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 NATIONAL HEALTH CARE PROFESSIONALS ASSOCIATIONS:

DR DONALD GUMEDE, NATIONAL CHAIRMAN

DR NQABAYETHU BUTHELEZI

DR THANDI MKHIZE-MABELA

MR JONAS NAIDOO

DR PRUDENCE BUTHELEZI

DR DESMOND LAMELA

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

TRANSCRIBER	:	S LAAS & A SCHEEPERS
DATE HELD	:	2019-07-31
DATE COMPLETED	:	2019-08-01
NUMBER OF PAGES	:	69
SIGNATURE	:	S SLAAS & A SCHEEPERS

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

PROCEEDINGS RESUME

CHAIRPERSON: Good afternoon. We are continuing the Section 59 investigation. This afternoon we have the National Health Care Professionals Association. Can we start with recording those who are present, just tell us what their names are and in what capacity they are here. So we should probably start with the gentlemen sitting at the front there.

MR NAIDOO: My name is Josias Naidoo. I am the Gauteng Chairperson for the NHCPA.

DR MKHIZE-MABELA: I am Dr Thandi Mkhize-Mabela, the Deputy Chair Gauteng.

ADV BUTHELEZI: I am Ngabayethu Buthelezi, counsel for the NHCPA.

DR GUMEDE: I am Dr Gumede, the Chairman-, National Chairman or Chairperson of the NHCPA.

DR BUTHELEZI: I am Dr Prudence Buthelezi, [indistinct-00:01:08] General of the NHCPA.

DR LAMELA: I am Dr Desmond Lamela, the Provincial Chairperson of the NHCPA.

CHAIRPERSON: Mr Buthelezi, what is the plan? How are you going to present your submission because those who are presenting, we would like them to take an oath?

ADV BUTHELEZI: Chair, the submissions are in three parts.

CHAIRPERSON: Yes.

ADV BUTHELEZI: The first parts would be a submission by Dr Gumede with regards to the topics that we've covered along the lines of our own overview of the-, our perspective on medical schemes. And then after Dr Gumede, it will be myself. I will be doing an analysis on how the forensic audits are a violation of Section 59 and other legislation and I will also do the section on racial profiling and in closing, Dr Gumede will close in terms of recommendations to the panel.

CHAIRPERSON: Alright. So the only people who will be speaking is yourself and Dr Gumede.

ADV BUTHELEZI: Indeed so Chair.

CHAIRPERSON: Now, the portion that you will be addressing, will that include facts or will you just be making submissions?

ADV BUTHELEZI: We've got legal arguments supported with evidence Chair.

CHAIRPERSON: Alright. I don't want get counsel to take an oath, but I don't want to get facts here either that are not taken under oath. So, you should decide how to de-, I have no problem with you making submissions based on facts that have been introduced by Dr Gumede. Anyway, shall I start with a non-controversial part which is Dr Gumede? Dr Gumede do you-, are you going to take an oath or the affirmation?

DR GUMEDE: Good afternoon Chair. I'm, I will also will ask my, the guys that I work with also to read an extract from my

presentation so I will request that they also being under oath.

CHAIRPERSON: Be sworn in?

DR GUMEDE: *Ja*, sure.

CHAIRPERSON: No, that's fine. Okay. Who, who will be doing those, let me just choose among you a team?

DR GUMEDE: *Ja.*

CHAIRPERSON: There are two [intervenes]

DR GUMEDE: *Ja*.

CHAIRPERSON: … sitting that side? Okay, very good.

DR GUMEDE: They just want to extract, *ja*.

CHAIRPERSON: Thank you. Shall I start with your oath then?

DR GUMEDE: Yes.

CHAIRPERSON: Just say after me, I, and then your name.

DR GUMEDE: I, Donald Gumede.

CHAIRPERSON: Swear that the evidence that I shall give.

DR GUMEDE: Swear that the evidence I shall give.

CHAIRPERSON: Shall be the truth.

DR GUMEDE: Shall be the truth.

CHAIRPERSON: The whole truth.

DR GUMEDE: The whole truth.

CHAIRPERSON: The only truth.

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

DR GUMEDE: So help me God.

CHAIRPERSON: Can I take the next oath now so that there is no problem with speaking here? Sorry, just, [indistinct-00:04:06] say after me, I, and then your name.

DR MKHIZE-MABELA: I Dr Thandi Mkhize-Mabela.

CHAIRPERSON: Swear that the evidence that I shall give.

DR MKHIZE-MABELA: Swear that the evidence that I shall give.

CHAIRPERSON: Shall be the truth.

DR MKHIZE-MABELA: Shall be the truth.

CHAIRPERSON: The whole truth.

DR MKHIZE-MABELA: The whole truth.

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

DR MKHIZE-MABELA: So help me God.

CHAIRPERSON: And the gen-, you are not going to be speaking? Thank you. So it will be, so it is Dr Mkhize?

DR MKHIZE-MABELA: Yes.

CHAIRPERSON: Dr Mkhize? Okay, very good. So Dr Gumede, the floor is yours, you can direct us about how you want to structure your presentation.

DR GUMEDE: Oraait. Thank you very much. During the break or the lunch I, I submitted files which are probably sitting at your table.

CHAIRPERSON: These are the green files?

DR GUMEDE: Ja, sure, sure, sure.

CHAIRPERSON: Okay. Are these the submissions that

you already made?

DR GUMEDE: Yes.

CHAIRPERSON: Okay.

DR GUMEDE: We printed them. We, we, *ja*, we had them printed out.

DR GUMEDE: Thank you. Alright, sure, sure.

CHAIRPERSON: But nevertheless, thanks you are the first person to run copies for the panel, thank you.

DR GUMEDE: Thank you very much. I'll just read through and then…, oh, my counsel was requesting if we could borrow the ones that we had given you to give other members who would like to [intervenes]

CHAIRPERSON: Follow [indistinct-00:05:48]?

DR GUMEDE: *Ja*. Thank you very much. Like it has already been stated, I am the National Chairperson for the National Healthcare Professional Association. We probably we'll say we are responsible for causing this storm probably and although we shouldn't be proud but we are very proud that the storm is here, so it can start raining from now. Thank you. NHCPA was formed in 2006 as an organisation intended to advance an advocate for the interest of healthcare professionals in South Africa. The need to establish an alternative board to represent healthcare professionals was realised by Dr Gumede and Dr Prudence Buthelezi who spearheaded the establishment of the National Healthcare Professional Association.

The initial purpose was to address the challenges faced by the private medical practitioners in their dealings with medical aid schemes but it soon became clear that all healthcare professionals require similar assistance whether in private or in, in public. NHCPA was, the National Committee was elected or, or is led by a chairperson and a secretary treasury and four other members. The provincial structures are led by provincial committees led by governance for each provinces, which are nine of them. The membership of NHCPA consist of a broad spectrum of independent practitioners such as doctors, dentist, optometrists, medical technologists, psychiatrists, physiotherapists and etcetera.

At a recent count, we have an average membership of around 2 500 members. Our growth as an organisation has recently grown exponentially as more people became aware of the organisation's challenges against medical schemes as well as the establishment of the Section 9-, Section 59 investigation panel established by the Council for Medical Schemes. There can be no doubt as to our role-, organisation as-, no sorry, there can be no doubt as to the role our organisation has played in the establishment of this inquiry. Thus as an organisation we appreciate and welcome the opposition to make their submission and submit that the establishment of the Section 59 investigation panel has been long overdue.

In our earnest hope, no man sorry, it is, it is our earnest hope that, following on the inquiry, health professionals in South Africa will

again develop a sense of pride in serving the health needs of our community. As present, a great number of health professionals are explicitly under siege and walking on eggshells from the prevailing claimant of mistrust, hostility that we see submit has been created by the big medical schemes acting in concert with each other. As a group of mainly black peop-, black healthcare professionals of various disciplines, disciplines, all we strive for is to be able to render our services where they are needed in an environment that has prioritised medical ethics and patient care, recognises us as proper qualified professionals.

It's conducive for us to proper-, to prosper as professionals and is founded in the constitutional values of equality and dignity. A number of points on constitutional values will be canvassed in more detail later in this submission. At this point however, we ask that the investigating panel remain alive to the constitutional ethos of our country in all its deliberations and decisions. As a country we come from a place where a lot of professions, professions were represented here today where the exclusive privilege of a certain demographic by design. The University of Natal and Medunsa were the only institutions that granted access to medical students of colour as there existed the notion that people of colour were either not intelligent enough to be trained in certain fields or were not desirable person in those fields.

It is therefore most concerning that 25 years after the supposed official destruction of segregation policy of

marginalisation, we find ourself here to ventilate a similar form of marginalisation of black medical professionals that may many perceive to be designed to which-, perceive to be designed to push us to the peripheral of the industry if not excluded us completely. We undertake and commit to be of assistance to the investigating panel whenever and wherever we are called upon to do so. We also plead with CMS that the investigating panel be given a space in support to do its job without any interference and obstruction.

We implore the investigation panel to be thorough and robust in how it approaches all issues. As an organisation we will follow this inquiry very closely and are confident in the credentials and independence of the members of the investigation panel to yield a just outcome for all parties that will form objects of this inquiry. As a direct-, as directed by the terms of reference, we will best endeavour to confine the thrust of our submission to the terms of reference. In this regard, we have prepared our submission to cover the following topics: perspective on the business of medical schemes; forensic audits; violation of Section 59 and racial profiling.

Perspective on the business of medical scheme, at the heart of the issue is a fight over money and this money it belongs to the patients. And unfortunately the money does not actually go to the patients because 35% of that money goes to the administrators and 40% goes to the hospitals which are partly owned by the same medical schemes or medical aids, and then 20% then goes to your specialists and allied workers and pharmacies. And the last, which

is 5%, goes to the GPs who are actually at the heart of this mistreatment by the medical aids most of the time. And that's the simplest way of putting this, this issue.

All the disputes that would be placed before the investigation panel are all in the final answers to have fight over financial interests. And previously we had Dr Nhlapo, he was talking about administrators owning more than 5% of what actually they are supposed to own. In this instance they are owning 35% and that's why they make huge profits as you will further hear under my submission. We submit that the medical schemes have over the time developed a culture that is at odds with the notion of them being administrators who are a non-profit organisation primary offering health insurance products to their members.

Upon a closer analysis to the general conduct, individually and collectively it becomes apparent that their underlying motive is maximising profit. As any business, they are perfectly entitled to grow their revenues in all ways they consider viable. However, what has emerged in South Africa is most disturbing in that the medical schemes have resorted to unlawful and unethical way of maximising these profits. One of the ways that they have aggressively pursued by the schemes to this end is to reduce to a minimum the cash that leaves their business as payments to the healthcare providers while receiving the maximum in their monthly premiums or substitution from their members.

To illustrate this point one only has to have a closer look at

the numbers of Discovery Group, which Discovery medical scheme holding company. In an article published in the Business Report just last year on the 8th of November entitled “Big Week take home 336 million in bonuses”. The group’s remunerating committee chairperson, Sonja de Bruin Sebota, is quoted to say:

> “33% surge in bonus payment was due
> to target having been exceeded”.

They actually further highlights that the total of seven director will share 15 million while a pool of 1 134 managers will share a 265 million bounty and 203 people will share the balance of the 85 million of the profit pool. The article also mention the chief executive of Discovery as being paid 12 million in bonus. To better understand the targets that have been exceeded, one only has to read the annual report to get the perspective of how company-, how a company in an economy with a growth rate of merely 2% for the past 5 years will be able to increase its bonus pool by 33%.

To avoid digressing from the substance of this submission, I shall only refer to the Discovery financial director’s highlight in an annual report where the total established business of which Discovery has is the biggest portion delivery combined 14% growth in opening profit, which is CPI above 5%. Discovery Health in particular reported 11% growth in operating profit and 13.9 growth in reserve while only having had a 1.3% growth in membership. Discovery Health is listing key issues, is listing key issues that impacted the patient lists, claims, pressure, management, the impact

of medical inflation as the first issue and the second issue identify as tough-, in this tough economic condition.

The last paragraph of the commentary under the heading states the following: "Our fraud control efforts projects recoveries from 2018 in excess of 500 million." In the case of Discovery Health Medical Scheme, Discovery have achieved risk management savings of approximately 5.7 billion during 2017 representing 11.9% of potential risk claims and return on investment to the scheme in its managed care risk of around 269%. The Afrocentric Group which is a med scheme holding company has also enjoyed similar prosperity. The audited annual results for the year end June 2018 highlights the following: 14% dividends increase; 118 increase in earnings per share; 100 and-, this here we are talking about administrators to illustrate my point of this 35% that we are talking about; 46% gross profit before tax; 79 growth in profit after tax.

In the commentary section under the title developments the following is stated:

> "The identification and recovery fraud or improper claim through our fraud management software has been a great development success with direct savings and recoveries of our clients in excess of 500 million."

It is difficult to escape the conclusion that in this massive bonus pools also sit monies that were illegally withheld from medical

practitioners through the process of forensic audits, non-payments which are in themselves unlawful process. It is in pursuit of this super profits that medical practitioners have become easy pickings and defenceless cash cows for extortion by the medical scheme through fabricated allegation of fraud. These points are further supported by findings in the health market inquiry. The provisional findings and recommendation of 5 July 2018 were the following, is stated:

> "The health market inquiry concerns are highlighted by instances where it appears that schemes have abdicated their duties to administrators and have no control over important aspects of their business."

For instant, a lot can be gleaned from the circumstances surrounding the Council for Medical Scheme investigating into PMB, which is prescribed minimum benefits compliance by the scheme. Where it was found what certain medical schemes were paying PMB benefits out of their members' savings account in clear breach of the medical scheme fiduciary duty to look after the members' interests. These reports further makes the following remarks:

> "The delineation of medical scheme as a non-profit organisation and medical scheme administrators as for organisations is unique to South

African-, to South Africa and tends to distort competition in the health ma-, care market. The health market inquiry has observed that there is no real competition through lower contribution premium and richer premiums and richer benefits between they open 22-, open-, sorry, between the 22 open medical schemes. Given the nature of the medical scheme being a non-profit-, for profit, there's a very big incentive for most medical schemes to grow because the trustees and the principal officers get paid regardless of the performance of the scheme. However, there's a small amount of medical schemes who have a very close relationship with their for-profit administrative-, administrator's [indistinct-00:22:52] competition on their behalf. These administrators see the value in growing the medical scheme as they benefit from increased revenue for medical scheme. The ob-, ob-, the observed dominance in the

> administrator market coupled with non-regulation on profit margin has meant that saving-, savings generated from these [indistinct-00:23:17] competition to the extent that [indistinct-00:23:21] has been taken out of healthcare and shared with shareholders rather than pass on to consumers, …"

Which in this case is your patients. For instant, the expected [indistinct-00:23:35] relationship between administrators costs and the number of beneficiaries does not hold in this market. And this point was also emphasized by Dr Nhlapo when he was talking about the pool because in the olden days if you had a medical aid, they will give you may 20 000. That money belonged to the family. So if any member in the family was sick, he will take from that money but now the medical aids they found a way to say if you are 5, they will cut that 20 000 to small chunks, meaning they will allocate 5-, 1 500 maybe to the main member, or 2 000 and then 1.5 to the child.

Now when the child's so-called benefits are finished that family cannot access the medical aid, it's exhausted for that child, they must start paying cash. Even if they pull all their money or any member of the family still has money. And it is by design because they want to recoup more money because at the end of the year when that money is not used, it goes back to the administrators, it doesn't go back to the patients. As part of the recommendation to

the funders in, in, in the constitution of this, re-, re-, report, it says the following:

> "To improve governance [indistinct-00:25:02] scheme interests with those of consumers. We propose…"

And this is a report-, they have market inquiry reports which Judge Sandile Ngcobo was sitting this, it has been on for the past five years and it has been [indistinct-00:25:23]. I've asked many commissions why it's not released and I will be told lots of stories. I presented to the Human Rights Commission and the medical aids themselves are the ones who actually came out and told us that it would be released in September. And we are worried, why that will be, should be the decision of the judge, not-, it's like me knowing when you guys are going to release the report or anybody else.

That should be the work of your, your, your panel, not information that I should know. And in the program that we had last, it was this year actually, with SG and the Minister. He has said that they blocked him many times when he wanted to release this report because it is not favourable to them. And we further asked them whether what they are doing in the market is dominance or is monopoly and one of the CEOs of Discovery refused to answer that question because of this same report that we are talking about now. But it's because they recommend the things that actually we are going to discuss later on.

As part of the recommendations to funders in conclusion of

this report, it says the following:

> "To improve governance and [indistinct-00:26:55] interests with those of consumers we propose that the remuneration packages of employees of schemes, particularly that of the trustees and principal officers be linked to more explicit to the performance of the scheme. Performance would be measured in terms of the value delivered to members, not to administrators."

Presently the remunerations of principal officers and trustees is poorly connected to their performance. So patients are left in the ledge, they go to consult, every time you go and see a healthcare practitioner you are bound to be followed by a bill. The medical aid does not, these days, pay full bills and I am a witness to that as well. We propose that the remuneration of principal officers and trustees be set at a minimum base level and that the rest of the package be linked to clearly define quantities-, quantitative objectives of the scheme such as reductions in non-healthcare costs or administrative costs because this is a bone of contention.

This is where the money goes. It goes to non-medical, so all the, the, the, the premiums that is collected, majority of it, it doesn't go to the payments of the healthcare practitioners, it does not

service the member or the patient. The second topic is forensic audits and violation of Section 59. Sorry for that. We have overwhelming evidence from our members as we will submit to the investigation panel as a supplementary bundle to this submission of how the medical scheme have been unlawful in taking monies due to medical practitioners exploiting fraud, waste and abuse the allegation.

This fraud allegations have cre-, have created what we deem a crisis and a ticking bomb in the medical practice through the exploitation of a supposed *lacuna* in Section 59 because I think this section is the one that actually is opening the loophole for the medical aids to do whatever they want to do. While the Council for Medical Schemes refuses to intervene or act decisively in resolving the issues, the Council for Medical Schemes will be shown later to use the said *lacuna* to defend or condone the unlawful actions of these medical schemes. As stated in their annual reports, the two schemes cited above have been them collected 1 billion just from this process alone in 2018.

Hence it is abundantly clear that what has caused the recent upsurge in forensic audits activity and its underlining objectives. For purposes of this submission we will use the experience of Dr Singh, a dermatologist from Durban with 28 years in medical practice. Dr Singh's case is in our view a classic case of the unlawful conduct of the medical scheme as experienced by the majority of our members. Dr Sing has made a submission in this-, in his personal capacity to

the very same facts. In 2019-, in, on the 19th June 2017, Dr Singh received two letters from Medscheme and Bonitas, both with subject "verification of service".

These letters were in essence a cut and paste version of each other with the only difference being the listed patient's name. They were both from one Devon Fleming, a forensic analyst from Medscheme. Dr Singh obliged to the request and sent the information that has been requested from him via a courier. On 7 August 17, he gain received two letters from Medscheme and Bonitas, both with subject "payments to your practice". Again, these letters were in substance a cut and paste of each other making the very same allegation in the very same wording. The only difference again being in the list of patients and the amounts being claimed which was 211 500 and something for Medscheme and 241 800 for Bonitas as an erroneous billing.

I think this issue you dissected it earlier on about this coding because majority of these things it emanates from this coding which is not co-ordinated. So you are found guilty and to be told you are fraudulent due to coding. So that's why it was very important that that issue was discussed thoroughly because majority of the so-called fraud it comes from coding because if, if, if you don't-, you use a wrong coding for a certain-, or wrong medical aid, it's wrong. So there is no uniformity like as it used to be in the olden days. Then on, on the 3rd of October 2017, Dr Singh responded to the med-, to Medscheme letters objecting to the alleged discrepancies going as

far as informing Medscheme that the Dermatologist Society had inform him that the codes he was using were correct and that money claim against were illegal.

It's exactly the point that Dr Nhlapo was emphasizing, that here these are medical issues, the coding. It's the healthcare practitioners who knows the codes and who creates the codes, then medical aids jumps into the bandwagon and go and misuse them. On 29 November 2017, Dr Singh received a letter from Medscheme by one Devon Fleming informing him that direct payment to his practice will be terminated as from 8 December 2017. Now, you see we are explaining again, if you are relying on the medical aids for your survival, to run your practice, to pay rent, to pay your workers, it's damaging if then they stop your payment.

I don't know which section of the law they are using to stop those payments. On the 29 November 2019, Dr Singh received another letter from Medscheme by one Reynard Nel with subject "blacklisting", they even blacklist you long even before you have a trial or anything, like everything is just done on the desktop in the office somewhere in your absence, Mr Singh informing him that his practice his practice has been placed on hold. Dr Singh had already on 27 June 2017 returned a detailed complaint to the Council of Medical Scheme about the conduct of Medscheme with the reference number CMS65173.

Dr Singh also wrote two letters to the CEO of Medscheme on 10 July 2017 where he express frustration with how he was being

treated by Medscheme. The second letter was not responded to. On 24 April 2018, the Dr Singh addressed an e-mail to Mr Sipho Makabane, the senior-, the senior strategist at the Council for Medical Schemes wherein he express frustration at the dispute between himself and Medscheme not being resolved within a stipulated 120 days for the dispute to be resolved and now the person, Mamsi Mashilo, assigned to the case had informed him that she did not know what to do about this case.

On 29 June 2018, the Council for Medical Schemes gave a written ruling, gave a written ruling by the Registrar where the finding summary were the decision by Medscheme to suspend payment was found to be in compliance with Section 57.4(c) and 57.6(a) of the Medical Schemes Act. The dispute regarding incorrect use of tariff codes and clinical codes discrepancy falls within the scope of the Health Profession Council of South Africa. The Registrar could not compel the respondents to release payments of claims whose validity was in dispute. Dr Singh appeal his ruling which was upheld on 19 June 2019, just last month.

Dr Singh's case effectively demonstrate the general *modus operandi* of this big medical scheme in recent years. How they effectively become prosecutors, judges in their own cases. That is the one aspect of improper due process in the use of Section 59. That needs to be looked at in terms of how the balance of power favours the scheme in instances where disputes arises. The bulk of the submission by our members are effectively into dual account of

such experiences with obviously practice specific dynamics. There are submissions by medical technologists with laboratories who also-, who, as part of the forensic audit, are compelled to provide confidential patients information with patient-, without patient's consent.

Ethically they cannot divulge such information to any person not in the medical profession, not involved in the clinical processes of treating the patient. Their refusal to do so in the-, on those-, on those grounds is the basis to withhold their payments and to have them blacklisted as well. As can be seen in the two verification of service letters received by Dr Singh, he was asked to produce complete member and dependant files. The request for files that contained confidential clinical treatment information is not only unethical but is actually a violation of Section 14.1 and 14.2 of the National Health Act 61 of 2003.

The substance-, the subsequent process and practice of cohersed medical practice to sign acknowledgement debt agreement admitting of fraud allegations not legally proven is actually fraudulent on the part of the medical schemes. I will pause there and give the advocate to delve into the Section 59 [intervenes]

CHAIRPERSON: Where is Dr Singh right now?

DR GUMEDE: He was supposed to be here today but he is part of our member.

CHAIRPERSON: I see and [intervenes]

DR GUMEDE: Yes, but he submitted that he would be

part of the people who will be submitting under your cross-examine if you require him, we can bring him.

CHAIRPERSON: And the, I mean, I know the reason why you are using his specific case but that's all by permission and consent [intervenes]

DR GUMEDE: *Ja*.

CHAIRPERSON: … that you can present his case [intervenes]

DR GUMEDE: Correct. 100%.

ADV BUTHELEZI: Thank you Chair. The substance of my submission in this regard is here, the essence of my submission goes to this point. Number 1, the use of Section 59.3 is wrong for the purposes that it is used for. There is actually another set of provisions that they should be relying upon to execute what it is that they want to do. Number 2, we dispute that the interpretation of Section 59.3 is actually correct in terms of the quantification of losses as contemplated in the Act. And I will take you through our arguments in that regard. Now, [intervenes]

ADV WILLIAMS: Sorry Mr Buthelezi, are you talking about the Council?

ADV BUTHELEZI: By everybody applying it. Everybody who is relying on this section is actually misapplying the section itself. And I will start here at this point, Section 59.3 speaks of an amount that have been paid *bona fide*, however, through the forensic audit process which is done through desktop audits

etcetera, they don't arrive at an amount, they arrive at an average. And for the purposes of auditing, audits and surveys are not the same thing. We cannot say you are doing a forensic audit and then you arrive at a mean or an average mean of what the number is.

We will get to the point where the Act says, find an amount and this amount has got to be cal-, correctly calculated. That's the starting point. So, and Section 59.3 does not make provision for aggregation of such amounts. Now, we've got a sample of a Medscheme survey or forensic audit and how it's done and they don't go and list claims 1 to 50 and say these claims are incorrect.

CHAIRPERSON: Where is that sample?

ADV BUTHELEZI: I'll get to it Chair. It's the, it's at the back. It's not appearing clearly, our pagination-, it starts with, I will tell you know, it's annexure "PA… [intervenes]

CHAIRPERSON: It is the one dated the 4th of December 2017?

ADV BUTHELEZI: Indeed so Chair.

CHAIRPERSON: Alright. So [intervenes]

ADV BUTHELEZI: We, we will, I want to talk you through the mechanism and, and methodology used here [intervenes]

CHAIRPERSON: So the point is that they don't decide an amount, they average?

ADV BUTHELEZI: Indeed so Chair.

CHAIRPERSON: Okay.

ADV BUTHELEZI: And that is their submission even in, in

Mr Singh's appeal, that they don't go forensically line by line item.

ADV WILLIAMS: Can you-, can you just refer me where in the bundle that is?

ADV BUTHELEZI: It's [intervenes]

ADV WILLIAMS: Can you give me, I know it's not paginated [intervenes]

ADV BUTHELEZI: Yes, well, the point is [intervenes]

ADV WILLIAMS: Does it have an annexure number?

ADV BUTHELEZI: There's Medscheme's head of arguments in Dr Singh's appeal where they actually detail the process that they use and it's a system of algorithms, it's a statistical integration system that they use and it's not forensic to the extent that they call it forensic because if they say 20% of claims were outside your average, then that's the number.

CHAIRPERSON: *Ja*, I mean, it's PA13/8 or something.

ADV WILLIAMS: And, and paragraph number in those heads of argument?

ADV BUTHELEZI: I beg your pardon?

ADV WILLIAMS: What is the paragraph number in those heads of argument?

ADV BUTHELEZI: In those heads of argument, it's, you are now getting ahead of my argument Chair. If you'll allow me the space to just build it up because I do get to those points where I quote specifics from those heads of argument. Thank you. Now, what we submit is the following [intervenes]

CHAIRPERSON: So I suppose this page 9 / 10… that's where they explain the methodology?

DR GUMEDE: *Ja*.

ADV BUTHELEZI: Yes Chair.

CHAIRPERSON: Anyway, sorry.

ADV BUTHELEZI: Thank you. Now, we're saying the application of Section 59 at his been done by Mr Singh-, in Mr Singh's-, in Dr Singh's case, is an outright misapplication of the law itself and it's erroneous to use Section 59 when Regulation 6 is actually the provision that is actually dealing about erroneous billing. Now, the forensic audit process as we will then get to the point which was what triggered this process in its entirety, it's also got a racial bias in terms where the dominance of these forensic audits are taking place but we will get to those numbers.

But what we request, that we believe is information that could prove this allegation in this regard, is the following: 1) Each of the schemes are to submit to this Commission a list of practices where forensic audits have been carried out since 2017 for each medical scheme. 2) A complete list of practitioners who've been placed on non-payment since 2017 and a complete list of practitioners who've signed admission of debt agreements for each of the schemes. And if what we say is not true, then the following should hold: the number has to correlate if 30% as a thumb suck figure of doctors, it's got the demographic of the split, it's got to correlate to what the demographic is.

But we've got another graph in the end which comes from the Health Professionals Council, which has got a very inverted number which supports this point. And number 2, and that's why we say, we ask that this Council also analyse the fraud statistics as reported to the Health Professionals Council of South Africa. And see the disparities there in terms of the patterns of fraud reported and what the numbers look like. And it is the submission of my organisation, the organisation that I represent here, that we are not opposed to forensic audits taking place. In fact, we encourage them to clean out the bad apples out of the system and eliminate fraud and eliminate waste and all sorts of misconduct.

So, we are not opposed to the process of forensic audits. What we say is, the forensic audit process must be transparent, just and lawful and in establishing that we also request the panel does the following: if you could have a view and request the employment contracts of the forensic audits [intervenes]

CHAIRPERSON: Auditors.

ADV BUTHELEZI: As well as the incentive schemes of- and bonuses tied to these contracts. As was submitted by Dr Gumede earlier, we believe that these forensic audits are conducted in an unlawful way, they breach constitutional values and a lot of them born on-, are criminal and we will get to the criminal aspects of it. All they are down for, as now the numbers of the profits and the earnings of these organisations now reflect, they are not down to eliminate fraud, waste and, and, and abuse. But they are inherently

designed to recover monies using this process of billing inaccuracies.

Now, and this abuse of power is most arbitrary and is ba- [intervenes]

CHAIRPERSON: Mr Buthelezi, I don't know if you know whether or not the medical-, med-, Medscheme has amended its process after it was found by the appeal panel, I think it was Coffierge SC who found that it was unlawful to follow the process they are following because it was not in accordance with a fair process, at paragraph 36 of his ruling. They set it out in their own heads of argument but that process was found to be procedurally unfair which [inaudible-00:49:49] amended it.

ADV BUTHELEZI: I don't know how long that ruling dates back to.

CHAIRPERSON: No, the ruling is June 2019. I mean, if I went through the process now, would I find it differently to what they did then or will it be the same?

ADV BUTHELEZI: Well Chair, I cannot confirm that but what we are discussing and what has brought us here is the process until now. What the process has been all along and if it's been recently found to be d-, to, to, to be unlawful then it supports our submission all along that we've been saying that what they are doing is unlawful. Well, talking to that process Chair, then I won't exhaust the point any further if the process is found to be unlawful but our submissions in that regard is that the process itself is arbitrary and is based on

flawed methodologies that yield flawed outcomes. And what those are is a desktop audit done with a computer algorithm and, and it then does a set of permutations that nobody knows what they are and comes out at a figure.

And that we cannot say amounts to a process. That process is: 1) not recognised accounting process of doing audits; 2) it's not a process that has been endorsed by the Health Professionals Council of South Africa or any other regulatory board to say you may conduct audits in this way. And everybody then signs up to the process that says, this is the method which is recognised in the industry as a legitimate way of conducting audits. Now, in addition to the problem with the methodology, as was applied to Dr Singh, is this point, they say you are billing outside your peers or the range of your peers, and the question we pose is, who are Dr Singh's peers?

Dr Singh has 28 years' experience as a dermatologist and has three practices. The universe of who the pier is that get benchmarked against is not defined and it cannot be right in law or in any other proper way of calculating things to then say, you shall be benchmarked against all dermatologists in the country over. That is inaccurate and the same way in which they've got arbitrary ways of determining these fees that doctors get paid to say we've negotiated a rate for doctors, X amount – R200.00 a consultation. That fails to take into account the economics of certain things. One, not all doctors are the same experienced.

We can't have a doctor of 2 years' experience charging the

same rates as a doctor of 40 years' experience or 30 years' experience. It is prejudicial to the doctor with more experience. Two, doctors by virtue of how the country is designed, don't operate in the same localities. If one doctor chooses to service the upmarket addresses of Johannesburg and another person chooses to service a rural community somewhere else, their operating cost as a business are different. And if the Sandton patient decides I want to go to this doctor who is popular for treating all sorts of conditions and that doctor is entitled to charge a premium.

That is also reflective of the fact that he's paying a much higher rate per square metre for running his operation. Now, practices are open for a fixed number of hours in a day and if he's meant to make a decent profit or a decent margin in his operation and he is confined to seeing 4 patients an hour for 10 hours within the day, how is he then to be set at the same flat rate as somebody operating somewhere where the rate is a fraction or a 10% of what this one is paying as a rental fee. That's just a basic calculation which I think is flawed in the method of imposing rates on these doctors.

Now, the second part then is if you look at Dr Singh's case is that this analyst then ventures on to start making pronouncements of a clinical nature and you say, no you doctor are not supposed to treat this condition. He is not qualified to make that opinion on the doctor. He does his own assessment and then determines that it is inappropriate for Dr Singh to have been able to remove certain

lesions from the skin in such a space of time, he is not qualified. And then what subsequently happens, he then draws his conclusion on his own from his own desktop, he's never been to the practice, he's never interviewed Dr Singh, all he asked for is a set of documents and then he decides no, you are committing fraud.

And thereof-, one person makes that one conclusion and without understanding this person's practice and what the dynamics in that community are, says, you've viewed this code excessively versus your peers in the area therefore the excessive use of this code amounts to fraud and you part. And that we say is improper. Now, in challenging this use of Section 59.3, Section 59.3 allows medical schemes to clawback amounts by way of deduction in circumstances that are theft, fraud, negligence and misconduct. And in our challenging this thing, we start at this point of losses. It says:

> "Where the scheme incurs losses caused by either theft, fraud, negligence or misconduct…"

What we challenge is the following: If a doctor claims fraudulently against a patient, and the scheme is able to prove that this claim was fraudulent, whose loss is it? Is it a loss for the patient or is it a loss for the scheme? Because, taking a claim that was done by Dr Gumede against patient Buthelezi to say, he's overcharged me by a R100.00, the recovery of the R100.00 that happens, who does it go to? Rightfully speaking it should come back to the patient but that is not happening here. And by way of

analogy I'll use this one, if anybody here has a fraudulent bank transaction carried out against their own bank account, what do the banks do?

The banks recover that money however way that they recover that money and the credit the customer. It doesn't then go to the pool of funds that the bank has to fight fraud in its general practice, and this is exactly the problem that is happening here. These losses are not the losses of the scheme, they are the losses of the patient and there is no subsequent process if monies are recovered to repatriate these monies back to the patients. The patient stays at a loss. If Dr Gumede has overcharged a patient by R1 000.00, that patient is never credited with a R1 000.00 even if that money is recovered two years later.

ADV WILLIAMS: Mr Buthelezi, I'm sorry I'm not following the submission. If the patient didn't pay for the particular service [intervenes]

ADV BUTHELEZI: Yes.

ADV WILLIAMS: … how has the patient experienced a loss?

ADV BUTHELEZI: It gets deducted out of their own medical savings. Commissioner, in this way, it starts at this point and this type of judgment does this point. If a patient arrives at a doctor, the first process that happens is they say, do you have-, they get authorisation to say, do you have enough funds for this practitioner to service you? And post your servicing an invoice is generated,

and that invoice is [indistinct-00:58:02] against what you have as an allocation of funds for the year. And if subsequently that money is then recovered by the scheme from either fraud or whatever process that the doctor may have overcharged you by, you don't get credited back for that consultation that overcharged you.

And that we submit is problematic. And, and that's why we say, the schemes then cannot misappropriate losses that are for thems-, that actually are incurred by the patient and come back through Section 59.3 and claim those losses as their own. And how they do that is by failing to reimburse those patients where fraudulent claims have happened because they didn't recover the money from the scheme and we will get to the points about prescribed minimum benefits and the risk pool and staying above 25% solvency rate, we'll get to that point.

Now, where this point is confirmed, and I will not read the judgment in detail and I will just get to the two key points, is the-, [indistinct-00:59:30] Medical Solutions and Others v Sekheti and Others which is an SCA judgment of 2016, and em-, it establishes the point of what the relationship is between the medical practitioners and the scheme or the administrator. And just to assist you, I'll just get to paragraph, because I think there's no need to read these judgments verbatim but there's two points [intervenes]

CHAIRPERSON: Sorry could you just tell me I just want to go back to this question of procedural fairness in the way in which because I think the bulk of complaints that your clients have are

about the fact that there is an arbitrary project that is used by schemes.

ADV BUTHELEZI: Handed up the heads of argument of Medscheme they explain the process from page 6 from paragraphs 20. Now this is the call back process under 59(3) as opposed to the settlement of the claim under 59(2) read with regulation 5. So this is what they do claiming parties and trends are analysed retrospectively. So they look at a sample presumably not each and every claim that was submitted but the administrator for irregularities or anomalies then says this is done as exceptional reporting editorial and financial analysis predictive analytical software and other controls. Reliance is also placed on member referrals or whistle blower tip offs to investigate specific health care providers or associated claims that are questionable despite having been paid. The number of highest billed claims which form part form hindsight an provide a good example of a potential irregularity to analyse. So this is presumably what they call an outlier. When a claim is submitted the second respondent's claims administration system [indistinct] by each claim individually based on the above claim's payment process however at the end of each month or financial quarter the scheme administrator conducts an analysis of claims received and paid. This is where billing irregularities or anomalies as claimants are claiming for more expensive medicines by normal certain health care providers which is physically impossible are detected. Now here is the point I want your comment on. In view of

the number of beneficiaries the second administer administers now this is Medscheme telling you that we've got large volumes and claims received per day as well as the prescribed time period within which health care providers must be paid. It is impossible to detect such irregularities or anomalies at the time of receipt and payment of the claim. So they are making two points my understanding, the one is that we have to honour the claim in 30 days' time so they submit a claim we pay it in good faith. After that we do this issue of putting things into a system which then produces anomalies and based on those anomalies we claw then go back. Now what is another realistic procedure that can be followed by the scheme that would be fair to your clients? Especially a large scheme like, well I mean Medscheme is an administrator but a large administrator like Medscheme which has thousands and thousands of this claims.

ADV BUTHELEZI: Chair it's a lame excuse, absolutely lame, absolute ridiculously lame excuse to come rely on that provision to say the volumes of claims that come through their systems. The starting point is the authorisation process, nothing happens without them authorising this claim to happen. What should happen which is a failure on their part and.

ADV WILLIAMS: Sorry can you explain what you mean by authorisation?

ADV BUTHELEZI: Well the starting point is that when you show up at a medical practice you present your medical aid details and they get authorisation from the scheme for you to get the

treatment that you've come to ask for. So already your medical scheme is aware that you are at practice, so and so's, Dr so and so's practice and they seek authorisation. In other words in seeking authorisation one has to get clearance to say do you have funds and that's why we have this notion of people who say my medical aid is maxed out, we've got no longer funds. You can no longer then claim thereafter if your benefits are maxed out for the year or for whatever period that it's allocated to. So they've got a process one of pre-clearing.

ADV HASSIM: Sorry before you continue. And that authorisation process you say takes place no matter what the, the health condition is of the treatment that's required?

ADV BUTHELEZI: Indeed [intervenes]

ADV HASSIM: [Intervenes] hospitalisation [intervenes]

ADV BUTHELEZI: [Intervenes]

ADV HASSIM: In rooms.

ADV BUTHELEZI: Regardless.

ADV HASSIM: If for consultation?

ADV BUTHELEZI: Same, same procedure. Sorry Commissioner what happens here if a patient or a person gets knocked over of the road and an ambulance picks them up and drives with them to the hospital what the hospital will very, the first thing is, is this patient covered under medical aid and if they're not they will do the minimum just to keep them alive and then dispatch them to a public facility where this requirement is not there. So

nothing moves forward without the starting point of establishing whether are you gonna be paid for by your medical scheme.

ADV HASSIM: But at that point.

ADV BUTHELEZI: Yes.

ADV HASSIM: The scheme is not aware of what treatment is going to be administered.

ADV BUTHELEZI: Then they must.

ADV HASSIM: If you're going in for a consultation.

ADV BUTHELEZI: Yes.

ADV HASSIM: And there's an authorisation process at that point.

ADV BUTHELEZI: Yes.

ADV HASSIM: Then isn't the scheme establishing what you've just said which are is there enough funds for you to be consulting?

ADV BUTHELEZI: Indeed so.

ADV HASSIM: Then an account is submitted.

ADV BUTHELEZI: Indeed.

ADV HASSIM: And then at that point it depends on what is included in the account which is a separate exercise, isn't that?

ADV BUTHELEZI: Yes well the law provides for them to fix that, regulation 6(2) and I'll ask to read regulation 6 to address this point which is 6(2) says if a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment it must inform both the member and the relevant health

care provider within 30 days after receipt of such an account, statements or claim that is erroneous or unacceptable for payment and state reasons for such an opinion. Three after the member and the relevant health care provider have been informed as, as referred to in sub-regulation 2 such member and provider must be afforded an opportunity to correct and resubmit such an account or statement within the period of 60 days following date from which it was returned for correction. That's regulation 6(2). 6(4) if a medical scheme fails to notify the member and the relevant health care provider within 30 days that an account, statement or claim is erroneous or unacceptable for payment in terms of sub-regulation (2) afford an opportunity for correction or resubmission in terms of sub-regulation (3) the medical scheme shall bear the onus of proving that such an account, statement or claim is in fact erroneous or unacceptable for payment in the event of a dispute.

ADV WILLIAMS: Dr Buthelezi I am still sorry Mr Buthelezi I'm still struggling with whether or not an administrator or a scheme knows in advance that a service has been rendered which, which my colleague will ask the question about but I just want to ask you where, where a scheme is faced with an actual fraudulent claim and let's say the fraudulent claim is in fact that the service hasn't been provided at all.

ADV BUTHELEZI: Yes.

ADV WILLIAMS: How then can they know what's been provided if nothing has been provided?

ADV BUTHELEZI: The bone is now let me deal with your first point then I'll get to your second point. The medical scheme if a person, patient goes to a Dr for a diagnosis they do not know what's wrong and the Dr is at liberty then to diagnose whatever and can charge whatever. So we're not saying that the medical scheme may have systems to know in advance what the diagnosis may be or what the treatment may be. All that we're saying is that they've got a pre-clearing system to say we give you the go ahead to go consult Dr X, that's the starting point. Now to get to the second question. Sorry I lost my trial of thought. Could you please rephrase that question for me Ms [intervenes]

ADV WILLIAMS: Yes I'm struggling with an instance where there is an actual case of fraud.

ADV BUTHELEZI: Yes.

ADV WILLIAMS: And the claim is not [intervenes]

ADV BUTHELEZI: [Intervenes]

ADV WILLIAMS: Service [intervenes] platform.

ADV BUTHELEZI: This is about section, what regulation 6(2) does.

ADV WILLIAMS: Okay.

ADV BUTHELEZI: I mean there's no account to be resubmitted because no service was rendered [intervenes]

ADV WILLIAMS: Well that's the point [intervenes]

ADV BUTHELEZI: Well then we go to section 66 of this legislation of the medical, section 66 which says the following.

Section 66 of the medical schemes act talks to offences and penalties and there's a process set down there. It starts at the point of saying and I'll, I'll start with section 66(1)(b) it says any person who makes a call to be made a claim for payment of any benefits allegedly due in terms of the rules of a medical scheme knowing such to be false commits an offence. The, the offence you ask about Chair is addressed in section 66(1)(b).

CHAIRPERSON: Ja but that's a criminal offence, I mean I'm just talking now about the process between the scheme and the, the service provider.

ADV BUTHELEZI: No well the scheme needs to provide better, better forensic auditing systems. In other words if, if, if they need to devise and this is where the failure has been on the part of the regulator in particular to set guidelines to, to safeguard the interest of the schemes and to safe and to make sure there is no largely fair and free for all in terms of what we submitted initially was unregulated audit and forensic process which everybody buys into and is bound by. So if erroneous errors of fraudulent and we don't deny that fraud happens Chair, we don't deny that.

CHAIRPERSON: There's something to the point which you made earlier which says that the system of aggregation is itself unlawful because it's not provided for anywhere in the act [intervenes]

ADV BUTHELEZI: Indeed so.

CHAIRPERSON: The act on the basis of a single account.

ADV BUTHELEZI: Correct that's what it is and so I am saying if they go back.

ADV HASSIM: But can you take that further because I agree that that is a compelling point. Section [indistinct 1:11:23] talks about [intervenes]

ADV BUTHELEZI: [Intervenes]

ADV HASSIM: An amount.

ADV BUTHELEZI: Yes. What we challenge is how this amount is arrived at.

ADV HASSIM: Okay so if the schemes which is what Medscheme argues in their heads of argument in, in that internal appeal that the volume makes it impossible for them to be able to do what you're suggesting they do which is very quickly pick up the error and say this was the amount and this was the invoice and this is what we want payment for, they have to do this retrospect-, retrospective analysis, right?

ADV BUTHELEZI: Yes.

ADV HASSIM: Okay and then at that point they say we've picked up these errors and its at that point when they aggregate, is that what you are saying?

ADV BUTHELEZI: Yes and let me say we've got two problems with that. One.

ADV HASSIM: Ja so just explain that to me from the way you understand it, sorry I'm interrupting you they're [indistinct] what do they do? They go back they look at your, your profile when they

determine you're an outlier they, they say what? You have, we find that you have billed irregularly on this occasion or on ten occasions or explain that to me what happens at that?

ADV BUTHELEZI: Let me tell you what happens there using you've got to submit advanced evidence from our members which says we've picked up in our one month samples that 20% of your bills were incorrect. We've got 20% errors therefore 20% of your bills for the last 2 years, for the last 2 years are then incorrect or however long they chose to go back and that we say is problematic. It cannot be to audit people, to say it's a forensic audit and then not a forensic one. It's not a survey. If Chair to get to your point of solutions. Then the solution for them is here. They need to get agreements with the health professional council of South Africa that due to the large volume of, of, of claims that we have to do, we have to then accept that deviations and averages that are outside, should then be accepted as irregular and there's a pre-, an upfront acceptance of this model and method of doing things that everybody then can buy into and nobody can object. But such process wasn't there and two the legislation hasn't said you may use an average of your calculation to determine that a fraudulent amount, the fraud equals to the average of what you've calculated. That is not provided for.

ADV HASSIM: Nor could you agree to it just because you might buy into it, it doesn't make it lawful.

ADV BUTHELEZI: Well it does not but I'm saying as, as, as,

as, as a compromise perhaps to address the point the Chair has to access about there being a voluminous amount of claims and unable for them to process them fast enough then there'll have to be an acceptance overall. It's like how the electricity is billed. That you get an average reading for the past three months and then at some point they'll reconcile their account to get it to a specific amount and then either up or down then they'll recalibrate to get to the specific amount that you actually do correctly owe them. That's how electricity is billed because they've got to bill all the houses every day and produce accounts for every day, everybody at the same time. So there is a system where what we are telling you now is your average reading and every now and again they'll come back and say you now have an actual reading and based on what we've billed you as an average and what we've billed you as an actual reading we've reconciled the two and we tell you how much you owe us.

ADV HASSIM: But isn't there another step that the scheme, the administrator takes which is you get that letter saying we, we put you up as an outlier in these two respects.

ADV BUTHELEZI: Yes.

ADV HASSIM: The amount involved is R200 000.00 but you still have an opportunity to provide the information and the records they request to show that they are wrong?

ADV BUTHELEZI: Yes.

ADV HASSIM: So it's not.

ADV BUTHELEZI: They do.

ADV HASSIM: So it's not an automatic penalty is it?

ADV BUTHELEZI: If you analyse the evidence as our members submit we give you one example.

CHAIRPERSON: Ja I suppose part of the problem is what is on paragraph 25 of their heads of argument. It says the health care providers concern is to engage him with a view of providing him with an opportunity to engage with different patients with regards to the schemes findings and then they say payments to the health care provider are withheld until the matter is finalised. I mean that's why [intervenes]

ADV BUTHELEZI: We, we get to that point. The point is here Chair that's where there's wrongfulness because you've got one analyst sitting on his own and in this very same answer, heads of argument he gives this point and says whether I deem this answer to be acceptable or not then do I decide whether to cut you off and withhold your payments. Now we've got a case of one Dr Naidoo whose an audiologist submitting to one of our leadership he relocated from Johannesburg, from KZN to start operating in Johannesburg and suddenly they say why are you billing from Johannesburg. He says but I've informed you that my practice has changed sites, we says well you're committing fraud and that's the end of it and now he owed a million rand on that arbitrary decision on its own and now he's on the blacklisted list, on the blacklisted list going around. It's the arbitrariness because they sit and say

providers give proof of your qualification, provide us with health, with your patient files. If the Medscheme letter says give us your patient files, not for the past month or for the time that you claimed from the start when you started seeing this patient. You miss one page of the patient files where there is a consultation dating back you are committing fraud.

ADV HASSIM: Aren't you required to keep records of [indistinct 1:17:48]

ADV BUTHELEZI: For who? They're not for the medical scheme to intersect. They are confined to where the matters pertain to them.

ADV HASSIM: Okay so is the argument that the information, that they shouldn't even be asking for the information?

ADV BUTHELEZI: Indeed.

ADV HASSIM: Because it's confidential?

ADV BUTHELEZI: Indeed.

ADV HASSIM: And so that doesn't, you'd be saying that that doesn't safe them from what they do?

ADV BUTHELEZI: No it doesn't.

ADV HASSIM: So their argument that if you just provided the information they requested everything becomes resolved and life can go forward.

ADV BUTHELEZI: Indeed because if you look at verification of services that letter that was received by Dr Singh the list of things that Dr Singh is asked for, proof of his equipment, proof of a whole

lot of things that have nothing to do with an erroneous bill. None of the things that they're asking for is to, has to do with an erroneous bill. It is a process designed to disqualify same from payments on other technical grounds that have got nothing to do with erroneous billing.

ADV HASSIM: And I see that they refuse the term blacklist by Medscheme?

ADV BUTHELEZI: Indeed it's there.

ADV HASSIM: So we tried to probe this yesterday with the funders, the difference between indirect payment or what a suspended, what does it mean to say you are suspended?

ADV BUTHELEZI: Well it means.

ADV HASSIM: Does it mean that you're not going to be paid directly but the patient will get paid and can, will be reimbursed is that what it means or does it mean.

ADV BUTHELEZI: [Intervenes]

ADV HASSIM: They advise even the members not to come to you?

ADV BUTHELEZI: I would not say they advise the members not to come to me

DR GUMEDE: They do.

ADV BUTHELEZI: If you read, if you read the GEMS letter.

CHAIRPERSON: Dr Gumede you are allowed to answer if you feel like answering this so.

DR GUMEDE: Yes, yes [intervenes]

CHAIRPERSON: Just don't feel like you're constrained.

DR GUMEDE: Ja let me deal with it. Counsel, commissioner the, the medical aids they are just playing ping pong like Dr Nhlape said. The truth of the matter it is that they blacklist practitioners and they are using financial means to actually leverage on practitioners. So what they will do is they withhold your money, aggregate it maybe to 1 million or half a million, I'm just giving an example, have it in, in their coffers and say to you okay we have identified claims. Mind you the claims that they're talking about its not the current claims that they are holding the money about, they are talking about the old claims. Saying to you we will pay you your money if, if you pay us the, the previous money. So it's not about the current money that actually it would be in dispute and again let's, let me bring some facts into this.

ADV HASSIM: That's because in their argument they don't want to throw good money after bad. If they've taken a view that there is, that there is erroneous billing and they need to recover the money they've said they are not going to continue paying until that issue of whether the, that issue of the irregular billing is resolved.

DR GUMEDE: Okay just maybe to go back a little bit and you'll hear it also tomorrow from one of my colleagues, you see they hold the money, they check and they realise that there were no erroneous claims because they, they checked and there was nothing. They withhold, withheld your money, it doesn't come back

with interest. You owe your landlord, you didn't pay your workers and whose, whose problem it is and they were wrong and they at many a times they've been proven to be wrong. And like we, we, we are always saying, always saying the, the fact that section 59 provided 30 days I don't think that it was by mistake that it must be identified within that specific time period to, to correct those claims. It is because you cannot just perpetually be in limbo. There has to be a period of time when things are addressed. I mean even legally you guys cases do prescribe or claims do prescribe. So we cannot be, perpetually be on a limbo to say okay one day I might wake up and then I'm, I'm caught up. I must know that for the past 5 years or 3 years I have a clean bill of, of, of claims or what not. And the issue of saying the, the claim volume is too much I don't think it's true because maybe let me bring something to your attention. Remember the administrators they are not medical schemes, I don't know if you are aware administrators are not medical schemes. They are companies that are supposed to be separate from medical, medical schemes and meaning that they can be many, as many as they, they can be. Metropolitan, they can be Medscheme it's just that unique situation of discovery whether they administer themselves which I don't know how did it happen because they were trying to separate this collusion. Because if you check in the health enquiry market there's this huge collusion whereby the, the administrators and the medical aids and the hospitals and their pharmaceuticals they are in one court and that's what's creating the

problem. The majority of time like I'm, I've just said in, in my previous point they have instances where they've flagged practises and people submitted invoices yet they didn't pay them and the, the point that I argued further previously is that why then do you say if I defrauded you 2 million you say to me Dr Gumede if you pay me R200 000.00 you are not a fraudster let's continue doing business together. To me that's problematic because if I'm a fraudster why do you want me, why do you want us to go back because these are mismanagement of debts. The reason why you don't have proper statistics earlier on with HPCSA and they, they use HPCSA to threaten us. You get to their office they say to you if you pay us we don't report you to the council. It was HPCSA us who went there to discover, to say to them that cannot be right that all the guys who signed acknowledgement of debts are not fraudsters. Hence in our submission we are asking that you find the number of people who are paying them and you'll see that there's too much discrepancy in that. Huge, if you pay them you are a good boy. So I mean if you are combatting fraud, let's be honest, you cannot be encouraging people to, to, to be continuing in doing fraud. You should be able to say okay this is fraud because they know that in truth its erroneous billing most of the time, which are the codes we spoke about. So it's about money making schemes it's not about combatting any, any, any criminality and, and what not. So we must be cognisance of the fact that their abusing section 59 to recover monies and we further submitted that according to the combatting crime and the, the

amount is above R100 000.00 they must report it to the, to the relevant authority, authorities. Do they do that? They don't and then it's an offence on their side and they've claimed millions from people, from practitioners. So we cannot say that whatever they are doing is combatting crime or stopping abuses. Not. Actually to me as far as I'm concerned it's just encouraging people to, to commit more crime rather than stopping it.

CHAIRPERSON: Sorry if I may continue too?

ADV BUTHELEZI: Yes.

CHAIRPERSON: At some point we need to get to Dr Mkhize if she's still going to speak.

ADV BUTHELEZI: She's still going to come in.

CHAIRPERSON: All right, all right.

ADV BUTHELEZI: You see linked to the point that Dr Gumede makes we then have to read section 66(2) of the act which says the following. In other words it places a limitation and qualifies the contraventions of the act to the extent in which they may be answered upon. It says no contravention of failure to comply with the provisions of this act shall be punishable under sub-section (1). If the act or omission contributes that contravention of failure to comply with any request or requirement it's punishable as an offence under provisions of any other act of parliament which controls the professional conduct of any health care provisions. Now there's another legislation which deals with this fraudulent behaviour which is section 34 of the prevention and combatting of corrupt activities

act. Section 34(1) which says any person who holds a position of authority and who knows or ought to reasonably have known or suspected that any person has committed an offence under the first schedule, I'll skip one. Two the offence of theft, fraud , extortion, fraudgery, uttering, and uttering a forged document involving an amount of R100 000.00 or more must report such knowledge or suspicion or cause such knowledge or suspicion to be reported to the police official. Now each have claimed recovering fraud in the tune of 500 million minimum. 500 million for Medscheme, 500 million for Discovery, just the two and none of that is reported to the authorities because the legislation is there for them to deal with these fraudulent issues and they should be pursuing this legislation as it, which can serve as a deterrent for the behaviour to stop. If people are committing fraud we should be having multiple cases of Drs appearing in courts for fraudulent claims so that the practise dies and those who carry on with it suffer the legal consequences thereof and not to be brought in to say sign an acknowledgement of debt that you owe us as you fraudulently, we shake hands and we carry on doing business with you. That is wrong and it's the second point that Dr Gumede makes about these billing errors which are supposed to be regulated by section 66(2) which read in its entirety are then used to tarnish everybody as, as conducting themselves fraudulently when in actual fact it's not. If you prove a billing error the section provide fix the billing error however long back you need to go, fix the billing error. If you pick up fraud report it to the police,

report it to the council of health professionals South Africa. You've got no business getting into negotiations to recover your money, you can lodge civil action to recover that money. The problems what happens is this misapplication of 59(3) our interpretation of it is the following. If a Dr through whatever means causes loss to the scheme itself in whichever way, that causes the scheme to loose monies. In other words there's various ways in which the scheme can be financially impacted through, then they can invoke section 59(3) if the scheme can prove direct losses to the scheme itself and not patients. And if they can prove then subsequently that the billing errors or the fraud amount to losses to the scheme itself then recover those specific amounts that you can determine through a proper process. Let's not have a survey of fraud and then decide there's a 29% unemployment rate in South Africa, 29% fraud is also going to be recorded. It's used up causing linear integrations and correlations which legally you cannot do. You've got to be particular, you've got to be specific, you owe us R602.00 we want to recover, recoup our R602.00 as it relates to invoice X, Y, Z that's for the service that you did not commit, the fraud you committed on 31 July 2019. It should go to that detail and they've got the resources and the means to do so even if they have to do it retrospectively for the kind of money that they recover. Discovery says they charge or they recoup in premiums per month 6.2 billion. There are businesses making far less monies and far more complex businesses that can get the accuracy right on that point, because it's not like it's retail

stores of people flowing through the till points throughout the day. If it means then the systems have to be changed to be like a banking system or to be like a retail system to make sure that the Drs does have till points that talk to a certain system somewhere the innovation and the technology is there. So they can do that and then we have dealt with.

ADV HASSIM: Have Dr Singh's case been resolved, so is the appeal, was there a review [intervenes]?

ADV BUTHELEZI: Yes we've got [intervenes]

ADV HASSIM: [Intervenes]

ADV BUTHELEZI: The ruling is attached.

ADV HASSIM: And there's no further.

ADV BUTHELEZI: No, no. Well the problem that Dr Singh faces with is that he's never been reinstated now as a service provider to the scheme regardless of the ruling going in his favour. He's still a blocked service provider and how this thing then comes about is this point [intervenes]

ADV HASSIM: You mean his patients must pay him upfront?

ADV BUTHELEZI: Yes.

ADV HASSIM: And then they can claim from the scheme after?

ADV BUTHELEZI: Yes and if, if you go to paragraph 20 of their heads of arguments I've got paragraph 18, 18.4.1 and they go, I think it's what the Chair mentioned earlier that's the methodology

summarised and that methodology for us we say it is flawed on two levels. In the methodology itself and in the process in that only one individual in that organisation an analyst who is not medically qualified then reaches into the space of making determinations even on a clinical nature to say you couldn't have done that procedure in the theatre within that period of time. He is not qualified to do so but he does in Dr Singh's case. All the findings of Dr Singh they are clinical findings based on which they say no Dr Singh you couldn't do this and they're not being done by a peer or somebody who is in the medi-,who is medically qualified to make those findings. So we, we, we, we deal with that point and we leave it at that and I think we've made the point. Now what this then does is a whole lot of unintended circumstances and consequences which the rights and the access to health care for patients is impaired and we now have instances of patients who've lost their lives and it's a publicly known case now of a lady in Mtubatuba where she was receiving dialysis treatment and Discovery blocked the service provider or the centre that was providing her treatment so that she must drive 100km up the road to Richards Bay to the nearest centre and they could not afford to do that, this one was right up the road next to her and she was blocked from providing the service by virtue of the fact that there's a payment and a billing dispute and there are many, many examples where patients with the funds but because a dispute arises and it's a billing dispute, and then the dispute is arising from these arbitrary processes where they say we don't recognise the

supplier, your supplier of medicines, he's not a supplier of medicines that we recognised or you are dispensing medicines that we haven't approved therefore we are blacklisting you and therefore we can no longer pay you directly. And it is not for the administrator to descend to that level of the arena to now quantificate to the Drs what they may or may not prescribe, which medicines are approved by them and that in itself presents problems that it is not their terrain.

CHAIRPERSON: Let's move on Mr Buthelezi.

ADV BUTHELEZI: Thank you Chair. I then get to the issue of racial profiling and it's a very short point.

CHAIRPERSON: Yes.

ADV BUTHELEZI: I am not too sure if it's presented to you but it says the.

CHAIRPERSON: Where are you now in your submission?

ADV BUTHELEZI: [Intervenes]

CHAIRPERSON: Is that the paragraph of 99?

ADV BUTHELEZI: Yes we've got this 22 page GEMS list.

CHAIRPERSON: One of my colleagues have a question to you on that thing, I can't remember now if it was?

ADV HASSIM: Let me get started first.

ADV BUTHELEZI: Well we cannot stand by these numbers as 100% because we've analysed these numbers prima facie without using people's names and surnames to give us an indication but with the margin of error if Naidoo wouldn't happen to be an Indian person or Khumalo wouldn't happen to be a black person we

allow for that ones but on that simplistic read and [intervenes]

ADV HASSIM: What did you do with Jones?

ADV BUTHELEZI: I beg your pardon.

CHAIRPERSON: Jones was mentioned yesterday.

ADV BUTHELEZI: Well but when you find Jones you're actually approaching Jones to where James name originates from so that.

ADV HASSIM: So then you use address?

ADV BUTHELEZI: I beg your pardon?

ADV HASSIM: What do you mean where originates from?

ADV BUTHELEZI: No we presume that if Jones appears, we presume Jones, Jones to be a person who originates from where Jones's name originally originates from. So we do not, it's a presumption. That's a presumption Commissioner.

ADV HASSIM: Where does it originate from, hê? Where does it originate from?

ADV BUTHELEZI: Jones?

ADV HASSIM: Ja.

ADV BUTHELEZI: Well I don't know where Jones originates from but it's not from this continent.

ADV HASSIM: Not from this continent? Okay.

ADV BUTHELEZI: He is not from this continent. It's simplistic, it's simplistic [intervenes]

CHAIRPERSON: If you see a name that appears neutral

you assume that's not black?

ADV BUTHELEZI: Indeed so.

CHAIRPERSON: All right.

ADV BUTHELEZI: Indeed so.

CHAIRPERSON: So your statistics are very, very conservative?

ADV BUTHELEZI: Yes indeed so and that's what we've done.

ADV HASSIM: What have you done? Explain to this table.

ADV BUTHELEZI: Well on that list that we've got that it shows dentists okay and 28.

ADV HASSIM: 32 white.

ADV BUTHELEZI: Dentists.

ADV HASSIM: But what are, why 32? 32 what [intervenes]

ADV BUTHELEZI: [Intervenes] yes on that list of.

ADV HASSIM: Right here.

ADV BUTHELEZI: Yes.

ADV HASSIM: And how many dentists are contracted with GEMS?

ADV BUTHELEZI: We don't know how many are contracted with GEMS we're just talking about this blacklist and what it represents. In other words of all the dentists that we could identify with our, our simplistic methodology we could believe we've got

reason to say 24 fall into the category of either being Indian or black of the 32 which constitutes like 80% of the total sample pulled and then the number goes into dieticians, optometrists, clinical psychologists and general practitioners. So the rest of them starting with the dental therapist all the way down to psychiatrist we could actually tell for example the physiotherapist, I mean the one oral hygienist is a 100%, it's one African person, there's no dismissing it. That register is countless 15 on that list, 15 of them are African names, registered nurses 8 of them, 8 African names, social workers, 33 social workers listed on that list. Make up either or, either Indian or African and that's it and that's the one statistic. But the most crucial statistic for me is the statistic from the health professional's council which is their recent publication and fraud cases lodged with them. This graph is from that presentation [intervenes]

CHAIRPERSON: Sorry just to go back to the paragraph 99, the last column which is, which has got percentages what is that 88%? Its 88% so which means its 88% African or Indian of 32?

ADV BUTHELEZI: No, no it's 80, it's a percentage of the sample.

CHAIRPERSON: Ja but it's 88 of that original, your starting base is 32?

ADV BUTHELEZI: So it's 28 over 32.

CHAIRPERSON: Ja that is what [intervenes]

ADV BUTHELEZI: Which gives you 88%.

CHAIRPERSON: 88%.

ADV BUTHELEZI: So of 38.

CHAIRPERSON: [Intervenes]

ADV BUTHELEZI: Of 38, of 32 dentists listed there.

CHAIRPERSON: Ja so it's 88 of 32.

ADV BUTHELEZI: Ja.

CHAIRPERSON: Ja that is not the problem what we want is the full list.

ADV BUTHELEZI: We've got it there chair.

CHAIRPERSON: No, no, no. What, how many dentists are contracted to GEMS? [Intervenes]

ADV BUTHELEZI: Well this is the people as, as a total [intervenes]

CHAIRPERSON: Precisely yes.

ADV BUTHELEZI: Well we don't have that number. Unfortunately what we're talking about is this notion of a blacklist and if you look at this, the demographic and the profile of the people on this list.

CHAIRPERSON: So I think the problem we're grappling with if I can just put it to you plainly so that you know maybe you can help in due course is that if that 88% correlates with the total number of contracted dentists then the statistics is neutral.

ADV BUTHELEZI: Indeed so Your Worship.

CHAIRPERSON: But if it is disproportionate then the statistics might mean something.

ADV BUTHELEZI: Indeed so Your Worship.

CHAIRPERSON: So at the moment what we have does not really help us to prove the case either way.

ADV BUTHELEZI: Between myself and you Chair you're more empowered to take the point further.

CHAIRPERSON: Yes ha-ha.

ADV BUTHELEZI: Ha-ha.

ADV HASSIM: Ha-ha.

ADV BUTHELEZI: And hence the question that we've put to you earlier to say [intervenes]

ADV HASSIM: You want us to get that information from GEMS? [Intervenes]

ADV BUTHELEZI: Yes you, you can then look at the total universe. You, you are now in the position to then look at the entire universe and tell us that this is nonsense or this is concerning. You can then use as a [indistinct] because what, what my initial position must be, was, was that all we seek is that the stats must be [indistinct] with whatever the general distribution of the demographic is. If we have 100% professional nurses all black then it makes sense that the list will have 100% all black but we want to have a representation of a number that fairly reflects the, the demographics as we have them put to us and where the challenges comes is in the next stage Chair [intervenes]

ADV HASSIM: At first brush this looks problematic but.

ADV BUTHELEZI: Yes.

ADV HASSIM: In off itself it does not establish.

ADV BUTHELEZI: No it does not.

ADV HASSIM: Racial profiling.

ADV BUTHELEZI: No it does not. No it does not, we cannot make that suggestion or that submission. Where it is concerning though is this next table for this May, June numbers. We've got the first column that talks about the complaint source. Now in other words is fraud claim forms made by the public and made by medical aid schemes in respect of legal representatives etcetera and it tallies them by race category. I've taken Indian, white there. Now members of the public have laid as per these stats eleven complaints against white Drs, 5 against Indian and 5 against African but in that sample of 21 complaints the white Drs are in the majority. Medical schemes on the other hand have laid 25 complaints against black Drs and one complaint against the white Dr.

ADV HASSIM: 25 against African?

ADV BUTHELEZI: Yes 25 against African.

ADV HASSIM: 28 against black?

ADV BUTHELEZI: Well if you combine black and African and Indian you get 28 and you get 1 complaint against a white Dr. I can take the point no further because our access to information is limited to things that gets surfaced to the public but this is what we are pointing to the commission's direction to say look these, these are the things that you need to be looking into and these are the numbers that the HPCSA sits with and they can produce, this is the

latest number for May, June. But if you were to analyse this number beyond that point we can take it no further and Chair I don't know if you've got any further questions but I think that's where the submissions end for me.

CHAIRPERSON: Thank you Mr Buthelezi perhaps we should go to Dr Mkhize then waiting her turn.

DR MKHIZE: Thank you Chair I will conclude, thank you Chair I will conclude the submission that has been made by my colleagues. This is in our view the biggest case of corporate fraud committed on the South African public and the medical profession as a whole that we have witnessed to date. The council for medical scheme is not only complacent but has aided and arbitrated this fraud by allowing the medical schemes to deliver, deliberately misinterpret the law and abuse it thereafter. They have in essence failed to fulfil their mandate and statutory obligation as a regulator. We therefore call upon the investigating panel to make a finding on the point that determination of losses as contemplated under section 59(3). We submit on a proper understanding of that the reign minimum of losses it will be clear that the medical schemes have not only acted unlawfully but have committed a crime so heinous against the South African public they also, they also stand to have their licences immediately suspended pending the outcome of a bigger investigation to take, to get to the very bottom of the, of this fraud. We also call upon the minister of health to immediately suspend the council for medical scheme if not completely abolish it and have its

function placed under another statutory body while its role in this fraud is also investigated. On the final analysis we identified the following problems. One the forensic audit process is flawed and needs to be properly regulated by a competent regulator and, and endorsed by HPCSA. The desktop audits using arithmetic and other software in particular have perpetrated an abuse of our legislation. The schemes are abusing legislation designed to eliminate fraud, waste and abuse to enrich themselves at the expense of patients and medical practitioners. If this is not true there should be evidence of monies recovered through audits being credited to patients and so far there is no such evidence. The acknowledgement of debt of more than a 1 000, R100 000.00 have even been signed by members of HPCSA are in our opinion fraudulent and unlawful. The law is clear that fraud and corruption detected by the scheme must be reported to the SAPS. How is it that each of, of the schemes have repeated failed to report more than 500 millions in fraud even for each year. The same misconduct should be reported to health care, health care professional's councils or the relevant statutory bodies. If the quantum of, of fraud and corruption is that high. It is our prayer to the investigating panel to find that the schemes have contravened regulation 6, section 59(2), section 59(3) and section 66 of the act. We pray that the investigating panel recommend the maximum sanctions as there are many health care providers that have lost their lives as a result of the schemes unlawful conduct. We also pray that any person found

to be in contravention of regulations 6, section 59(2) and section 59(3) of the medical scheme act be criminally charged in terms of section 66(1) of the act read with section 34(1) of the act of 2004.

CHAIRPERSON: Okay.

DR MKHIZE: Thank you.

DR GUMEDE: Lastly I would like to as a chairperson for the national health care and professional association to thank the panel of investigation and to also say that we have all the cases which we received that are many. We sent them to the SSMS hoping that they will reach you and we still also have lots of bundles of those evidence and we will request that you get this acknowledgment of debts from these medical aids. That's where you'll see the bulk of the real problem because if you look statistically they've made 28 billion, the BHF they will tell you that in their statistics last year apparently in fraud, waste and mismanagement. Apparently that's a lot of money, it's a huge figure. 28 billion and now if they make that 28 billion how many people if you look at it in twelve months.

CHAIRPERSON: Mr Gumede where do you get the 28 billion from because my understanding of what, I mean from I think because this is a public platform?

DR GUMEDE: Yes.

CHAIRPERSON: You know news can quickly spread.

DR GUMEDE: Okay.

CHAIRPERSON: If they're not properly managed. My

understanding of what BHF says is that 28 billion is the estimated loss from FWA [intervenes]

DR GUMEDE: [Intervenes]

CHAIRPERSON: It is not as if they have made 28 billion.

DR GUMEDE: Yes but that's what I'm saying. That if they've lost that money you, yes if they've lost that money that's, that's my point yes. So we, we, we, we have requested that you get that and also the, be cognisance of the fact that the HPSA list like I said it might not be the same with the list that they have but that's the good part about it because it will emphasise this point that I'm saying that most of the people that get reported is those who refuse to sign this acknowledgement of debts. Those who sign this acknowledgement of debts, the majority of them they do not report them. So you might get that information. We want to investigate also why those people that they had made to sign acknowledgement of debt they were not reported to the council or to the relevant authorities because that's, that's, that's very important and the reason, and another thing is we ask the medical aids when we met at the human rights commission do they investigate all the frauds that is flagged by the algorithms, they said not they only investigate some. But that is because we are asking them because we know that the majority of people that they investigate they're investigating the black ones so it doesn't mean the algorithm probably doesn't flag our white counterpart but because maybe the, the because of whatever reason that they have they don't investigate them and the

chairperson even said to them but fraud is fraud. Even if it's R5.00 or it is committed by way of that it must be investigated. So we are saying no to fraud by all health care professionals and if we indeed want to uproot fraud we need to be, to act seriously, we can't wishy washy about it. If it's indeed fraud we can't be talking, you say we are losing 28 billion and then you're not doing anything about it, you're just encouraging people to sign acknowledgement of debt year in and year out. You don't report it to the relevant authorities, they pay you back. You don't report it to the police. There is nothing that is structured to, to combat the, the behaviour so we believe that, that is not right. And it took us, its coercion and extortion because they know what we have realised is as administrators if they pay you more money they will come for you. All the practices which have few medical aids they are never visited but if you see lots of patients and their horrible things that we can share with you where they'll phone your wife and ask what time does your husband come home while he is seeing 35 patients. Yes and I mean that's, that's abuse and we are saying let's respect each other, let the patients be respected, let the medical aids be respected and let the health care professionals be respected so that we have a proper health care system in our country thank you.

CHAIRPERSON: Thank you Dr, thank you Dr Gumede. I want to thank your association the national health care providers association not only for your efforts in, in this panel setup but also in coming through with your presentation which has been very

enlightening and indeed helpful to us. So you might be requested for more information, you might be called back for clarity and you might be called back for other engagements on a bilateral basis with the panel.

Chair?

CHAIRPERSON: Yes Mr [intervenes]?

ADV BUTHELEZI: I've got an additional instruction that i.

CHAIRPERSON: Say again?

ADV BUTHELEZI: An additional instruction that I have to make regarding the process going forward for my clients, we want the money back.

CHAIRPERSON: Sir you have an instruction?

ADV BUTHELEZI: To say he's asked me to make this point on his behalf.

CHAIRPERSON: Oh is see what's the point?

ADV BUTHELEZI: No to say that the point is to solicit the money, not to solicit a response from the panel. He says, he says we couldn't leave here without having made this point and the point is we want this money back and we are going to fetch this money and in fetching this money Chair we're also going to fetch government money which government is a contributor to the schemes and if fraudulent money or fraud is committed against government after we part here from you our next appointment is with the office of the public protector to look into possibly government monies or state monies from government employees and state

owned enterprises that have been unlawfully withheld by the schemes and thereafter we may find our way to the courts to quantify the money that is due to us based on these points. Thank you Chair.

CHAIRPERSON: Good luck. The session is adjourned until tomorrow at 10:00. Tomorrow being the 1 August we will start with the national, no sorry with the South African medical association exactly at 10:00 and then in the afternoon we will have the independent practitioners association. We are adjourned thank you.

PROCEEDINGS ADJOURN

END OF AUDIO