.
27. Need the buy-in of the medical service providers
28. Ensure that all interventions are aligned to the best interest of the Funds and ensure collaboration is taking place if synergy seems not to exist on any particular issue to avoid disjointed between NAMAF and Funds.
29. None
30. all stakeholder to work together for common goals and not to compete or undermine each others in the industry
31. Inclusive decision making.
32. Hospital costs
33. I suggest a tracker for the implementation plan.
34. The workshop should be transparent and non biased and aim at keeping it professional and appreciate that all comments is to ensure a Sustainable Private Funding Industry. Rigorous discussions will deliver a good outcome.