SECTION 59 INVESTIGATION

DATE: 2019-07-31

HELD IN: IMBIZO BOARDROOM,

COUNCIL FOR MEDICAL SCHEMES OFFICES, CENTURION

PANEL: **ADV TEMBEKA NGCUKAITOBI, CHAIRPERSON**

ADV ADILA HASSIM, PANEL MEMBER

ADV KERRY WILLIAMS, PANEL MEMBER

PRESENT FOR HPCSA:

DR RAYMOND BILLA, REGISTRAR

DR MUYEZWA KWINDA

DR KGOSI LETLAPE

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.
2. Since this is a true reflection of the record and it is transcribed as heard, grammatical errors may occur because of role-players speaking throughout.

PROCEEDINGS ON 31 JULY 2019

CHAIRPERSON: Good morning everyone, we are continuing the public hearings into the allegations of racial profiling and abuse of Section 59. Today's hearing, we are scheduled to hear from the HPCSA. I see that there are two tables reserved, and there's no one there, and there's another one in front of me. Who is appearing for the HPCSA?

DR BILLA: Good morning, my name is Raymond Billa. I'm the registrar of the HPCSA.

CHAIRPERSON: Alright Mr [intervenes]

DR BILLA: …[indistinct 00:00:44].

CHAIRPERSON: Mr Billa?

DR BILLA: Dr Billa.

CHAIRPERSON: Dr Billa, okay. The hearing starts [intervenes]

DR BILLA: They will be joining us later.

CHAIRPERSON: The hearing starts at ten, and that was what was conveyed to everyone.

DR BILLA: My apologies then …[indistinct 00:00:59].

CHAIRPERSON: No that's fine, I just wanted to record that, that we should've started at ten. Alright, how do you propose we proceed Dr Billa?

DR BILLA: …[indistinct 00:01:14] late, I think he mixed up the times, he is on his way, but we could proceed.

CHAIRPERSON: Yes, alright the way we've been

[intervenes]

DR BILLA: …[indistinct 00:01:24].

CHAIRPERSON: Sorry, do you still want to say something?

DR BILLA: No, I was just saying because of time constraints that you've delayed the [intervenes]

CHAIRPERSON: No, that's fine. But I need to take your, are you going to be the presenter on behalf of HPCSA?

DR BILLA: Uhm, I will just do the introduction, but Dr Kwinda will do the full presentation.

CHAIRPERSON: Okay, that's fine. So both of you will be speaking?

DR BILLA: Yes.

CHAIRPERSON: Alright, okay the way we've been running it is that you will take an oath, so that the evidence you give can be factored into the record and our report writing. So if you don't mind then saying after me, I and then your name.

DR BILLA: I Raymond Billa.

CHAIRPERSON: Swear that the evidence that I shall give.

DR BILLA: Swear that the evidence that I shall give.

CHAIRPERSON: Shall be the truth.

DR BILLA: Shall be the truth.

CHAIRPERSON: The whole truth.

DR BILLA: The whole truth.

CHAIRPERSON: Then please raise your right hand and say; so help me God.

DR BILLA: So help me God.

CHAIRPERSON: Thank you, and your colleagues name is?

DR KWINDA: Dr Kwinda.

CHAIRPERSON: Kwinda?

DR KWINDA: Yes.

CHAIRPERSON: Okay. Dr Kwinda I also need to take your oath now, so that it's easy for you to speak later. Will you also say after me, I and then your name?

DR KWINDA: I Munyezwa Kwinda.

CHAIRPERSON: Swear that the evidence that I shall give.

DR KWINDA: Swear that the evidence that I shall give.

CHAIRPERSON: Shall be the truth.

DR KWINDA: Shall be the truth.

CHAIRPERSON: The whole truth.

DR KWINDA: The whole truth.

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

DR KWINDA: So help me God.

CHAIRPERSON: Thank you. Alright, so Dr Billa you can take us through your presentation then.

DR BILLA: Ja, thanks Commissioner. I will just today start our introduction to say that as the Health Professions Council of South Africa, we, what we're going to be presenting is purely based on the complaints that we've received from the public, and

from the practitioners, and because of our of systems we have not been able to give, to look back on the previous years. We will only be looking at information that we have that has been, that we've collected this year. Dr Kwinda will go into detail about what we have, and the nature of the complaints that we have received have been categorised into the types of complaints that we have.

So it will be negligence primarily, it will be fraud, and also consultations. But I think Dr Kwinda will be able to take us through the, the whole lot as to what has happened, and we looked at the, the number of practitioners we have nationally, and then we looked also at the type of complaints that have been presented, and then we look at the register that we have, because we keep a register. The register that we keep is only for the people who paid their annual subscription, their renewals for this financial year. It does not give us a complete picture of all the practitioners there. But the practitioners who are out in practice, they should be registered with us, and if they're not registered then they're practicing illegally.

But I think that's the, just to give you, and we also look at where the practitioners come from, at which universities they've been trained. So that's the kind of information that we have, and then we also look at, because I think for the sake of this, not that we did it intentionally, but I think that's what we have. It's looking at the, in terms of the profile where, who are making the complaints. It is by race, to look at who are the complainants, and then we look at the, the, and then who are the people, the complainants, who are they

complaining against in terms of the race. Then we also looked at the medical aid schemes when they send complaints to us, and then we look at the categories in terms of the race that they've presented.

But I think Dr Kwinda will give us more detail as to, to look at the trends that we've picked up. But as I've indicated it's only for the first two quarters of this year. If need be, we may have to go back and drill down into what information we have for the previous years. But that will depend on our, the sophistication of the manner in which we can be able to get that information. Okay, so I think that's just an introduction, and I'll ask Dr Kwinda then. We, we, unfortunately we were not able to do a written presentation, because I think there was a problem with information in the way we were contacted. We only became aware last week that we should be coming here.

So we're doing an oral presentation, but I think what Dr Kwinda will be doing is information that we look at in our quarterly reports, based on our reports. Dr Kwinda comes from the legal and regulatory department of the HPCSA, so this is information that he presents before the head of the department on a quarterly basis.

CHAIRPERSON: Thank you, Dr Kwinda?

DR BILLA: …[indistinct 00:06:25] information.

CHAIRPERSON: You do have something in writing, so is it a PowerPoint presentation?

DR BILLA: It's a PowerPoint presentation.

CHAIRPERSON: Okay that's fine, so maybe you can leave

that with us?

DR BILLA: Ja.

CHAIRPERSON: And then we will send you more specific requests for information in due course.

DR BILLA: That's in order Sir.

DR KWINDA: Thank you. As the registrar had said, in the past we were not collecting enough data, and we started the process of really collecting data at the beginning of this quarter, that we can use for different purposes, and the presentation that I'm going to do is just a first quarterly report, and I will explain through the presentation as I go along. Now, that is in terms just of the complaints that we received just in the first quarter, just to give you a picture of the number of complaints that we received between April and June this year. We had 603 complaints and basically that is only in terms of our register.

Now when we look at the register of practitioners, which is currently sitting at 185 176, it's only 0.3% of our register. Meaning that in the whole quarter, only 0.3% of the practitioners on our register have got complaints brought against them, and out of that, because when complaints come, they are either mediated, or they go for preliminary investigation [intervenes]

ADV WILLIAMS: Dr Kwinda, sorry to interrupt, how many practitioners did you say are registered?

DR KWINDA: 185 176.

ADV WILLIAMS: So that's approximately 185 000

individual practitioners?

DR KWINDA: Yes.

ADV WILLIAMS: Thank you.

DR KWINDA: And we are only talking about practitioners, not including interns, or students. So students and interns are excluded from that number. So it's only those ones who are practitioners.

ADV WILLIAMS: And apologies for interrupting again, and you said, or your colleague said earlier that you have the racial demographics of those practitioners, is that correct?

DR KWINDA: Yes, we do.

ADV WILLIAMS: Thank you.

DR KWINDA: …[indistinct 00:08:56] I adopted my quarterly report for this purpose, and some of the information, I do have the other presentation though here. In terms of the real numbers, so we'll leave it here, we could not save it on the memory stick, but we do have the figures in terms of how many practitioners per board, and also per province across the country. We have that information. I was still saying, out of the complaints that we received there were those that we, we resolved before we registered them, but 63% of our complaints go through preliminary investigation process, whereas 32% go to the office of the ombudsman for mediation.

How do we receive complaints? Most of the complaints, at 94%, we receive them through emails, and only 3% post, and then

we have 2.7% as walk-ins. Where do the complaints come from? Now, my majority of complaints are coming from members of the public, and what I have there is just the real numbers, it's not in terms of percentage. But majority are coming from the members of the public, followed by the medical schemes, and the followed by other entities, and by other entities we are referring, for example, to officers versed under compliance, or even the consumer commissioner.

They also refer complaints to us. Then you have got those complaints that are, that could not be mediated by the ombudsman that will be taken back for preliminary investigation, and also, we do have legal representatives submitting complaints on behalf of their clients. Then we have our inspectorate office that is enforcing compliance that also fit into our complaints, and then other departments within the HPCSA. Now in terms of the board [intervenes]

ADV WILLIAMS: Apologies Dr Kwinda, just to interrupt again so I understand correctly, it's just because you're moving quite fast that I'm taking you back. But just a point of clarification, in relation to those approximate 185 000 practitioners, do you have a disaggregation of the number of those in private and public practice?

DR KWINDA: No, we don't have that.

ADV WILLIAMS: Thank you.

DR KWINDA: We don't have that. Now I've not given, I've not, I don't have, I've not put a slide for the numbers in the

boards, but what you have there now is the percentage of complaints per board, and the picture that we have there is that the majority of the complaints that we receive are against the medical and dental professions practitioners, registered in the Medical and Dental Professions Board. That is where the medical doctors, the dentists, the medical scientists, and the clinical associates are, in that particular board.

That is the second biggest board in council, and the other slide that you will get later will show you that the biggest board in council, out of the 12 professional boards, is the Emergency Care Board currently sitting with 57 000 practitioners in that board. Followed by the Medical and Dental Professions Board, currently sitting with 54 000 practitioners, then followed by the Psychology Board. Now Psychology Board is the biggest of what we call the small boards, because from 54 000 in the Medical and Dental Professions Board, then the Psychology Board, which is now the third biggest board, is sitting at plus minus 14 000 practitioners in that board.

Then the rest of the boards follow from there.

ADV HASSIM: Did you say one four, or four zero?

DR KWINDA: 14 000, one four, yes. Then the Medical Technology Board and the other, the smallest board in council is the Speech, Language and Hearing Professions Board. Now in terms of the distribution of complaints across the boards, 76.6% of complaints are against the practitioners registered in the Medical

and Dental Professions Board, and majority of them are medical doctors. We really don't have complaints against medical scientists, and very few complaints against clinical associates who are very small anyway in the register. But majority are against the medical doctors in that particular board.

Then you will see then 8.6%, from that 76.6% 8.6% are against practitioners registered in the Psychology board, which is the third biggest board. Whereas the biggest board, which is the Emergency Care Board, is sitting at 1.1% in terms of the complaints that we have received, and then I won't talk about the other boards, but you can see the rest follow. We don't have complaints against environmental healthcare practitioners, we hardly have, in the previous term of the board the preliminary committee of enquiry, for that board, never met for five years because there was never a complaint against an environmental healthcare practitioner for a period of five years, so they never met.

CHAIRPERSON: Mr Kwinda do you break down the complaints by race?

DR KWINDA: Yes, I'm still coming to that.

CHAIRPERSON: Oh, you're still coming to that, okay.

DR KWINDA: Maybe I, should I rush there or [intervenes]

CHAIRPERSON: No, no, no, no take your time, take your time.

DR BILLA: Maybe I should just mention, if I were

allowed?

CHAIRPERSON: Yes.

DR BILLA: I think if you look at the practitioners, I think we, we oversee a wide spread of practitioners, and I think it's within the council it's everybody else who's involved in healthcare, except the nurses and pharmacists. So that information you will not be able to pick it up from what we have here.

CHAIRPERSON: Okay.

ADV WILLIAMS: And a further point of clarification, because I think it's important that we understand your date before we start delving into some of the detail. Are your complaints, do you know if they emanate from public sector and private sector services, or is it a mix of public sector and private sector complaints?

DR KWINDA: Currently we are not looking at that, but I can tell you from experience that majority of our, the complaints that we receive are from practitioners who are in private practice. We have got very few complaints really against practitioners in the public service. But I cannot tell that, but from the experience of dealing with complaints, the majority are from practitioners in the private sector.

ADV HASSIM: And is that [intervenes]

DR BILLA: …[00:15:39].

ADV HASSIM: Sorry.

DR BILLA: Maybe if I can, I think this, why it is so, it is because the, I've worked in the public sector for many years, I've

just, so in the public sector the complainants have an avenue of lodging complaints. They would then lodge the complaints within the hospital structures, and these complaints would be dealt with primarily, and only if they do not have a joy out of getting responses dealt with within the health sector, in the public sector, would they then come to the, to the HPCSA. But in the private sector, the first point of call, when anybody's got a complaint, they've got to go straight to the Health Professions Council.

So I think there's a buffer between, in the public sector, that's why the complaints would not necessarily go straight to the, to the Health Professions Council, because there is a place where these complaints can be dealt with.

ADV WILLIAMS: I've been asking my questions, partly because we have evidence from the health market inquiry preliminary report, that there are 14 951 practitioners, so that's where my line of questioning is coming from. Just so I understand better, and it does seem that in the private sector there's a far smaller proportion with that 185 000 doctors registered on your system, and there's only 14 000 out in the private sector. Then the vast majority of doctors are registered and practising in the public sector. Is that correct?

DR BILLA: Ja, but I think the, you have to look at the, because the majority of the practitioners, we'll have specialists and general practitioners, and so the, in the public sector you have people who are training, who are in the large bunch. But I think

because the public sector caters for 80, almost 80% of the population, and 20%, but you find that the resources are a bit skewed. They are not in line with what is the service that is given. You find that the majority of the practitioners who would then be working in the private sector, rather than in the public sector.

ADV WILLIAMS: Yes absolutely. This is why I'm trying to understand this point and let me just be more explicit. The health market's provisional report says there are approximately 14 000 or 15 000, it is GP's, so my apologies, it's GP's not the whole, and now I see that you are actually listing every allied health professional.

DR BILLA: Yes.

ADV WILLIAMS: You're including every doctor, every specialist, every allied health professional. Thank you.

DR KWINDA: Okay, now we also look at the proportion of the practitioners against whom the complaints are lodged, against the register. Now the picture changes, when you look at the proportional, in terms of the size of each board. Where, although the Medical and Dental Professions Board is still sitting at 0.84 of the register in the first quarter, then you see now the Optometry and Dispensing Opticians Board, also start to pop in now with the Psychology Board. Although the Psychology Board, in the previous light, if you remember, they were the second. But in terms of proportionally looking at the numbers in the register, the Optometry and Dispensing Opticians Board also comes up at the same level with the Psychology Board.

Very interesting as well, is that then your Dental, Assisting Dental Therapy, and Oral Hygiene Board also comes up, and the smallest board, which is the Speech, Language and Hearing Professions Board, looking at the number of practitioners there, also come a little bit up. So that is in terms of the register now, in terms of the practitioners in that particular board. Now, we also look at the specialities across the medical and dental professions board, and this is my slide now.

If you look, majority of complaints are against the GP's, followed by general surgery, and then the dentists really is not necessarily on a, it's all the dentists including the GP's in dentistry, and also the specialists in dentistry, and then internal medicine, OBS and gynae as well. Then psychiatry there, and then anaesthesiology, and really commonly in anaesthesiology, I can tell you that commonly most of them are related to their fees. Informed financial consent because patient's always say; I get a bill from this person that I never met in my life. Because some of them meet anaesthesiologists in theatre, those are the common complaints that we receive related to the fees that the anaesthesiologists charge.

So that is basically across the specialities in medicine, because you do have lots of complaints against the specialists. Then the provincial distribution of complaints, now the slide that is not there, that is on the other presentation is that most of our practitioners are in Gauteng. That is, the majority of the practitioners are in Gauteng, followed by Western Cape, and then KZN, and then

Eastern Cape, then Limpopo, and then rest follow. So even in the provincial distribution you can see Gauteng is leading. Then KZN overtakes Western Cape, because Western Cape has got second in terms of the majority of the practitioners.

But when it comes to complaints, KZN overtakes Western Cape, and then Free State also overtakes Eastern Cape when it comes to the complaints that we receive. Then in terms of the proportion now, of the register in terms of where the practitioners are. Then Gauteng is still leading, then followed by KZN, then you start to see North West coming up with Free State and Eastern Cape and Western Cape are at the same level now, when you are looking at the register. So you can see that in terms of the numbers in the provinces, then Western Cape, although they have got fewer practitioners but in proportion in terms of the complaints lodged against those practitioners, then they come at number three together with Free State.

Now this, this line is very interesting. Here we look at the nature of complaints that we receive. Now in the first quarter the leading nature of complaints that we are receiving, are related to negligence, and they are leading. Then the second one is related to accounts, and I will say that some of the matters related to accounts, really is related to issues that if you were to go to issues of fraud, some of them are, have got an element of fraud in them. But fraud is the third highest nature of complaint that we are dealing with as council at the present moment, so then followed by matters of

medical reports and communication, and then the rest follows.

In terms of percentage; in our first quarter 36% of our complaints were related to negligence. 16% related to accounts, and then fraud which is the third highest sitting at 12%. Then medical reports 8%, then communication 7%, and the rest follow.

CHAIRPERSON: What is the difference between accounts and fraud?

DR KWINDA: Matters of accounts include situations where a patient is not issued with a statement of account. For example; a practitioner can see a patient on a cash basis, but there's a requirement that they must issue a patient with a statement of account, anyway in terms of Section 53 of our Act, and Section 59 of the Medical Schemes Act. It makes that provision that you need to issue a patient with a statement of account within a reasonable period, that is from our side, in terms of the Health Professions Act, whereas the Section 59 also talks about the same thing. But regulation five also prescribes how that statement of account has to be.

We have cases where practitioners issue patients with invoices, or receipts from the books that they buy from CAN. So they just write that a person has paid R300, you know, just like how that receipt book looks like, and it's not like a statement of account as prescribed in regulation five of the Medical Schemes Act. So you find that schemes do not pay the member that consultation fee that they paid cash, and then the practitioners say; that is all I can give you.

Then the patient comes to us to say the practitioner is not giving me a statement of account, then we deal with those matters.

Most of these matters are dealt with in the office of the ombudsman. So that, basically that is in the majority in terms of the accounts that practitioners have to issue to patients. Sometimes there's a delay, sometimes what happens is that the statement is given to the patient very late, and sometimes it is where it has prescribed in terms of the number of days for the scheme to reimburse that particular practitioner.

CHAIRPERSON: So what about inaccurate information on an account? Where do you classify this, as an account query or as a fraud query?

DR KWINDA: It also, it also fall into that as well. That's why I said earlier, that is why sometimes you pick up that in the accounts, and it also goes with the issue of billing as well, you find that. I'll give you a practical example. An anaesthesiologist need to do a pre-anaesthetic assessment before you put somebody to sleep, and the interpretation of that, you find that the patient says; I see pre-anaesthetic assessment, but this person never came to the ward, they met me in theatre, when did they do the pre-anaesthetic assessment? Sometimes we've had cases where there is a particular procedure done, which is in the statement, but the patient says; but this was never done on me, but it is on their statement.

So it's like the person is charging services [intervenes]

CHAIRPERSON: But, I mean, is that an account query or a

fraud query?

DR KWINDA: That's why I said, some of the matters that are categorised as accounts, you find that along the way they become fraud cases. Now the picture I'm giving you here, is what we capture at the receipt of the complaints. But as it goes along, as part of the investigation, you may realise that in fact this is not an account matter, it's a fraud matter. So some of the matters that are sitting at accounts, you may find that they may end up adding to fraud, and you may find that fraud may end up becoming the second highest nature of complaints that we are dealing with.

CHAIRPERSON: Yes, I mean I was also looking for coding complaints and I don't see them?

DR KWINDA: Ja we, usually they are part of the billing. Do I have billing there?

CHAIRPERSON: No, there's no billing either.

DR KWINDA: Ja, it may, it means possibly they are sitting at accounts. We have not, we have not taken the words coding and billing. Usually we club them as accounts. But we do have cases where there are issues of codes, and that becomes a little bit tricky.

ADV WILLIAMS: Dr Kwinda may I ask just on this type of issue, like a coding complaint, how do you manage your regulatory role with the CMS and determine which complaints are appropriately dealt with by the differing regulatory bodies?

DR KWINDA: I didn't hear your question?

ADV WILLIAMS: So, so well let me take the example of accounts. You mentioned the Medical Schemes Act and what should be on the doctor's statement, is this a complaint which is in effect a breach of the Medical Schemes Act? Is this a complaint that is considered by the HPCSA as unprofessional conduct?

DR KWINDA: Okay, ja the issue here is the Medical Schemes Act prescribe how a statement of account should be, and if a practitioner registered with us does not comply with that, then the patient is the one who will suffer as a result. As an example that I gave, if the patient pays cash, and the practitioner issues a receipt which does not contain the information as prescribed in terms of the Medical Schemes Act, then the patient is not going to be reimbursed by the scheme.

So that issue may not be within the ambit of the Health Professions Act, but in the practice of their profession there are all these laws that impact on the practitioner, and the definition of unprofessional conduct in terms of the Health Professions Act is quite very broad, and if you go now into our ethical rules, we talk about you must act in the best interest of your patient, and if the best interest of your patient is that you must ensure that you patient is able to claim from their medical scheme, then if you don't act in their best interest then we can hold you accountable. So it is on that context.

CHAIRPERSON: Okay, if I want to know the prevalence of coding disputes, where do I look on your table?

DR KWINDA: Unfortunately you will, you're not going to see it there, we have not captured that.

ADV HASSIM: Dr as I understand it the HPCSA also has a responsibility for monitoring ethical pricing, ethical charging by the members of your association, and whether it falls within your ethical tariffs. But I don't see that recorded here as a complaint. But if I misunderstand the legislation or the policy, then please tell me. My understanding was that a member of the public could complain to the HPCSA about, basically, overcharging, and there's a specific provision that provide, that makes provision for that. But I don't see it here?

DR KWINDA: I was just checking if we do have a …[indistinct 00:31:02] called financial consent there. We only have got informed consent, but then [intervenes]

ADV HASSIM: Informed consent relates to [intervenes]

DR KWINDA: But let me just explain in terms of, that is in terms of Section 53, which also says that the practitioner must inform the patient about the cost of services before they render the service. But when it comes to the issue of the tariff, that is where the board has to develop and publish the tariffs that are used by the board in a case where a patient enquires from the board, if what they were charged is normal.

ADV HASSIM: Is reasonable.

DR KWINDA: Is reasonable. So currently that has not been done, and there is a history to that which I hope if, maybe we

can give an opportunity for the president to be put on board so that he can also respond to some of the questions, it will also be helpful to do.

DR BILLA: I thought maybe we should just introduce Dr Letlape as the president of the Health Professions Council, and chairman of the Medical and Dental Board. I thought maybe you'd want to air some views on this matter, if you can just allow him to be part of the delegation.

CHAIRPERSON: I've known Dr Letlape in my previous life. So will you just take your oath Dr Letlape? So will you just say after me, I and then your name.

DR LETLAPE: Is the oath the only option?

CHAIRPERSON: No sorry, there's an affirmation as well. Okay, would you rather do an affirmation?

DR LETLAPE: I'd rather do an affirmation.

CHAIRPERSON: Alright, you're the first, at least in this inquiry. Alright, will you then say, I and then your name.

DR LETLAPE: I Dr Kgosietsile Letlape.

CHAIRPERSON: Solemnly affirm.

DR LETLAPE: Solemnly affirm.

CHAIRPERSON: That the evidence that I shall give.

DR LETLAPE: That the evidence that I shall give.

CHAIRPERSON: Shall be the whole truth.

DR LETLAPE: Shall be the whole truth.

CHAIRPERSON: And nothing but the truth.

DR LETLAPE: And nothing but the truth.

CHAIRPERSON: Thank you.

DR LETLAPE: I guess I'd like to, the issue about the ethical pricing.

CHAIRPERSON: But you don't have to limit yourself to the questions.

DR LETLAPE: Ja, but I'll start with the question. It's a thesis in answer to the question. The misnomer of ethical pricing dates back to around 2008, where there was a departure of negotiated settlements. When the Competitions Commission came in and said there was collusion in terms of the ways tariffs were set, it created and impasse in terms of tariff creation. You then had an inability for the professions to come together, because they were considered to be colluding, the medical aids could not come together, they were considered to be colluding. The hospitals could not come together, so no service providers could come and negotiate tariffs.

We then ended up with a void for a few years about tariffs. The department then tried to step in to create tariffs, and they created the national reference pricelist, which after it had engaged, and it was difficult because at the time I was with the association. We couldn't freely participate, because we had just been, in our opinion, defrauded to close of a million Rands by the competitions commission on a fine for collusion, when we were doing a civic duty. There was great difficulty in terms of getting exemptions, so that we

could come and talk about issues of tariffs. But be that as it may, a national reference pricelist was, was created.

It was then challenged by parts, by the industry, and it was negated by the courts, so there was no pricing. Then at that time, the council at the time, through the registrar at the time, decided to adopt the national reference pricing list, that came from the department, as an ethical pricelist. There was then confusion inside the organisation, because there were differing opinions. Because when you're talking about access to healthcare, how can pricing healthcare be considered ethical? So that created confusion, and I think that's where your issue of an ethical pricelist comes from. So it was born out of a decision that was made by a council, that had no reference.

Now prior to the issue of the ethical pricelist, what was happening before the intervention of the Competitions Commission, was that there was a statutory body called Representative Association for Medical Schemes, RAMS. Now RAMS was mandated to negotiate on behalf of schemes tariffs. The Medical Association represented the medical doctors, but there were other associations representing other practitioners. The association created codes for the different procedures, and anytime there was a new procedure there would be a process inside the association to look at whether is there scientific proof, is it part of common clinical practice or is it experimental.

A code would then be created in terms of the criteria that

were used about the difficulty, the resources, etcetera, and there would be units apportioned to it, and there would be a Rand value at the end. So what happened historically was when the Medical Schemes Act was originally acted upon in 1967, through time the Medical Association was recognised as the negotiator for the profession, and because of that there was a medical association rate that was determined in accordance with a complex process that occurred inside the Medical Association. Now that process, dependant on intellectual property that was borrowed from the Americans, called the clinical procedural technology, CPT, and it was licensed to the Medical Association.

That was the basis of creating billing codes in South Africa. So what would then happen was that there would be a Medical Association rate, but the medical schemes would then come and say we want a discount, and they created what they called a scale of benefits. So there was a rate that was called a medical schemes rate, and the conditions were fairly simple at the time. As a practitioner you could contract-in or contract-out. If you contracted in it means you are agreeing to charging the scale of benefits that has been determined by the Representative Association of Medical Schemes.

Initially it was negotiated, but with time because of not finding each other on a pricing point, and no mechanism of an agreed tariff, what was created was a scheme of tariffs where there was the Medical Association rate, then the schemes would discount it for

themselves, and they would create a scale of benefits, or the RAMS rate, and the workman's compensation would come in and go to a mid-point between what RAMS had put up, what the association had put up, and they created a rate for injury on duty. That is what was happening historically, and it was always accepted that codes can only come through a strict process that started with the medical profession.

Because, I mean, funders or handlers of funds don't know what happens inside a profession, and that had been the process. So when a procedure had not been coded, it could not be paid for by the schemes, because it had not been paid for. But there was a process of agreeing to that issue, and that's where the issues of the codes came in, and there was a battle historically about who owns the codes, at some point. But that's the background about the tariffs that were there. So you had a scenario where there was a statutory tariff, and all medical aids paid in accordance with the statutory tariff.

So on the eve of liberation, pre-94, the then minister dismantled the system in the sense that in the previous system, care to patients were guaranteed, and payments to providers were guaranteed as long as it was in accordance with the scale of benefits that were determined, and with other scheme rules that applied. That was taken away. Care to members was not guaranteed, and payment to providers was not guaranteed. So you then had the era where medical aids, despite it being declared a not for profit business, it then began to run like insurance models, and it

created the scenario that you have today.

Where the only time, as a member of a medical aid, you're guaranteed care, is if you don't get sick. If you get sick, your problems begin, and there's no protection in the law, and the power of the CMS was eroded from beginning of the medical schemes being allowed to create as many options as they have. Remember, before it was fairly simple. For a procedure, I am an ophthalmologist, a cataract would have a scale of benefit rate, there'd be a Medical Association rate. Now in terms of the duty of council, it was to adjudicate when there are complaints about fees, and it needed to have references that it could refer to in terms of doing that adjudication. Now the process had always been knowledge of the different tariffs that exist.

That there's a scale of benefits, there's an injury on duty, and there's a Medical Association rate, and the approach of the regulator was that the Medical Association rate was seen as sort of a maximum that you could charge. That's what the profession feels the procedure is worth. This is what the medical aids feel they could pay, and this is the middle point for Council for Medical Schemes. So you take all those tariffs into consideration when adjudicating. There was never an issue of which tariff was ethical, but there was a tariff plateau that, which you could refer to. But the regulator itself has never had the ability to create tariff.

It's also never been the duty of the regulator to create a tariff, because if you created the tariff you would be controlling the market.

You'd be creating a straightjacket, and you can no longer adjudicate on complaints about tariff, because you have your own tariffs that would take you out of the complaints in terms of those tariffs. So that's the matrix that was used. So I hope I've tried to explain where the ethical misnomer comes from.

CHAIRPERSON: Just to take you beyond the ethical, I mean at some point I'm sure we'll need to explore that. We've heard evidence in the past two days, that currently there is complete confusion about the appropriate tariffs, and that confusion emanates from a ruling made by the Competition Commission, right? What is your experience about, I know you're coming here as HPCSA, but maybe you can also enlighten us in relation to your broad experience in the industry, about the impact of the absence of a standard tariff that will be charged by everyone, and everyone will know when you are outside a particular range of a tariff?

I mean there are, my understanding is that there are three numbers. There is a number you get when your own doctor charges you, and that's your rate you negotiated with your doctor, alternatively the doctor imposes it. Then there is a medical aid tariff, and then there is a tariff that is in the reference pricelist, which you may or may not comply with, and the fact that there are three different numbers is causing immense confusion within the industry.

DR LETLAPE: I think causing confusion would probably be considered the biggest understatement of this century. It has actually destroyed the private sector. It has destroyed the ability for

populations to be protected if they have cover, because they currently don't know what they're covered for, and it doesn't matter how well educated you are. Even if you are in health like myself, you really don't know what you're covered for until you get sick, and there are disclaimers, and you have to sell this and sell that to cover costs, and that's what this has created. And the only victors out of this, are administrators.

ADV WILLIAMS: Dr Letlape we heard yesterday, Letlape sorry, we heard yesterday from one of the witnesses, I think from the BHF, who said that the difference between the various, let's call them tariffs, is actually immaterial. So the, effectively how I understood this witness was, the difference is being overpaid, particularly in relation to, not necessarily the amounts, but in relation to the description of the procedure. How would you respond to that?

DR LETLAPE: I would say I am not surprised that it comes from BHF. I would be surprised if they gave a more ethical answer, because I don't think they can spell the word ethical. That would be my response to it. Now let me illustrate why rates matter. If you come as a patient and you're covered, or you're not covered, you need to know what the procedure is worth, what it is going to cost you. Now they say it doesn't matter, because that's where their power lies. It's in the uncertainty, because it doesn't matter as a member, you don't know what you're entitled to.

There is nothing that you are entitled to, because nothing is prescribed. All that you are told, it's within scheme rules. They can

meet overnight and change things, and those are the scheme rules that are applicable, and the scheme rules are written such that even those that write them don't understand them. They are written such that they are not comprehensible, at least not to an average doctor like myself. Now each scheme can create its own tariff, so there isn't an agreed tariff that's called a medical aid rate.

So this medical aid can change it by ten cents, that by R10, that by R15, but it's a scheme rule because there's no overarching scheme rule, and a scheme can have 100 options. So under one scheme, you don't actually know what their tariff is. The same scheme will tell you; depending on which sector you come from, we'll pay three times the medical scheme rate. Now what has happened is that there used to be a scale of benefits, but it was left behind when the Competitions Commission interfered. There was an NRPL which could not be promulgated, because it was challenged. So what people have done, they've taken that NRPL and they've adjusted it for inflation, and they say they have a scheme rate.

But there's no law that says what you must do, so you can do anything that you want. You can adjust it by inflation, you can adjust it by zero, you can deflate it, you can do anything that you want, because there are no rules. It's the scheme rule that matters, and the schemes can come up with anything that they want. Now [intervenes]

ADV WILLIAMS: Sorry to interrupt again [intervenes]

DR LETLAPE: The issue of lack of tariff has created

uncertainty throughout the industry, the only people that are certain [intervenes]

ADV WILLIAMS: Dr Letlape I don't want you to move on just before I understand. I completely understand what you're saying in relation to tariff, that the power is with the schemes, that is your evidence. Just so I understand, because the evidence again, and it's an important distinction again I think, because there's a difference as I understand it, in the RPL, and the old ethical tariff, and the schemes own tariffs. There's both a procedure code component, and a tariff component. So there's about quantum, what a doctor can charge, and a question about whether they have accurately described the procedure that they have performed, or the service they've given.

So the evidence yesterday, as I understood it, and I'll be corrected if I understood it incorrectly, was that in relation to the procedural descriptions there is a, not much difference between all these different codes, to put it that way. The reference pricelist, the schemes own RPL's for want of a better word. So the evidence was that in terms of how you describe your service, was that there's not much difference, and that goes to this coding issue. Where there's a coding complaint about a doctor.

DR LETLAPE: That might be true to a certain extent. A cataract is a cataract. The cataract removal is cataract removal. So you have a code, 3047, which is for cataract removal in a particular manner, extra capsular manner, or 3045, intra capsular manner, or

3049, phacoe. That's just a descriptor for a procedure. So the codes will remain the same. The slight difference might come when there's a new way of doing that thing, and you need to create a new code, you know? I'll give you, we used to take out cataracts using a cryo-probe, taking the lens whole, and we gave you thick glasses. You were then able to leave part, something behind, put a lens in, scrape it out, and pull it out.

We're now able to use a small incision, break it up, and suck it out. We may in future be able to do it with laser. So you'll create different codes for those issues, but if you describe that I've taken a cataract this way it will be common throughout.

ADV WILLIAMS: Whose control is that within?

DR LETLAPE: Well those are professional duties, those are professional activities, and traditionally in the organised system before it was disassembled, destroyed, it was the preserve of the profession. Because it's in the professions that treatments are made available that advances are made. That's the practice of medicine, speaking as a medical doctor, but not confining to that. It could be the practice of psychiatry, or practice of optometry. That's a professional domain. But what has happened right now is that we've created a monster that thinks it can also practice medicine, and decide who does what, and decide that this that the professions is going to do is not acceptable.

But that is a professional domain, that unfortunately because of the terror in the country, you have people that have never seen

the door of a medical school, that have de-professionalised the profession, and are dictating to the professions what should happen at a professional level. Go back to what I said, originally the Medical Association coordinated that, so if there was a new procedure, it would then be debated in the right forum as to whether is it standard, is it experimental, has it become normative, etcetera, that [intervenes]

ADV WILLIAMS: So [intervenes]

DR LETLAPE: Has been destroyed.

ADV WILLIAMS: So has SAMA stopped doing that?

DR LETLAPE: SAMA can't do it because then they'd be colluding. So if they're doing it, the Competitions Commission will be charging them. So if they are doing it, they are breaking the new laws.

ADV WILLIAMS: Dr Letlape, one of the, the reason we are here, is because of two, there are two things. One is the complaint by the funders of fraud, waste, and abuse, and they defined those terms. Fraud, waste, and abuse, and that includes over-servicing, over-utilisation of services by members, I mean broadly speaking that's the one thing. The other is a complaint that in the process of investigating fraud, waste and abuse the funders are discriminating against Black practitioners. Why the codes, and the tariffs where we started off is important, is because in order for there to be a determination that there has been over-servicing, and I guess I'm also more interested in that aspect of fraud, waste and abuse, the

WAMA, because fraud often is quite easily identifiable.

But it might be, and I'm testing the proposition with you, it might be more difficult to determine where over-utilisation amounts to abuse or not, or over-servicing, if there is no agreement about the tariffs, if there isn't a standard. If there isn't some anchor that you can refer to, to say; well it doesn't have to be this, but there's a guideline. So what is your response to that, the complaint and the relevance of the tariffs to the complaint? That in order for the funders to control waste and abuse, they need to investigate it, and they investigate it with reference to something. What is the thing that they reference against, or should they reference against?

And the second is, your comment, and your response to the allegations that when the funders do these investigations that they do so in a manner in which they racially profile practitioners?

DR LETLAPE: That's a tough one, but I will attempt to provide an answer. Now firstly, one man's food is another man's poison. So when they talk about fraud, waste, and abuse, they need to define what they mean, and clearly there are elements of that throughout the system. From the administration side, from the provider side, from the patient side, all those issues occur. I mean historically admin fees were at some point limited to 2%, it rose to 4%, it can now hit 20, 25%. That's a fraud, waste and abuse on its own, but nobody talks about that. Nobody talks about proper bills, that are legit, that go unpaid that may far exceed the amounts that we talk about in terms of fraud, waste, and abuse.

So there's an essence where they say the victor writes the history, so it's a question of who says it. So when they said we as practitioners we look bad, and when we say it, we'll expose them for what they are, and I think that should be taken into account. You go globally, there's nowhere where administering a system should cost more than 5%. Why are we into the levels that we are at, and that's not considered waste, and an abuse of power, and in a sense systematic organised fraud legitimised by an act of parliament. So for me, I think we should look at this broadly.

Now it does not mean there aren't issues of fraud amongst practitioners, but what I find fascinating is that every time they target a person, they do it unlawfully, and when they catch them, they go into an agreement with the person, of repayment, and by the time they refer it to the regulator you are dealing with a poisoned chalice, where evidence has been obtained unlawfully. But people have already made deals. Now you tell me, who's the biggest fraudster? When you catch people and you put them back on your patients, and you compromise the regulator from doing their job properly, where you are doing things that are unlawful.

We've spoken to them and we've said; why don't you go to the NPA? We have a collective duty to get rid of fraudulent practitioners. But you can't have somebody that has might acting unlawfully, intimidating, and the problem is that when you look at their positive rate, it's much lower than how they cast aspersions. Now there's the issue of the racial profiling. It's a systems issue.

Now here's the beauty. If you stay outside, and you're dealing with a population that can pay out of pocket, and you say to them this is what I charge. It might be four times the NRPL list, and the patient knows, the patient pays.

You then have an issue where this issue of fraud, waste and abuse doesn't come in, but in the absence of agreed tariffs they then come and use whatever they want to use, and accuse you of fraud, waste and abuse. Where they had taken out clear review as used to happen, where they've taken out coming to the profession, and saying your member is an outlier, and here's the evidence for the outlier. So that the profession can deal with it, because you are alleging improper professional conduct, but it is not left to the profession in terms of associations or the regulator to deal with. It's being dealt with by the funder, in the funder's interest, not necessarily in the patient's interest.

ADV WILLIAMS: So your proposal is that the way it should be investigated is first to refer it to the health profession, or whichever is the professional body that the practitioner belongs to, to first do that?

DR LETLAPE: No, I'm saying even if you don't do that first, whatever you do as an administrator; follow the laws of the country. We are not saying, if you think this practitioner is billing R5 million a month he should be working 30 hours a day, which is not possible, that medical aids should not investigate that. But what we are saying is, they need to go to the NPA, put up a case, so that it's

legit, it's watertight, it's legal.

ADV WILLIAMS: But it might take [intervenes]

DR LETLAPE: So if they do a sting operation, it's authorised in terms of the laws of the country. So we are not saying they can't do what they do, but they can't be a law unto themselves.

CHAIRPERSON: Alright, just to finish up the question that my colleague, Ms Williams, was asking around coding. Now my understanding around the issue of coding is, we can look at it as two aspects. The one is coding in respect of medical procedures, and the second is coding in respect of actual tariffs. So on the first one, medical procedures and time, you say ordinarily that should be the responsibility of the profession because they have the expertise? But in reality, because of the absence of self-regulation, that power is exercised by schemes. On the second one you say the determination of the tariff, ordinarily that should be the function of the regulator.

But because of the weaknesses in the regulatory system, it ends up being exercised by schemes, and so there is the over-concentration of power on the schemes, both on clinical issues really, and also on tariff determination which are regulatory issues.

DR LETLAPE: Okay, can I rephrase it?

CHAIRPERSON: Ja.

DR LETLAPE: The schemes are overstepping their boundaries.

CHAIRPERSON: Ja.

DR LETLAPE: It should never be because there isn't this, they can do that, because the fact that there is no statutory tariff.

CHAIRPERSON: Yes.

DR LETLAPE: Does not mean there is no proper practice of medicine.

CHAIRPERSON: Ja.

DR LETLAPE: Does not mean there are no advances in medicine where new procedures need to be coded, and that is not the forte of a funder.

CHAIRPERSON: Yes.

DR LETLAPE: The duty of a funder would be to say, to do its due diligence of saying is this accepted practice, is this experimental, are we going to pay for it or not pay for it. That becomes their jurisdiction. But they cannot say because they are not paying for it, it's not a proper procedure. That's beyond their pay grade. But because they have the might they're crossing the boundaries. Now what you do is, once you have coded procedures, it's up to the scheme whether they'll pay for them or not. You know, just like we can code a liver transplant, but you can then decide on the resources available, we can't give the benefit of a liver transplant, you know?

We can't give renal transplant; we'll pay for dialysis. Dialysis will be coded, a renal transplant will be coded, and it's not your duty as a funder to code it, it's for you to look at, within the plans that we

have, these are the services that you're going to provide. What you then do, is based on the codes, which will be weighted in accordance with complexity by those to whom it belongs, which is the medical profession. For example, we'll put relative unit values. We'll say a cataract is ten units, brain surgery is 100 units.

What funders then do is that, okay our conversion factor, and the job was simple before, they'll come up with what they call a Rand conversion factor. We're paying R10 per unit, injury on duty pays R15 a unit, SAMA says it's R30 a unit. So you are able to code, to convert the codes with the units, into a tariff.

ADV WILLIAMS: Ja.

DR LETLAPE: But your duty as a funder is on the side of conversion to tariff, not on deciding on the codes. You can also have a duty to decide what you pay for and what you don't pay for, but it's not your duty to say this is appropriate or not appropriate, that's a professional domain.

ADV WILLIAMS: Dr Letlape we, let me just ask another question on this point. Because I mean as you can see the panel was, is grappling with it. It's not clear to me why the professional associations, who are the doctors, can't make some recommendations in relation to the procedural codes, so the description of what should be done. Let's say. Or could be done. Could you respond to that? Because I certainly don't understand the Competition Commission who gave evidence on the first day and on this point it was brief. I do admit. But I don't understand their ruling

from 2004 to mean there couldn't be some agreement on these descriptors, so to speak. I understood their ruling to be, there shouldn't be any agreement on price.

DR LETLAPE: Remember I alluded to the fact that the way the association operated was, we have a contract with the American Medical Association. And medicine is universal and global. So, those things are not unique to South Africa. So, when there are new procedures, they'll have codes for procedures that we have not even considered doing here. And when we use the CPT framework, which they update on a constant basis, you'll have the new codes for the new procedures that exist. It's then a question of are this treatments available in our setting? For example if you have robotic surgery for prostate cancer, would have been available elsewhere before it was available here. But the code would have existed, in terms of it being coded. So, we'd be able to look at it, bring it in and be able to look at our matrix.

So, the answer is yes. Societies can code. But what has happened is that people have used their might, their might, to say we don't accept that code. And they've used it to rubbish those procedures and tarnish reputations of professionals. Just like when the ethical myth came up, they'll then tell their members, that doctor is not charging an ethical tariff. So, the doctor is not ethical. So, there's a gross abuse of power and an asymmetry. Now here's the key issue. The key issue is about direct payment. This is the problem. In the old system there were tariffs published, you are

contracted in, you'd get direct payment, and you'd work according to that tariff. Now, being paid depends on the mood of the administrator. You get no legal right to be paid by the funder. Irrespective of how you behave or what you do. You can do everything correct and they send the money to the patient. Now this is an issue about direct payment. Now the issue of profiling [intervenes]

ADV WILLIAMS: But would an exception to that, would an exception to that be the Designated Service Provider? Because there you're contracted [intervenes]

DR LETLAPE: No, it's not an exception. It's further abuse of power. Where you decide as a medical aid which doctor is going to live, and which one is going to die. That's their abuse of power. Because you see, the initial system was open and fair. This are the tariffs. Are you in or are you out? Patient choose your doctor. Now, it's administrator choose the doctor. So, people will be moved from Soweto with a designated provider in Kempton Park. All the other issues about taxi fare, how you get there, a relationship with something you don't know, language barriers, they are mute. So, our rules are being violated. Where actually medical aids are stealing patients from practitioners, planting them with other practitioners, what we call supersession. Why? Because they can.

DSP's are uncompetitive, unlawful, unethical and discriminatory. And they should not be allowed. Because you are taking away the choice of the patient. You are deciding which

doctors live, which doctors don't live. Now, this will tie up to the issue of the racism that we're alleging. Now, when you go into the realities of people. I mean I've been in private practice for more than 30 years. And I know where my patients come from. I mean some of them, the medical aid contribution is a big chunk of their salary. They don't have spare cash to pay me. So, I find it unethical to have someone sitting in front of me whose circumstances I know. Who's now battling for taxi fare because it's the 9th of the month and I want them to pay me upfront. So, what happens is that most Black practitioners, African and Indian, would be working with the customer base in that position.

So, what do they do? They are dependent on payment directly from medical aids. What happens? They are the ones that get victimised. Now, the people from affluent communities are not affected by this issues. They have, you know, tap machines, swipe machines. You pay before you are seen, or you pay before you leave. They don't have creditors. They don't send accounts. And they are not impacted by this behaviour of medical aids. Now, it even extends to issues of just racial profiling. It also extends to demeaning the profession. Asking for confidential information. Using some act from the Medical Schemes Act that says, if I pay you directly, I can have access to that information. And that information is not used in the interest of the patient.

They want to use that information to deny care to their member. They are not using it to provide them with care. And they

want the provider to be an accomplice to harming the interest of the patient. And how do they do it? Dependence on direct payment. Now if you are an affluent practitioner that does not take payment from them, but takes it directly, they can't access that information. So, this is where, the racial profiling is basically about the demographics of the Country, about the history and about the situation of people. So, whether you call it racial profiling or not, but what they do will affect Black practitioners in general and Black patients in particular.

CHAIRPERSON: Can we do this? Can we get to the mandane business of facts and figures and then we will come back to Dr Letlape once we have finished. I know that we took you off-track, so you can blame the panel for this.

DR BILLA: Thank you very much. I'll thank you because I think we, in the council I think we're more into the administrative part of the business and we give you facts as we see them and it is up to the investigation team to determine what's, they mean. I think the lawyers they are, and I think that's what we'll do.

DR KWINDA: Thank you. Let me continue with my presentation. Now I'm about to finish and here now we are also showing you our register in terms of the race. So I think it talks to the last question that was asked now. The majority of our practitioners are African, followed by Whites, Indians, Coloureds and of course those who are [intervenes]

ADV WILLIAMS: Which is unknown.

DR KWINDA: Ja, they are confused about their race

and then the Chinese. What it simply means is that on the register they did not indicate their race.

DR BILLA: It's not a race per sé.

DR KWINDA: Now in terms of percentage [intervenes]

ADV WILLIAMS: Sorry, can you just go back to that?

DR KWINDA: Ja.

ADV WILLIAMS: Okay.

CHAIRPERSON: I mean of the doctors, because that 87 000, so just on the doctors, what are the figures?

DR KWINDA: We have not zoomed into specific boards and specific professions. What we are just, so in terms of the register in general. Should I move on?

ADV WILLIAMS: So, these are GP's and specialists and [intervenes]

DR KWINDA: These are [intervenes]

ADV WILLIAMS: Clinical psychologists.

DR KWINDA: Yes. All the professions registered under the Health Professions Act.

CHAIRPERSON: Ja, I mean that's the problem. Is that it might be distortive if you don't isolate GP's for instance where we know on the facts that the largest, on your own facts, the largest number of complaints by schemes are directed at doctors.

DR KWINDA: Ja.

CHAIRPERSON: So, that's why I am looking at [intervenes]

DR KWINDA: Of course, ja, of course this is the first

time that we are extracting this data.

CHAIRPERSON: Ja.

DR KWINDA: And we can go as deep as we can for a particular purpose. So, but that's [intervenes]

CHAIRPERSON: I mean [intervenes]

DR KWINDA: What we have at the present moment.

CHAIRPERSON: Ja, it might be helpful that you actually do that deep dive so that we get a proper picture of what the figures look like. Because on what we have been told without data, is that basically in this country the racial spread of doctors is overwhelming the White but racial, a spread of complaints, it then becomes Black. And that's the basic fact we've been told. And so, you are the persons who have the stats, who can help us to know whether that's true or not.

DR KWINDA: Okay. So, basically that is our [intervenes]

ADV WILLIAMS: Doctor Kwinda, would you be willing to make your raw data available to us so that we can work with it as well?

DR KWINDA: The what?

ADV WILLIAMS: Certainly not the three of us, ja. But would you be able to make the raw data available to us?

DR KWINDA: In fact, I have it here with me. And I can give it to the secretariat then they can work on it. It's our register as of the 3rd June 2019.

ADV WILLIAMS: Thank you.

DR KWINDA: We can share that with the secretariat, and they can use it whichever way they want it.

CHAIRPERSON: Yes.

DR KWINDA: Now, in terms of percentage. 50% of our register is African practitioners and 30% is White. 9.4% is Indian. 6.8% is Coloured. 3.8% is the unknown, and Chinese is 0.2%. Now we go into complaints. Now, I'm giving you the figures as of May to June, because that is when we started and when this issues of racial profiling started. We started now to profile as well, from our side, from the complaints that we receive. And we started doing that in May 2019. And this is the picture that we have in terms of the numbers now. Majority of the complaints we have received, in those two months were against White practitioners, who are 30% of the register. Then followed by African and then Indian and Coloured. Now, in terms of percentage while African practitioners are 50% of the register, then the Whites who are almost 30% then should in terms of the complaints register against them to 50%. Of course, we still have to dive in in terms of the nature of complaints per race. We are still going to get to that.

So, this is just the information that we are gathering and whenever we gather information then it make us think, let's dive deeper, which we have done.

CHAIRPERSON: Where are this complaints from?

DR KWINDA: The complaints, I will show you. It's

[indistinct - 1:15:13.7] that for now, I've only picked up the ones of fraud which I'm going to demonstrate but we have gone deep into. Now, when we look at the general complaints against Africans, where are they coming from?

CHAIRPERSON: Yes. Now, you see, remember that I think in slide number 2, you showed us that the sources of complaint could be members of the public.

DR KWINDA: Yes, that's true.

CHAIRPERSON: And which is the largest proportion. But that's immediately followed by schemes.

DR KWINDA: Yes.

CHAIRPERSON: Now, what I want to know is, of the complaints you've shown here per race, how many come from the members of the public and how many come from schemes as against White or Black?

DR KWINDA: On general complaints we have not dived into that. We only dived into issues of fraud for now. I have that slide that will show that information. Now, in terms of the proportion in terms of the register, then it shows us that the Whites and the Indians are at the same level when you look at the register. In terms of the complaints lodged against them. And the Africans are at 0,2 which is almost half of the Whites and the Indians. And the Coloureds are 0,002. 02, and the Chinese is 0. Now, this now is fraud. And it talks to what picture do we see as a regulator from the issue of racial profiling. Now, we looked at the source of complaints

of fraud and the picture says, if you look at members of the public, they reported 5 African, 5 Indian and 11 Whites practitioners.

But the medical schemes reported 25 African, 3 Indian and 1 White. Our inspectorate office, two African [indistinct - 1:17:01.5] to African practitioners to African. Now, this is the picture we are giving you from what we have collected between May and June and it is up to you to interpret it.

ADV WILLIAMS: And you could, you could do the same exercise over a longer period?

DR KWINDA: What we are thinking of doing, we're going to be doing this of course from May and we're going to see how far back can we go in terms of gathering information like this. But I can promise you that moving forward from May, we are gathering information like this.

ADV WILLIAMS: But you will be able to do a retrospective [intervenes]

DR KWINDA: We want to explore if we can from the data that we have been collecting, if we can go retrospective. But this is what we captured from May [intervenes]

ADV WILLIAMS: For two months.

DR KWINDA: For two months. That is the picture. We leave it to you to interpret.

CHAIRPERSON: Yes, but what we'd like, I'm not going to do interpretation now, but what we would like is that a realistic timeframe is probably 2016 up to now, if that is possible at all. That

is the realistic timeframe if you look at the complaints that are within our scope of investigation.

DR KWINDA: Okay.

ADV WILLIAMS: 2014.

DR BILLA: Well, I think we accept that this [intervenes]

CHAIRPERSON: My colleagues are respectively, one is saying 2014, the other is saying 2012. I think we should probably stick with 2016.

DR KWINDA: Ja, I think I'm understanding our capacity. We would respectfully request that perhaps we; they will go back as far as 2016. That's where [intervenes]

DR BILLA: Ask for resources.

DR KWINDA: Well, ja. Well, if resources are available, we would appreciate that. I would try to make a link, you know, without [indistinct - 1:18:40.3], but I think if you listen to what Dr Letlape said about the nature of the patients or good practitioners and you look at the data that we have, it tends to tie in very well. It deals with the nature of the people who may be going to a particular practitioner and whether they in terms of the type of complaints. The second factor that we may also look at, we have not looked at though. Maybe look into the public sector what happens. Is there, who are the, who are most likely to complain in our population and I think it's, you know, even looking at the data that we have, and other evidence, is that the White patients are most likely to complain

compare to the Black patients, and looks at the level of healthcare, you know. Receiving of their healthcare services.

But I think this picture is quite interesting to look at as the way it is. Yes, we need to also look at who's, is it a Black patient complaining against a Black patient? White patient against a White patient. I mean, a practitioner. So that's information that we thought we should look at and the source of the complaints when you look at that.

CHAIRPERSON: Why do you say White patients are more likely to complain?

DR KWINDA: That's what I've, what we've, what I've seen that the, when you look at, because I think the, in terms of their empowerment, in terms of their [intervenes]

CHAIRPERSON: Because of what levels of education?

DR KWINDA: That's could be the factor also.

CHAIRPERSON: Or levels of affluence?

DR KWINDA: Affluence, ja.

CHAIRPERSON: And then when you compare that to the Black clientele, you know, they are less likely to be aware of their rights.

DR KWINDA: Yes, ja.

CHAIRPERSON: Because of their socio-economic circumstances.

DR KWINDA: Yes.

CHAIRPERSON: I see. But how does that tie up to the fact

that there is a huge disparity between complaints originating from members of the public and complaints originating from medical aid schemes?

DR KWINDA: That's what I'm saying, that's the [indistinct - 1:20:27.7] that one should look at. To say if we have that understanding, we should now look at the nature of [intervenes]

CHAIRPERSON: Because I mean presumably the schemes have all of the resources to complain. I mean it's not as if there's a power dynamic that's influenced by socio-economic background.

DR KWINDA: Ja. What I'm saying, the complaints that we receive from the public, but I think if you compare with what is happening there.

CHAIRPERSON: Ja, alright. No, I get you.

DR KWINDA: I think that is my last line that there's just something else that of course I mean I cannot be able to share this information, but it's very much linked to the, some of the investigations that we are doing. Where, you remember the [indistinct - 1:21:09.9] of the global fees a few years ago and we were involved in that but there're also other issues that are coming up in some of the investigations that we are doing. They say an investigation that we are doing currently where we have picked up issues that we have got questions in terms of the medical schemes Act and that deals with some of the entities that are performing the functions of managed healthcare organisations, while they are not

necessarily accredited under the Medical Schemes Act by the Medical, Council for Medical Schemes, and that has come up in terms of now they are contracting with practitioners and where there are payment arrangements between this entities where they will contract with the scheme and then entities will then negotiate prices with the practitioners.

And it talks to what Dr Letlape was taking to earlier on but some of our investigation and I do have the report currently, although because it's a Section 41 investigation that we are doing about this entities, that shows that indeed the entity is not accredited by the Council for Medical Scheme and we've got information from the Council for Medical Scheme to that point to say this entity is not accredited. But they say to the practitioners that they contract with, we are a managed healthcare organisation. But when you look at the fact that they are not accredited by the Council for Medical Schemes, meaning that the schemes are contracting with them while they are not accredited as a managed healthcare organisation and practitioners, because they depend on this entities for the benefits of their members to claim for them, then it becomes a challenge.

So, that is what we have also picked up and I think, looking at our processes, we can be able to share that information with you later on because we are asking ourselves, why are this entities allowed to be contracting with the schemes and ultimately contracting with the practitioners registered with us, while if you look at it, they are not accredited in terms of the Act.

CHAIRPERSON: Do you have the names of the schemes for 20, for May and June 2019 who have lodged these complaints that are in column 2?

DR KWINDA: We can get that information for you. That will be easy to get.

ADV HASSIM: A further question about your data, I see that you've reported on complaints. But of course the Health Professions Council makes findings in relation to the complaints. There will be determination of whether there's professional misconduct or not. So, do you have data on what, what happens to complaints? Are there ultimate findings and the same data in relation to those findings other, in other words a breakdown on, in terms of racial demographics?

DR KWINDA: Ja. Currently we don't have data that I could present the way I'm presenting this data. But now moving to the aspect, this is now from secretariat. Then we move to the aspect of our govern instructions in terms of our preliminary committees of enquiry, and also our professional conduct committees. And I don't have the data that we have already collected in terms of what happens. What I can just tell you is that in terms of the preliminary committees of enquiry and the professional conduct committees, what we have currently introduced, because we have picked up a challenge and the challenge that we have picked is that you have practitioners who are found guilty of unprofessional conduct at a preliminary committee of enquiry, related to issues of fraud. And

their matters are finalised at a preliminary enquiry level. And our preliminary committees of enquiries are limited in terms of the penalties that they can impose.

In terms of our act, we have got penalties that range from caution, reprimand, fines, suspension and also restitution. But the preliminary committee of enquiry is limited to only a caution and a reprimand and a fine. They cannot go to restitution. Meaning that if somebody is found guilty of fraud for example, and the preliminary committee of enquiry finalise the matter, even if there could be restitution where the person could be forced to pay the money that they defrauded, that cannot happen at that level because only a professional conduct committee can impose a penalty of restitution. Now, we have develop also guidelines, even for govern instructions to say, if there is a case of fraud, it's better that the matter is more finalised at a preliminary committee of enquiry. It's finalised at a professional conduct committee so that at least all the options can be available if a person is found guilty.

But I can only say this is what we introduced at the beginning of this year and is still really moving at a snail's pace. But we can go back and say all matters that were finalised at preliminary committees of enquiry and conducting enquiry level, we can be able to gather some of the information as much as we can for the panel.

ADV HASSIM: And my last question is this, I understand you'd like us to interpret the data and we will draw on experts to do so, but you must be a data expert in your own right and what is your

view on the value of two months worth of data?

DR KWINDA: Of course when we look at the data, we asked ourselves a question, panel. And from us, we even went further then, to say does the socio-economic status, does this have to do the socio-economic status of the practitioners or does it have to do with the eyes of who sees Black and who sees White. Because really, we asked ourselves if members of the public can identify five, the schemes are able to identify 25, while members of the public can identify 11 from the White race, but the schemes can only identify 1. We really [intervenes]

ADV WILLIAMS: My question more relates to the value of two months worth of data. So the, really two months. Because one has to be careful about making an extrapolation which are not reasonable.

DR KWINDA: Sure. Ja. In terms of the value of course, this is only two month data, and that's why I said earlier, we're going to be collecting that prospectively, moving forward and see how it reflects although we're going to go back, but that's why I said earlier, this is what we have in two month. And we thought it is interesting for the panel to note this. As to what the picture will be as time goes on, or if we go retrospectively, of course the data will tell.

CHAIRPERSON: Ja. I mean you did say that your resources will enable you to look at, at least, from 2016.

DR KWINDA: Ja. But maybe to just go back to the question. In the nature of our business, we don't collect such data in

this way, to do a racial profiling. Yes, we're just collect information about practitioners where they come from. But I think because of the matter that we, that has brought us here, we had to go that way. But it is not ordinarily how we would be collecting data. That is why we do not have such information.

ADV WILLIAMS: But the data that you do have, in your database, will allow you to conduct this exercise going backwards in time?

DR KWINDA: Yes.

ADV WILLIAMS: And how long would that take?

DR KWINDA: You see from where I'm sitting, knowing how, when we started to collect some data, I can only vouch for 2017 April, from 2017 April we could pick up something. Going back to 2016 it will really mean, ja, lots of hard work that has to be done because we were not necessarily collecting data like this, but we'll see how much we can get from 2016.

ADV WILLIAMS: And how long would it take to get from, at least from April 2017?

DR KWINDA: From April 2017 it shall not take long. Within the next two weeks [intervenes]

DR BILLA: Should be able to have that information.

ADV WILLIAMS: Two weeks?

DR BILLA: Yes.

ADV WILLIAMS: Thanks. Of course the medical aids say to us that they don't racially profile because they don't know the race

of the health service providers. They use a system.

CHAIRPERSON: Practice numbers.

ADV HASSIM: Ja, and practice numbers that are anonymous. So, how could it be that they would be racially profiling, so they argue, when they don't have that kind of information. What do you say to that? Because that seems to me quite a very, quite a strong argument to say we don't have the race. We don't know the race. We are blind to the race.

[indistinct - 1:30:20.0].

CHAIRPERSON: [indistinct - 1:30:27.1] started the response earlier because he mentioned that we cannot look at racial profiling outside the context of South Africa's history. So, perhaps he wants to dive into this one.

DR BILLA: Yes.

ADV HASSIM: But with specifics.

DR LETLAPE: Ja, they are correct and to do racial profiling they don't need to have the race dynamics. They just need to know who's contracted in, who's contracted out. Because by that [intervenes]

ADV HASSIM: Like, by that you mean name and surname and [intervenes]

DR LETLAPE: All I'm saying [intervenes]

ADV HASSIM: And address. What do you mean?

DR LETLAPE: 99% of the practitioners that are contracted in, that are dependent on direct payment, would be

people that have Black practices and largely Black practitioners. And those that are contracted out, would largely be White practitioners with White patient basis, and the affluent societies. So you don't need to have a racial matrix to get the racial information. Because the natural settings of South Africa will do the demographic profiling for you. Just like we say, you know, poverty is general, but its face is black. It's by the same token. A poverty doesn't do, a racial register doesn't say are you African or are you Indian. But we know what the face of poverty looks like.

So they can come and rightfully tell you, we're neutral, it's practice numbers. And that might be true. But does not mean there's no anxillary information that they have. Those practices have practice addresses. So, they would know where the practices are located. So, there's other information that they have that will give you the racial distribution. I'd rather call it racial distribution than profiling. But once you have the distribution, you can profile. I mean, like I've said, there's no racial profiling of African male drivers in the US, but they are the ones that get shot most of the time, or all the time.

CHAIRPERSON: Thank you.

DR LETLAPE: I don't know if that answers your question? So, I mean it's a simplistic answer that they give you. What they are not telling you is that we have our own way of defending ourselves for racially profiling, but we know what the profiles are. And even if you took, take race out, is the vulnerable

communities that are being affected and they're those that serve the vulnerable communities. And that give them leeway and access to care that get victimised by this policies that they have. Because the ones that are rich say, I don't give a damn. Swipe, or get out. Now, those that care are the ones that get victimised.

And I accept that there would be White practitioners like the one that is sitting out there saying, pay me what you can pay me. It's not a Black practitioner. But he's not doing it to the White population. He's doing it to Black patients. So there will be those [indistinct - 1:33:41.3] that we have in our society. But we should not be, you know, when things become legalistic, they become problematic. Because legal issues can actually blind you from the reality on the ground.

CHAIRPERSON: I wonder whether there's no way of interpreting this data sort of benignly and looking at medical aids from what you are saying that if the majority of those contracted by medical aids are African, where, yesterday we had BHF and I posed a similar question to them and they said if you look at the spread of GP's in townships that explains why the most complaints, I asked them the blind question, why do most of the complaints before our panel come from African practitioners. They said it's because of their spread in the township and the population that they serve. What do we know about the numbers that are contracted to medical schemes or [intervenes]

DR LETLAPE: What does he mean by the populations

and the number that they serve?

ADV HASSIM: Can I? He means that most of the practitioners in the townships are, see members of medical schemes. They provide services to patients who are on medical schemes. That, that's what he is saying.

DR LETLAPE: I don't know what the dynamics are. And I'm not in GP practice, but that might be true for certain geographics. So it would depend on the location. So if you look in urban environments, that might be true but if you go into small towns and you go into rural towns, there are GP's there and the profile should be different because it also depend on the town that you are in. If there's a mine that's the main employer and only management is on medical aid, then the profile of those practices will be different. That the profiles of practices 20 years ago were different because most Africans were not on medical aid. The majority of Africans are not on medical aid.

So what you could say is that the major income streams of those practices might be coming from patients covered by medical aid. But that might not necessarily be the majority of the patients that they see. So, we need to be able to make that distinction. So, he wouldn't be able to know about the non-medical aid patients that go into those practices and what their numbers are. So, the key issue is that the practitioners that sit in townships have chosen to not charge their patients directly and are dependent on direct payment from medical aids. That's the truth and that's the key issue, and that's

what they use to abuse the practitioners. Now, you have to understand that when you sit in practice and you've taken the decision that you're not going to be asking for money upfront, because you're serving the community. Basically you are salaried by the medical aids.

I mean for most practitioners if that GEMS cheque doesn't come in, and you're serving teachers and whatever in your community, you can't pay your bills for that month. And they know that. And that's the power that they command. And they can choose not to pay you. Whether you are one of the profiled ones or not one of the profiled ones. And a lot of people will tell you they wait for their legit money that gets paid 90 days after the service, with no interest. So there are many other issues that need to read into this issue. So, my answer to you is that they are just looking at one profile and it is true that if you sit as a GP, in the urban environment, it might be your main income, comes from medical aid patients. But it will also mean that you get paid in the first quarter because by the second quarter, they've run out of funds anyway.

So, but the practices continue, patients get served to December when there's no money. I mean, the absence of a tariff, statutory tariff, the absence of compulsion to pay for services, has created a system where it's hospisentric. And GP's are being taken out of business. Because what they do, the medical aids have transferred the risk to the patient. If you're young and healthy we give a smoothie and an Apple-watch. If you're old, you're just going

to run out of benefits, and you may get your hypertension medication from May in the public sector if you can. That's what happened. So, care to people has been terribly compromised on this issue. And because they run like an insurance company instead of social solidarity, people are individually rated.

You run out of money as an individual. It's not a scheme pooling resources. So what do you have right now? It's just money for jam, for those that go into administration and they can spin off health management companies, service providers for this, that group to do dialysis for them. You go there for your dialysis. They spoil all this things because they generate money and they can build glass houses for themselves.

ADV HASSIM: Are there organisations that represent patients that we could, we could ask to provide evidence to our investigation? So patient's representative organisations.

DR LETLAPE: I think there are some that have been in the process of the Presidential Health Summit. There's a representative of patient organisations that sits in there. So you should be able to, she sits in the steering committee and there are lots of patient organisations that are behind them. So it would be easy to get those. But you'll also understand that a lot of them are sectored around particular diseases. I have a relative that has this disease and I start the group and we look for treatment for that disease. But there are the patient groups. They are not generic. You might also want to get the Consumer Council to give you evidence of

health-related complaints that have been taken to them by patients, because of not knowing where to go. Those would be the two suggestions that I would have. I can't refer you to people living with HIV and AIDS, because the State is taking better care of them than the private section ever would.

ADV WILLIAMS: It's true.

ADV HASSIM: Doctor Kwinda, may I just ask you one more question about the data again with the huge proviso that we will take advice on this and it's a very difficult issue. You're properly interpreting data, so fully aware of that. But if you could go back to your slide on the total breakdown of all practitioners, so that 185 000 divided, broken down in terms of racial demographics.

DR KWINDA: Ja, that is the information that I'm sharing with the secretariat.

ADV HASSIM: Sorry, I think it was the third or fourth slide. Is that right? On your presentation? I think we have it. We had it.

DR KWINDA: Okay.

ADV HASSIM: If I remember correctly. That one. So, my thought or question is, and I really stand corrected on this because you will be much more familiar with these analytical tools than myself. But is another benign interpretation simply because there are more Black practitioners, total Black practitioners, that just statistically there'll be more complaints just because there're more practitioners.

DR KWINDA: But maybe, if you look at this and the picture that we have been seeing, even not looking at the race. You look at the boards, you look at the provincial distribution, but you will see that it change. But this is not the case. Although you do have more African practitioners, but the number of complaints are more against Whites.

ADV HASSIM: Sorry? The number of complaints are more against?

DR KWINDA: They are more against Whites.

ADV HASSIM: Ah, thank you. Can you take us to that slide?

DR KWINDA: And that's why, here it shows 50% of practitioners are African. And 30% are Whites. But when you go to complaints per race, 50% is White and 31%, 32% is African.

ADV WILLIAMS: And these are complaints from all sources? Just, from all sources?

DR KWINDA: From all sources.

ADV HASSIM: From all sources. It's not broken not.

DR KWINDA: It's not broken down.

ADV WILLIAMS: And so how does this then match the last table we are looking at?

[indistinct - 1:42:46.6]

ADV HASSIM: This only goes to show that perhaps I shouldn't be delving into this area.

DR LETLAPE: What I would hope the secretariat will be

able to do for you, is to segment out the Medical and Dental Board. So that they do the same work but concentrating only on the Medical and Dental Board. Because that's 90% of your complaints. And when you look at the Medical and Dental Board, most of the register is White, not Black. So it might then, it will flip the whole thing and the complaints that you have, profiling it's general against the health practitioners, but it's mainly against medical practitioners. So, I think that [indistinct - 1:43:28.4] would be important for it to be extracted out and analysed in the same manner but specifically Medical and Dental Board.

CHAIRPERSON: Can I get your comment on this that Dr Billa or Dr Kwinda? I mean the slide that really intrigues me is the last one for May and June. Because in that slide you are able to draw a distinction between complaints coming from the public and complaints coming from the medical schemes. And the public complaints are evenly spread, and the medical scheme's complaints are skewed. 99,9% against Africans. What is the explanation for that?

DR KWINDA: Are you referring to this?

CHAIRPERSON: Yes. This is the slide that troubles me a lot.

DR BILLA: Of course we are not at the point where we are able to explain because we just zoomed in to specifically the issue of fraud. And if we were to go and look at all the nature of complaints and look at the sources, maybe we'll have a clear

picture.

CHAIRPERSON: No, I mean our concern here is Section 59 and that's where the issue of fraud in accounts is most prevalent, and that's why I, this is a more useful slide for our purpose, you know. And the disparity I'm drawing is, the members of the public, that tends to be evenly spread and to match probably the representation in the profession. And then on the medical schemes, I mean that is, seems to be grossly disproportionate.

[indistinct - 1:45:06.2]

DR LETLAPE: I think it goes back to the issue that I was raising that when you take medical aids, they can only profile on people that are dependent on direct payment. Practitioners that segment themselves out and charges directly, they can't touch them because I've told you my service is X. And the understanding is between me and you and no one can accuse me of fraud. You can make a judgement call that my services are too expensive, but that's a judgement call but you cannot denote it as fraud. And you'll see the link that they'll ask for information if they are paying you directly. If you've sort of contracted out because this is where people have opted to be out, they can't get that information.

So those that work in affluent practices with affluent communities work outside this constraints. So those relationships would be directly between them and the patient and the medical aid can't interfere with that. So, the only time they can claim you're overcharging or you're abusing, or you are fraudulent, it's on issues

where you are putting a bill to them and they are adjudicating on that bill and they are paying that bill. When you put the bill directly to the patient, they are not able to interact in that. So it might be, that might be part of the explanation of what you see in that profile.

[Simultaneous talking]

CHAIRPERSON: What are the mutual explanations for the benefit of the schemes that are available for this data so that we don't make lazy and general conclusions about it? That's what I'm trying to tease out from your side. Whether, I mean the data obviously strikes you as [indistinct - 1:46:57.9] but it's too lazy to say therefore it's evidence of racial profiling and I'm simply trying to explore what are the neutral ways of interpreting what we see, if there are any. And you don't have to, you know.

DR BILLA: I was not trying to interrupt you and to say. But I think what I, I just made a note here because when I look at this information. If maybe the medical aids or BHF can help us and give us information, I think, I note what Dr Letlape is saying. Get a percentage of how many of the White practitioners are not claiming direct with the medical aids. So that might give us an information because then it is at least way of a better basis to compare to say 90% of White practitioners bill patients directly and 90% of Black practitioners. So then the avenue for the medical aids to make an intervention is only with the Black practitioners. So that information, whatever they get, whatever information they get of fraud, or perceived fraud, will only because the base at which they

are looking at, it's higher amongst the Black practitioners and it is much lower with White practitioners. So that may be the explanation that I would perceive at this stage.

ADV WILLIAMS: So, one of the issues that concerns me in addition to Mr Ngcukaitobi's concern about this slide is this question of direct and indirect payment. Because it translates into rich and poor. Because you won't need direct payment if you serve people who can pay you directly. You as a practitioner would not need direct payment. But that, it troubles me because, because again, it's easy to draw a link and a conclusion between that and race. And I want to understand more about what. Are we correct to say that we understand there's no relationship between the practitioners unless you're a member of a DSP? There's no relationship between the health service provider and the medical scheme. So there's no obligation on the medical scheme to pay a practitioner directly. That, that is correct. Isn't it?

DR LETLAPE: Yes. The law was changed prior to 94, to that effect. Because prior, an account would not expire if it was a proper account and payment was guaranteed to the provider in accordance with the rules and payment was made to the provider by law. They took that away. It is now discretionary. And they've made it clear that there's no contract between the provider and the scheme. So the only contracts that they make would be DSP's. And in those contracts, we have a concern that the professionals might be surrendering their autonomy for payment because in the DSP's the

medical aids prescribes the conditions to be met to be a DSP. It's not open to all ethically practising practitioners. It's open to people that are going to follow the laws, the prescripts of the funder and not the prescripts of the profession.

CHAIRPERSON: Why do you say the DSP's are discriminatory?

DR LETLAPE: Because what they do, they choose who the patients can go and see. And they select from among the practitioners. And those that are outside, so you don't have your choice. If you come and see me and I'm not a DSP, you're on your own.

CHAIRPERSON: But yesterday what BHF said is, anyone can join, anyone can [intervenes]

DR LETLAPE: Ja. You see that's why call it a DSP. You are designated. It's not anyone.

CHAIRPERSON: Ja, what I'm [intervenes]

DR LETLAPE: You see the old system was anyone. Because you contract in or you contract out. And as a practitioner you'd say I accept medical aids and I abide by the fact that there'll be no balance billing, you know. I'll take the payment, etcetera, etcetera. Okay?

ADV WILLIAMS: But isn't that what the DSP is trying to do? Is to prevent balance billing [intervenes]

DR LETLAPE: No, that's not what a DSP [intervenes]

ADV WILLIAMS: It's to keep it down with pressure on cost.

DR LETLAPE: No, that's not what the DSP tries to do. Because if the DSP was trying to do that, it would just be saying, here are the rules. Any doctor that abides by this rules, gets paid. DSP is about, we will pay Billa, we won't pay Letlape. You go to Billa, we pay. You go to Letlape, we don't pay. That's what DSP is about. It's not about if Billa meets this conditions, we pay. If Letlape meets the same conditions, we pay. That's not what it is about. It is about telling them. If you go to the one that is not on our list, we don't pay.

ADV WILLIAMS: But is it that they don't pay or that they don't pay the full amount? Meaning there might be a co-payment if it's the first [intervenes]

DR LETLAPE: You see, when you're dealing with vulnerable communities that are dependent on getting care because they can't pay for it, if they come to see me and their medical aid is not going to pay me, what am I expected to do? What are they expected to do? Because they choose me. They must now pay directly. Something that they can't do. So this are not things that are done loosely. This is about power. This is about control. This is about diminishing a profession. This is about largely; this largely impacts on Black practitioners. So, I'd like to not make it a racial profiling, but make it, who does it hurt the most? It hurts Black practitioners the most.

Whether you are doing it as a profiling mechanism or it's a default mechanism, the lay of the land is such that it's going to affect

Black patients and Black practitioners the most. And you cannot say it's not intended. It might not be driven by race, but this people employ actually. This people employ senior Advocates. Nothing is left to chance. And it can't just be a default situation. They may not be driven by race, but it's an ability to maximise on profits and minimise on provision of care and payment to providers.

CHAIRPERSON: So when you say it's not driven by race; you mean it's not intentional profiling but the impact of it is primarily on Black practitioners because of their socio-economic background.

DR LETLAPE: Ja. Because of the lay of land. So they might argue that it's not racial profiling, but they know it's going to have an impact on Black practitioners and Black patients. That they, and they are doing it with that full knowledge.

CHAIRPERSON: Just tell me, I mean, saying that they know that the impact will be felt the most by Black practitioners, I mean that's one thing. He may not know, but they may be negligent about that knowledge. Now they are saying information might be available if they wanted it, but they don't care enough to look for it.

DR LETLAPE: But I think you probably haven't met them. And you are giving them too much credit. And I just want to be frank. They know what they are doing, and they know they can get away with it, as long there is no statutory tariff. As long there's no rules that surrounds solidarity, medical aids, a system that everybody understands, a common benefit structure, a statutory tariff. That is the protection and that is how you do an open choice

designation by providers. They say, this are the rules. We stick by the rules. So the patient know that they can come to us. We don't stick by the rules, they don't. They've created further things. I mean, there are horrific things where they would say to you, we're doing global fees now. We've selected you and after the hip, there should only be two physiotherapy visits.

If you don't comply with that, you're not going to be a DSP and you're not going to be part of that. So they are now dictating care. They are now acting unlawfully. They are practicing medicine. And they are not registered to do so. But that's what they do. That's what DSP's do. I mean, the issue is that, and maybe we should take the blame. I mean we are regulators sleeping on the job. And we are a profession that does not fight for its rights. And maybe they are doing this, because the profession is weak. Maybe they're doing this because the regulators are not worth their salt in regulation. And because the profession is not standing up for its right as a profession, it's not standing up for its patients. They'll continue to do it. It's no different from where we were with the State with HIV and AIDS. When they did what they wanted to do. The patients were dying, and the doctors were silent.

There's absolutely no different. And why did the State do it? Because they could. Why are the medical aids doing it? Because they can. It gives them ability to sponsor English Premier League and all other things that they sponsor, without paying for care. It gives them the right to tell a practitioner that we are not going to pay

you and a patient on dialysis dies. And they watch. Why? Because they can.

ADV HASSIM: Dr Letlape you speak very eloquently on this subject. But I want to ask you. Is it not inevitable when there is a limited pool of resources that the schemes have to ration those resources and so there has to be a cap on what benefits and limitations on benefits that are made available? Is that not another way of looking at what you've just explained about how the benefits are determined by the schemes. Is it, I mean, if there's a limited pool of money, isn't it a full gone conclusion that members will not be able to access all of the health services that they want and maybe even require and isn't it also an inevitable tension between practitioners and the funders that the practitioners want to provide services.

Not because you're trying to over-service or because it's wasted, but because you're trying to do the best for your patient. And, but the funders on the other hand are trying to protect the pot of money for the whole pool. Isn't that also an inevitable tension?

DR LETLAPE: There will be tensions but let's go back to the beginning. Pooling. There's no pooling and that's the problem. Pooling would mean we're all in one pool as medical aid patients. We're all in one pool as in a scheme. There's no pooling. There's individual rating. If you're young and healthy, we give a smoothie and an Apple-watch. If you're old, we load you so as that you can't afford it and we don't have to pay for care. There's no pooling. People are individually rated. Your funds are exhausted. There's no

pooling. So, I agree fully with what you say. But what they've done, they run a business insurance model under the guides of pooling based on an act of parliament.

When there's an absence of pooling, it's individual rating. It's not pooling of resources. It's not that we as a fund will pay for this forms of care. It's about Ms X, your money for dialysis is gone. Die. That's not pooling. So, I fully agree with you and what we need is to pool. So that we can defy what we will pay for, for the pooled resources. When I'm saying, if you come from Bryanston, I will pay 10 grands for your cataract. If you come from Soweto, I will pay a grand for you cataract. That's not pooling. If I'm saying for the same procedure I can pay three times NRPL, or NRPL, that's not pooling. So I fully agree with you and the problem is that we're talking about pooling consent that's being run on an insurance model where people don't have policies but are dealt with as individuals.

There is no pooling. And I fully agree with you. Let's pool. And that's what the scheme was before. Let's pool the resources so the scheme's benefits that are pooled, there's agreed tariffs based on that pooling and you are prepared to work for this tariffs. We've pooled everyone. We work on the basis of solidarity and we negotiate with you as a group. So I fully agree with you but anybody that thinks there's pooling now, does not understand how they operate. I mean, people have been dumped in ICU. Families have been told come and collect. There's no pooling. So, let us not, and I agree there will be limitations, but let there be proper pooling. And

that's why you need common package for people that are under medical schemes. Negotiated statutory tariff. Then all the smoothies and watches can happen outside that framework.

DR KWINDA: Can I just give an example of some of the things that Dr Letlape is talking about. And we assume that this entity is accredited, it's one of the entities that is not even accredited. You go, I mean. I'm happy that all of you are wearing spectacles. You go to your Optometrist and after you leave, you receive an SMS that says, an optical benefit enquiry has been made on your profile by an out-of-network provider. Your frame benefit is 50% more if you visit an in-network provider. Click here to find a provider. What it means is that you have got your Optometrist who is not in this network. You go there because this is the Optometrist who have got your history, they've been treating you. I mean, they know how your eyes are doing, then you go there now because it's two years after your last spectacles. Then you receive this SMS to say, you have gone to the out-of-network provider. If you go to an in-network provider, 50% benefit. Click here.

Meaning that now are being diverted from your practitioner, who is close to where you stay and it is convenient for you because anyway, you have been using this person but now, because the person is not in the network, you need to go to somebody else who is in the network. And these are some of the real things that are happening. The DSP could be good in terms of what you are ascribing, but now, what is really happening practically shows you

that there are problems.

DR LETLAPE: So effectively when you sign to [indistinct - 2:03:02.7] DSP, this medical aid is going to market for you. And it's going to steal patients from other practitioners on your behalf. That's effectively what this is. This is tactic and it makes a mockery of all our ethical rules, about advertising, about supersession. So, I'm not stealing your patients. The medical aid is doing the stealing on my behalf. That's what we deal with. That's what DSP's are about.

CHAIRPERSON: Alright. Thank you very much.

ADV WILLIAMS: May I ask a last question about the slide which has disturbed us so much in terms of trying to understand how to interpret it. I know I take a risk. Can I just ask? So, would you be able to give us a similar slide, broke down in exactly the same way with all complaints?

DR BILLA: Ja. Other than fraud?

ADV WILLIAMS: Ja, not just isolating fraud. All complaints.

DR KWINDA: Yes. We, according all the nature of complaints, we can be able to do the same slide.

ADV WILLIAMS: Yes. And a complete one? I mean I don't think you have to break it down and, I think you had 20 to 30 different types of complaints that there were. But just a complete. Full complaints, same breakdown.

DR KWINDA: Ja, we can do that.

ADV HASSIM: Thank you.

DR LETLAPE: That means fraud and everything else?

DR KWINDA: Yes.

CHAIRPERSON: Yes. Thank you. It remains of me, unless there are any other submissions to be made by the HPCSA. But it remains of me then to thank the President, the Registrar and the, I think, Head of Legal. [indistinct - 2:04:39.0]. You are the Ombudsman? Oh. Let's say Ombudsperson.

DR LETLAPE: I think, I hope what we may have tried to bring to you is this important of having a statutory tariff. The importance of proper pooling. The importance of not having 101 packages, because that creates confusion amongst beneficiaries, amongst providers and you're spending more money on administration than on what you should be doing. That those issues will not be lost and the fact that the statutory tariff was destroyed by the Competitions Commission. And the sooner we get it back, the better for all of us.

CHAIRPERSON: Yes. I think the Commission also acknowledges the problems that have emanated from its ruling and there's divergence whether it should be statutory or what is really necessary, is a common tariff and how it comes about is debatable.

DR LETLAPE: If the funds are collected based on a statute [intervenes]

CHAIRPERSON: It should be able [intervenes]

DR LETLAPE: It would be advisable that there be a statutory tariff.

CHAIRPERSON: Yes. Certainly. A regulated tariff. Thank

you. I wanted to just express our gratefulness that you made the time this morning and you've made a presentation and you've done your research and of course the, I mean, the presentation itself was enlightening for us and especially coming as non-participants to the industry and coming specifically to dive into an isolated area. So, thank you. The session will be now be adjourned until, I think it's half past one, when we will be hearing from [intervenes]

ADV WILLIAMS: The National Healthcare Professional's Association.

CHAIRPERSON: Yes. The National Healthcare Professional's Association. Thank you.

PROCEEDINGS ADJOURN

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