29 August 2023

The Principal Officer
Rennaisance Medical Aid Fund
Att.: Ms Esther McLeod
Via Email: rmainfo@prosperitynam.com; tiaan.serfontein@prosperitynam.com

CC: The Registrar of Medical Aid Funds
C/o Mr. Sydney Sikwana Lishokomosi
Via Email: slishokomosi@namfisa.com.na

Dear Ms McLeod

REDUCTION OF BENEFITS FOR IN-HOSPITAL TREATMENT

1. The Namibian Private Practitioners Forum is a Section 21 Company advocating for the sustainability of the private healthcare industry.

2. In a letter dated 3 August 2023 the Renaissance Medical Aid Fund (RMA) informed General Medical Practitioners (GPs) and Medical Specialists (Specialists) that as of 1 September 2023 the benefits payable by RMA in respect of in-hospital treatment by GPs and Specialists will be severely reduced.

3. As far as we could establish, and this is not clear from the fund's website, the reduction will be as follows:

Elite Care: 125% NAMAF Rate	- reduced from 200% NAMAF Rate
Prestige Care: 125% NAMAF Rate	- reduced from 200% NAMAF Rate
Status Care: 125% NAMAF Rate	- reduced from 200% NAMAF Rate
Caliber Care: 125% NAMAF Rate	- reduced from 200% NAMAF Rate
Esteem Care: 100% NAMAF Rate	- reduced from 180% NAMAF Rate
Access Care: 100% NAMAF Rate	- reduced from 180% NAMAF Rate
Evolve Care: 100% NAMAF Rate	- reduced from 180% NAMAF Rate

4. We have calculated the reduction in benefits to range between 37% and 44% of the current benefit, depending on the specific fund plan.

5. The benefits payable by a medical aid fund is governed by the rules of the fund, and the rules of the fund can only have effect once approved by the Registrar of Medical Aid Funds (the "Registrar").

6. Medical aid funds, including RMA, are administrative bodies, and as such subject to Article 18 of the Namibian Constitution.

7. As such, RMA has a legal duty to act fairly and reasonably and to comply with all the common law principles relating to administrative bodies. One such principles is the *audi alteram partem* rule. In short, an administrative body, such as RMA, may not prejudice its subjects, i.e. the members of the fund and those deriving claims from members, such as GPs and Specialists who claim directly from the fund, without affording them the opportunity to be heard before making a decision which will affect them adversely.

8. The fund's decision to reduce benefits for in-hospital treatment is clearly prejudicial to both members and their healthcare providers. They were not provided the opportunity to be heard.

9. Conjecture has it that the Registrar approved a rule amendment that allows for the intended reduction in benefits. This could not be confirmed by us as RMA refused to provide proof of such amendment to a GP who requested same. We pause to reflect on the deplorability of this refusal:

    a. RMA explained it's as refusal as follows: "*... we cannot disclose confidential communication between the fund and Namfisa to a third party. Therefore, we advise that healthcare providers contact Namfisa directly to obtain the necessary confirmation of the rule change*".

    b. It was well known to the fund that the GP who made the enquiry claims directly from the fund, on behalf of her patients (members of RMA) on a regular basis.

    c. Rule 4 of the RMA rules states that: "[The] *Rules and any amendment thereof registered in terms of the Act shall be binding on the Fund and the Members and officers of the Fund and so on any person who claims under the Rules or whose claim is derived from a person so claiming*."

    d. Despite the rules (and thus all rule amendments) being binding on doctors who make direct claims to the fund on behalf of their patients, the fund refuses to provide the alleged approved amendment to doctors, in clear defiance of its legal duty to do so.

    e. Not only did RMA not comply with the *audi alteram partem* rule before it unilaterally and substantially prejudiced its members and those deriving claims from members, RMA then also elected to keep that information secret from the affected subjects, even after the prejudicial rule amendment was allegedly effected / approved.

f. This does not bode well for the integrity and transparency of an administrative body such as RMA; also not for the prudence of the Registrar, who effectively aided the fund in its actions herein.

g. To add insult to injury, last week a member of RMA requested the fund rules from the Registrar, and the Registrar then provided only the main body of the rules. The Registrar did not provide annexures A, B and C to the rules, which annexures, as per rule 17.1 of the fund rules, contain the actual details of benefits payable by the fund.

h. Those adversely affected by RMA's unliteral decision were thus further hampered by the Registrar himself in their attempt to obtain information they are clearly, by law, entitled to, to enable them to exercise their right to fair and reasonable treatment

10. To better understand the circumstances of this matter, and the impact of RMA's decision, the NPPF conducted a survey amongst GPs and Specialists in private sector. 88 GPs responded and 77 Specialist responded. The results were as follows:

a. 97% of respondents claim directly from medical aid funds on behalf of their patients. The same percentage of respondents confirm that they were not consulted by RMA before RMA took the decision to reduce the benefits as described above.

b. 99% of respondents confirmed that they are not aware that their patients (who are also members for RMA) were consulted before RMA took the decision to reduce the benefits.

c. 80% of respondents received the said letter from RMA informing them that benefits will be reduced.

d. Asked how the current benefit paid RMA (<u>before</u> this intended reduction) compares with their normal fees for in-hospital treatment the results were as follows:

i.	Substantially lower than my normal fee	3%
ii.	Lower than my normal	27%
iii.	About equal to my normal fee	49%
iv.	Higher than my normal fee	3%
v.	Substantially higher than my normal	1%
vi.	Not applicable to me / I don't know	17%

e. Asked how the benefit <u>after</u> the intended reduction compares with their normal fees for in-hospital treatment the results were as follows:

i.	Substantially lower than my normal fee	66%
ii.	Lower than my normal	16%
iii.	About equal to my normal fee	5%

iv.	Higher than my normal fee	<1%
v.	Substantially higher than my normal	0%
vi.	Not applicable to me / I don't know	13%

f. 15% of respondents confirmed that they concluded a contract with RMA to provide services at a fixed fee.

g. Of those contracted with RMA to provided services at a fixed fee, 80% confirmed that the agreement prohibits them from split-billing (whereby they are not allowed to charge a patient, in a separate invoice, an additional fee to that agreed with RMA)

h. The NPPF obtained a legal opinion from the Namibia Competition Commission which concluded that healthcare providers are subject to the Competition Act (2 of 2003) and may thus not enter into agreements with funds for the provision of services at fixed fees. 30% of respondents were aware of this opinion and 70% were not aware.

i. When asked what they intend to do after the reduction of the benefits by RMA the respondents answered as follows:

i.	I will continue claiming directly in line with the reduced benefits	18%
ii.	I will continue claiming directly from the fund but will provide an additional invoice for a top-up payment payable by my patient (split billing)	64%
iii.	Stop claiming directly from the fund on behalf of my patient	13%
iv.	I already do not claim directly from the fund on behalf of my patients. They must pay first and claim from RMA themselves (commonly referred to as "not contracted")	5%

j. When asked whether they were aware that, since the NPPF commissioned an independent cost study in 2014, NAMAF has removed public access to the NAMAF Benchmark Tariffs, which means that no member of any medical aid fund can access the actual descriptors or tariffs contained in the NAMAF Benchmark Tariffs anymore, 26% of respondents stated they were aware and 74% of respondents stated that were not aware of.

11. From the survey result we conclude the following:

a. The current benefit for in-hospital treatment paid by RMA covers the healthcare provider's normal fees for about half the affected healthcare providers, while it is already lower than the normal fee for about one third of the healthcare providers.

b. If the benefit is reduced, the amount paid by RMA will cover the healthcare provider's normal fee for only about 6% of the affected healthcare providers, while it will be lower than their normal fee for about 82% of the healthcare providers.

c. From the above it is clear that the impact of the reduced benefit on fund members will be severe. For in-hospital treatment, less than 20% of healthcare providers are likely not to require an out-of-packet payment from their patients. Co-payments to those currently claiming, will increase substantially.

d. Also, the number of healthcare providers who will cease to claim directly from the fund will increase, in which cases patients must make full upfront payments and claim refunds from the fund at a later stage. In such cases the refunds by RMA will also be substantially less than is currently the case (roughly between 37% and 44% less).

e. Neither the members of RMA nor the doctors deriving their claims from members were consulted before RMA took a final decision to reduce benefits.

f. At least some GPs and Specialist entered into an agreement with RMA to fix fees, while the majority (if not all) who concluded such agreements were not aware that same are highly likely to be offensive of the laws governing competition.

g. The majority of healthcare providers were themselves unaware that their patients, the members of medical aid funds, do not have access to the actual tariffs used by RMA in its benefit structure. It must be noted: any percentage of an unknown tariff, is useless information. The fund's annual benefit guide, which is the only document provided to members in terms of benefits payable, thus almost exclusively contains useless information.

h. Although 76% of respondents indicated that they would provide financial support for a new independent cost study, which is crucial for the sustainability of the private healthcare industry, given NAMAF's continued practice of unscientific methodologies in setting tariffs, such cost study cannot be done for as long as NAMAF refuses to avail the NAMAF Benchmark Tariffs for public scrutiny.

12. Based on the above the NPPF is of the opinion that RMA's decision to reduce the benefits of its members for in-hospital treatment by GP's and Specialists was unlawful and will have a severe impact on members of RMA as well as the private healthcare industry.

13. The NPPF is also of the opinion that the Registrar, when he approved a rule amendment to allow for such reduction in benefits (if such rule amendment was ever presented and approved), was misinformed or did, with respect, not apply his mind to numerous crucial issues, some of which are raised herein.

14. In the premise RMA is hereby **requested not to proceed with the intended reduction in benefits** by 1 September 2023, and to **confirm this to the NPPF in writing by 11:00 on 31 August 2023**.

Yours faithfully

Pp.: Dr Dries Coetzee
CEO: NPPF

Drdriescoetzee@gmail.com
0811289029