SECTION 59 INVESTIGATION

DATE: 2019-07-29

HELD IN: IMBIZO BOARDROOM,

COUNCIL FOR MEDICAL SCHEMES OFFICES, CENTURION

PRESENT: **ADV TEMBEKA NGCUKAITOBI - CHAIRPERSON**

ADILA HASSIM - PANEL

KERRY WILLIAMS - PANEL

DR NOMAEFESE GATSHENI

DR PONKY RAMOSOLO

DR TABEHO MMETHI

DR CALVIN CHABALALA

DR SEECO

DR SP DIALE

DR TS MAEBANE

DR SIBUSISO SITHOLE

DR HLENGIWE ZWANE

CERTIFICATE OF VERACITY

I, the undersigned, hereby certify that in as far as it is audible the aforegoing is a true and correct transcript of the recording provided by you in the conversation:

Section 59 Investigation

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Notes:

1. This is a verbatim transcription and transcribed without the benefit of any documentation for the verification of spelling of names and places.
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PROCEEDINGS ON 29 JULY 2019

CHAIRPERSON: Alright, good morning everyone. We are about to start. Perhaps we should just start by introductions. My name is Tembeka Ngcukaitobi, I'm the chair of the Section 59 investigation panel.

ADV WILLIAMS: My name is Kerry Williams, I'm part of the Section 59 investigation panel.

ADV HASSIM: My name is Adila Hassim, please can cell phones be switched off? Adila Hassim, I'm a member of the panel.

CHAIRPERSON: Thank you, who will be speaking on behalf of Solusionist Thinkers? No we need one spokesperson, so you should select someone who's going to be making the main address. Sorry, just give us your name so that we know who will be doing the address. I understand that, but I need a main spokesperson so that you can introduce yourself. No, just press the button.

DR GATSHENI: My name is Nomaefese Gatsheni, the chairperson of the Solutionist Thinkers group.

CHAIRPERSON: And who are your co-spokespersons?

DR GATSHENI: That will be Dr Godfrey Mmethi …[intervenes]

CHAIRPERSON: Can they introduce themselves?

DR GATSHENI: Can you hold a second, he's coming?

CHAIRPERSON: No, the hearing should have started at ten o'clock, and so we would have expected everyone who wanted

to play a role to be here at ten.

MALE SPEAKER: He's talking to the security out there.

CHAIRPERSON: No, but he should have been here at ten. Can we get other people who are going to speak to introduce themselves?

DR RAMOSOLO: I'm Ponky Ramosolo.

CHAIRPERSON: Thank you.

DR CHABALALA: I'm Bokosi Calvin Chabalala.

CHAIRPERSON: Thank you Mr Chabalala. Alright, so I want …[intervenes]

MALE SPEAKER: …[inaudible 00:02:47].

CHAIRPERSON: Are you also one of the spokespersons? Can you come to the front? Uhm, so we will have to find a spot for you just at the front here. Do you have a microphone?

MALE SPEAKER: No, I will move when I'm presenting.

CHAIRPERSON: When you're presenting, okay. Alright thank you, and is there no one else who will be one of your co-presenters?

MALE SPEAKER: …[indistinct 00:03:55].

CHAIRPERSON: I'm sorry?

DR DIALE: …[indistinct 00:03:55] Diale.

CHAIRPERSON: Papi Diale? Alright, thank you Mr Diale. Alright, because there is media present, I thought we should give a couple of opening remarks, just to say where we are, and what the plan is for today and the rest of the week. Alright, sorry excuse me

Sir, can you introduce yourself?

DR MMETHI: I'm Dr TJ Mmethi, I'm the chairperson for the Solutionist Thinkers group.

CHAIRPERSON: Thank you, just to reiterate, you were not present when I announced that the hearings were advised to start at ten, and it's way after ten and we had to wait for everyone to come in, and we sent two messages that everyone should come in, and people were still late. If we can just make sure that when the time is set for ten o'clock, then we start at ten. We try, we're not trying to set this too formalistic, but in order for us to make progress we just need to observe time. The media is present, so we thought we would give a couple of opening remarks. So I've already introduced myself, and I also have my colleagues Advocate Hassim and Advocate Williams.

All of us are members of the Johannesburg bar, I'm also a member of the Pan African Bar of South Africa. We have been appointed by, sorry can we just get some order there, that side? I mean, if you still have issues that you want to attend to, because I would just rather, we, alright thank you. We have been appointed by the Council for Medical Schemes. Our mandate is contained in the terms of reference which were published, and particularly paragraph six of those terms of reference. What we are expected to do is to investigate complaints and allegations received by the Council for Medical Schemes in terms of Section 59 of the Act, and regulations five and six of the regulations passed under the Medical Schemes Act. We are also supposed to make recommendations to the Council

for Medical Schemes in relation to how to address the complaints and allegations.

Thirdly we have to identify trends emerging from the complaints and allegations which may require further legal, or policy interventions. Fourthly we must make recommendations to the Council for Medical Schemes in relation to appropriate further administrative, legal, or policy interventions. Lastly, we must make recommendations to the Council for Medical Schemes in relation to appropriate amendments in legislation and regulations that may be required. We just want to emphasize that we are not the Council for Medical Schemes, what we are, is an independent panel. Our function is not adjudicative, we will not be making binding decisions.

What we will be looking is, essentially playing an investigative role, taking facts and evidence, identifying trends, and making recommendations about what we think is wrong with the way in which Section 59 is interpreted, understood, and applied, and we will be making recommendations on how it can be changed and improved. We have received a couple of, a number of complaints, our own calculations are that there are probably more than 100 complaints that we have received. They fall broadly into two categories. The first category of complaints is that the administrative systems that the schemes, the medical schemes, use when they investigate and decide on complaints, are unfair to medical practitioners.

The second is that the schemes are accused of racial

profiling, and the accusation of racial profiling is that the schemes are unfairly targeting Black and Indian doctors, and when I use Black and Indian, I don't seek to unnecessarily distinguish within the category of Black as used in legislation. But that distinction is a distinction drawn by the Council for Medical Schemes itself. So there are those two primary complaints, the one is that there is an unfair implementation of Section 59, and the second one is that when Section 59 is invoked, the way in which it is done is racial discriminatory, and unfairly targets Black and Indian doctors.

We have appointed an expert to assist us with the understanding and analysis of data, and hopefully in due course we shall be requesting data from the medical schemes themselves which would be of assistance to our work. So today, what we hope to do, is to listen to Solutionist Thinkers, which is, my understanding is that it is an association that represents a broad section of interests of medical practitioners, primarily Black medical practitioners. They are one of the stakeholders that made a submission to the panel, and today they will be giving us an oral submission, and perhaps while I'm on this topic I could mention that the process that we will be following.

We've already taken complaints that have been received generally from the public, we've also received submissions by the, I think it was the 19th of July, which was the final date for the submissions, and so we are in the process of analysing those complaints and those submissions. But this week we shall be

hearing orally, in the public hearings, on the nature of the complaints and the nature of the submissions that have been made. This afternoon we shall be hearing from the Competition Commission. The Commission will be explaining to us the structure of the market, and particularly the relationship between the medical schemes and independent medical practitioners, and it will also be advising us as to whether or not there are any particular features in the market structure that may lend themselves into unfair practices, or may lend themselves into abuses of powers on the part of medical schemes.

As I say, we are independent, we don't practice in the area. We also come into this area, in many respects, ignorant of some of the peculiar and unique attributes of the market, and we hope to be educated by the submissions that will be made during the course of this week. And so, without wasting more time, I think we should probably start with the presentation for the day. We think the evidence will be taken on oath, and we have made available the oath, or affirmation, that may be taken. So the speakers will all be required to speak under oath, and they will be questioned by us as members of the panel, in relation to the submissions that they are going to be making.

Oh, thank you Jesus. That is such a relief. In fact, I did ask whether or not we were deliberately kept in the dark, but it turns out that I was wrong. Alright, so can we get the first speaker from Solutionist Thinkers to take the oath?

DR GATSHENI: I will take the oath.

CHAIRPERSON: Alright, so you should say then after me, so I, and then your name?

DR GATSHENI: I Nomaefese Gatsheni.

CHAIRPERSON: I swear that the evidence I shall give.

DR GATSHENI: I swear that the evidence I shall give.

CHAIRPERSON: Shall be the truth.

DR GATSHENI: Shall be the truth.

CHAIRPERSON: The whole truth.

DR GATSHENI: The whole truth.

CHAIRPERSON: And nothing else but the truth.

DR GATSHENI: And nothing else but the truth.

CHAIRPERSON: So will you raise your right hand, and say; so help me God?

DR GATSHENI: So help me God.

CHAIRPERSON: Thank you. We have received your submission in writing, and perhaps you should start by taking us through it, and if there are any aspects of it that you want to emphasize.

DR GATSHENI: Thank you very much. I'm going to start by introducing Solutionist Thinkers group. Give a brief background of where we come from, and we then further discuss the issues of concerns which are firstly racial profiling. The second one; the Section 59(6) subsection two, which is more on validation and audits. We will then split the presentation amongst four of us, and we will also elaborate more on the list of people that we have compiled

to come and give witnesses. That's how the whole presentation will be, if I may start?

CHAIRPERSON: Yes.

DR GATSHENI: I'm going to start with the introduction. Solutionist Thinkers group welcomes and embrace this opportunity to be part of the investigation of Section 59.2, launched by CMS on behalf of healthcare practitioners, after a plethora of challenges felt for some time. We will coherently cooperate with all processes to be followed throughout the investigation, hoping to achieve the best results of, until the end. Our objective for this submission is to assist CMS investigations to issue, including racial profiling, entrapment, cohesion, bullying and extortion, and illegal investigation conducted by medical aid schemes.

I'm now moving to point two, which will be the background of Solutionist Thinkers group. The Solutionist Thinkers group started on the 1st of April 2019, after a vast number of private healthcare practitioners felt aggrieved to address a longstanding phenomenon of what is perceived as racial profiling by medical aid schemes, and medical aid administrators. This phenomenon has raised its ugly head in more than one form, which are illegal audits, and irregularities in validating claims paid to their service providers. The organisation consists of 200 members, and the focus to address discrepancies found in Section 59 of the Medical Aid Schemes Act of 1998, and medical aid policies versus chapter two of the constitution.

The association also seeks to work together with medical aids in order to promote social justice, in a democratic approach with elements of inclusivity, and three tiered participation in decision making, and design of medical aid policies. Solutionist Thinkers group also looks at how to continue towards solutions in the private healthcare sector in South Africa. The association believes that addressing economic divides and past economic barriers can lead to effective and productive results, where everyone in the equation is a winner. A three tier approach is highly encouraged in minimising every risk or threat to economic development of the healthcare sector in South Africa.

Lastly, the association puts it as its own mandate to liberate healthcare practitioners from any form of discrimination, or compromised ethical dilemma that are posed by unjust policies of medical aid schemes. We also note that we do not condone fraud, waste, and abuse in any form, but we support the rights of practitioners in terms of professional discretion in the rendering of services to patients, and the right, and we hold the right to reply on any allegations of fraud that might be laid by medical aids. Number three, it’s going to be a problem statement. The dissatisfaction and the plight of healthcare practitioners stemmed from the observation of how medical aids, and their administrators use illegal audits, or validation of claims to extort money from the service providers.

These medical aid audits have been going on for a very long

time, and advancing year after year with allegations of fraud, wasteful expenditure, and abuse of tariff codes. The argument about the above indicated allegations had been proven to be true on a very small scale, estimated to plus minus 15%. However the impact of managing the problem, has dire consequences on most healthcare practitioners, especially Black and Indian healthcare practitioners.

CHAIRPERSON: Can I ask you there, where do you get that 15% from?

DR GATSHENI: The 15% we got when we were discussing, on our first discussion with CMS.

ADV WILLIAMS: Was that provided by CMS, that percentage?

DR GATSHENI: Not necessarily CMS, but the meeting, there was someone who raised that it's almost 15%, or plus minus 15% of fraud and wasteful expenditure.

CHAIRPERSON: But you as Solutionist Thinkers, you don't have an independent verification that out of all complaints, only 15% are successful?

DR GATSHENI: No.

CHAIRPERSON: Thank you, you can continue.

DR GATSHENI: Okay, a second challenge that had been observed is that even though these audits are meant to eradicate fraud and crime against the medical aids, there are pitfalls on how they are conducted. They're experienced as racially discriminatory in nature, based on how the information demanded from Blacks, and

Indian healthcare practitioners is completely different compared to the information demanded from their White counterparts. Thirdly …[intervenes]

ADV WILLIAMS: Sorry, may I intervene there to ask a question on that point. Can you describe how it is different, the information that is demanded from Black practitioners versus White practitioners?

DR GATSHENI: Okay, our experience and observation is that when it comes to a Black and Indian healthcare practitioners, when the audits, or letters, are sent the letters will be demanding clinical notes, confidential information of the patients, details of what is happening within the consultation rooms. However, when we compare with our White counterparts, their information that is needed from them, often when they approach the office, or they're going for interviews, they will be coming back to tell us they only needed diaries, and no clinical notes.

ADV WILLIAMS: Sorry, would you mind repeating that, kind of with the specificity, so that we're sure we get it, because I saw on page nine of your submission, you've given what I understand is a typical note that is received, or a typical letter that is received from a Black, by a Black practitioner. Is this what you're saying is typical that Black practitioners receive?

DR GATSHENI: Receive, yes.

ADV WILLIAMS: Okay, and that is different to what White practitioners receive?

DR GATSHENI: White practitioners might be getting the same letters, but when they go for audits the information needed in the offices where they are investigated, it will be only diaries.

ADV WILLIAMS: Thank you.

DR GATSHENI: Okay, thank you. The fourth part that I want to represent are the medical aid benefits are quickly exhausted, and this creates a crises regarding patients healthcare. So that was the last point. That was the last …[intervenes]

CHAIRPERSON: Sorry, just explain what you mean by this, by the fourth point?

DR GATSHENI: Oh, I was just finishing, and before I finished, I was asked some questions. So I was just saying, on the problem statement, that was the last point that I have.

CHAIRPERSON: I understand, but what does it mean? "Medical aid benefits are quickly exhausted", what does that mean?

DR GATSHENI: Okay, normally most patients will reflect that their benefits are finished far before the end of the year, or even before the half of the year.

CHAIRPERSON: But does that apply, how does that effect your, my understanding of your complaint is that there is racial discrimination.

DR GATSHENI: Okay, on what I've represented, I talked about the racial profiling.

CHAIRPERSON: Yes.

DR GATSHENI: And I also indicated how the audits, the

unfairness of the audits, and I also covered who is affected within the process.

CHAIRPERSON: Yes.

DR GATSHENI: So by adding the last statement, it was to show also, or elaborate on who else is affected in the picture.

CHAIRPERSON: I see, but this is not a complaint about racial discrimination?

DR GATSHENI: No, that is not the complaint. I would also like to continue on the presentation, focussing on medical aid policy versus human rights and ethics. So in this part I've extracted Section 10; declaration, signed by the member on joining. The reason I'm presenting this part, it is often giving us a problem when we are faced with investigation or validation of claims.

ADV WILLIAMS: Are you referring to part of your submission?

DR GATSHENI: Yes.

ADV WILLIAMS: Tell us which paragraph in your submission you are now dealing with?

DR GATSHENI: Okay, I'm now dealing with the part where we were not happy to give clinical notes, or to give …[intervenes]

ADV WILLIAMS: Which paragraph, or page number?

DR GATSHENI: I didn't take the whole presentation that I gave you, I took parts, and my colleagues will also represent parts. So it's difficult for me to tell you exactly which part is this. Do you

have a full document? Let's check the full document so that we can give that.

MALE SPEAKER: About what?

DR GATSHENI: Just say page what. Just page what on.

MALE SPEAKER: …[indistinct 00:25:04].

DR GATSHENI: Ja, on the document we submitted, because they're looking on the document.

ADV WILLIAMS: Is it page 11?

DR GATSHENI: Yes, that would be page 11. Ja, it must be page 11.

CHAIRPERSON: Is that where you're talking about a declaration by the principle member?

DR GATSHENI: Yes.

CHAIRPERSON: Alright, carry on.

DR GATSHENI: The reason we are bringing this, this is what we often have a problem when the medical aids are demanding clinical notes or demanding private information of the patient. So we brought this because it had a lot of conflict with either the ethics of the practitioners, of the rights of the members. So we decided to take this and question it, or analyse, or criticise it. So if we go through Section 10; declaration, signed by the member, it reads as follows; "I hereby authorise and request any doctor or medical professional person, or any other person who may be in possession of, or may thereafter acquire any information concerning my, or nominated dependants health, whether such information relates to

the past or future, to disclose such …[intervenes]

CHAIRPERSON: I'm sorry Ms Gatsheni, can people who have cell phones switch them off please?

DR GATSHENI: I'll continue; "to disclose such information to the scheme or its administrator and agree that this authorisation and request shall remain in force after my or their debts, as well as prior thereto. I indemnify the scheme and its trustees, agents, and administrators against any claim of whosoever nature which may be made against them as a result of, or arising out of, the disclosure of my test results, or medical information." We often have a problem when dealing with this, when we have to respond to the medical aids for example, they will tell us that we have to give based on what the patients have signed.

So you have to give the information as they need. So we have few questions on this, and I highlighted in parts. You might not have it in your document as highlighted, but everything is in that document. Number one, what we criticise here, I'm going to quote; "I hereby authorise and request any doctor or medical professional person, or any other person who may be in possession of or may hereafter acquire any information". The question on the above statement is whether the medical aid did put in mind ethical consideration and the rights of those involved in drafting this policy?

The second question; were there any specifications of information they require, and the reasons it requires? Who qualifies to review this information within the scheme? What about the ethics

of those who should demand this information from the members? and then I'll quote again; "any information". Is the member aware of selling out her rights, or his rights, to privacy and confidentiality as stipulated in the Bill of Rights, chapter two of the Constitution of South Africa? I'm still on the declaration, according to Bathopele principles, as they are aligned to the Constitution.

The focus of Bathopele is that every citizen in South Africa should have an informed information in any decision making, and it continued, it reads like this; "Know the service you are entitled to". This requires information and transparency and openness, especially when they are signing fine prints. Were members aware that they are signing for what, for whether any information that is in their best interest, or the information that will help them to care for whatever medical needs? Or were they aware that they are signing including audits, on that statement? Sharing of information within the healthcare team is usually assumed if the patient, for example, has agreed to being referred to a specialist.

In this case file sharing should be limited to need-to-know requirement. Patients do have the right to request that certain information be withheld from a team, but many are unaware of this right. They should be made aware through notices of verbal information, or by means of any kind of communication, so that they are aware of their rights. I quote again from Section 10 that is signed by a patient; "Whether such information relates to the past or future". I quote again, from the same Section 10; "I indemnify the scheme

and its trustees, agents, and administrators against any claim of whosoever nature which may be made against them as a result of, or arising out of the disclosure of any test results or medical aid schemes."

We guess medical aids often manipulates the clause above when they want to audit healthcare practitioners, however their clarity is, their clarity is of utmost importance in this regard.

CHAIRPERSON: So how do they manipulate the declaration? How do the schemes manipulate the declaration?

DR GATSHENI: Okay, during the declaration, the member signed not being aware what is written there. The information is just explained, or on forms that you signed here, you will the information here, and members are signing. So members are not aware that what they're signing for is whether to do audits on their private information, or whether is it for qualifying to be a member for that specific medical aid, or for their treatment should there be a need. So we feel that because the member is not even aware, most of the time when you go to the member to request just a consent, a member will ask where is my information going, didn't you say that whatever we discussed on that consultation ends in that room?

So now what makes you to demand the consent to access my clinical notes? So when you go back to the medical aid to say the member is refusing to give us a consent to these clinical notes, because it's their private information, they quickly send Section 10 to say a member signed for this clause. So they question that I was

posing on this is that; is this clause clear for everyone who is part of for either audits, validation of claims, patients accessing their treatment, or medical aid accessing audits? So it was quite a challenge.

However, we mentioned that we guess medical aids are manipulating that information, because there is nothing clear there. Then we'd also like to present on Section 59(6); the manner of payment of benefits, stated as follows; "sub-regulation two gives guides on validation of claims." I'm going to go to the policy, or Section 59 of the medical aid schemes. Six, I'll read six, according to Section 59, number six is the manner of payments of benefits. Number one; "A medical aid scheme must not in its own rules, or in any other manner in respect of the benefits to which a member, or former member of such medical aid scheme, or a dependant of such a member, is entitled. Limit, exclude, retain, or withhold as the case may be, any payment to such member, or supplier of services, as a result of late submission, or late resubmission of the account or statement before the end of the fourth month."

It is stated on A; "From the last date of service rendered as stated on the account statement or claims, or during which such account statement or claim was returned for correction." Sub-regulation two; "If a medical aid scheme is of the opinion that that account, or statement, or claim, is erroneous or unacceptable for payment, it must inform both the member and the relevant healthcare provider within 30 days after receipt of such account.

Statements or claims that it is erroneous or unacceptable for payment and state the reasons for such an opinion."

Number three; "After the member and the relevant healthcare provider have been informed, as referred to in sub-regulation two, such member and provider must be afforded an opportunity to correct and resubmit such account, or statement, within a period of 60 days following the date from which it was returned for correction."

Number four; "If a medical aid fails to notify the member and the relevant healthcare provider within 30 days that an account, statement, or claim is erroneous or unacceptable for payment in terms of sub-regulation two, or failed to provide an opportunity to correction and resubmission in terms of the sub-regulation three, the medical aid scheme shall bear the onus of providing that such account, statement, or claim is in fact erroneous or unacceptable for payment in the event of a dispute.

If an account, statement, or claim is correct or where a corrected account, statement, or claim is received as the case may be, a medical aid scheme must in addition to the payment contemplated in Section 59(2) of the act, dispatch to the member a statement containing at least the following particulars; the name and the member number of the member, the name of the supplier of services, the final date of services rendered by the supplier of services on the account or statement which is covered by the payment, a total amount charged for the services concerned, and the amount of the benefit awarded for such services."

Now when you look at this regulation it specifies that immediately when there is found any mistake on the claim that is submitted by the service provider, the medical aid within 30 days must notify the member and the service provider about the mistake that happened, or any irregularity that happened, and within the specific days, or months, or actually specific months of 60 days, this should be corrected and once it is corrected then the matter is settled. However …[intervenes]

CHAIRPERSON: Is it your understanding that this regulation should be followed by schemes when they are enforcing their rights under Section 59?

DR GATSHENI: Yes, that is my understanding.

CHAIRPERSON: Because the schemes say that this regulation doesn't apply?

DR GATSHENI: How doesn't it apply? What are their reasons for not?

CHAIRPERSON: No I understand, I just want you to explain to us why you say it should be applied. I know there's a dispute between what you say and what the schemes say.

DR GATSHENI: Okay.

ADV WILLIAMS: It might be helpful to explain what you understand is meant in that regulation by the words; "erroneous or unacceptable for payment", and to actually spend some time on that because that's important for understanding how these two sections work together.

DR GATSHENI: Okay.

CHAIRPERSON: Just explain what you understand by the phrase used in the regulation, which is, I m e a n in the regulation you are talking about, well you've spoken about one, two, three, in fact you read the whole regulation, so if you look at two; "If the medical scheme is of the opinion that an account or statement or claim is erroneous or unacceptable for payment", what is your understanding of erroneous and unacceptable for payment?

DR GATSHENI: Erroneous, my understanding is that there might have been mistakes that the medical aid suspect, and therefore because of those mistakes, it will be unacceptable to proceed with the payment, hence the validation of claims.

ADV WILLIAMS: And just so I understand, in practice what kind of mistakes would those be?

DR GATSHENI: Common mistakes might be you are submitting the claim while you were not, before you received maybe the authorisation, sometimes it is the coding, sometimes the progress report was sent very late to the medical aid, or sometimes the member himself disputes that specific claim. Okay, okay someone wants to …[intervenes]

DR SEECO: Yes, sometimes it can be when you enter information you find that, say I've entered the date of birth …[intervenes]

MALE SPEAKER: Sorry, …[indistinct 00:42:32] it's very difficult to hear.

CHAIRPERSON: No look, that's why we asked for spokespersons, but I will allow the gentleman to just continue making the point he wanted to make. We will give you a microphone, come closer to a microphone so that your statement can be recorded.

DR SEECO: When they mean the thing could be erroneous, it means that maybe sometimes you may have added the wrong date of birth of the patient. So when they are about to process the claim, they find that it doesn't tally with that claim. Sometimes it could be the date, the dates, maybe wrong dating, say maybe I wanted to write 2019, then I write 2020, or maybe the month, then they would say that there is an error and that, that one should actually correct that. Sometimes it could be the medical aid number, you find that there are about 11 digits, you have entered 10 digits, so you've got to go back and check and then, that's how I understand to be erroneous.

CHAIRPERSON: Thank you, there's another gentleman. Sorry, we, oh sorry we didn't take your name and your role here?

DR SEECO: I'm Doctor Seeco, S E E C O.

CHAIRPERSON: And what is your role, are you a member of Solutionist Thinkers as well?

DR SEECO: Yes, I am a member.

CHAIRPERSON: Alright, thank you. Alright look, we will have to manage this rather delicately because you should have probably just taken the oath of everyone who will be speaking. So

that what you say is on record, and it can be evaluated by us, but I understand the gentleman in the front also wants to talk.

DR CHABALALA: Thank you Advocate, I'm Bokhosi Calvin Chabalala. I think our understanding, or our broader understanding in terms of erroneous basically when the schemes themselves are saying they are paying the practitioners in good faith, so normally then in erroneous, they are referring to perceived fraud, or to say the practitioner might have claimed in bad faith. Even if you go into the either, maybe the wrong information loaded, it might be part of that but also, we must also be aware that in most cases they perceived fraud. That is what they normally say it's erroneous, and perceived fraud to them, once they say it's erroneous, when they perceive it as fraud, they have done their conclusion that it is fraud.

That is what we are saying. It takes long because some of the, their application it's, they have got 30 days basically to evaluate, and we understand that they might be paying quicker which they always say they are paying in good faith. But they've got 30 days to verify and make sure, that there's validation. But we had a problem where you find that they can come and query a claim as late as three years, which we disagree that where is the, where is the good faith. If you say you want to validate a claim after three years, and you want to go and apply the section which is talking about 30 days, there is a huge disparage in that regard.

CHAIRPERSON: Alright, thank you. Can we do this just to get some order? Will you continue Ms Gatsheni with your

presentation, and people with additional things to say will come after you, because they also need to put themselves properly on the record?

DR GATSHENI: Thank you Advocate. We also looked at one of, or extract from that declaration, Section 10. I quote; “To disclose such information to the scheme or its administrator.” The biggest challenges we have here, to disclose information to the administrator, is that the member agreed that they will disclose. But however when you go and approach the member to say; release your consent because this is needed, the member doesn’t understand. We also don’t understand, because we find ourselves compromising our ethics. Or contradicting yourself, because you tell, you discuss the confidentiality later, because the medical aid, because the member signed that specific clause. So you are now compelled to disclose information, even when you feel that you are not comfortable with that information.

According to the National Health Act 2003, it makes, it makes it an offence to disclose patient’s information without their consent, except in certain circumstances. Without assurance about confidentiality patients may reluctant, may be reluctant to give practitioners the information they need in order to provide good care. So most of the challenges why patients will not agree to release that information, they’ll even tell you that the understanding of releasing information, it’s either for my treatment or because the medical aid wants to change the medication for some reason.

So we still do not understand your audits, but however if you want to send my information because you are due, or you won't be able to be paid then you may release it. Then they release. That's where we start to have problems. In Section 14, 15, and 16 of the Act, are pertinent with regard to confidentiality. In particular Section 15 and 16 describe how patient information may be disclosed …[indistinct 00:48:47] healthcare worker; "for legitimate purposes, within the ordinary cause a scope of his or her duties where such access or disclosure is in the interest of the user."

It is not just in law where confidentiality is described. The HPCSA views it as a central to the doctor-patient relationship, and a core aspect of the trust that holds the relationship together. This is clearly understood that these clauses may assist in deciding on the best treatment required, or suggested, by the medical aid on behalf of the member, not necessarily for the audits. That is our understanding. The next point …[intervenes]

ADV WILLIAMS: Sorry before you move on may I ask, it does, I think it's going to be an issue that carries through the inquiry, how one understands these provisions of the National Health Act with the Medical Schemes Act, and I know you've mentioned a further provision in your submission. So perhaps it's an appropriate time to talk about it, but it's regulation 15(J) of the medical schemes regulations. Now the, it reads that, and it comes under a provision dealing with managed healthcare arrangements, and it reads that a medical scheme is entitled to access any treatment record held by a

healthcare provider, and other information pertaining to the diagnosis, treatment and health status of the beneficiary in terms of a contract entered into pursuant to regulation 15(A).

So it doesn't give an absolute blanket entitlement to this information, but if there is a contract then the medical scheme is entitled to that information from the provider, and presumably this Section 10 comes from that type of contract. Is that correct?

DR GATSHENI: Yes, I hear you but I'm still saying it is not correct ethically, because who are these people that we are disclosing to? Are they healthcare practitioners relevant for that specific case that you are discussing? How safe is it with that information, because often that information is given to ex-colleagues, I mean ex-police in forensic audit, and sometimes that information gets to the admin staff who will handle the whole making of copies?

ADV WILLIAMS: So as I understand you, and please don't let me misstate what you're saying, as much as this regulation might allow it, your challenge is to the regulation itself in terms of what it may allow, both, let's say from a constitutional and ethical perspective?

DR GATSHENI: Yes.

ADV WILLIAMS: Thank you.

CHAIRPERSON: Can I just understand one thing, I mean, so you get a scheme that says to you; I want your clinical notes because I think the claim you submitted is fraudulent. How should

they get it, because if the only way to verify if it's not fraudulent or not is to get the clinical notes, because one of the letters that I've seen from your submission, the scheme writes a letter and they say; give us your clinical notes because we want to check the time that you spent, that it's in excess of what would be reasonable, and one of the doctors says; well, it's because I've got locums, and that's why I've got more time than would ordinarily be reasonable.

So you say; well I don't want to give you clinical information, where should they get it from?

DR GATSHENI: Okay, I want to first explain what's written in the clinical notes. Clinical notes might be in the form of genograms, or you can use any tool, and by just drawing a genogram it takes less than a page to draw that genogram. But the explanation on the genogram connecting your client to what the story is, it might be even more than an hour. We also use approaches to enter the lives of patients. We'll use maybe your propositions of Carl Rogers, it's 19 propositions. There is no way that in those propositions I'm going to write word by word, and it is very difficult for someone else, who is not in the profession, to understand that we are not taking statements like police.

We are working with tools, approaches, we take brief notes so that you can attend to your patients, because by not attending to your patient, it is also so unethical. You will actually lose your patient in the process of helping. So if the information that they need, needs to prove on the, on the written statement, which I see it as a

statement rather than a clinical notes, to decide whether this is an hour or not an hour, I find it very challenging.

Hence, we are saying there is a challenge, either the challenge in the policy making, or the challenge in ethical considerations which might have to be changed when we have to release clinical notes. Or even some of the regulations might have to change, because that's where we get most of the challenges.

CHAIRPERSON: I understand, but I mean I still, I'm trying to understand this. The scheme says; we think your claim is fraudulent, right? You say; I don't want to give you clinical notes. I mean, what are you suggesting the scheme should use in order to verify the validity of the claim?

DR GATSHENI: Okay, we, in mental health, and I know it's, we are different disciplines in the house. In mental health we have what is called DSM form. In the DSM form your psychiatrist will specify what is needed to be covered in treating this patient. So you would get a psychiatrist notice, I mean, or ticking the boxes that okay, this patient is going to need psychosocial treatment, psychological treatment, any other treatment that they want to add they would add, and they would specify the period of that treatment, and immediately they will send that to the medical aid to approve. If the medical aid says; yes that treatment can be, then it comes back then we receive.

So that DSM form serves as a motivation. So there is no reason that a medical aid shouldn't believe, unless there are some

questions from the medical aid's side.

ADV WILLIAMS: Thank you for that explanation. In the example where the medical scheme enquires in relation to the number of hours worked, I presume you would be able to share your appointment schedule. Is that correct?

DR GATSHENI: Yes.

ADV WILLIAMS: And would there be any objection?

DR GATSHENI: No, if the medical aid needs what you made when the patient was coming in, say a register, or a diary where you were making your appointments, as it is the same information they demand from our White counterparts, they often need just diaries to verify and that is enough. But coming to Blacks and Indians, the information is not just that. They need a list of things. So that's where most of the problems are starting.

ADV WILLIAMS: Can I, can I just push you a little further, because that example you gave was interesting, but it was a specific type of example. There might be cases where treatment is prescribed, that is not, where it is not required to get authorisation from the scheme. Is that, before I go any further, am I right in assuming that there is such, there would be …[intervenes]

DR GATSHENI: The treatment, remember after the doctor is seeing the patient for the first time, the doctor decides that okay, based on the diagnosis of this patient, this is the treatment that will be required. So that should be enough. Immediately when the medical aid receives that DSM form and return it to say; okay, yes

you can go ahead. That should be enough.

ADV WILLIAMS: But I'm enquiring about examples where you're not seeking authorisation. So it may not be in the field of mental health, it might be a general practitioner practice or something like that.

DR GATSHENI: Oh, okay.

ADV WILLIAMS: How would you, if the scheme wanted to verify for example, the ICD10 code, how would they do so?

DR GATSHENI: Yes, I'm going to allow also some of the members who are GP's within ourselves, to elaborate on that. I hope you are noting it and putting it aside so that you can answer that question.

CHAIRPERSON: Ja, I think you should continue with your presentation, and your colleagues can note and then once your presentation is over, they can supplement.

DR GATSHENI: Okay, thank you very much. Some of the challenges that we experience with medical aids it's, is the AOD's. So I'm going to also present on information on the AOD's, and our understanding of the AOD's. However, my colleagues will still cover the rest of the things that I mentioned at the beginning. Once the medical aid finds that a practitioner has submitted a certain information, and some information is not there, or may argue the notes that they are demanding, they may decide to say; okay, your notes are so brief, or your notes are not clear and therefore we assume that over the past three years you've been practising, you are owing the medical aid

this specific amount, and therefore you need to sign so that we can continue working with you, and this poses a lot of threats to the practitioners.

Because a practitioner will start to think; okay, if I don't sign this AOD, that means I might not get paid. AOD it's acknowledgment of debt. So the acknowledgement of debt, is just calculated based on the problem that you have this month, or you have on that specific claim or the least of maybe 20 files. Then they will just check the past three years and say okay, this is the amount we calculated, and this is what you must pay.

MS WILLIAMS: May I interject again and just take you back a second because it is important what you are saying about the clinical notes. So we've, you've explained how the clinical notes might be requested by a scheme in order to determine if a consultation let's say, took place. But it also sounds that you are, sounds to me like you are saying those clinical notes are also assessed in relation to the time spent during the consultation.

DR GATSHENI: Yes.

MS WILLIAMS: So they are, I'm just checking I'm understanding the evidence correctly. So are you saying, let's say as a general proposition, the schemes are using the notes to determine what is the appropriate time you should have spent retrospectively?

DR GATSHENI: Yes.

MS WILLIAMS: Thank you.

DR GATSHENI: And however whoever is deciding on that

information knows nothing about your work.

CHAIRPERSON: I mean you are saying that they are using ex-policemen?

DR GATSHENI: Yes.

CHAIRPERSON: But can I ask you something else. You said that in relation to white medical practitioners, the audits request different information. Now where do we get that?

DR GATSHENI: We, these are colleagues that we work with.

CHAIRPERSON: Yes.

DR GATSHENI: And because of our relationship with our colleagues, we get to share everything. When they are called or receiving letters, we get to see their letters. When they come back, we get to see what they signed for. We get to know, do they need lawyers now, what, we share a lot of information, because of knowing each other.

CHAIRPERSON: So other than what you've just said, which is based on other people who have told you, you have nothing here that you can show us that the requests on the auditing side to white doctors, are different to the black and Indian doctors?

DR GATSHENI: You know where it is difficult is that they will receive the same letter but when they attend the hearing, the things that were needed on the hearing were not necessarily the things on the letter because they were able to say, no, I don't have all that, or I can't give you all that. All I have is the diary. Then it's understood.

CHAIRPERSON: I understand. Do you have white members in Solutionist Thinkers?

DR GATSHENI: It's unfortunate that we don't have. Hopefully in future we're going to have them.

CHAIRPERSON: Alright. But you are open to white members?

DR GATSHENI: Yes, they are.

CHAIRPERSON: Alright. Now I just want to know where we can get this information that you're talking about, whether we just got to rely on hearsay that you've given us.

DR GATSHENI: I've tried to contact two of my white colleagues. Unfortunately they didn't want to come out because they were kind of wondering what if that will have implications. Next time it changes for them as well. So they were not so open to talk about or come in meetings like this. Which will be very helpful because they've been supporting me throughout the process.

CHAIRPERSON: Alright. Thank you. You want to talk about AOD's.

DR GATSHENI: Ja. Now I'm going to talk about the AOD's. Medical aid schemes and administrative versus AOD's. As I explained that when practitioners are so afraid that my practice might be blacklisted, my practice might be blocked or the moneys might not be released, the medical aid says, sign, this is an amount that we are estimating that you might have robbed the medical aid over the period of three years or four years. So practitioners will sign the AOD. So now our most concern is that we reject unlawful audits. We find it so unlawful to be in a position of signing an acknowledgement of debt because our understanding of the acknowledgement of debt, according to the National Credit Act, number

34 of 2005, AOD purpose is to promote a fair and non-discriminatory market place for access to consumer credit and in order to achieve such claims, there's strict regulation of consumer credit and improved standard of consumer information is paramount.

The National Credit Acts places the onus on the credit providers to ensure that it is substantive and procedural requirements are met, the application of the National Credit Acts to acknowledgement of debts has however cause much debates in our field. An AOD is a written contract entered into between the debtor and the creditor in terms of which they agree that the debtor accepts an unequivocal administration of liability towards the creditor in respect of the amount advanced by the creditor to the debtor. The debtor acknowledges that he or she is indebted to the creditor for a particular sum of money advanced and on a payment, terms agreed between the debtor and the creditor. So we find it very difficult, hence I say we are rejecting this AOD because we never signed a contract that we will either be creditors of the medical aids or medical aids being debtors, no one, there's no business into this.

We simply give the business to our patients and it is due to us when we claim the services. So we are very confused on how one, how the AOD is calculated and how people are coerced in signing it. They are not necessarily pushing you to sign it but however, because you know pressures is around money, you will end up deciding that let me sign so that I can have food on my table. For some of us who refuse to sign, then you are blocked, you can't practice, you can't even see patients. So we wanted to check if that act of the National Credit Act is applicable to be

used between the service provider and the medical aid.

ADV WILLIAMS: Do you have personal experience of that kind of interaction and the meeting that leads to signing of an AOD?

DR GATSHENI: Yes, I had.

ADV WILLIAMS: And it is as you've described?

DR GATSHENI: Yes. My challenge that led me to be blocked by the medical aid, a specific medical aid, it was basically on the argument of releasing the clinical notes. I was more willing to release anything else that they would need to validate claims, but I didn't agree to release the clinical notes, but at some point, or should I say for my first investigation of audits, which happened three years before the second one came, I was forced to sign and AOD because I refused with my notes. Then I signed the AOD. Then I had to pay. But on the second time when they came, I refused to pay an AOD by questioning it or criticising it based on the national credit act.

CHAIRPERSON: Will you just explain why is the scheme important to you, to your practice? Why don't you just charge patients directly?

DR GATSHENI: It will be very nice to charge patients directly of which I also suggested when I was blacklisted from seeing patients. I requested that okay, it is fine, I won't do business with you. I will directly get the money from the patient. The patient can claim. Then the medical aid refused. The medical aid started to write all the patients that I've seen to say you will no longer see this service provider. And they said even if the patient comes with the cash or a receipt from me, they will not

reimburse that patient. And the second challenge, patients do not have money at their disposal. That's why most of the time we find ourselves having to give charity work. Because it's also very difficult to disconnect from the trust that you built with the patient or the relationship you built. So we therefore give it free.

ADV WILLIAMS: May I take you back a moment, just to your personal experience. I've seen that in the submission there're a number of, we'll call them complaints, attached to the submission where detailed correspondence is disclosed between the scheme and the provider. Is your experience one of those complaints that are attached to your submission or was it something separated?

DR GATSHENI: It's exactly the same as that, those ones.

ADV WILLIAMS: Okay, but the actual correspondence is not attached. So there's nothing in the documents that reflect what happened specifically with you?

DR GATSHENI: In my case it should be there. It should be in that file. I submitted my stuff. I sent you via the email.

ADV WILLIAMS: Okay, perhaps we can just confirm that it is there.

DR GATSHENI: Ja.

ADV WILLIAMS: Thank you.

DR GATSHENI: If not, I will still send it in to submit it.

CHAIRPERSON: Carry on.

ADV WILLIAMS: One question before you carry on, sorry for that. What is, what do your patients, the members of the schemes, the

beneficiaries, the clients, whatever you want to call them, but in your case your patients, did they express any view on this? Did they leave your practice and seek services elsewhere? Can you say something about that?

DR GATSHENI: Yes. Most patients because of their desperation of needing help, they leave the practice. They go and seek help somewhere. And in some cases the medical aid will direct them where to go.

ADV WILLIAMS: Do you have evidence of that?

DR GATSHENI: Yes. The recent case was when the patient who was due for dialysis treatment in KZN. It was, the case went on media as well, whereby a patient, the service provider was blocked from seeing the patients of that specific medical aid and the patient was, tried to call the medical aid to say why can't I see my service provider and the medical aid said no, you may not see that one, but there are some of the service providers and on the way, the patient driving a 50km from the closest service provider that is blocked by the medical aid from seeing her, or him, then the patient left and unfortunately I will not finish the story.

CHAIRPERSON: When I do at one point for you to help us with the evidence. It doesn't have to be now, because I'm interested in two things you've mentioned. The one is the reason you can't simply charge patients directly, is because the schemes interfere in that relationship by telling the patients that they are not to see you and if they do that, they will not be reimbursed.

DR GATSHENI: Yes.

CHAIRPERSON: Alright. Well we need some evidence on that because [intervenes]

DR GATSHENI: I have an evidence on that.

CHAIRPERSON: I have not seen anything on the documents.

DR GATSHENI: I'm definitely going to send it.

CHAIRPERSON: Carry on.

DR GATSHENI: Thank you very much. That was my presentation. I'm going to hand it over to my co-presenters.

CHAIRPERSON: Thank you. You know let's do the following. Who else is still going to speak? Alright. I think let's just take a joined oath. If you don't mind. Just after me saying, I, and mention your names.

DR RAMOSOLO: I.

CHAIRPERSON: Your names.

DR RAMOSOLO: Ponky Ramosolo.

CHAIRPERSON: Yes. Swear that the evidence I shall give.

DR RAMOSOLO: Swear that the evidence I shall give.

CHAIRPERSON: Shall be the truth.

GROUP: Shall be the truth.

CHAIRPERSON: The whole truth.

GROUP: The whole truth.

CHAIRPERSON: Raise you right hand and say, so help me God.

GROUP: So help me God.

CHAIRPERSON: Thank you. Alright so you can decide the order that you will be following.

[Indistinct - 1:12:53.1].

CHAIRPERSON: Okay, and after you've spoken.

[Indistinct - 1:13:02.6].

CHAIRPERSON: Before, alright. Alright. Are you going to do that now? Do you think they should come before you? After? Okay that's fine. We will manage that. Sorry, just, I forgot your name again. Doctor at the corner there?

DR CHABALALA: [indistinct - 1:13:25.2] Calvin Chabalala.

CHAIRPERSON: Chabalala?

DR CHABALALA: Yes. With a C ne?

CHAIRPERSON: Oh, C H?

DR CHABALALA: C H A, yes. Yes. With a C. That is the Chabalala with a C.

CHAIRPERSON: Alright. Okay, Dr Chabalala the floor is yours.

FEMALE 2: Sorry, [indistinct - 1:13:42.4] would you mind if we can allow her? She's on treatment. She wants to leave. She cannot stay [indistinct - 1:13:49.3].

DR CHABALALA: Yes, she can start. Ja. Two minutes and then I can [indistinct - 1:13:50.7].

DR ZWANE: Do I also need to?

CHAIRPERSON: What do you want to do?

DR ZWANE: No, I need to leave. I'm not feeling that well, but I just want to know that do I need to give the oath as well.

CHAIRPERSON: Yes. Are you going to speak or give

testimony or?

DR ZWANE: Yes, testimony.

CHAIRPERSON: Alright. Is the point that you have to leave, so you want to do that now?

MS WILLIAMS: She's not [indistinct - 1:14:16.0].

DR ZWANE: Ja, I can try and wait a little bit, but I'm not sure how long.

CHAIRPERSON: Alright. Fine.

FEMALE 1: She's not fine. [Indistinct - 1:14:21.6].

CHAIRPERSON: Okay, I understand that you are not well. Alright. Can you stay or do want to leave now?

DR ZWANE: If I, if it's possible for me to give the testimony now, I can do that and answer some of the things I had and then I'd go.

CHAIRPERSON: Okay. Well, ja, you should take the oath because we need to take all of this evidence.

DR ZWANE: Okay.

CHAIRPERSON: Okay. Say I, your name.

DR ZWANE: I, [indistinct - 1:14:42.9].

CHAIRPERSON: Swear that the evidence.

DR ZWANE: Swear that the evidence.

CHAIRPERSON: That I shall give.

DR ZWANE: That I shall give.

CHAIRPERSON: Shall be the truth.

DR ZWANE: Shall be the truth.

CHAIRPERSON: The whole truth.

DR ZWANE: The whole truth.

CHAIRPERSON: And then raise your right hand and say so help me God.

DR ZWANE: So help me God.

CHAIRPERSON: Thank you. So, my understanding then, she will talk first and then all of you will follow after her. Alright. Thanks.

DR ZWANE: Alright. I was also one of the people that were audited by Discovery and in my presentation, it will be just a little bit of confirmation of some of the things that [indistinct - 1:15:15.5] said. But also some of the things that you raised and I'm just going to answer with some of the questions that were raised by the panel. Thanks for the time. So [intervenes]

ADV WILLIAMS: Just a moment before you, is it Dr Zwane or Ms?

DR ZWANE: No, you can just call me Hlengiwe. Hlengiwe Zwane. Zwane. Clinical psychologist, sorry.

ADV WILLIAMS: Clinical Psychologist. Is, in the file, in the submission that's made by Solutionist Thinkers, is there any correspondence that's directly related to your case?

DR ZWANE: Yes.

ADV WILLIAMS: There is.

DR ZWANE: Or are you recalling something. Okay. Great. Alright. So the impact for me has been more on the patient than anything else, yes even on myself, but I just want to first start by answering some

of the things that you were asking. You asked about the, what the medical aid could do then if we are saying that the clinical notes must be submitted. So part of the things that was a bit of conflict for me, even following calling the council of medical scheme and HPCSA was the conflict between the Section 59 in terms of what the medical scheme raised as well as the Booklet 14 from the HPCSA, which is talking about giving of patient's information to the third party. And when I consulted the two parties, it was a bit of a conflict because the, this one side says that they are allowed as a scheme to request information from my side and on the other side, because of being under HPCSA, we are not allowed to disclose confidential information without the consent of the patient. But if the patient consents then that's fine.

I want to say that I did consult, contact most of the patients and they said no. And I think part of it is because of the type of people that I tend to work with. They felt that they don't even like, they wouldn't want anyone else in the media to know that they are in therapy or their children are in therapy because some of the people I see are high profile people so they were a little bit uncomfortable with that because for them they felt like who is it going to. So when I called back the medical scheme, they said that unfortunately it's my business. They don't care and I did feel bullied in that moment. I actually used the word that I feel bullied now, because for me I have no problem with releasing the files. They are here. But if the consent is received, I am okay with you taking the files. But now, if this information is suddenly on the news and I'm the only one who knows what happened to whoever, whoever's child, now we are more

than three people in the space who knows.

If, for example, it's a child. It's me and the mom and the dad and the child. But now we have other people who I don't know, might receive this information. So then for me it was a bit of a difficulty. I think in that moment answering that question, if the consent is given, for some us, we could be okay with just releasing when it's written consent based on HPCSA. However if it's not, then our hands are tied. So what then they did as they closed immediately all my files in terms of paying. Answering the second questions. My patients that have to struggle. I got a lot of calls from suicidal patients, parents. And it became difficult for me that I actually saw some patients for free, a lot of them for free, because for me I still have the interest of the patient first, because that's the person that I decided to join this field for.

So you end up having to see a lot of patients. If you want evidence, I'm okay, and some of my patient are okay with saying that I have seen for free because I continued to see them for free. Because I needed them to be stable before I can refer them to government. Having worked in a government space, it is also a bit of a problem because in government space you have a long waiting list. Then we throw them, and they fall between the cracks. This are the high suicides that we then hear. So for me started to cause a bit of stress as well in that it's overwhelming to be seeing people for free and yet you're not getting paid. You're good heartened. They were kind of conflict. One of the person that called me, I don't have this records from medical scheme, if there is in terms of recording, said to me it's none of my business that I choose to see people

for free. He doesn't care, and I said, you know what? In most cases, it's answering one of the questions regarding the time frames, in most cases this people run out of funds way early in the year and they have serious illnesses and they're suicidal.

So it becomes very difficult for us if you want to treat somebody who is actually calling and say, the mom is saying my child is like this. You can't say bye-bye, I don't care. So when somebody says to you it's your own discretion. Why did you decide to see them for free? It became a bit of a hurting spot even for me personally. So I think I was answering those two questions but also incorporating some of my own experiences as well. So I think when I say that people's medical aid ends quickly. There're a lot of people that I've continued to see, and I'm okay with providing evidence, that have run out of funds from April. Discovery for one, runs out of funds. GEMS, when you have admitted patients in the hospital, by the second week, they don't have funds.

For myself and the psychiatrists I work with, we always almost all the time know that by the last week we don't get paid. The hospital gets paid, but we don't. And when I said this to the guy, he says, who told you to go see people for free. Why didn't you release them? How do I release somebody who's going to be waiting for a bed in a public hospital and currently they are suicidal? That I know that I may be sued if ever they get home and they kill themselves. Obviously because the funds are being paid for the hospital, we will just bend down and tell them. So and I'm sorry, and continue to see them. So for me it has been a difficulty. I have recently had two major surgeries and I think in that challenge that I've

had, I may have had some operations but I think the high stress level that I've been going through have also impacted on my health as well. Significantly so.

So it is not to say I'm blaming medical schemes. I'm saying, can we not work together? If there is a fraudulent maybe, what do you call, the submission, call me. I'm okay with submitted and I'm sure most of us here are okay with wanting to keep the ethics in hand. But if you call me three years later and you want to ask me about a patient that I need track down and I don't know what their phone number is, I can say to you as the medical scheme, call your client and ask them to send a consent, then I am okay with releasing the files. To be honest, as I've said under oath, I'm okay with releasing files as long as the consent is submitted. So I think those are the challenges that I've had and I think if you think about the timeframe as well, we don't use the same interventions.

There are intensive interventions that sometimes take even way more time than what we give patients and when they say to us that they need the notes, my notes may be two or three lines, but the work I did with that patient who was crying the whole session. I can't write he was crying at 5 to 10. He was crying at 5 past 10. I can't do that. But that's containing a patient, which is the therapeutic approach you will use based on your training. That can take you long and sometimes with the families. You engage with the family and they go on and they talk and sometimes a patient walk out. Do I need to write that they walk out, and they spent 30 minutes walking out and then they came back? Sometimes we spent like two hours on a patient, because the family meeting just kept going and

going and you know that this people drove from far. So you'll have to sit there and help them.

So for me I've been really, really stranded. The last part that I just want to cover is the patient's leaving or going to other medical, health practitioners. We do get those who leave. But we get those that stay. The reason they stay, for example, I see for my own health reasons, I don't see how I can change to go and see another Gynae for example, following all that I've gone through, because there's a personal relationship with that. That's just an example I'm giving. So the same thing with therapy. To change to her it takes a lot of rapport building to actually get a patient to want to go somewhere else. So they opt to stay.

Those that opt to stay, they opt stay then they will get refunds from medical aids. I've received two letters from medical schemes and several calls from Bankmed as well, saying that if I continue to see their patients, now they are going to hand me over. Because I'm seeing their patients and the patients are going to claim. I said to them, I have decided in my practice that I'm no longer going to see them, but they opt to come and pay cash. What they do with the invoice is none of my business. I paid you. We have exchanged. So now, you go back to the person. So that's where the difficulty is now, with some of the patients that have decided to stay.

CHAIRPERSON: Will you just tell me about the issue of consent?

DR ZWANE: Alright.

CHAIRPERSON: My understanding is that the schemes rely on the so-called Section 10-declaration. So what's wrong with that?

DR ZWANE: So hence I'm saying that then they can go back to their own patient. I also have my consent that I have with HPCSA about the patient confidentiality. Because if now I have to release third party, it says in section, in Booklet 14, that patient has to give consent. So that's where the confusion [intervenes]

CHAIRPERSON: But the point they are making is that the patient has already given consent.

DR ZWANE: No, to me. The patient gave consent to them. To me, they didn't. The only consent they gave to me is that you will keep your information confidential. That's all they said, and I mean if you need evidence of their signed consents, it's there. So we have different types of consent form that are signed.

CHAIRPERSON: I see. So that Section 10 doesn't, you say it doesn't apply because it's a relationship between the member and the scheme.

DR ZWANE: Yes.

CHAIRPERSON: And not a relationship between the member of the scheme and you?

DR ZWANE: Yes. Because when they come, sometimes you'll find that they are on Momentum, or they were paying cash, then in the middle they decide to move to a medical scheme. They've already signed my relationship or treatment consent. When they go sign the other one, this is a different relationship. Hence, I'm saying they must get a

consent from their own client as much as I'm getting mine from my own client.

CHAIRPERSON: Now you said you were one of the medical practitioners that were, what happened with your relationship with Discovery?

DR ZWANE: Firstly they wrote me a letter and their letter came early this year. But they were already owing me money. So they didn't pay that money, and then after that I relayed the information to the patients and the patients had unfortunately, they, some of them left. They went to other practitioners saying that they can't afford to pay cash. But my relationship with them is that now they send me a bill that stipulates a particular amount that says that I must pay that amount. I must give that patient's clinical notes and I must give the diaries and must also show I can proof the time that I say I've spent. So the relationship has gotten a sour point where now a lot of my patients decided to stay in and now, they are claiming from their side. So they have to pay the patient but then that means that on their side they are now compromised because they can't reach me to stop me or cancel my connection.

So even though they stipulate to patients that you must go to this listed practitioners, some of them actually still stay with us because of the relationship that was built, that took a while to build.

CHAIRPERSON: Yes. You heard you colleague saying sometimes the problem is, even where the scheme has essentially blocked you, you can't charge the patients directly and they claim back from the scheme, because the scheme will write to them that this doctor

is blocked and you may not use them. If you do, we are not going to honour the payments.

DR ZWANE: Okay. So for me, at the moment I haven't had a patient that came back to me to say that they didn't pay them. I have received that last one that you said, while, because I was, like I'm saying I've been very, very ill. While I was ill, that was the call I received, and to a point where they said to me, if you continue to see them, then we are no longer going to pay. Now, it becomes a challenge because these people don't want to stop. So they still do pay even after they've said that. So to me it felt like threat. That I need to act. So I opted not to act because I thought I didn't ask John to walk into my practice. I have stipulated that I no longer take this so and so practice. John decided to give me cash as per our new agreement. What John does with the invoice, I don't know.

ADV WILLIAMS: And do the patients get reimbursed by the schemes afterwards?

DR ZWANE: Previously they were. So I don't know now that they have sent a new letter saying that if I continue they are no longer going pay because they are saying I am in arrears with them. So it's a bit of a conflict for me because I'm feeling like if you notice a problem that happened in 2016, why didn't you call me in 2016 and you come and call my in 2019. Because if you think there's a discrepancy somewhere, I don't have a problem with proving to you that there are methods I used to use this code. Because for me the other thing is, if you place a code on your list of codes, you expect it to be used. Right? So

now, when I choose to use that particular code, it's based on my clinical discretion that I can stand in court and say that this is why I'm using this code.

If a person is admitted, I use this code. If a person is discharged, an out-patient, I use this code. And I can explain to you why. Therapeutically, in our studies they've shown, that certain interventions are much more helpful for people that are continuously seen in one space while they're doing groups, and you integrate all of this. You minimize how the will be able to do more follow-ups as out-patients. But I can't decide if it's a personality disorder for example, whether the personality disorder will be suicidal afterwards. I can't choose that. So it, sorry, it becomes a little bit difficult when you have to now later on, navigate
how to explain to somebody who's not qualified within your field why you used a particular approach and why that particular approach tend to take more time than somebody who uses a 30 minutes type of approach.

ADV WILLIAMS: How did the complaint against you arise? Do you know how it arose? Did the, when the scheme wrote to you, was it as a result of it being brought to their attention by a member or by somebody else, or was it as a result of a general review process by the schemes that picked up information in relation to your practice [intervenes]

DR ZWANE: To be honest [intervenes]

ADV WILLIAMS: And then what specifically was the complaint by the scheme?

DR ZWANE: I'm not sure if it's a standard letter, but I've seen others with a similar letter like my own. So I as shocked as anybody

can be, because I didn't expect it. I didn't know about it. I didn't hear anything from any patient. When it came through, they said that you are an outline as compared to other practitioners. So my question was which practitioners are you talking about? Are we talking about practitioners that are working in hospital? Are you talking about practitioners that are working outside or as out-patients? Because if you see, even if there's different codes I'm using or procedure codes, I have the right to use them because you've placed them there. Otherwise then give us one code and say use only 86205, only. Then I will understand that I walk in knowing. But if I spent two hours and you don't have a code for two hours, what do you want me to do? To split the two hours or to not? Because that's what I was saying to that guy. That sometimes I stay at the hospital at 11 at night because a person is uncontained, are having a panic attack, but you should have been home at seven with your own family members.

So that code doesn't exist, but that is now when a person say you're using your own. Why do you take time to see them? It's your own choice to do something like that.

ADV WILLIAMS: And have you provided that explanation to the scheme?

DR ZWANE: I have. I have, and I think that's the day I really, really felt so overwhelmed because that guy was literally just bullying me. He said to me, you know? I don't care who decides to do, who told you to go out there and do that and see people for free. And I think for me, one of the patient that actually hurt me a lot, is that, on top of it, this patient is on a top cover. So the top level of their cover and they

generously are paying, but it's not a patient that we can refer to somebody else. I had to continuously try and seeing that patient for free. I got calls from Cape Town, saying that your patient is unravelling. What are you going to do and I'm like, you know what? It's hands tied. I literally remember her calling me saying you know what, let me rather then, let's agree I will see you for free when I have time. So now it's outside of my working hours because I need to do it just out of the goodness of my heart.

So I think those are the things that people struggle to understand, that when you go into the health field, you care for a person. It's not that you are working with machines. You're working with a day to day human being. Until it affects you directly within your family, it becomes difficult. It just sounds like just information and noise. And I think for some of the people that have come to me, who happen obviously because of confidentiality I can't mention their names, because it affects them personally that's when that they say, they say that, you know what, we are happy to also come in and give a word, because they realise that in the middle of the month they don't have cash because our fees are not necessarily cheap when it's cash.

CHAIRPERSON So did you explain what you mean you say you were bullied by the investigators?

DR ZWANE: It's the sentence that I just stated and like I'm saying, I'm not even, it's not like I'm uncomfortable to say it, given the fact that it's recorded. If medical aid want to check their records, it's there. When I mentioned the fact that we actually even go out of our way and

see you patients for free, this person said to me, who told you to do that because it's your own time. You decide to do something like that. And I literally said, you are harsh to say that. At least you should just say that, oh well, thank you for seeing our patients or our clients. We do understand. We do understand that there's a problem. Unfortunately policy says this. But to cut me off like that, it's like I'm just not, I don't count in going out of my way.

So for me that felt difficult especially when I say to him, which is more of answering your question, if you contact your own clients and ask for consent and they give you consent, then I will understand because this, this Booklet 14, makes it difficult without you contacting them. Because on my side they are saying no. Maybe on your side, they will agree. And the guy said no, it's your thing. Go and contact them on your own. All I'm telling you is that it means that if you don't give us what we're looking for, we will stop paying you and obviously they stop paying me.

ADV WILLIAMS: Can I ask one further question. Just going back to your experience with Discovery. You said you were flagged as an outlier, but there're a range of ways as we understand it, that Discovery flags outlier. What were the specific allegations made?

DR ZWANE: So, they mentioned the fact that I have a lot of clients. So and for them they were thinking that if I have so many patients, then it means, this is like on the phone, when I was asking him exactly the same question. He was like, no you see a lot of people. How do you see that, how do you manage to do that, and a lot of people is not like he's talking about like 30 people a day, or, I mean I don't see that

much people in a day? I don't even get to like 10 people or something like that. But I mentioned to him that you should also understand that when I see the patients, who told them to come to me, matters. So I work at the hospital and at the practice. So yes, I may see more people than someone who's working two patients and is working in government. I'm in private. So I can see seven people in a day. And that is within, because it's not ridiculous numbers. It's within my time.

So I said to him if you were thinking that I'm seeing, I have too many patients, like why is my practice big. I'm like if you are in media or in different platforms, your advertising method will be different. So you will get a chance to have many patients coming to you. But it's not that an outlier in a day I see 50 people. No. It's just that why is my practice growing because other people are not seeing, having grown numbers as much as you have. So that's the one. I mean obviously you have a locum but to be honest I have not seen like so many people in one day.

ADV WILLIAMS: So just to be clear, so I am understanding the evidence clearly. So was that the only allegation?

DR ZWANE: The other one was the time. That they wanted me to proof that I do really see them by the diary. So I said, if you come to our work setup, we work at Akeso. So Akeso is a clinic where we have psychiatrist, psychologist and social workers that work together. So we're all allocated particular timeframe when we can see them. They first have to attend groups. I can give you a diary and say which period and when was I seeing them but I can't tell you exactly at four, five past because sometimes you find that she's

waiting for me. The psychiatrist call her. I had agreed this time for the patients. So I don't know where you're going to get the proof. So I don't know if there's a camera that's going to proof that I did see this person at that time. But the time have changed from the diary to the time that is on the book, so there could be a bit of a change there because they wait outside for us.

I don't know, others, people might have different experiences. They wait outside and then while you are waiting the psychiatrist has called a patient or the social worker has called a patient. Now you have to wait a bit longer to see, sorry, to see your particular patient. So those are the things. The other one that was also raised was the code. The procedure codes. So the procedure codes I explained to them that the timeframe that I sometimes put there, is not even a true reflection because you don't have. I avoid to put the right one because you would, you'll complain. So end up putting maybe 86206, yet I spent 2 hours with that person. So my other time is not calculated there. So they will ask, why do you put 86205 and 86206 and 8207? I'm like because sometimes they stand, are over time.

Sometimes there's an approach I'm using. There is some approach called intervention approach. Where that intervention, I mean intensive, sorry, intensive approach. It means that you first integrate some of the things that happened in the groups. And you integrate how the person is, then you start with some of it. Sometimes you have role plays. You sit across a chair and you engage with that patient. So you, it can be not as strict that all psychologist do 55 minutes or they do 45 minutes, or

they do 15 minutes. So just because you does 15 minutes doesn't mean that we are trained the same. If she's trained psycho dynamically, she may stick to 15 minutes. If I'm not trained psycho dynamically, I may not even like it. I may be open to, I need to focus on this because you're in hospital. So that's when the changes and the different codes that I had to make them think maybe there's something different.

ADV WILLIAMS: When they sent you the letter, did they say that you're an outlier in relation to your peers?

DR ZWANE: Ja.

ADV WILLIAMS: And do you understand how they define piers? Do you understand what the definition is of piers in that context?

DR ZWANE: It's not written. So as I ask, I said to them explain to me what do you mean by that? And they said I have too many patients. So having too many patients is not, it's here and there. So for me I wonder that do you rather, I have one patient per day or would rather that I have four. Stipulate and let me sign something that says that. When it comes to patients that are Discovery based, per day, you can't see three or more.

ADV WILLIAMS: But you would have a diary or a schedule of the patients you've seen on a particular day. Is that right?

DR ZWANE: I should if it's at the practice. At the hospital it's a bit of a difficulty. You can have their names but to have a proper diary to say at 10 past 9 I will see this one. It's slightly different. I mean, you can, the people work at Akeso will know what I mean. But in terms of the practice, I do have that. And I did say that also bearing in mind that

because you are talking about years back, years back I have notes. I am obligated to keep the notes for five years, but with the diary, if you are working with the practice where you are all joined in one reception, I have to depend on the fact that did they keep everything for 2016 somewhere filed. That would be a bit of a challenge for some of the diaries.

CHAIRPERSON: Do you have anything else to say?

DR ZWANE: No.

CHAIRPERSON: Thank you very much. If you are.

DR ZWANE: Sorry, I'm tired. Sorry Chair.

CHAIRPERSON: You are released.

DR ZWANE: Is that all?

CHAIRPERSON: It's Doctor, so thank you. You are released. You may attend to your other personal matters.

DR ZWANE: Thanks.

MALE 2: She leaves. We were requested by all the members to observe a moment of silence for our members who are depressed, who committed suicide and some of us amongst us, who have really, going through traumatic clinical situations, adversely affecting or seriously affecting their health. So we just, just one, five seconds.

CHAIRPERSON: Alright. Shall we do that five seconds then.

MALE 2: Before she leaves.

CHAIRPERSON: Thank you. Right. Dr Chabalala.

DR CHABALALA: Okay. Thank you Chair. Firstly we'll like to extend to our appreciation to the Council of Medical Scheme for the opportunity to, which we have been given to submit the information in

writing relating to the conduct of the medical scheme and medical aid administrators and the designated service providers, consider to be both unethical and unlawful. In essence such conduct as we have presented or on the presentation involve the manipulation and extortion of healthcare practitioners, which fall within the terms of reference for the Section 59 panel as defined in the Circular 45 of the Council of Medical Schemes. The Solutionist Thinkers group are here because they wish to participate in this process and to make sure that the justice is served to all the healthcare professionals and the patients and the medical schemes themselves, to say they function within the confine of the law.

I'm going to add on what the Chairperson Nomaefese have alluded, and I will start with the declaration term basically

on what one of your colleague have indicated more official on Regulation 15(J). That the Regulation 15(J) doesn't only, and where it says the medical aid have got the monopoly to request the file or the clinical notes, but it also goes further when you look into 15(J)(2) to say a, but a written consent of the patient is needed for that. So the contract like the previous speaker who have said that the, on Section 10 declaration, that contract which has been entered by the member of the scheme and the scheme itself, it is between them but when you want to involve us practitioners as third party, an express consent. When you go, you read that section further, it says an express consent by the member is required. So the member needs to come and give consent to say I'm asking you to release that information to the particular medical aid.

So we, the medical aids can't just look into it blanked it like that

and then they put a full stop where a full stop is not needed. And maybe before I can go further, I will also like to highlight on what you did ask Chair, like why is the scheme important for the survival of her practice. Why not charge the patient directly. One, we understand the demographics of black people or black patients because once they rely on a medical aid, it is very difficult in their circumstances to can say they will go and get cash somewhere to come and pay you. That is the first thing. Second thing is, some of the patients which we have, we had this patient before they joined the medical aid, so when they decide to join the medical aid, they have seen that as a means to can look after their health rather than to can say I will go into my pocket and pay. That is the second thing. Thirdly, yes, the patient will move or change the practitioners if you go and tell them that you need to pay me, then I can pay you, then your medical aid will refund you. It is very inconvenient to most patient to say, when I come I need the treatment. I didn't have money. And even if I go and pay you and wait for the money, I'm not going to go to the scheme, and they give me that money today. It is going to take a week or two depending on the processes which the particular schemes follows.

Some of the scheme needs an invoice to can say they, to proof that you did pay. Whereas other schemes basically, when she was talking about indirect payment, when I submit my claim without even issuing the invoice, they will pay directly to the member. In that regard, we can say that is where most of the fraud nowadays is happening because now, you are giving a patient more power to can decide whether he can just definitely bring that money for the service which have been rendered or

he can just use it for what he perceive it as important at that particular time. So we are saying such process it is very wrong, and if you look into that, more especially as a point of departure, when we look into the very same Section 59, that is paragraph 2, when it relates to the payment or re-imbursement of the health practitioners by the medical aids. There has been a judgment. Basically it's commonly known as Sechaba judgement, because it was by the Sechaba, and it was handed down by the appellant division, which is the second highest court in the land. Where in summary, I'm not a legal person, but you'll definitely help me. But if you [intervenes]

CHAIRPERSON: We've got three sitting here, so.

DR CHABALALA: Ja. In summary what it says is, the medical aids doesn't have a right to chose whom they pay once the service has been rendered. One, when the patient comes to me and I offer the service and I submit the claim to the medical aid, that person has given the authority to can submit on his behalf and so that the medical aid can reimburse me. So that's what, how I understand on the summary of that judgement. And then if you look into that, again, also it was the judgement by Judge President Ngoepe. I'm sure it was in 2016, where it has recommended to the Council of Medical Schemes, to can say, it was against Polmed the SAPS medical aid, SAPS medical aid, to say, it is not really, it is not their right, the medical aids to decide who they want to pay.

Once the service has been provided by the healthcare practitioner, such needs to be paid to the healthcare practitioner because he submitted an invoice on behalf of the, on behalf of the patient, and my

understanding is that the Council of Medical Scheme, as the regulator of the medical schemes, have just said on that report, they do nothing in that regard to can force the medical to can follow in that because we do see most of the medical schemes who refuse to pay practitioners. It might be based on the fact that they are saying the schemes, the practitioners are uncooperative when they claim that there is some perceived fraud or erroneous claims which have been paid. As I have alluded before that most of the schemes they will tell you that we pay in good faith, but we are saying as practitioners, we also give the service in good faith and we are hoping that such should be reciprocated by the medical aids.

When we look, I will just juggle on, if I remember the page, I will tell you. What I've done is because we have given us the portions which we need to submit, some of, mostly all of the things which I'm going to say, it's definitely here, but I'll just decided to take the portion which I was going to talk about and summarise it. Again, on the very same executive summary as I was, I'm still talking about, we do see the three role players when it comes to medical aid and health practitioners and the members. Then you have got the medical aid itself. You have got the medical aid as administrators. Who'll try to separate themselves from the medical aids. Ja. There are those who are medical aid but they do administration but there are those who are administrators only but they are not medical aids, and then on the other hand, you have got what we, what it has come to us to be known as network or the designated service providers. Which we can say they are also administrators, and some of the questions which we have with them is that most, some of them are not accredited to

function and, but the Council of Medical Schemes is not acting on them.

The problem where, if you have got someone who functions and is not accredited is that they are not accountable to anyone. So we are saying all the designated service providers need to be accredited so that they can be held accountable by the very same CMS. Whether they have given them an exemption to function, they need also to hold them accountable to all what we feel it's unlawful or unethical conduct by them. And the fact that maybe you, when you have a problem, you'll complain to the scheme which is contracted to the DSP, the scheme will tend to take you back to the designated, to the network. In that case we are saying the scheme it's trying to run away from, there obligation. They are [indistinct - 1:51:17.7] their duty by trying to say, if you want something, go to the designated service provider because that's the person who is dealing with you.

But we are saying our contract basically, even though some do sign with the networks, some refuse to sign, but our problem is that we are not servicing the members of the networks, but we are servicing the members of the medical aids. So when we have got a problem and we encounter problem with the network and we don't find justice, we need to go back to the medical aid itself.

CHAIRPERSON: Tell me something. I mean if I look at a typical profile of a general practice, how much of the revenue is dependent on medical aid?

DR CHABALALA: It depends on where; it depends on where your practice is located.

CHAIRPERSON: Ja. But on your, on average in terms of your own members?

DR CHABALALA: In my case almost 98%, it comes from the medical aid scheme.

CHAIRPERSON: Alright. So I mean any problem that you have with the medical scheme, essentially it means you must close down your practice?

DR CHABALALA: Yes. And as the previous, the last speaker has just alluded. One, or not the last speaker but the Chairperson has alluded, one. We also feel when the medical aids write to the patient to can say, you cannot go and see Chabalala. I think they are entering into a territory which doesn't need them. I think the best thing it's to say, they can't decide on my patients whether they have got the right to see me or not. They can't decide on that. That is our main problem. If a particular medical aid has got a problem, I think it is for them to deal with me and then it should end up between me and the medical aid. But they cannot come and say we have got a problem with a particular doctor; you cannot go and see that particular person.

And I'll also put something on the racial profiling allegations. At the moment, because we are still saying it's allegations because we are saying we don't have a concrete evidence and they'll want you to help and, us in that but we believe there is a serious case about that. Because as a group we are always, when things like audits come, we are always contacted by our members to give them guidance on how they need to handle those audits, and in most cases, basically the audits, when you go

there, it is not a matter of it is an erroneous claim like we'll like to belief. Basically, one, it's perceived fraud or they will tell you about incorrect billing. They will tell you about excessive pricing on your services and once they, basically those are the three main problems which they, when you go there, they will tell you.

If it's, they're telling you on a fraud, they will tell you incorrect billing. You are charging for this codes where you are not doing. Other than that they will tell you about excessive pricing. And in most cases like when you sit with them and tell them that if you look into, I'm sure the committing commissioner will follow us, is that they cannot come and tell me how much I need to pay based on the ruling by the competition commission. That is one thing. The second thing is, if they have got a tariff amount, even if I go and claim R6 000 on a particular procedure code, if they are saying their tariff it's only R3 000, then it is much easier to can, we'll pay only R 3 000. The other one it will serve as a co-payment but some of the medical schemes don't do that. They are saying, they are paying R6 000 and after they have paid you R6 000, they say, hey my brother. We've got a problem with you. You are overcharging our patients.

But I've got a code and I can just put my tariff on that. I can just put my price on that. I can't be dictated by any one based on the competition act. So if I were to charge private tariffs with the codes, it is up to the scheme to pay what they believe. It is their code, but they can't come and tell me that that is excessive pricing. They have no right in telling me how much I need to charge. Unless, maybe I have entered into an agreement maybe with the designated service provider to say I signed

this way. When I see your patients, I will charge that, this much. But if I am not part of the people who have signed that, you have got no right you can say after they have paid you and they call you to say those are, you have charged excessively on their patients. That we think it's very much unfair and if you don't co-operate, then they will come and basically come and reintroduce Section 59 and said look, we are going to put you on indirect payment. Or we are going to offset a certain amount which we think you billed, you have benefited incorrectly. We shouldn't have paid that.

Then they can just send you to say for the particular four years, you have claimed R4 000 000 and we think R1 200 000 is definitely, you shouldn't have claimed that and then want it. If you agree, then you, you sign an acknowledgement of debt. Not to say you agree that you have done wrong. That is one thing which we need to clear here today. You sign an acknowledgement of debt because, one, [intervenes]

ADV WILLIAMS: Dr Chabalala, sorry, I need to just interrupt because I was waiting for you to pause, but you weren't pausing. So before you leave this topic, I just want to understand. I hear your submission about the unfairness when it comes to the tariffs and the claim of excessive pricing where the scheme can just pay what they, what they understand to be the tariff and not the full amount and the balance can be a co-payment or whatever. Why do you say that's racial profiling though?

DR CHABALALA: Well I'm saying it's racial profiling because if you look into the more officially white practices, they do that. If you have

gone into a white practice or other practices, you will see that they have written that we don't charge, we charge private rates and then they charge whatever they want, and we don't see those people being called there.

ADV WILLIAMS: Can I ask a slightly more pragmatic question just on that point. What do the schemes use as the, let's say, baseline for determining what is or isn't excessive in those meetings?

DR CHABALALA: I can't completely answer that one but after the competition commission ruling, there has been something which they called NHRPL. Which is National Health Reference Price List. So most of the medical aids normally used to use that as a guidelines.

ADV WILLIAMS: Thanks, you can continue.

DR CHABALALA: Thank you.

CHAIRPERSON: Just want to make sure I get this numbers right. So you have the reference price list, that's published. Everybody knows it.

DR CHABALALA: Yes.

CHAIRPERSON: That's the first number. But then you have the tariff of the scheme. That's another number, and then you have your actual cost to the patient. That's the third number.

DR CHABALALA: Yes.

CHAIRPERSON: Alright. And so where does the issue then of excessive pricing come in there? Because presumably the scheme uses the reference pricing to decide its own tariff and you charge within that tariff. If it is in excess of that tariff, it's regarding as co-payment. So where

do you then become an outlier for charging more than you should be charging?

DR CHABALALA: You don't become an outlier. What we are saying is as that is a guideline, it's a guideline. It doesn't mean that I need to stick to that. I also need to see my worth. If the guideline says it is R800.00 my consultation, if I say my consultation is R1 000.00 it means R2 000.00 should be a co-payment. But when I, you see mostly we have got what you can, also called as split billing where some medical aid will say we don't want to you split billing. And what you do with that is, I have to submit the whole R1 000.00 to the medical aid to say I have rendered the service, my price was R1 000.00 but on my scheme, on, on, on, if I don't split bill the, the invoice it will come as medical aid portion R1 000.00.

So the medical aid portion, the medical aid has got the right to say we are not going to pay you R1 000.00, we can pay you R800.00 and the R200.00 will go to, to the, to the member. So when I get the remittance to say the medical aid have paid out for my patient to say your medical aid it didn't pay the full amount. Obviously they also sign on my invoice to say if the medical aid doesn't pay full amount or doesn't pay, the member is liable. So there is no way in which a medical aid can come and tell me that this is an excessive billing. That's what I'm saying. The medical aid have got no right to tell me that it's excessive pricing on whatever I charge. That is my price, it is not excessive.

And if they are saying it is excessive it is, what is it

based on? Is it based on the National Health Pricelist? No, I don't follow that. Is it based on the Tariff Code? No, I don't want to follow that.

CHAIRPERSON: There could be another model of excessive, you know in the sense that you've spent more time than you should have on a particular patient but that is not the same thing as the actual amount that you've charged.

DR CHABALALA: Yes, sometimes you spend a lot of time and just because you have got a price which you normally charge, you are not going to say normally I charge R300.00 on this, then because I've spent more time I will charge you R600.00. You stick to that, to whatever you are doing. So in that case the medical aid can't say now you are undercharging our patients because you see them a lot, you see, you spend more time with them but you charge little. The only thing which is applicable to them is the other way around. So such things need to be balanced basically to say the medical aids can't and will never be allowed to, to, to really determine what a particular practitioner needs to charge.

It sh-, that, they cannot take that right from me because I am the one who run that practice, I am the one that knows what I am doing and basically in most cases I've calculated my, what I charge based on the time which I spend with the patients.

ADV WILLIAMS: Just a follow-up on that Dr Chabalala, I presume, I am really trying to understand this, also from what the medical aids might say and of course they will come here and say it for

themselves but just to give a moment to expand upon your submission. So in your submission you give an example of how the medical aids send these standard letters and it is one of the reasons that your flag does an outlier is this and the wording is “higher cost per claim when compared with your piers”. Now is it this flag that leads to the discussion around excessive pricing?

DR CHABALALA: It is one of it but not, sometimes not really and can I, let me further clarify you on the, on the PR review basically. The PR review its, its, it’s the mechanism which the medical aid maybe use to see how you, not how you claim basically as they will want to put it. It is how, how your practice is performing compared to people close ar-, in the amenities next to you. But there are different ways in where one practice can always perform better than the others. One, they need to look into the practice and how you do your things. The same things is you might be having two, Shoprite / Checkers, one is here and the other one is let’s say at Eco Park, people coming from that side might pass the Shoprite / Checkers in Eco Park and still come and shop here.

So you are not going to say this practice because its, this Shoprite / Checkers it’s selling more compared to the other one and you say it means there is a problem with this one here. There is no problem. It’s maybe it is the marketability, how this people are marketing. So if I’ve, I am in my private practice and then there are also six doctors around me and I market my practice well and I do my job diligently, obviously my claiming pattern in all the medical

aids will be high. And then in this regard, my claim pattern in a specific medical aid might go high and that is common because one, if you look into the private practices which have been set up maybe let's say in the townships or somewhere where one, you'll find that there is a municipality office close to them or there is a police station close to them.

Those people, let's say it is a police station, it means they are in a closed medical aid, which means most of your patients will come from that particular medical aid. By nature of seeing a lot of those people who are close to me, my claiming pattern within that particular medical aid will definitely go high. If you are in a municipality you will find that there are few medical aids, you have got LA Health, you have got Hosmed, you have got Discovery. Those are the only medical aids which are contracted by the municipality. So, and we know our people, when they decide to say let's, let's go into Hosmed, I find joy in that, he is able to convince majority of the people within that particular area who can shift from one particular medical aid and then joint that.

So, when January / February comes and you find that many people have changed to a particular medical aid and if my claiming pattern let's say it is Hosmed it goes up, Hosmed will say why, we used to pay you so much but your claiming pattern have just jumped. But they don't, what they don't realise is that most of the patients whom I've, who I am seeing it's no lon-, it is not new patients, they are my old patients but they have changed their medical aid. What

they need to look is that because the practice of this particular person is going high, can't we look into, into this people why it's like this.

Are the claims coming from the, most of our old pa-, members or is it new members? So in that case it can also help them and the fact that they don't even go and say this particular practice was seeing so much it has gone up but now it has gone back down. The problem in that case my claims at Discovery will always go up. When they move out from Discovery medical scheme, my claims at Discovery will go down and then if they are going to Medscheme, which means my claiming pattern at Medscheme will go up.

But the medical aids they are not interested in that, they are just interested in when they talk about PR reviews to say you are seeing a lot of people I mean compared to your piers so it means there is something wrong which you are doing and in essence there is nothing wrong. And like we say, when you go into that and you reach that log and you realise that my practice will just shut down, you have got no choice, you have to sign an acknowledgement of debt, then you start paying the medical aid, then your life continues.

And what I am saying is by signing an acknowledgement of debt, are we saying the medical aids themselves are the ones who are promoting fraud because if they are saying that is fraud but if you pay us so much we can let you continue to practice, continue to work like that, you are paying us, what is that? I think it's one of the things which I can say, even the medical aids themselves they are

promoting fraud in that because they, they, they've got a duty to, to report that.

CHAIRPERSON: I mean, so if you are saying we are not signing the AODs because we are acknowledging liability, why are you signing them?

DR CHABALALA: If you don't sign the AOD and they say well we are not going to pay you. That means you are closing down. You don't sign, you are taken out of the payment system. So they don't take you to SAPS to say here is the person, this is the fraudulent claims which we see, which is basically the medical aid have got a duty if the fraudulent amount is over R100 000.00 to report you to the security cluster to can say once the fraudulent amount is more than R100 000.00 it is their duty to report that to the SAPS to do an investigation. You will see they will send you that you owe R700 000.00, they don't report you.

If you refuse to sign an AOD that money it will just continue a correspondence and no action but you are taken out of the system being paid. So in most cases many people have find joy in that to say I am going to sign an AOD, I will continue to work but the moment you finish the first AOD or before you could finish another one will be coming, another love letter to can say can you visit our office, there is some irregularities which we have picked up with your practice and when you go the very same procedure will be done. If you agree to sign, you sign, you continue to work. So we can say all these medical aids which are promoting the signing of

acknowledgement of debts, they are the ones who are promoting fraud where it is not there because to me that is fraud or it is, it is a me-, it's blackmailing, they are blackmailing me.

You don't do this, we are putting you out of the system and will also inform other medical aids of your conduct. So you have got no choice and in most cases you will see if one medical aid investigate you immediately after signing, majority will tell you that a week or two after that they will receive another love letter from another administrator talking about you visiting their office so that you can, they can discuss your, your claiming pattern.

ADV WILLIAMS: Sorry Dr Chabalala, are you, I just want to confirm, is this your personal experience?

DR CHABALALA: It is my personal experience and the experience of other practitioners.

ADV WILLIAMS: And have you been reported to the HPCSA by the administrators?

DR CHABALALA: Not at all. And I will come that on my submission that they've got the duty if they feel there is an unprofessional conduct, which we have done to can report you to the Health Professional Council. And that its if you look into our notes it is where we wrote the legal status of payment arrangement between the healthcare practitioners and the medical schemes where I've indicated that the payment arrangement between the practitioner and the medical schemes are legally binding if they are lawful. They can't be legally binding if they are not lawful and if they are unlawful,

they are only legally binding if they are lawful.

An example is the unlawful agreement we, we, we can disc-, disc-, put it as the one which is entered or is reached with a condition that a medical, a particular medical scheme or a particular medical aid administrator will not report you as a practitioner to any law enforcement agents or your regulatory board, to your regulatory body if you agree to their terms and conditions. So that is unlawful and that is what is happening time and again. Although the medical aids, the medical aids themselves may exercise their choice in terms of reporting unprofessional conduct to the Health Professional Council or any regulatory body. If it is a pharmacy, it's the Pharmacy Council. If it is nursing, it's Nursing Council.

They have a duty in terms of common law and Section 66 of the Medical Schemes Act to report practitioners to, to the regulatory body if they feel they have done something wrong. So by not doing that because their main aim to ask is just to make sure that they extort as much money as possible from the practitioners.

ADV WILLIAMS: Sorry Dr Chabalala, you said it was your personal experience, in relation to which scheme have you had this experience?

DR CHABALALA: With me it's only one scheme. I am not sure if I can just make a submission in the correspondence if they, if, if, if they haven't submitted but I wouldn't like to mention the scheme here but it was a particular scheme. May I continue?

CHAIRPERSON: Yes, you may.

DR CHABALALA: Okay. And then the, the, the chairperson, the chairperson has also, but I'm sure I've done this one, the, the access of clinical records where I've said the, express consent is needed from the members. The medical aid schemes basically when they do the, that, that, that section 10, I think they need to make sure that it's all covered. One, unless if there is a court of law, court order to can release the, the patient's records, you don't need anything unless if the regulatory body, you have been reported to the regulatory body so the regulatory body can request that because they will say somebody is claiming that you have done something so we need to see that.

So those are the only two conditions where you need to submit the clinical records or the clinical cards. I think I've already alluded that. And then I will like to conclude with the audits basically, which we, we, we think the random audits which are claimed to be it's, it's, it's random, we never believe that they are random. My take will be in the, in the history of South Africa basically, the legacy of *Apartheid*, we still have more white healthcare practitioners compared to blacks even though we have more blacks than whites. And majority what we have seen, majority of the audits are not done to white practitioners even though they are in numbers but the audits are only, it's, it's in, in, in numbers when you look into the ratio it's more to blacks, Indian, let's say blacks which covers both Indians and coloureds, let's say just put blacks there rather than to say blacks and Indians.

ADV WILLIAMS: Where would we find that ratio?

DR CHABALALA: Eh?

ADV WILLIAMS: Where would we find that ratio in your submissions?

DR CHABALALA: In the, in the, I will, I will, I will later e-mail it to Grace and then she can give it to you.

CHAIRPERSON: No it's, we've got it at page 18, paragraph 18 but the problem is that I don't know where it comes from.

DR CHABALALA: I, I will, I, I did search it and that's what I am saying I will, I will make sure that you get it and I will, I will e-mail it to you, that the majority of healthcare practitioners is still whites compared to blacks counterparts.

CHAIRPERSON: No, sorry, I think we are talking about different numbers. The number I am interested in is that in page 18, paragraph 18 of your submission you say the fact that more than 95% of those being audited are blacks speaks for itself. So where do you get the idea that 95% of audits are targeted at black practitioners?

DR CHABALALA: To, to, to, to put that, we can't just really put that as 95% but majority, let's put it as majority of those who are audited are blacks, majority. And that number it's not 95, we can't quantify it, it might be more than that but it can't be less than 80.

ADV WILLIAMS: What do you base that on? You said that evidence you are still going to submit to us.

DR CHABALALA: No, no, the evidence which I say I will submit is

that the majority off the healthcare practitioners [intervenes]

ADV WILLIAMS: Oh I [intervenes]

DR CHABALALA: … are whites [intervenes]

ADV WILLIAMS: I see.

DR CHABALALA: … compared to blacks but the audits are, most audits are conducted to blacks which in itself it doesn't make sense, what, what, what, why I am saying that is if you have got let's say 10 green balls and you put them, 8 green balls you put them in a, in a box and then I've got 2 orange, when you've got 10 balls and they blindfold you and they say pick up one ball there, the chances are you will, you will pick up the green balls because they are in numbers. So what we are, what I am saying is we have got more white healthcare practitioners compared to a black counterpart but we also see most black coun-, practitioners who are being audited. And even though within that number of black practitioners those of African descent are the worst.

ADV WILLIAMS: And what do you base that on?

DR CHABALALA: I can, my, personally I can base on the fact that I have gone with most practi-, practitioners to the medical aids to go and represent them on, on, on, when they were called by the medical aids. So I, I, I have seen that most of the people who I go with is, it's mainly blacks, and I had only two Indians whom I've gone with but almost everyone was black.

CHAIRPERSON: Am I right that it's purely anecdotes?

DR CHABALALA: Purely anecdotes, I agree with you.

ADV WILLIAMS: Follow-up question on this paragraph 18 of your submission, so you've said that we, we challenge the medical schemes to show us the number of white practices being audited but the issue of confidentiality comes to play. Does this mean you've actually written to the medical schemes and asked them to provide these numbers?

DR CHABALALA: We, we told them when we, we go with other practitioners and even when, when personally I went there myself, I told them because I, I disagreed with almost everything from the, the procedure in which it is done. Then I told them to say show me the white practices which were, which you are investigating, then I can provide you with all the information which you need. Show me a letter which is written to a white practitioner then I see how it looks like. Obviously if you have written Mr Viljoen, I won't know where he is, but I need to see Mr Viljoen, the letter and see if the content of the letter which I have received and that of Mr Viljoen is the same.

But they have refused based on confidentiality, that whatever they do is between them and their practitioner, it can't go to the third party. That's why in most cases some of us have refused to co-operate in inside things.

CHAIRPERSON: Your colleague, Ms Gatsheni, she told us that the information requested by schemes from white doctors and black doctors differs during the audit phase. Do you have any experience on that?

DR CHABALALA: I don't have any experience because I haven't

seen any white practitioners being called there but I've seen, I was trying to check on my, my, my documents, I have seen one on social media where a white practitioner basically to say it's, she has seen people are being requested to submit their recent clinical notes. She was never requested of such things. I was looking into, into that information but it looks like I've deleted that, but it went into social media, it was two white practitioners if I remember well. It was them; it was the very, the white practitioner who said themselves that they are not requested to submit most of those things.

If they just go there if they have been called and then it's just a matter of a, to verify, verification that you have seen such person. No clinical notes required even though we know that the standard, the letter is standard, they only change the name of the recipient there, but everything is there. What we are saying, if the white practitioner say no I was called no clinical notes were required even though my letter says that. It was just only a matter of valida-, va-, validation of the claims where only I was told to validate whether I have seen those people or not and the process was done within in a, in a, in a matter of minutes.

CHAIRPERSON: Thank you. Do you still have more submissions?

DR CHABALALA: No, in the interest of time I will like, we still have two colleagues who can do that and then we can collaborate in terms of their, their failing but I think I am done for now.

CHAIRPERSON: Thank you. Alright. Look, we have a slight challenge. We had planned to finish your joined submissions by

12:30, the time now is 12:52. How many of you still have to speak? Three?

DR CHABALALA: *Ja* but the others are just brief.

CHAIRPERSON: Alright. Look we can continue now until half past one and take everyone's submission and then we take a break at half past one. But I don't want to curtail you because you know we shouldn't be driven by time; we should be driven by the importance of your submissions. So maybe I am wrong in saying we should continue now. We should probably just take a break even if it is for 15 minutes and then we've been sitting through a rather tough session. So maybe let's take a break for 15 minutes and we come back and we continue with you. We will have to make arrangements for the Commission, so we are adjourned. One member? Okay, well that's fine. I, we have to be flexible. I think you must sort out your, the fact that your colleagues are already heading off.

PROCEEDINGS ADJOURN

PROCEEDINGS RESUME

DR SEECO: Good afternoon, mine will be very brief in that I have already submitted my submissions to you. So in case maybe that you will want to in the future to come and you know cross-examine me you know, that would be fine. I have submitted to, to, to you the following. I am a general practitioner who have been in private practice for the past 24 years. So I was then confronted by a medical scheme [intervenes]

CHAIRPERSON: Sorry, just remind me your surname, is it Nako?

DR SEECO: Seeco, Seeco, J Seeco.

CHAIRPERSON: Seeco, yes of course.

DR SEECO: Yes, yes.

CHAIRPERSON: Thank you. You are saying you are a general practitioner?

DR SEECO: Yes. So I was approached by this, I received a letter from the scheme on the 26th of January 2015 whereby I was told there was an irregular claiming pattern to my practice and that I should provide them with files. And in my submission, well I've indicated, they have given the reasons why, why they have sub-, withheld funds to my practice, and they told me that they will want [intervenes]

ADV WILLIAMS: Dr Seeco, sorry to interrupt you. Are you talking about a submission that is attached to the main submission and if you are can you point us to the pages we should be looking at?

DR SEECO: Well, *ja,* I think the group will attach it because I had already submitted it to you, to the, to the council before.

ADV WILLIAMS: So it's a separate complaint?

DR SEECO: Yes.

ADV WILLIAMS: Okay, thank you.

DR SEECO: So that's why I say that [intervenes]

ADV WILLIAMS: And not to worry, we have those. I am just trying to know where to locate the documents.

DR SEECO: Yes.

ADV WILLIAMS: Thank you.

DR SEECO: So then there were conditions that were put in, in line with the request that they will only pay me as soon as I have given them the files and then the at the files must be given to them before the end of that month. And then they wrote to me a clause that says I, they said:

> "Please note the application for membership includes a clause that says the following: I agree the scheme is entitled to obtain a diagnosis of any condition for which the scheme is required to make payments in respect of services rendered to members or their beneficiaries registered by them as prerequisite for such payment."

On the strand of this I then submitted the claims, I mean I submitted the documents to the medical aid scheme and then it was followed by subsequent follow-ups to find out if did they receive the claims or no-, I mean did they receive the documents or not. And the lady who was investigating me didn't come back to me but then I'll just be very brief. There was another lady that worked at the scheme that I requested to send the documents because this other lady who was investigating me did not come back to me, the e-mails are there. And the lady then who was responsible for investigating me then intercepted and said I shouldn't have given the, the, the claims to the lady that I have requested before.

So she then wrote me another letter to say that look the condition still stands, we are going to withheld payment to your practice until such time we get the documents, bearing in mind that I had already given her the documents. So after some time I then went to see them because she kept on saying that she had not received the documents, I went to the head office somewhere in Roodepoort and when I arrived there she didn't want to see me but fortunately when I purs-, you know I resisted to, to see her. She did come and then she was with another colleague. They then said to me look this is what we want, they gave me, you know the conditions of, for me to can be paid but they said I must actually give them the files.

And then I did give them the files, I did e-mail the files and then they, in my e-mail you will see that they've acknowledged receipt of the, of the files. And then they told me that the verification process was going to take place. So we then, I then wait, they told me it will take about 10 days. After 10 days there wasn't anything coming from them. I then decided that I should phone the lady, I think it was on a Wednesday, to find out about the outcome of the verification. When I phoned her she said no the files were, there was one file that was missing but then I asked her but you have written to me that you have acknowledged receipt of the files but then why now when I want the outcome of the verification, you know you're flip flopping.

Then she said no that's how, that's how it is. Then I said okay

I will come, that was on a Wednesday, I will come on a Friday to come with the files so that you can then tell me which are the ones that you did not receive. Then on the Thursday because it was February month I had to pay SARS, I had to do all the arrangements you know to pay for the practice so I was not in the practice the whole of the day, then I had to come back late and work very late. Then on Friday I went. I remember saying to her that look please be available on that particular day so that we can get the matter to closure.

So, on that Friday when I arrived, she was not there. In summary I then took the matter to the Council for Medical Schemes and the Council for Medical Schemes came with a, a ruling whereby we were supposed to, you know to work together. It is in my submission. So they did not comply with the ruling instead they actually, how could I say, they, they waive it from the ruling and then they wanted to introduce a parallel process. And then when I went back to Council for Medical Schemes to say look these people are not responding accordingly, Council gave them an extra 60 days. And then the Council advised me to meet with the CEO of the medical scheme together with the forensic investigators to sort out the mess.

We met but unfortunately, they did not want to comply with the ruling. They told me that they do not recognise the ruling and that's how it is going to have, it's going to work. And then from there I wrote to Council for Medical Schemes to explain to them that look

they are holding your ruling in contempt, what then? Then Council was very [indistinct-2:32:58] and then on the deadline of them to submit to Council, Council wrote me a letter to say that they've written me a letter about the ruling. Then they misrepresented in the ruling to say that you know everything we discussed was well and noth-, they didn't, I have agreed to anything.

And I did-, and then from there Council wrote me that, sent me that communication and then communication I wrote back to Council to say no that was not true, we never had that kind of a situation. Then later on I was then fined R1 million, R1 037 840.18 and the reason was I did not attend a meeting and then they said the used Section 59.3 and that was the reason. But yet Council explained to them about Section 59.3 that it was misplaced because they didn't find anything wrong, they failed to provide substantial evidence of my wrongdoing and all that but then they wen-, then they went ahead with that.

So after some time I then approached Council again you know to complain that this is not fair because the scheme now already is no longer paying me even for other medical schemes. And then Council then wrote and then I'm, I'll, I'll say this enclosure, they then wrote a letter, maybe I should read it to you. They say:

> "We have received feedback from this medical scheme and upon reviewing it certain anomalies were identified in the claim quantification and the formula

applied. We have raised our concern with the quantification formula. There were also information, which was not adequately addressed, and we could not forward same to you without raising the issues with the medical scheme. Other issues relate to quantity of sampling and the rationale behind the 61% aggregation. We will most definitely revert to you soon with comprehensive feedback, but it must be noted that the process is rather cumbersome as the medical aid has changed administration from Medscheme to Discovery Administrators. The funds on hold have reportedly been transferred to the new administrator. However, Medscheme has to first clear the quantification discrepancies before we can engage a disciplinary hearing action. I trust this will suffice for now."

So from where this was written on 3rd February 2017. Now I had a problem as a practitioner because then I, I have a lot of patients that I had to be seen. It was Polmed and Bonitas. And I

raised this question to the scheme that but why are you still prejudicing me of not paying me for work that has been done for other schemes where the, you know, I've done nothing. And so there was no answer. I wrote to the CEO of the scheme, there was no answer. As I speak now, I am still seeing the members because they are my members and the monies that are supposed to be sent, paid to me are still being withheld by the scheme.

The members come, they show me that yes, the scheme has p-, has paid into your practice but this we don't understand what is happening. Some of my members have tried to, you know approach the scheme, but the scheme has not actually even being helpful to me. So like I say I am still seeing the members and I am not being paid and the amount is very huge.

CHAIRPERSON: What's the amount?

DR SEECO: I think the amount rais-, comes to about 5 million now.

ADV WILLIAMS: Just repeat that number.

DR SEECO: [indistinct-2:36:53] plus 5 million. And this is from 2014 up to now I am not being paid by the scheme.

CHAIRPERSON: Which scheme is this?

DR SEECO: It's Medscheme Holdings.

ADV WILLIAMS: That the administrator, in which schemes [intervenes]

DR SEECO: The scheme was Glencore Medical and Bonitas and Polmed and this has really impacted on my, you know my family

because I'm caught between, I can't help, I can't fire the patient because the patients have been with me for many years. So for now it's just this, the practice reserves that is keeping the practice going.

CHAIRPERSON: How are you keeping the practice going?

DR SEECO: Like I say because I have been working for many years so I had put some money in the reserves so I, not anticipating that this could happen, so this is the money that has been you know, helping to make the practice work. Because otherwise I was afraid to lose my patients that I've been with all these years.

CHAIRPERSON: Sorry, just to make sure that I understand the essence of your submission, are you saying that the CMS is failing to enforce its rulings against [intervenes]

DR SEECO: It does, it does, it has failed because we, we, we, I have on many occasions said to them that they have not really been fair. At some stage I had asked them why couldn't they call us together with the medical aid scheme so that they can hear the two versions so that we can then, they can make an inform decision based on facts as been presented to them.

CHAIRPERSON: And schemes you say are contemptuous of the CMS?

DR SEECO: Yes, I mean the CEO did not even want to hear anything. Even the forensic guys didn't want to do it, you know to agree to the ruling

ADV WILLIAMS: And have you asked your patients to pay directly?

DR SEECO: No, I've been using the reserves of the practice so

that's why you know we [indistinct-2:39:17] seeing the patient, give them medication and the scheme would withhold the funds but then all that must have been happening was that we would use the reserves from the practice, the practice reserves was the one that was sustaining the practice and is still sustaining the practice now.

ADV WILLIAMS: But did, is it because your patients are not able to pay you directly, I am trying to under why are using the practice reserves?

DR SEECO: They can't because when I try to introduce that then I realise that they will be in a posit-, they will leave me, they will leave the practice because they wouldn't actually afford to come to my practice if I will want cash from them. So in the light of that challenge I then said okay let me just sacrifice, have them, look after them whilst in the meantime pursuing this, this, this case.

CHAIRPERSON: Thank you Dr Seeco. Are you finished with your [intervenes]

DR SEECO: I'm finished.

CHAIRPERSON: Thank you. Alright let's do this, let's take a 15-minute break and we will continue with the balance of the three submissions before we call in the Competition Commission.

PROCEEDINGS ADJOURN

END OF AUDIO